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# The Role of Feelings in Informed Consent: An Application of Bernard Lonergan's Work on Affect and Cognition

by

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A dissertation submitted to the Faculty of Theology, St. Paul's University
in partial fulfillment of the requirements for the Degree of
Doctor of Philosophy and Doctor of Theology

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# The Role of Feelings in Informed Consent: An Application of Bernard Lonergan's Work on Affect and Cognition

## Abstract

Without the unprecedented progress which was experienced in the medical sciences during the last 150 years, it is unlikely that the legal doctrine of informed consent would have arisen. As a result of the advances and treatment innovations, claims against physicians became more common. The legal doctrine arose out of the realization that it was unethical to exclude the patient from choices concerning his/her treatment. As such it was paradigmatic of a relationship between the law and morality, in which morality informs the law and not vice-versa.

However, this attempt at addressing an ethical issue by using the law as a guide and the ensuing shift in focus from trust in the physician's beneficence to the rights, autonomy and self-determination of the patient has created another problem in that it has strengthened the alienating behaviour common to many physicians, that of talking at patients rather than with them.

The legal doctrine of informed consent has become an overly bureaucratic, impersonal, legal document which fails to adequately consider the highly personal nature of the physician-patient professional relationship. Further, the malaise in the doctrine of informed consent not only has implications for the practice of medicine but also for the authenticity of the human person, since, from an ethical and moral theological perspective, consent (from the Latin *consentire* — to feel or sense with) touches the entirety of the human subject as a person endowed with freedom, rationality and feelings.

Given the integrity of the human person as a combination of both intellect and affect, consent as an expression of the combined faculties of reason and feelings implies a far more significant human action than a verbal expression or a written word. It is essentially a dynamic process of ongoing decision making which precludes its being limited to a mere rational-cognitive perspective.

It is the hypothesis of this thesis that if feelings are interpreted and included in the process of decision making in the way in which Bernard Lonergan suggests, we could not only rehabilitate the doctrine of informed consent to a patient-focussed experience but we might also transform it into an effective therapeutic tool that is capable of encouraging human authenticity and enhancing the physician-patient relationship.

In attempting to provide a new framework for informed consent, this thesis attempts to reshape the process of discourse. Since the expression of the affective has cultural variations, it has implications not only for personal authenticity, but also for societal transformation. This thesis will be both an analytical argument delving into the structure of informed consent and an attempt at formulating a new foundation for consent which blends the theological with the medico-legal.

# Dedication

This work is dedicated to my family whose support and patience gave me the courage to complete this work. To them, particularly my husband Christopher, I want to say thank you. Your faith in my ability to succeed in what I set out to do has nurtured this writing. Without the sacrifices that you made throughout the years in which I was engaged in this academic adventure, I could never have succeeded. Thank you for your love.

"*These three remain, faith, hope and love, but the greatest of these is love*."

# Acknowledgements

This journey has been influenced by many people. First and most importantly, my family to whom this work is dedicated. To my husband Christopher, my sons Jason and Adam, and their wives Valerie and Melanie who understood throughout the years the need to have protected time to write and study, thank you. Their commitment to supporting me through this process was evidenced in many moments throughout the years, most recently in their accepting that I needed to read this work during the hours in which we were all gathered at Women's College Hospital awaiting the birth of the newest arrivals to our family, Jason and Valerie's twins, Jacob and his sister Jamie who were born only a few hours before I had to leave for Ottawa to defend this dissertation. To my mother Lenore McFadyen and my mother-in-law Margaret Markwell my heartfelt thanks for all of the years of encouragement and love and for the joy in your faces as you watched my defence. To my father, Walter McFadyen and my father-in-law Ian Markwell, both of whom died before the completion of this work, thank you for always encouraging me to follow my dreams and for your unwavering belief in me.

To my friends and colleagues who encouraged me through the various stages of this thesis, thank you. Particular thanks to: Marilyn Bruner, CEO of St. Joseph's Hospital, Toronto, Marion Leslie, past CEO of Providence Centre, Toronto, Mary Beth Montcalm, CEO of Providence Centre, Toronto, and Jeff Lozon, CEO of St. Michael's Hospital, Toronto who generously allowed me to take time away from work and encouraged and supported my endeavors and to Lynda Sullivan and Rosemary MacDonald for their questions, editing and research skills.

To my friends and colleagues at St. Paul's University, I also extend my heartfelt thanks. Dr. Ken Melchin's knowledge of developments in Lonergan studies helped to keep this work current. His encouragement and words of support carried me through many crucial moments in the unfolding of this dissertation. Similarly Dr. Gregory Walters was invaluable in helping to place this work within recent developments in virtue ethics and also in encouraging me throughout the years. Dr. Noel Simard's comments regarding the theological significance of this work helped to keep me more focussed at my defence. Elise Larocque was a voice of calm and support in the many phone calls throughout the year which led up to my defence. Dr. Ramon Martinez de Pison helped in many instances to keep me on the right track as I approached the end of the process. My director Dr. Hubert Doucet, provided many words of wisdom throughout the years and agreed to direct this thesis even after leaving St. Paul's University for a new position at the University of Montreal. I am very grateful to all of you for your support. Thanks also to my external reader, Dr. Mark Miller, whose thoughtful and careful reading resulted in many key suggestions for future work.

Finally, none of this could have happened without the many patients, families and care-givers whose often painful experiences provided the foundation from which to begin to develop an improved model of informed consent. Thank you for allowing me to enter into your world and to share in your struggles. I am forever grateful to have met you and to have witnessed your courage and commitment to the patients and loved ones you have cared for.

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## Introduction

Without the unprecedented progress which was experienced in the medical sciences during the last 150 years, it is unlikely that the legal doctrine of informed consent would have arisen.[1] At the outset it must be noted that the Canadian articulation of the legal doctrine of informed consent arose out of its development in the American context. While there are certainly differences in its articulation in practice, the author believes that these are not significant in that they share the same legal roots in English common law and are both grounded in the same ethical principles of autonomy, beneficence and non-maleficence. As such, we will speak of the legal doctrine of consent interchangeably between the U.S. and Canadian contexts. Nonetheless, it is as a result of the advances and treatment innovations that claims against physicians became more common. These were rooted in the English common law concerning battery,[2] in which non-consensual touching of a patient by a

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[1] For a discussion of the relationship between medical advances and informed consent, see Jay Katz, *The Silent World of Doctor and Patient* (New York: The Free Press, 1984), p. xvi.

[2] The earliest reported case which dealt with consent to treatment is commonly accepted as *Slater v. Baker* and Stapleton, 95 Eng. Rep. 860 (K.B. 1767). In this case, the patient, Mr. Slater, sued his surgeon, Dr. Baker, and Dr. Baker's assistant, Mr. Stapleton, an apothecary, for restraining him and re-fracturing his leg against his expressed wishes in order to attempt to lengthen his leg following the development of a post-fracture callous. See also "The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research," *Making Health Care Decisions: A Report on the Ethical and Legal Implications of Informed Consent in the Patient-Practioner Relationship*, Vol. 1, (Washington, D.C.: US Government Printing Office,1982), p. 13, footnote number 3. This report notes that "non consensual medical treatment involves either a harmful or offensive touching of the person and has therefore long been remediable, at least in theory, under the writ of trespass.

physician was considered a criminal offence. In its early history, few of these cases were focussed on the need to disclose information to patients, but rather were limited to the protection of patients against unauthorized procedures. Although a patient had the right to refuse treatment, he/she did not at this point have the right to be properly informed as to the risks, benefits, or alternative possibilities for medical intervention. Not until 1957 with *Salgo v. Leland Stanford Jr. University Board of Trustees*,[3] did the courts begin to synthesize the duty to gain consent with the duty to warn, or an obligation to disclose risks and benefits, a synthesis which formed the embryonic stage of the doctrine of informed consent. The legal doctrine therefore arose out of the realization that it was unethical to exclude the patient from choices concerning his/her treatment. As such it was paradigmatic of a relationship between the law and morality, in which morality informs the law and not vice-versa.

However, it has been suggested that this attempt at addressing an ethical issue by using the law as a guide and the ensuing shift in focus from trust in the physician's beneficence to the rights, autonomy and self-determination of the patient has created another problem: it has strengthened the alienating behaviour common to many physicians, that of talking at patients rather than with them.[4] In fact, as the

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[3] Salgo v. Leland Stanford Jr. University Board of Trustees, 317P. 2d 170 (Cal. Dist. Ct. App. 1957), cited in Katz, *The Silent World of Doctor and Patient*, p. 60. This case involved a man, who following aortography for leg cramps, was permanently paralyzed.

[4] *Making Health Care Decisions*, p. 172.

President's Commission suggests, the legal doctrine of informed consent is an overly bureaucratic, impersonal, legal document which fails to adequately consider the highly personal nature of the physician-patient professional relationship.[5]

It appears that there has been a further paradigm shift in the relationship between law and morality, from a law informed by morality to a morality determined by and expressed in the law. It is this author's opinion that the effort to address the issue of medical paternalism has given rise to an unsuitable legal adversarial model which is overly rationalistic and therefore does not meet the needs of the patient.[6] Further, the malaise in the doctrine of informed consent not only has implications for the practice of medicine but also for the authenticity of the human person, since from an ethical and moral theological perspective, consent (from the Latin *consentire* — to feel or sense with) touches the entirety of the human subject as a person endowed with freedom, rationality and feelings. In making decisions which are oriented toward that which is valuable for us, we constitute ourselves as human beings who are capable of "moral self-transcendence, of benevolence and beneficence, of true

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[5] *Making Health Care Decisions*, p. 26.

[6] For an elaboration on this issue see Howard Brody, "Transparency: Informed Consent in Primary Care," *Hastings Center Report* (September/October 1989), pp. 5-9. Regarding the concept of informed consent, Body writes, "It is worth asking whether current legal standards for informed consent tend to resolve the problem or to exacerbate it. I will maintain that accepted legal standards, at least in the form commonly employed by the courts, send physicians the wrong message about what is expected of them."

loving."[7] In other words, when we make good choices, we ourselves become better persons.

In clinical care and in medical practice, informed consent has often been assessed from the point of view of the medical expertise made available to a patient. This approach has been pointed out[8] as being overtly centred on the medico-technical knowledge dispensed to the patient by the physician, almost indirectly prompting the patient to confirm the physician's choice of medical treatment. The emphasis therefore is placed on the rational and cognitive aspects of obtaining the patient's consent, visibly manifested by the patient placing his/her signature on a sheet of paper. It is this author's opinion that this approach has reduced informed consent to a mere intellectual assent devoid of full and total personal involvement and participation of the patient in his/her role as a human subject. This full involvement is the source of a diversity of intra-personal and interpersonal relationships guided, nurtured and healed by a host of feelings, which forms an intimate component of the person as a decision making subject. Given the integrity of the human person as a combination of both intellect and affect, consent as an expression of the combined faculties of reason and feelings implies a far more

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[7] See Bernard Lonergan, *Method in Theology*, second edition (London: Darton, Longman & Todd, 1973), p. 37, for a discussion of the relationship between making choices and authenticity.

[8] This is the position taken by Jay Katz in *The Silent World of Doctor and Patient*.

significant human action than a verbal expression or a written word. It is essentially a dynamic process of ongoing decision making which precludes its being limited to a mere rational-cognitive perspective. Approaches which fail to see the expression of consent as a process of decision making pay little or no attention to the way in which feelings play a determinant role, particularly in decision-making processes that involve the entire person's biological, psychological and spiritual life and well being.

Thus, there exists a problem which raises questions:

> 1) What is the role of feelings in decision making and, in particular, in a specialized aspect of decision making, i.e., informed consent?
>
> 2) What would informed consent look like in medical practice if we allowed the participation of feelings?

In addressing these questions, the writer will pursue the objective of this thesis, which is to complement the legal doctrine of informed consent with a practical application that enriches the legal dimension: i.e., to add the aspect of feelings to the present legalistic and rationalistic doctrine of informed consent, which not only does not meet the needs of the patient but also has created a rift in the physician-patient relationship. While there have been attempts to address the difficulties in informed consent, it is the belief of the author that inherent to these attempts is the role of the affective component of human personhood. It is here that the theological anthropology of Bernard Lonergan can provide a foundation from which to begin to complement the existing model of consent. Lonergan is not the only author to write

on the role of feelings and cognition, nor is he the only theologian to write on the authenticity of the human subject. However, he is unique in that he links human authenticity and flourishing to understanding and decision, and understanding and decision to feelings and intellect. As such, his work provides a unique foundation from which to pursue the objective of this thesis, which is to complement the legal doctrine with a practical application which encompasses the legal dimension, i.e., by adding the dimension of feelings to informed consent.

It is the hypothesis of this thesis that if feelings are interpreted and included in the process of decision making in the way in which Bernard Lonergan suggests, we would not only rehabilitate the doctrine of informed consent to a patient-focussed experience but we might also transform it into an effective therapeutic tool capable of encouraging human authenticity and therefore enhancing the physician-patient relationship. This will become particularly clear in the final chapter of this thesis, which will focus on how this new framework impacts the realm of decision making involving the clinician/patient and family. In attempting to provide a new framework for informed consent, this thesis attempts to reshape the process of discourse. Since the expression of the affective has cultural variations, it has implications not only for personal authenticity, but also for societal transformation. However, it must be made clear at the outset that the author is not implying that the practice of informed consent is exactly the same across cultures. In fact, we know according to research that even

the principles embedded in the doctrine of informed consent, particularly the duty to disclose, are not necessarily applied in other cultures.[9]

While there is a body of literature on the cognitive function of feelings, very little has been written on the theological significance of the inclusion of feelings in the process of decision making. Similarly, while medical curricula acknowledge the importance of empathy in the therapeutic relationship, few address feelings and ethical decision making in the medical forum.[10] This project would provide a theological approach to the function of feelings in a specific form of decision making in medicine — i.e., informed consent. As such it would be a unique synthesis of the theological with the medico-legal.

This thesis will be both an analytical argument delving into the structure of informed consent and an attempt at formulating a new foundation for consent which blends the theological with the medico-legal. This will necessitate different approaches at each stage of development. It will be presented through the following steps:

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[9] See Kenneth G. Marshall, "Prevention: How Much Harm? How Much Benefit? The Ethics of Informed Consent for Preventive Screening Programs," *Canadian Medical Association Journal* 155, 4 (August 15, 1996), pp. 377-83.

[10] E.S. More and M.A. Milligan, eds., *The Empathic Practitioner* (New Brunswick, N.J.: Rutgers University Press, 1994); Timothy E. Quill, "Barriers to Effective Communication," in *The Medical Interview*, edited by Mack Lipkin, Samuel M. Putnam, and Aaron Lazare (New York: Springer-Verlag, 1995), pp.110-21; H. Spiro, "What is Empathy and Can It Be Taught?" *Annals of Internal Medicine* 116, 10 (1992), pp. 843-46.

1. In its early history, relative to the issue of patient involvement in treatment decisions, bioethics was focussed on the need for compassion towards the patient who was suffering as a result of medical experimentation.[11] Although the legal articulation of the informed consent doctrine was rooted in the English common law concerning battery, it arose out of this need to respond to an ethical problem, i.e., the exclusion of the patient from medical choices regarding his/her treatment. The doctrine of informed consent is the legal articulation of a response to an ethical problem. The legal articulation was not intended to state, nor should it remain, the definitive response to the ethical questions surrounding the involvement of patients in medical decisions. While ethics and the law are linked, the law cannot and must not preclude or replace the need for ongoing ethical reflection on the needs of patients. Unfortunately, however, the legalistic reduction of an ethical problem is but one example of a cultural shift in which morality is seen as an expression of the law.[12] As a result, dissemination of information has been equated with knowledge and human understanding limited to rationality.

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[11] See Hubert Doucet, *Au pays de la bioéthique: l'ethique biomédicale aux Etas-Unis*[French], (Génève: Labor et Fides, 1996), p. 25. Doucet notes that around the time of the founding of the Hastings Centre and the Kennedy Institute of Ethics, two major themes also arose. "Le premier est celui de la protection des sujets vulnérables . . . Le second a trait au consentement éclairé qui naissait à peine dans le domaine du droit médical américain."

[12] See Hubert Doucet, *Au pays de la bioéthique*, pp. 51-53. Doucet notes that our moral principles have become juridical precepts as set out in the Canadian Charter of Rights.

Chapter One will present the development and shift in values that are intrinsically connected to the historical development of the doctrine. This will involve not only a discussion of the legal aspect of consent, but also three existing models for consent, the first of which is focussed on beneficence towards the patient, the second of which is focussed more on the common good, and the third of which is primarily focussed on the law — i.e., 1) The Patient Benefit Theory of Informed Consent 2) The Social Benefit Theory of Informed Consent and 3) The Self-determination Theory of Informed Consent. This discussion will serve to pinpoint the limits in the doctrine as it presently stands by showing that in practice each of the models of consent is inadequate on its own.

2. It is from within this cultural milieu that "principle-based" ethics arose with the ensuing attempt at correction seen in the "narrative-based" and "virtue-based" ethical frameworks. However, as Pellegrino and Thomasma note, the standards and guidelines of principlism must be linked to and encompass a virtue and care-based ethic.[13]

Chapter Two will provide an exposition of the work that has been done in these two areas of ethics. The focus of this chapter will be on the work of

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[13] Edmund D. Pellegrino and David C. Thomasma, *The Virtues in Medical Practice* (New York: Oxford University Press, 1993).

those authors dealing with models which focus on the relational structure between physician and patient. We will not provide an exhaustive study of these fields but rather we will focus on selected writings of Dr. J. Katz, Dr. H. Brody, Dr. E. Pellegrino, Dr. D. Thomasma, Dr. R. Charon and Dr. W. F. May, because they are simultaneously critics of the present relationship between physician and patient while supportive of the role of feelings in the therapeutic alliance and therefore medical decision making.

Chapter Two will begin by exploring Jay Katz's proposal for a model of conversation and Brody's development of the conversation model by the addition of his "transparency standard." It will then discuss the attempt of Pellegrino and Thomasma to blend virtues, principles and duties. Finally it will discuss the work of Rita Charon and William F. May and the implicit emphasis on the role of feelings in their work. In making the distinction between the "what," or the tactics and data involved in evaluating cases in medical ethics, and the "how," or the manner and decorum with which one imparts the data, May notes that not only is the "how" more important, but that it is ultimately dependent "upon the character and the virtue of the actor."[14] In calling for a focus on the "how," we get a sense of the belief in the connection between an

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[14]William F. May, "Commentary: Listening Carefully," *Second Opinion* 20, 1 (July 1994), p. 47.

affective component to decision making and the authenticity of the person engaged in making choices.

Similarly, Charon points to the limits of the rationalistic and scientific approach to patient care and notes that while medicine has made good progress in the areas of diagnosis and therapy, it has not had the same success in the area of recognizing human suffering. As a result of this situation, she challenges physicians to comprehend "their patients' suffering so that they can accompany patients through illnesses with empathy, respect and effective care."[15] Throughout Charon's work, we see evidence of a focus on the affective element of human interaction, and its relationship to the therapeutic alliance.

This analysis will set the stage for the hypothesis of this thesis, which is that feelings must play a crucial role in every successful model of informed consent.

3. Both the sterile approach of principlism with its focus on the intellect and the approach of care-based ethics, with its focus on feelings, are, however, insufficient on their own. Just as the intellect and feelings are mutually

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[15] Rita Charon et al., "Literature and Medicine: Contributions to Clinical Practice," *Annals of Internal Medicine* 122, 8 (April 15, 1995), p. 599.

corrective in the human person, so too should they be in ethics.[16] With the sustained theological efforts made in the post-Vatican II era, we often hear of the focus on the human subject as the centre but not locus of all rights, duties, responsibilities and obligations. Personalism and humanism coupled with the reinforcement of the fundamental values of freedom, dignity and subjective self-determination have to a large extent contributed in the last five decades of this eventful century to reemphasise and restore the centrality of the human subject. Here again the positive and creative role of feelings has received greater attention and emphasis. The issue then of the role of feelings in decision making in general is foundational to a discussion of their role in the specialized area of decision making that is informed consent.

Chapter Three will present a systematic analysis of Bernard Lonergan's work on feelings as it relates to his notion of the human person who struggles for authenticity. This analysis will serve to provide the groundwork for complementing the present model of consent with a practical application that is focussed on the patient's desire to make decisions which are right and true and good for him/herself and on the consequences of making those decisions in terms of personal authenticity. Here the method is both descriptive as well

[16] See Erich H. Loewy, "Care Ethics: A Concept in Search of a Framework," *Cambridge Quarterly of Healthcare Ethics* 4, 1 (Winter 1995 ), pp.56-63.

as interpretive in that it will involve a reading of Lonergan's earlier writings in light of his later works in which this issue underwent further development.

4. The final section will sketch a theological approach to the role that feelings might play in informed consent. The section will suggest that all prior approaches of rehabilitating informed consent do not go far enough in focussing on the needs of the patient who is in need of both medical and spiritual healing, and are therefore doomed to failure. The example of psychiatry will be used to demonstrate that there is a multi-faceted complexity to the relationship between feelings and consent. In fact, current research being done in the area of psychiatry and informed consent suggests that informed consent itself may be therapeutic.[17] By borrowing from Lonergan's position on feelings, we will argue that his work provides a new and more authentically human framework for addressing the issue of consent, and therefore can make a substantial contribution to the area of medical ethics.

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[17]See J. Marta and F. H. Lowy, "Le consentement éclairé: un atout pour la psychothérapie?" *The Canadian Journal of Psychiatry* 38 (1993): 547-51; also Peter S. Jenson, A.M. Josephson , and J. Frey, "Informed Consent As A Framework For Treatment: Ethical and Therapeutic Considerations," *The American Journal of Psychotherapy* 153, 3 (1989), pp. 378-86.

## Chapter One

## From Medical Paternalism to Legal Adversaries

Before one begins to embark on developing an improved model of consent, it is important to understand the historical development of the doctrine. While many have written on this topic,[1] the first section of this chapter will focus on a review of Jay Katz's work in this area. Katz's work is important to this thesis because he looks at the legal development of the doctrine of consent in light of what it was intended to do, i.e., articulate a legal response to a moral problem. His analysis concludes with the judgment that the doctrine of consent has failed in this regard.

The chapter will proceed with a review of three models of consent and a discussion of the values which they are attempting to articulate. The first model focusses on beneficence towards the patient, the second on the common good, while the third model focusses primarily on the law. From this theoretical discussion of models grounded in various ethical theories, the chapter will turn to a more concrete discussion of how informed consent works in practice. This section will begin with a discussion of criteria for determining the validity of consent. While the doctrine of informed consent is grounded in the belief that patients have the right to make choices regarding their bodies, this right is dependent on their capacity to make

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[1] See Ruth R. Faden and Tom L. Beauchamp, *A History and Theory of Informed Consent* (New York: Oxford University Press, 1986).

decisions. Of crucial importance to this thesis is a notion of capacity as encompassing not only one's cognitive capacity but also and equally, in this author's opinion, affective capacity. The chapter will further proceed from this understanding of capacity to a discussion of how one determines another's capacity. The discussion will conclude with a summary of the difficulties inherent in the process of informed consent.

## 1.1 History of the Legal Doctrine of Informed Consent

One sees a reaffirmation of the narrow right of refusal typical of the early stages of the legal doctrine of informed consent in two early twentieth-century cases, *Pratt v. Davis (1905)* and *Schloendorff v. The Society of the New York Hospital (1914)*.[2] The *Schloendorff* case in particular is worth noting, in that Justice Cardoza laid some of the groundwork for a patient's right to self-determination in noting that

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body: and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages.

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[2] Katz, *The Silent World of Doctor and Patient*, pp. 50-53. In Pratt v. Davis, Mrs. Davis sued her physician, Dr. Pratt, for operating on her without informing her of the nature of the surgery. While Mrs. Davis believed that the surgery was required to cure her epilepsy, she did not realize that it would involve the removal of her uterus and ovaries. In Schloendorff v. The Society of New York Hospital, Mrs. Schloendorff sued her surgeon for removing a fibroid tumour without consent. While Mrs. Schloendorff had agreed to an examination under ether, she had told her surgeon that she did not want any operations.

However, these words cannot be taken out of context in the sense that one needs to be aware that Justice Cardoza was not concerned with defining the need to provide information to a patient in order that he/she might consent. In fact, his denial of damages to the patient in this instance provides further evidence that the law at this time was not concerned with the relationship between the process of disclosure/ consent and self-determination. While cases such as *Haskings v. Howard (1929)*[3] indicated some support for patient participation in decision making, such instances were not indicative of the general legal mood. In fact as late as *Hunt v. Bradshaw (1955),*[4] there was still evidence of a disregard for both disclosure and consent.

Not until 1957, did the courts begin to synthesize the duty to gain consent, with the duty to warn, or an obligation to disclose risks and benefits: a synthesis

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[3] Haskins v. Howard, 16 S.W. 2d (Tenn. 1929). This case involved a woman with suspicion of ovarian tumour. Dr. Haskins had operated on this patient despite the possibility that she was pregnant. When a miscarriage ensued the appellate court found the physician not only guilty of lack of good care but also guilty of having failed to adequately disclose the risks involved.

[4] Hunt v. Bradshaw, 88 S.E. 2d 762 N.C. 1955). This case involved an operation for removal of foreign body in the upper left quadrant of a patient's chest following a work-related injury. When asked by the patient, John Hunt, as to the seriousness of the operation, Dr. Bradshaw responded by saying that risk was minimal. Following surgery, Hunt was unable to use his fingers. The case was dismissed due to lack of expert testimony on the plaintiff's side and was affirmed by the Tennessee Supreme Court on appeal. Relative to the lack of disclosure, the court noted that it was "understandable [that] the surgeon wanted to reassure the patient so that he would not go to the operating room unduly apprehensive. Failure to explain the risk involved, therefore, may be considered a mistake on the part of the surgeon, but under the facts cannot be deemed such want of ordinary care as to import liability."

which formed the embryonic stage of the doctrine of informed consent. Now, it was no longer considered adequate to merely let patients know what the physician planned to do, but rather the patient too now had a role to play in the process of decision making, in that it was his/her right to decide whether or not intervention was acceptable in light of the risk/benefit relationship. The phrase "informed consent" first came into being on October 22, 1957 in *Salgo v. Leland Standford Jr. University Board of Trustees (1957)*[5] and was later affirmed in two opinions by the Kansas Supreme Court in *Natanson v. Kline (1960)*.[6] In Natanson, and other cases like it,[7] the court noted that patient consent alone is an insufficient defence against negligence. Justice Bray, in Salgo v. Leland Standford Jr. University Board of Trustees, in attempting to answer the question as to how much information should be disclosed, or withheld in order to elicit a non-induced consent, noted that

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[5] See Introduction, footnote no. 3.

[6] Natanson v. Kline, 350 P. 2d 1093 (Kan. 1960). This case involved a woman who had been severely burned by radiation therapy to her chest. She sued on the grounds that the potential dangers had not been adequately disclosed.

[7] See Mitchell v. Robinson, 334 SW 2d 11 (Mo 1960), in which the patient, having received ECT as a treatment for schizophrenia and having suffered several fractured vertebrae, won damages in court. For an excellent discussion of further examples of legal precedents in informed consent, see Alan Meisel, Loren H. Roth, and Charles W. Lidz, "Toward a Model of the Legal Doctrine of Informed Consent," *American Journal of Psychiatry*, 134, 3 (March 1997), pp. 285-289.

> A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment.[8]

However, in attempting to answer the question as to how a physician avoided frightening an already anxious patient while at the same time disclosing adequate information in order that a decision might be made, one becomes aware that while *Salgo* generated significant discussion and introduced the term "informed consent", Justice Bray's words did not clarify the law. In fact in noting that discretion should be used in disclosing how much risk was involved in a particular intervention, while at the same time noting that it was a violation of a physician's duty to withhold any facts, Bray appeared to be speaking at cross purposes. Jay Katz speaks of this apparent conflict in direction and notes

> Thus it is not surprising that the informed consent part of the *Salgo* opinion has all the eyemarks of a dream, though not one originally dreamed by Justice Bray, as I once thought, but one elaborated by the surgeons and lawyers in the twilight of their deliberations . . . Similarly, only self-conscious reflection can make it clear that such contradictory intentions as 'full disclosure of facts' and 'professional discretion' are reconcilable only in the kingdom of dreams.[9]

Regardless of its shortcomings, *Salgo* effectively began a process which compelled medicine to relinquish its feudal habits relative to disclosure. Similarly in *Natanson v. Kline,* which is recognized as being a landmark in the advancement of the doctrine of informed consent, one sees a similar difficulty in Justice Schroeder's

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[8] Salgo v. Leland as cited in Katz, *The Silent World of Doctor and Patient*, p. 61.

[9] Jay Katz, *The Silent World of Doctor and Patient*, p. 63.

attempt to marry patient self-determination with the competing laws of negligence and battery. Schroeder's judgment was clear in noting that the treatment of Mrs. Natanson was not assault and battery since she had in fact given some consent, rather than no consent. However, his attempt to distinguish between unauthorized treatments and battery was at best problematic. He noted

> What appears to distinguish the case of the unauthorized surgery or treatment from traditional assault and battery cases is the fact that in almost all the cases the physician is acting in relatively good faith for the benefit of the patient . . . The traditional assault and battery involves a defendant who is acting for the most part out of malice or in a manner generally considered as 'antisocial.' One who commits an assault and battery is not seeking to confer any benefit upon the one assaulted.
>
> The fundamental distinction between assault and battery on the one hand, and negligence such as would constitute malpractice, on the other, is that the former is intentional and the latter unintentional.[10]

However, in placing the focus on negligence law rather than battery, Justice Schroeder in essence placed additional burden on the patient, by requiring that he/she prove that fuller disclosure would have resulted in a refusal of treatment. While the next and final landmark decision relative to informed consent (*Canterbury v. Spence*)[11] was an improvement on the *Natanson* judgment, Judge Robinson of

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[10] Canterbury v. Spence as cited in Katz, *The Silent World of Doctor and Patient*, p. 67.

[11] Canterbury v. Spence, 464 F. 2d 772, 784 (D.C. Cir. 1972). This case involved a 19-year-old man who had a laminectomy for back pain. Following surgery he was paralysed and incontinent of urine and feces and sued the physician for negligent performance of surgery as well as negligent failure to disclose the risk of paralysis.

Canterbury, like Justice Schroeder before him, rejected battery and based the requirement to disclose in negligence law. As such, while *Canterbury v. Spence* essentially failed to promote patient self-determination, it did raise the crucial issue of what a reasonable standard for disclosure might be.

One sees a similar difficulty in the two Canadian cases which marked the birth of the legal doctrine of informed consent in Canada — *Reibl v. Hughes*[12] and *Arndt v. Smith*.[13] Both of these cases resulted in negligence findings, levied because of the court's position that there had not been adequate disclosure. These cases and other like them pointed to the inadequacy of the legal requirement to disclose, particularly when consent goes beyond the technical aspects that accompany medical procedures. As a result of the judicial systems' findings in these cases, Mr. Justice Allen Linden was prompted to say,

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[12] In Reibl v. Hughes, the patient consented to surgery to repair an artery in the neck. While this was done to reduce the risk of stroke, the patient in fact suffered a massive and debilitating stroke. Here the courts ruled that disclosure had been inadequate. However, while this case involved a surgical intervention, the application of this precedent to other cases not involving surgery has proven contentious.

[13] In Arndt v. Smith, the patient Mrs. Arndt contracted chicken pox in her 12th or 13th week of pregnancy. When she contacted her doctor, Margaret Smith to ask about possible consequences for the fetus, she was informed that there were risks of limb and skin abnormalities. She was not informed of other more serious but less frequent occurrences. When her baby was born with congenital varicella syndrome, and was permanently unable to eat as a result, therefore requiring tube feeding, Mrs. Arndt sued her physician on the grounds that she had not been adequately informed. While the judge ruled that chicken pox had caused the deformity and that the physician was negligent in not adequately disclosing risks, he did not draw a causal link between negligence and the birth defect and therefore no damages were awarded.

> Under the reasonable patient standard, the patient's right to know is no longer to be limited by what the medical profession customarily tells them; henceforth, the patients' right to be able to make an intelligent choice about any proposed surgery transcends the interests of the medical profession in setting its own autonomous standards of disclosure.[14]

However, many questions remain for physicians, such as "Is it possible to inform patients of all risks?" and "Is it in every patient's best interest to do so?" In fact, not only do some physicians[15] still believe that it is impossible to inform patients, they also maintain that the process of informed consent increases anxiety and is not in every patient's best interest. Very few caregivers "realize that the requirements of informed consent can be met in a manner that improves, and does not impede, patient care."[16] It appears that most of these criticisms arise out of a belief that

> there is a fundamental incompatibility between the patient autonomy that informed consent is intended to promote and physician responsibility for a patient's well-being and on the fear that well-being will be severely compromised.[17]

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[14] As cited in Anne Gilmore, "The Nature of Informed Consent," *Canadian Medical Association Journal* 132, 10 (May 15, 1985), pp. 1198-1203.

[15] For an interesting discussion of the limits of informed consent, see Amnon Goldworth, "Informed Consent Revisited," *Cambridge Quarterly of Healthcare Ethics*, 5, 2 (Spring 1996), pp. 214-220.

[16] Paul S. Appelbaum, Charles W. Lidz and Alan Meisel, *Informed Consent: Legal Theory and Clinical Practice* (New York: Oxford University Press, 1987), p 1, preface.

[17] Alan Meisel and Mark Kuczewski, "Legal and Ethical Myths About Informed Consent," *Archives of Internal Medicine* 156,22 (December 9/23, 1996), p. 2521. Further corroborating opinions appear in the article by Michael J. Green, et al., "Do Actions Reported by Physicians in Training Conflict with Consensus Guidelines on Ethics?" *Archives*

While no doubt this was a more common perspective early on[18] in the history of informed consent, in this author's opinion it nonetheless remains to some degree today. However, studies have proven that this is a false belief, in that the vast majority of patients want to be informed about the risks of a given procedure, and that this information does not result in overwhelming fear and refusal of treatment.[19] Given the reality that courts generally see only cases where undisclosed risks connected with medical procedures lead to actual injuries, rather than cases in which the outcome has been favourable,[20] courts have been attracted to what has become known as an "objective standard" which requires that juries view issues as if they themselves were an "average reasonable person" taking the place of a particular patient. To the extent that the decision of this hypothetical "average reasonable person" differs from the particular "average reasonable standard," then the law's objective standard fails to foster the particular patient's right to self-determination.

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of *Internal Medicine* 156, 3 (February 12, 1996), pp. 298-304.

[18] For a further discussion of the difficulties some physicians faced early on, in complying with the legal doctrine of informed consent, see Ralph J. Alfidi, "Controversy, Alternatives, and Decisions in Complying With the Legal Doctrine of Informed Consent," *Radiology* 114 (January 1975), pp. 231-234. See also Michael Baum, "Do We Need Informed Consent?" *Lancet* 2, 8512 (October 18, 1986), pp. 911-12.

[19] For a discussion of patients' reactions to informed consent for angiography, see Ralph J. Alfidi, "Informed Consent: A Study of Patient Reaction," *JAMA* 216, 8 (May 24, 1971), pp. 1325-29.

[20] This has been referred to as the "materialized risk requirement." For a more complete discussion of this requirement and the legal precedents from which it developed, see *Making Health Care Decisions*, p. 22, footnote 35.

As a result, while it seems clear that this standard for disclosure often contradicts the right of a particular patient, some suggest that a more subjective standard, while better able to support the needs and values of each patient, could have the potential for placing enormous practical demands on the litigation process.

While the litigation process has no doubt shaped the legal doctrine of informed consent, the reality is that court decisions relative to informed consent have failed to meet the law's stated commitment to the value of self-determination, central to which is an acceptance of respect for each individual and particularly his/her ability to delineate his/her own goals and to make choices on those goals and values. While no doubt improvements have occurred in the legal doctrine of consent, as a result of the court's intervention in the cases mentioned, the legal doctrine itself does not "equal the ambitiousness of the moral doctrines of informed consent themselves,"[21] which place consent within the framework of values, both the protection of the patient's values and the use of both the patient's values and the physician's in guiding decision making. It is toward an understanding of the values underlying the legal doctrine of informed consent that this chapter now turns.

Following this we will proceed with a discussion of the limits of three current models which attempt to articulate the underlying values implicit in informed consent and the criteria which all of the models rely on for determining the validity of

[21] Peter A. Ubel, "Informed Consent: From Bodily Invasion to the Seemingly Mundane," *Archives of Internal Medicine* 156, 12 (June 24, 1996), p. 1262.

consent. The chapter concludes with a summary of the difficulties which result from the limits of the three models of consent discussed.

## 1.2. Values Underlying Informed Consent and Models of Consent

Given the difficulties outlined above relative to the attempts of the Courts towards objective standards, one recognizes the importance of determining which values and therefore principles should guide decision making. While no doubt one could discuss myriad values relative to the issue, this section will focus on the values of promotion of a patient well-being that relates to the principle of beneficence and respect for self-determination that relates to the principle of autonomy. While the principle of justice is crucial to every civil society, it will not be discussed here since

> The major moral and conceptual problems about informed consent are not justice-based and do not directly confront issues of social justice. [22]

What becomes apparent in this discussion is that although the values of well-being and self-determination are related and appear compatible in theory, in practice they often conflict.[23]

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[22] For an excellent discussion of these values, see Faden and Beauchamp, *A History and Theory of Informed Consent*, pp. 7-16. The issue of justice and its limits in the discussion of informed consent occurs on pp. 14-16.

[23] This is the position taken throughout the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research in *Making Health Care Decisions*.

Given the frequent absence of objective medical criteria and the subjective preferences of the individual, it is normally a matter of individual judgment as to whether or not a particular intervention will or will not promote a patient's well being. While most of these decisions are left up to the patient involved, informed consent is not always an absolute right in the sense that a patient may not demand whatever he/she wants. Rather, the principle of well being

> . . . circumscribes the range of alternatives offered to patients . . . it is a choice among medically accepted and available options, all of which are believed to have some possibility of promoting the patient's welfare, including always the option of no further medical interventions, even when that would not be viewed as preferable by the health care providers.[24]

In the sense that well-being is a relative notion in that it is only definable in relation to each person's experience, in most situations it corresponds to self-determination, or autonomy. The Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research defines self-determination as being "an individual's exercise of the capacity to form, revise, and pursue personal plans for life."[25] Faden and Beachamp note that autonomy is the most often used moral principle

> . . . where it is conceived as a principle rooted in the liberal Western tradition of the importance of individual choice, both for political life and for personal development. 'Autonomy' and 'respect for autonomy' are terms loosely associated with several ideas, such as

[24] *Making Health Care Decisions*, p. 67.

[25] *Making Health Care Decisions*, p. 41.

> privacy, voluntariness, self-mastery, choosing freely, the freedom to choose, choosing one's own moral position, and accepting responsibility for one's choices.[26]

One respects an autonomous person by treating him/her as an end in him/herself. This means that one must appreciate the person's

> . . . capacities and perspective, including his or her right to hold certain views, to make certain choices, and to take certain actions based on personal values and beliefs.[27]

Not only does the respect for autonomy place a burden of justification on those who would restrict another's autonomy, the principle of autonomy provides the justification for the patient's right to make autonomous decisions. This then ". . . takes the form of specific autonomy related rights,"[28] including the right to refuse life-sustaining treatment.

In most instances, the particular outcome which will prove beneficial to a person depends on a subjective judgment about the individual. This has been termed the "instrumental value of self-determination."[29] However, while self-determination places intrinsic value on each person's ability to make personal choices which reflect a particular lifestyle, as well as appreciating that such choices

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[26] Faden and Beauchamp, *A History And Theory of Informed Consent*, p. 7.

[27] Faden and Beauchamp, *A History and Theory of Informed Consent*, p. 8.

[28] Faden and Beauchamp, *A History And Theory of Informed Consent*, pp. 7-8.

[29] *Making Health Care Decisions*, p. 41.

should be free from external control, there are nonetheless restrictions on an individual's right to self-determination. [30]

For example, some personal choices are so contrary to the good of others that society prohibits medical interventions which are oriented towards these ends. Numerous examples can be found of such instances of conflict between the good of society and the wishes of the individual. While some are clear cut in terms of prohibition, for example, surgery to remove fingerprints, others, such as refusal of immunization, are more problematic. A further example of the limits to self-determination occurs when an individual's ability to make decisions which promote his/her personal goals is so impaired as to be contrary to his/her best interests.

The principle of beneficence which arises out of a concern for the patient's well-being or best interest, includes the notions that

> (1) one ought not to inflict evil or harm; (2) one ought to prevent evil or harm; (3) one ought to remove evil or harm; (4) one ought to do or promote good.[31]

However, although these duties are ordered hierarchically, in practice, the duty to avoid harm may not always take precedence over the duty to prevent harm. Faden and Beauchamp use the example of the harm caused to the blood donor in withdrawing his/her blood, in order to avoid the harm which may be caused to the

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[30] See James F. Childress and John C. Fletcher, "Respect For Autonomy," *Hastings Center Report* 24, 3 (May/June 1994), pp. 34-35.

[31] Faden and Beauchamp, *A History and Theory of Informed Consent*, p. 10.

hemmhoraging patient if he/she does not receive a transfusion. As a result of this difficulty, Faden and Beauchamp note that there can be "no mechanical decision rule asserting that one principle must always outweigh the other."[32]

A more difficult problem with the value of well-being and the principle of beneficence arises in clinical practice in discussions of whether or not one should override a patient's decision in order to prevent them from harm. This is the problem of paternalism, one which occurs repeatedly in the practice of informed consent.

What appears possible is that the values of well-being and self-determination, which ground the principles of autonomy and beneficence, like the legal doctrine of informed consent, not only conflict but may also be less than absolute. This conflict will impact all three models of, or theories, of informed consent; the patient benefit theory, the social benefit theory, and the self-determination theory, albeit in differing ways. While this work has already been done by Robert Veatch,[33] it is important to briefly summarize his discussion in this area because it points to the inadequacy of the models. However, it must be pointed out that Veatch's work was about consent in the research milieu where the process

[32] Faden and Beauchamp, *A History and Theory of Informed Consent*, p. 10.

[33] The use of these terms is borrowed from Robert Veatch, "Three Theories of Informed Consent: Philosophical Foundations and Policy Implications" in *The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research: The Belmont Report*, Appendix, Volume 11, Bethesda, MD, 1978, pp. 6-43.

of consent is somewhat different. In research the requirements for the validity of consent are more stringent and the process of obtaining consent much clearer than in the therapeutic situation. As such, Veatch's work provides some useful insights. However, he is a limited tool. Nonetheless, if one is to develop an improved model of consent, it is important that one recognizes and learns from the shortcomings of existing models, and Veatch's work provides the clearest and most comprehensive accounting of these.

### 1.3 The Patient Benefit Theory of Informed Consent

In examining the history of medicine from a medical perspective rather than a legal one, one recognizes that experimentation was considered an integral part of the practice of Hippocratic medicine, and, as a result, the requirement for a physician to obtain consent was not part of medicine's early tradition.

> In spite of the fact that Hippocratic and Galenic medicine viewed medical problems as natural phenomena, these traditions did not rationalize and systematize medical experimentation as we know it . . . It was not until well into the modern period that medical experimentation was undertaken in the sense of systematically designed research for the purpose of gaining medical knowledge. It is in part for this reason that consent is absent from the Hippocratic tradition.[34]

However, given that the dominating ethical standard which guided the Hippocratic physician was one which stated that it was his duty to do what would

[34] Veatch, *The Belmont Report*, pp. 6-7.

benefit the patient according to his judgment and ability, one could suggest that informed consent may have had a place even in classical ethics on the basis of patient-benefiting grounds. Similarly, for modern medical professionals who hold to Hippocratic ethics, consent is directly linked to the risks and benefits regarding the patient. However, as we will see in the following section, this approach has obvious shortcomings, especially when the question of non-therapeutic interventions arises.

One sees evidence of this difficulty in the 1971 FDA regulations relative to consent for experimental drugs which note that consent must be obtained except in cases where the "investigators deem it not feasible or, in their professional judgment, contrary to the best interests of such human beings."[35] This statement raises the possibility of a major flaw in the patient benefit approach, since it would appear that it supports lack of disclosure to patients in those instances where obtaining consent would do more harm than good. This appears somewhat illogical in terms of the relationship between informed consent and patient benefit since if consent is to be grounded in patient benefit, then it cannot also function to waive the obligations of the model of patient benefit.

Similarly, with regard to non-therapeutic interventions such as experimentation, this model would seem to prohibit any such procedures which,

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[35] Veatch, *The Belmont Report*, p. 9. The report further notes on p. 8 that the decisive situation for testing the relationship between patient-benefit and informed consent should be those situations in which "someone (usually the physician) believes that getting patient consent will do harm to the patient rather than produce benefit."

while potentially beneficial to society, might have risks that could not be justified solely on the grounds of patient benefit alone. As stated previously, while the focus in this thesis is on informed consent in the therapeutic environment, one sees a clear picture of the sense of the limits of a theory of social benefit in the following discussion of Veatch's perspective on the issue.

### 1.4. The Social Benefit Theory of Informed Consent

Many who find it unacceptable or insufficient to hold to the patient benefit approach to informed consent in which the primary purpose is the protection of patients against risk, advocate a model of social benefit, which is similar to the views articulated by Bentham, Mill and others.[36] According to this perspective, a course of action is correct if it produces the greatest good for the greatest number. While this view has been limited by some to economic considerations, this is a misinterpretation of Bentham and Mill's perspective which took into account aesthetic, psychological, cultural and religious goods and harms. Interestingly, this theory came about not only as a result of changes in medical technology, but specifically as a result of a transformation of the perspective towards experimental medicine. As noted

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[36] See Jeremy Bentham, *An Introduction to the Principles of Morals and Legislation* (Oxford: Claredon Press, 1879); John Stuart Mill, *Utilitarianism*, second edition (London: G. Routledge, 1895); G.E. Moore, *Principia Ethica*, (London: Cambridge University Press, 1903); and Henry Sidgwick, *The Methods of Ethics*, (London: Macmillan and Co., 1907).

previously, experimentation in early medicine occurred in the context of patient therapy and, as a result, any ensuing social benefits were considered supplementary.

However, with the modern era, research became more directed towards the gaining of knowledge and as a result the potential arose for conflict between patient benefit and benefit to others. While researchers often date the onset of experimental medicine to 1628 with William Harvey's animal studies,[37] Harvey's work, while an example of research in the pursuit of knowledge, differed from modern research in that it did not involve risks to human subjects.

At the beginning of the 19th century, Thomas Percival, a physician in Manchester, England, was asked to write a code of ethical conduct in response to a dispute among physicians in the hospital. It is this code which has become the basis for Anglo-American ethics. In this document, Percival clearly justifies medical experimentation on the basis of the greater public good. However, what is obvious by its absence is any mention of a requirement for patient consent:

> Whenever cases occur, attended with circumstances not heretofore observed, or in which the ordinary modes of practice have been attempted without success, *it is for the public good*, and in especial degree advantageous to the poor (who, being the most numerous class of society, are the greatest beneficiaries of the healing art) that new remedies and new methods of chirurgical treatment should be devised.[38]

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[37] See William Harvey, *The Anatomical Exercises: De Motu Cordis and De Circulatione Sanguinis* (New York: Dover Publications, 1995). Harvey's work involved study of the circulatory systems in animals.

[38] Chauncey D. Leake, ed., *Percival's Medical Ethics* (Huntington, New York: Robert E.

While Percival justified experimentation in terms of the general good, in 1865, Claude Bernard went even further in advocating not just the permissibility of human research, but also the obligation to participate in anything that could help one's fellow human being. In this sense his approach goes beyond that of classical utilitarianism. Interestingly, his proviso, which prohibits harmful procedures, is reminiscent of the patient well-being theory, although upon close observation he appears to grant both an equal place. However, in stipulating that harm should not be done, his proposed guidelines raise a doubt as to whether or not any one theory on its own is capable of grounding a theory of informed consent:

> Christian morals forbid only one thing, doing ill to one's neighbour. So among the experiments that may be tried on man, those that can only harm are forbidden, those that are innocent are permissible, and those that may do good are obligatory.[39]

With a policy based solely on a theory of social benefit, one could suggest that the requirement for informed consent might impede the acquisition of the greater good and that consent should only be required in order to expedite the research process.[40] One sees an extreme example of a distortion of this type of

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Krieger Publishing Co., 1975), p. 76. Due to the pressures which the Manchester hospital was undergoing at the time of the request to Percival, it is perhaps understandable, given the unspoken need to rehabilitate the hospital image, that Percival's code serves a more general social purpose, including protection of the poor, than had been the case with prior ethical directives.

[39] Claude Bernard, *An Introduction to the Study of Experimental Medicine*, (New York: Dover, 1957), p. 102.

[40] See Veatch, *The Belmont Report*, pp. 16-17, for a discussion of this issue.

argument in the Nazi's justification for human experimentation.[41] As a result of these atrocities, what became clear at Nuremberg was that human rights were placed in jeopardy in those instances where non-therapeutic research was based solely on a desire to attain society's greater good.

### 1.5. The Self-Determination Theory of Informed Consent

If a theory of informed consent that focuses on optimizing the good of society has the possibility of encroaching on individual human rights, and a model of consent based on patient benefit logically excludes all non-therapeutic research, and yet medical research is viewed as being necessary for the benefit of humankind, how does one protect the individual while not abandoning the needs of the community in which he/she exists? In an attempt to address this issue, the drafters of the Nuremberg code were led to the inescapable conclusion that individual subjects had individual rights that superceded those of society. As such they noted that

> Anyone who imposes an informed consent requirement on medical research for a reason other than the instrumental value that consent might have in furthering research for the common good must recognize that individual subjects have claims against the society, claims so strong we call them 'rights'. There must be rights of the

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[41] See Michael R. LaChat, "Utilitarian Reasoning in Nazi Medical Policy: Some Preliminary Investigations," *Linacre Quarterly* 42 (February 1975), pp. 14-37; relative to some common difficulties in justifying human experimentation by means of utilitarian reasoning.

> individual which we have standing even against the claim that the greater good would be served if those rights were compromised.[42]

The principle of autonomy or self-determination is intended to guarantee the right of each individual to consent for each and every infringement on his/her body. As such while it may occasionally result in either the patient's or society's best interest, its primary objective is to provide a foundation which moves past consequentialism and is independent of the question of risks or benefits to both the subject as well as society. While we have pointed out that both the social benefit theory and the patient benefit theory each have limitations, it would also appear that the right to self-determination, and to informed consent, may also be less than absolute. As well, in determining whether or not consent is valid, issues such as capacity, voluntariness, communication of information and situational differences bear heavily.

## 1.6. Capacity and Criteria for Determining the Validity of Consent

The *Consent to Treatment Act* in Ontario, lists four elements that are required for consent to treatment:

1. The consent must relate to the treatment.
2. The consent must be informed
3. The consent must be given voluntarily
4. The consent must not have been obtained through misrepresentation or fraud.[43]

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[42] Veatch, *The Belmont Report*, pp. 18-19.

While informed consent is grounded in the basic assumption that patients have the right to accept or reject medical interventions on the basis of their individual values and goals, it is nonetheless dependent on the legal presumption of capacity.[44] Since informed consent is intended to support the values of well-being and self-determination, it begins from the assumption that most patients have the mental capacity to make decisions in the majority of cases, and that incapacity should only be accepted as eliminating the need for consent in a very small minority of cases. Related to the issue of capacity is the fact that consent must relate to a specific treatment. As a result, general and vague consents do not satisfy the requirements of the legislation on informed consent.

> Decisionmaking capacity is specific to each particular decision. Although some people lack this capacity for all decisions, many are incapacitated in more limited ways and are capable of making some decisions but not others.[45]

As the *Consent to Treatment Act* notes,

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[43] Statutes of Ontario, *Consent to Treatment Act 1992*, Chapter 31 (Toronto: Queen's Printer, 1994), Section 5(1), p. 5. See also Edward Etchells et al., "Bioethics For Clinicians: Capacity," *Canadian Medical Association Journal* 155,6 (September 15, 1996), pp. 657-61.

[44] While no doubt there are subtle nuances between competence and capacity, in that competence tends to imply a more legalistic frame of reference than capacity, which is more patient focussed and situationally specific, for the purposes of this thesis, these terms will be used interchangeably.

[45] *Making Health Care Decisions*, p. 3. See also Ministry of Health Ontario, *Consent to Treatment: A Guide to the Act* (Ottawa: Queen's Printer, 1994), p. 7 for a similar opinion.

> A person is capable with respect to a treatment if the person is able to understand the information that is relevant to making a decision concerning the treatment and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.[46]

However, not only must a person be able to understand and appreciate all details which are relevant to the giving of consent, it is mandatory that he/she give consent voluntarily, without coercion, force or constraint. No doubt there are difficulties encountered with patients who lack liberty — such as prisoners and certain research subjects who are also clinic patients.

> In contrast with children, the senile, and the mentally incompetent, there is no reason to presume that prisoners lack the capacity for self-determination. If self-determination is a fundamental right in our society, then we should be very cautious in infringing upon that right even in the name of protecting the individual's welfare . . . While prisoners do not lack the capacity to consent, however, a social judgment has been made that their right to self-determination should be greatly constrained . . . Thus the prisoners' general presumptive right to self-determination has been compromised. . . If, however, retribution is the basis of the imprisonment conceivably that right could be limited . . . Like prisoners, clinic patients do not in principle lack the capacity to consent, but may be coerced into consenting because of serious constraints on their options for receiving health care.[47]

While some patients clearly possess capacity, others, such as the comatose and infants clearly lack it. However, between these two extremes lie many instances in which capacity is ambiguous and as a result, a process of patient evaluation ensues. However, in evaluating the ability of a patient to make a decision, one must

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[46] Statues of Ontario, *Consent to Treatment Act*, Section 6(1), p. 5.

[47] See *Making Health Care Decisions*, pp. 45-48.

be clear on the issue of which elements constitute capacity itself. The question of capacity can be approached from many perspectives. For example, the law considered capacity under the heading of competency and presumes all adults to be competent unless previously deemed incompetent. For the purposes of this thesis, however, capacity presupposes that all human autonomous actions are affected by the capacity to act voluntarily.

> Effective patient participation in health care decisionmaking rests on three foundations that correspond to the traditionally accepted elements of legally effective informed consent: decisionmaking capacity and voluntariness . . . [and] information.[48]

The President's Commission for the Study of Ethical Problems in Medicine discusses capacity as requiring

> (1) possession of a set of values and goals
> (2) the ability to communicate and to understand information
> (3) the ability to reason and to deliberate about one's choices.[49]

The possession of a set of values is mandatory in that it provides a framework in which choices can be evaluated. The stability of this framework is crucial in order that choices can be made with a measure of consistency. Similarly, the ability to give and receive information and to articulate questions relative to the issue at hand is crucial. In other words, the patient must first receive information regarding the

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[48] *Making Health Care Decisions*, p. 55.

[49] *Making Health Care Decisions*, p. 57.

proposed treatment and about alternatives to that treatment. Consent is considered to be informed, if before giving it,

> (a) the person received the information about the treatment, alternative courses of action, the material effects, risks and side effects in each case and the consequences of not having the treatment that a reasonable person in the same circumstances would require in order to make a decision; and
>
> (b) the health practitioner responded to the person's requests for other information about the treatment, alternative courses of action, material effects, risks and side effects, and consequences of not having the treatment.[50]

Finally, the third element of decision making capacity, that of reasoning and deliberation, is important in that it pertains to the ability to compare and contrast the influence of alternative consequences on one's individual life goals. No doubt many patients possess these attributes and yet cannot employ them effectively. In such instances, it is important both to remember that informed consent is a process which often requires repeated conversations with patients and to recognize that communication is never a simple process. However, capacity should not be evaluated on a purely cognitive level as it always includes emotional elements.

> . . . Cognitive competence applies to the capacities of attention and perception, language usage (fluency, articulation, and comprehension), memory and cognition itself, intelligence, calculation, insight and judgment, manipulation of data, and abstract thinking). Affect broadly understood includes the emotional and motivational systems. Affective competence applies to feelings, motivations, and behavioral control. These abilities to internalize and respond to one's

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[50] Statutes of Ontario, *Consent to Treatment Act*, Section 5(2), p. 5.

> circumstances determine how persons feel, and when, to what extent, and how they act upon their feelings. Dually (i.e., cognitively and affectively) competent persons are able to acquire information from the world, respond emotionally and behaviorally to that information, and use it to increase their knowledge and control of their environments.[51]

Both cognitive and affective competence, in Cox White's opinion, must play a crucial role in making health care decisions in a way that is mutually inclusive rather than exclusive. She outlines three separate arguments which note that any determination of competence must include both the cognitive and affective systems. The first argument proposes that

> . . . the two systems are so functionally intertwined that whatever affects one variously affects the other. Any situation that provokes a strong emotional response stimulates, in virtue of that response, changes in cognitive processing as well.[52]

The second argument rests on the belief that

> . . . human information systems include more than the ability to calculate. They also depend on the capacity to recognize and take note of important data, some of which are feelings . . . Because thinking and feeling are both important sources of information, anyone interested in insuring autonomous choice and the welfare of persons is advised to consider both systems in assessing decision making.[53]

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[51] Becky Cox White, *Competence to Consent* (Washington: Georgetown University Press, 1994), p. 117.

[52] Cox White, *Competence to Consent*, p. 117-118.

[53] Cox White, *Competence to Consent*, pp. 117-118.

The third reason that Cox White offers in support of the mutualistic approach to competency determinations holds that

> . . . both affective and cognitive systems . . . contribute(s) to the values that the practice of informed consent was designed to protect — patient autonomy and welfare.[54]

Given this understanding, it is erroneous to believe that capacity to consent can be limited to cognition.[55] However, as authors like Margaret Olivia Little[56] point out, not only is there a tendency to separate reason from emotion in moral judgements, but moral epistemology stresses that there is a suspicion as to the role that emotions might play in ethical decision making.

> To make considered, sound moral judgments, we are told to abstract from our emotions, feelings, and sentiments. Emotions are not part of the equipment needed to discern moral answers; indeed, only trouble can come of their intrusion into deliberations about what to do. . . To be objective is to be detached; to be clear-sighted is to achieve distance.[57]

According to Becky Cox White, the first exercise of cognition is to receive the information that is needed in order to begin the process of decision making. Following this, persons attempt to understand the information which they have

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[54] Cox White, *Competence to Consent*, pp. 117-118.

[55] For an excellent discussion of two major schools of philosophical thought which diverge on this issue, see Cox White, *Competence to Consent*, pp. 118-125.

[56] Margaret Olivia Little, "Why a Feminist Approach to Bioethics," *Kennedy Institute of Ethics Journal 6*, 1 (March 1996), pp. 1-18.

[57] Little, "Why a Feminist Approach to Bioethics," p. 12.

received before they can make a judgment as to its importance to one's own life. In engaging in the activities geared towards understanding, patients must have some knowledge of probabilities and potential outcomes of each possible decision, and the risks and benefits of each alternative.

> In sum, to reason about possibilities is to understand them in terms of their likelihood of promoting one's own goals and values, as well as the burdens of doing so.[58]

Following the exercise of understanding, however, comes a judgment as to which option is preferential to the person. Such judgment implies a resignation to make a decision and to hold to that decision. The movement from understanding to judgment and decision, for Cox White, is a cognitive one in which patients analyse and assess information, sorting out relevant information from that which is extraneous. However, her view of affective competence is one which complements cognitive competence in that several types of emotions work to impact the nature of decision making.[59] Not only do one's emotions provide insight into what one feels about a particular decision, emotions themselves are an intrinsic part of the process of decision making itself, and can be experienced by others in their expression.

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[58] Cox White, *Competence to Consent*, p. 127

[59] Cox White's work derives in large part from D. N. Perkin's writings on human creativity, particularly *The Mind's Best Work*, (Cambridge, Mass: Harvard University Press, 1981. For a further discussion of the relationship between "felt emotions," "cognitive emotions" and "expressed emotions," see Cox White, *Competence to Consent*, pp. 128-129.

> The feelings that accompany the decision-making process indicate how efficient cognition has been in identifying the best option, for one's present situation (including one's values and desires).[60]

Louis C. Charland, takes a similar approach to Cox White in arguing that appreciation, one of the criteria for capacity, is heavily laden with emotional components. He notes that

> . . . in addition to their negative role, emotions also have an important *positive* role to play in competence. This is partly because the 'cognitive' capacities that are thought to underlie competence actually *include* emotion. . . *appreciation*, a central theoretical concept in competence, requires emotion . . . in addition to their negative role, emotions also have an important *positive* role to play in competence.[61]

## 1.7 Determination of Capacity

While both the National Commission and various legal texts appear to agree on what constitutes capacity, and also that such determinations have both an affective as well as cognitive component, there is more divergence of opinion when one discusses incapacity. Questions of incapacity characteristically occur when a patient chooses, or refuses a treatment other than one which the physician finds reasonable.

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[60] Cox White, *Competence to Consent*, p. 130.

[61] Louis C. Charland, "Appreciation and Emotion: Theoretical Reflections on the MacArthur Treatment Competence Study," *Kennedy Institute of Ethics Journal* 8, 4 (1999), pp. 359-376.

However, such divergences in opinion should provide a clue that more discussion is needed, rather than indicating that a verdict of incapacity should be made. In attempting to articulate what criteria should be used to determine incapacity, several proposals are common. One is based on the outcome of the decision, another on the status of the patient and a third on the patient's ability to function as a decision maker.

The outcome approach "bases a determination of incapacity primarily on the *content* of a patient's decision,"[62] in which a patient who makes a decision which is unreflective of conventional values or wisdom about proper health care, is deemed to be lacking in capacity. However, this approach is clearly inadequate, in that any standard which is based on what may or may not be objectively correct could allow a health professional to declare incapacity whenever a patient's decision appeared irrational or incompatible with his/her own. Not only could this approach fail to appreciate the subjective element inherent in every decision regarding value, it appears to be the antithesis of any approach which attempts to adhere to the value of self-determination. Of particular relevance is the opinion that while a patient's disagreement with a physician does not prove lack of capacity, neither does agreement establish capacity. However,

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[62] *Making Health Care Decisions*, p. 170.

> as testimony before the Commission made clear, coherent adults are seldom said to lack capacity (except, perhaps, in the mental health context) when they acquiesce in the course of treatment recommended by their physicians.[63]

Similarly, Betty Cox White criticizes outcome or consequence based approaches to competency in which she notes,

> Consequence-dependent competence fails to protect patient autonomy and beneficence in consent situations. As such, . . . (it) . . . fails to promote the values for which informed consent was instituted. . . . Consequence-independent competence is the appropriate approach within the practice of free and informed consent.[64]

With an approach which focusses on the status of the patient, certain categories of people have traditionally been found to be incapable of making decisions regarding treatment, regardless of any "moments of capacity" which they may have in specific situations. While some, like the unconscious, are clearly lacking capacity, others who are assumed to be incapacitated purely on the basis of their status, may in fact be capable of making certain decisions in some instances. For example, mildly or moderately retarded persons can hold preferences regarding their health care, as can some psychiatric patients. One sees a similar approach with regard to children in the new Ontario legislation on consent, which makes the point that

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[63] *Making Health Care Decisions*, pp. 61-62.

[64] Cox White, *Competence to Consent*, p. 116.

> There is no fixed age at which a person becomes mentally capable of consenting to treatment. Many people mistakenly think there is a general "age of consent" for treatment. This is not the case under common law and will not be under the Consent to Treatment Act.[65]

This approach further reinforces the situational dependency of decisions relative to a patient's capacity. For example,

> A child with the necessary mental capacity to decide about a proposed treatment has the right to make the decision. Of course, a very young child would likely not be able to appreciate the consequences of, for example, accepting or refusing a needle against measles. Inability to appreciate the consequences would mean the child was mentally incapable, even if he or she understood the information about the treatment.[66]

The importance of the relationship between the specific nature of valid consent and the variability of capacity is evident in the Act's attempt to allow a combination of a patient's consent with that of a substitute decision maker, within the management of each individual case.

> Some treatments need related treatments — for example, procedures done before and after surgery. What if a person is mentally incapable of deciding about the surgery but capable of deciding about some simple related treatments, such as blood pressure and temperature readings? In such cases, those treatments are considered part of the same treatment decision. A substitute decision maker who has authority to consent to surgery may also consent to the related treatments.[67]

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[65] Ministry of Health Ontario, *Consent to Treatment: A Guide to the Act*, p. 7.

[66] Ministry of Health Ontario, *Consent to Treatment: A Guide to the Act*, p. 7.

[67] Ministry of Health Ontario, *Consent to Treatment: A Guide to the Act*, p. 7. For a more comprehensive discussion of the relationship between capacity and substitute decision makers, see Statutes of Ontario, *The Substitute Decisions Act*, Chapter 30 (Toronto:

Given the inadequacy of both the outcomes approach, and the patient status approach, as well as the stance that capacity is specific to each particular decision, one becomes aware that capacity itself is best comprehended and implemented in a functional way, i.e., in a manner in which one bases capacity on an individual's actual performance in situations involving a decision regarding his/her health care. This approach is of particular significance for children again, in that "rather than considering children under the age of majority incompetent to decide . . . these patients could be regarded as competent unless shown to lack decision-making capacity.[68] However, it also impacts others as well as children, in that it ascribes incompetency to situations rather than to categories of people and, as such, incapacity is by and large situationally dependent in that it relates to specific instances in which a patient is unable to make decisions in conformity with his/her personal set of values. The fact that someone may belong to a specific group or category of people who are sometimes incapable of making their own decisions should be an indication that more care is needed in the procuring of informed consent, but not that the process itself should be denied.

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Queen's Printer for Ontario, 1992). See also Nancy M. P. King and Alan W. Cross, "Children as Decision Makers: Guidelines for Pediatricians," *The Journal of Pediatrics*, July 1989, pp. 10-16.

[68] *Making Health Care Decisions*, p. 170. See also A.M. Capron, "The Competence of Children as Self-Deciders in Biomedical Interventions," in Willard Gaylin and Ruth Macklin, eds., *Who Speaks For the Child* (New York: Plenum Press, 1982), pp. 55-114.

From this perspective, decision-making incapacity is not a category determined by medical diagnostic criteria but instead a judgment of the sort that any lay person might make, i.e., that this particular patient, in this particular instance lacks the ability to comprehend a situation and make a choice based on that comprehension.

> Rarely — again the unconscious patient is the main exception — will incapacity be absolute. Even people with impaired capacity usually still possess some ability to *comprehend, to communicate and to form and express a preference*. In such cases, even when ultimate decisional authority is not left with a patient, reasonable efforts should be made to give the person relevant information about the situations and the available options and to solicit and accommodate his or her preferences.[69]

With this approach, it is far easier to identify the causes of incapacity and to work to remove or remedy them. However, as was previously stated, informed consent is a process which requires ongoing conversations between patients and health care professionals, and historically dialogue between these two groups has been laden with difficulties.

## 1.8. Difficulties in The Process of Informed Consent

While the law has a crucial role to play relative to informed consent in that it defines minimal standards and processes, "the intimate and necessarily diverse

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[69] *Making Health Care Decisions*, p. 172.

nature of therapeutic relationships cannot be fully prescribed or enforced by law."[70] As was noted in the first section of this chapter, the legal doctrine of informed consent is limited in scope in that it has focussed on the physician's duty to warn, rather than encouraging the role that patients might have in the decision-making process. It has been suggested that this perspective has strengthened the alienating behaviour common to many physicians, that is, one of talking at patients rather than with them.[71] As a result, the opportunity to move toward what many believe is needed, i.e., a new dialogue, has been largely missed. The President's Commission has discussed this dialogue between patients and physicians as one in which

> . . . both, appreciative of their respective inequalities, make a genuine effort to voice and clarify their uncertainties and then to arrive at a mutually satisfactory course of action.[72]

While the Commission feels that this approach is unattainable if one relies solely on the legal system, a relationship of intimacy and conversation between health care professionals and patients is one which is foreign to medicine. In fact the skepticism with which medicine views patients' capacity for self-determination can be detected in the Hippocratic oath which directs physicians to perform their duties

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[70] *Making Health Care Decisions*, p. 114.

[71] See *Making Health Care Decisions*, p. 26 for a discussion of the limits of the law in facilitating the process of informed consent.

[72] *Making Health Care Decisions*, p. 26.

> . . . calmly and adroitly, concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and sincerity, turning his attention away from what is being done to him, sometimes reprove sharply and emphatically, and sometimes comfort with solicitude and attention, revealing nothing of the patient's future or present condition.[73]

However, in spite of the fact that the law provides an incomplete foundation for informed consent, and regardless of the difficulties inherent in the physician/patient relationship, what has been learned from both of these perspectives is not only that conversation is a prerequisite for informed consent, but that it must be based on mutual trust. While in the past, patients have been willing players in participating in a paternalistic approach which places blind trust in a physician's ability to "do what is best," the legal doctrine of informed consent which demands disclosure and consent, has made mutual trust possible for the first time.

However, while possible, it is inordinately difficult for a physician to trust a patient, in the sense that the requirement to disclose has placed physicians in a position of disclosing uncertainty to their patients whom they have heretofore believed should be protected against an awareness of any lack of certainty.[74] Of

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[73] Hippocrates, "Decorum," in *Hippocrates*, trans. W.H.S. Jones (Cambridge, Mass: Harvard University Press, 1967), as quoted in Jay Katz, "Disclosure and Consent: In Search of Their Roots," in Aubrey Milunsky and George J. Annas, eds., *Genetics and the Law 11* (New York: Plenum Press 1980), p.124.

[74] This is an area in which Jay Katz has written extensively. Katz believes that not only does this mask of silence banish patients to a painful solitude, but the underlying attitude of physician paternalism, albeit disguised as altruism, is flawed in that it cannot resolve the conflict which sometimes exists between a physician's goals and a patient's values. See Katz, *The Silent World of Doctor and Patient*, pp. 165-206.

more fundamental importance is the fact that both must understand that in holding to the viewpoint that the interests of the physician and patient are identical, any possibility for communication disappears, with the result that the only voice which can be heard is the one belonging to the doctor, who "knows best."

However, the issue of dealing with uncertainty is a crucial one since the dimension of uncertainty underlies all of the elements in the professional/patient relationship. Both the physician and patient need to become aware not only of the type of uncertainty involved in diagnosis and treatment, but also of their own and each other's attitudes towards this uncertainty. While medical research is constantly advancing knowledge, knowledge in fact breeds more ignorance, in that with every answer further questions arise. However, this type of uncertainty is more easily dealt with by both physicians and patients. Of more distress to both is the probabilistic character of medical science which results in the need for a physician to give an opinion as to the likelihood of success of a particular treatment.

Similarly, while most diagnostic tests are highly accurate, neither these tests nor the professionals who evaluate them are infallible. Finally, one encounters a type of experiential problem in dealing with uncertainty when an individual is placed in the position of attempting to imagine what life might be like under different medical circumstances.

In summary, one can discern at least three problems which impact the patient/professional relationship relative to the issue of uncertainty: one produced as a result of the relationship between certainty and uncertainty which is intrinsic to medical knowledge itself; another created by disclosures of uncertainty to patients; and, finally, the problem which results from the consequences of physicians' increasing recognition of uncertainty. It is an awareness of this influence which uncertainty, fallibility, lack of trust and paternalism have exerted on the process of communication and therefore in the process of consent, that has resulted in the authors of the Belmont Report offering a variety of proposals concerning ways in which to ameliorate the situation. These suggestions can be placed in two broad categories, one relating to patient education, the other to training of medical personnel.

Suggestions for patient education have been geared towards preparing the patient for more effective participation in his/her own health care. While the intent is not to transform patients into experts in medical diagnosis and treatment, nonetheless today's patient is being encouraged to become more informed in issues relating to his/her case management. One of the areas in which inroads have been made is in the use of medication, with pharmacists being encouraged to take more of an educational role in their work with patients and to place and discuss information pamphlets as part of the dispensing process. Related to this is the fact

that in many cities, medical libraries are being opened to the public in an attempt to untangle the web of secrecy which has for so long surrounded medicine.

Another suggestion for enhancing the patient's role in health care has been to involve family members in the process of informing the patient. Not only has this been found to enhance physician/patient communication, it also appears to be therapeutic in that it ameliorates the loneliness of illness by making it an event which can be shared with one's family.

It has been suggested that the professional dominance view, which permeates the patient/physician relationship, is not only deeply ingrained in the history of medicine, but is continued "by the process of medical education and socialization into the professional role."[75] As a result, two suggestions relative to improving the physician's ability to communicate effectively with the patient arise; one is to restructure the admission criteria in an attempt to admit those individuals who are more likely to be capable of delivering humane care, while another proposes a reorientation of the curriculum in an attempt to augment those components of professional education which are instrumental in developing good communication skills.[76] However, while it appears appealing to reorient admission protocol, there

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[75] *Making Health Care Decisions*, p. 129.

[76] See *Making Health Care Decisions*, p. 130-131, for a discussion of the attempts to select more "appealing" students.

has been insufficient evidence to suggest that it might be possible to select "appropriate" individuals with any measure of certainty.

While one proposal has been to admit larger numbers of "applicants belonging to groups traditionally associated with nurturing or caring roles (notably women),"[77] there is no substantial verification that these groups persist in maintaining whatever nurturing orientation they may have possessed on entry into medical school, after years of internship and residency. The attempt to change curricula, on the other hand, appears to offer more hope for the future. Historically, the training of physicians has placed substantial importance on factual memorization, to the detriment of the development of observational and problem solving skills. As well, nurses and physicians, although eventually working closely with each other, are historically not specifically educated to collaborate with each other. Finally, the training of physicians in a university hospital environment has been linked to later difficulties in communication between physicians and patients in "regular" day-to-day practice.

As a result of these findings, the National Commission has made attempts to change medical school curricula that have been reoriented towards an integration of

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[77] *Making Health Care Decisions*, p. 133. Further suggestions have been to admit those with "characteristics thought likely to improve sensitivity toward the concerns of minority groups and with the ability to communicate with patients 'in their own language' (blacks, Hispanics, and members of other minority groups)," since some differences do arise in the admission tests of women and racial or ethnic minorities.

the humanities into medical education. The Commission has expressed a desire to encourage the teaching of human values which underlies the relationship between physician and patient, as well as the offering of courses in medical ethics. While this has resulted in a more interdisciplinary approach to medical education, unfortunately, in most instances, the reality is that the majority of graduating physicians have not been exposed to these new curricula and, as a result, are inadequate in many areas which relate to informed consent.

Clearly the advances which have been made in medical technology need to be twinned with advancements in the more compassionate side of medicine. Ultimately this can only come about if physicians and patients learn to communicate better with their associates and ultimately with each other. No doubt, much more needs to be done, and with every answer or solution, further questions arise. With those questions, there is perhaps a growing awareness in some minds of the worth of prior moments in medical history. Perhaps Katz is correct in espousing a regaining of some of the past in an effort to move forward, when he suggests that in studying informed consent, we have the opportunity to

> . . . reestablish a rightful place for the ancient practice of the art of medicine. The practice of medicine's art has been given short shrift in this age of science, in the expectation that treatment only requires silent scalpels, wordless monitors, and mute pharmacological agents.[78]

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[78] Katz, *The Silent World of Doctor and Patient*, p. xx.

This chapter has presented the basic values underlying the legal doctrine of informed consent, patient well being and respect for self-determination. We have seen that, while compatible in theory, these two values often conflict in practice. As a result, it appeared possible that the values, like the legal doctrine itself, may not be absolute. In examining three theories of consent, the patient benefit theory, the social benefit theory and the self-determination theory, it became clear that each has its limits. The patient-benefit theory appears to support lack of disclosure to patients in those instances where obtaining consent would do more harm than good and therefore is intrinsically incoherent in that if consent is to be grounded in patient-benefit as this model suggests, then it cannot also function to waive the obligations of the model of patient benefit. The social benefit theory of informed consent is limited and problematic in that it seems to have the potential for disregarding the rights of the individual in favour of the greater good of society. Conversely, the self-determination theory of informed consent is inadequate on its own because it has the opposite potential for disregarding the needs and rights of society. This model could effectively exclude all non-therapeutic research.

Since each of the three models share the common characteristic of being dependent on and impacted by the capacity of the individual from whom consent is sought, this chapter focussed next on the criteria for determining the validity of consent. What became clear in this discussion was that there is a serious divergence

of opinion in determining incapacity and that findings of incapacity tend to occur more frequently when a patient chooses, or refuses a treatment other than one which the physician finds reasonable.

Three common proposals which attempt to set criteria for determining incapacity were discussed, one based on the outcome of the decision, a second on the status of the patient and a third on the patient's ability to function as a decision maker. As we have seen, the role which emotions play in capacity and incapacity is of crucial significance.

As with the three models of consent and the values which they attempt to articulate, we showed that there are also serious flaws in two of the three proposals to set criteria for incapacity. While the outcome approach fails to appreciate the subjective element in decisionmaking, the patient status approach excludes certain "categories" of patient, like the mentally retarded and children, from any moments of capacity which they may have.

The functional approach to incapacity seems to hold the most promise since it takes the perspective that incapacity is situationally dependent in that it relates to specific instances in which a patient is unable to make decisions in conformity with his/her personal set of values. However, while this approach to incapacity is preferred to the other two, it too is dependent on the relationship between the patient and the health care provider and is heavily impacted by emotions.

The chapter concluded with a summary of the difficulties in the process of informed consent. Here it was noted that as a result of the focus on the legal duty to warn the process of consent has encouraged the deterioration of the relationship between the health care giver and the patient. In speaking of the need to improve the relationship between the physician and the health care professional, we noted the need for patient education and improved training of medical personnel. Underlying both of these suggestions is the need for trust, openness and an acceptance of uncertainty.

What also becomes apparent in the discussions throughout this chapter is the underlying sense of the importance of communication and conversation between the physician and patient and the character of the physician who supports and directs the patient in the process of making medical decisions.

# Chapter Two
# Addressing the Malaise of Informed Consent

In the previous chapter, it was noted that in its early history, relative to the issue of patient involvement in treatment decisions, bioethics was focussed on the need for compassion towards the patient who was suffering. The legal doctrine of informed consent appeared as a legal response to a moral problem — the need to disclose information to patients in order to protect them from battery. Unfortunately, the ensuing legalistic reduction resulted in a further abandonment of the patient and an ever increasing isolation from choices affecting his/her being. It was from within this cultural milieu and this perspective that "principle-based" ethics arose with its focus on autonomy, beneficence, non-maleficence and justice, followed by the ensuing attempt at correction seen in "narrative based" ethics, with its focus on the patient's story, and "virtue-based" ethical frameworks, with their focus on the character of the moral agent.[1]

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[1] For excellent discussions of how differing approaches, both in terms of varying ethical stances and patient-physician relationships, result in practical differences in the "doing" of medical ethics and also the outcome of a particular decision, see Benjamin H. Levi, "Four Approaches to Doing Ethics," *The Journal of Medicine and Philosophy* 21, 1 (February 1996), pp. 7-39. See also Ellen Fox and Robert M. Arnold, "Evaluating Outcomes in Ethics Consultation Research," *The Journal of Clinical Ethics* 7, 2 (Summer 1996), pp. 127-138; Joseph J. Fins, Matthew D. Bacchetta, and Franklin G. Miller, "Clinical Pragmatism: A Method of Moral Problem Solving," *Kennedy Institute of Ethics Journal* 7, 2 (June 1997), pp. 129-145; Ezekial J. Emanuel and Linda L. Emanuel, "Four Models of Physician-Patient Relationship," *JAMA* 267, 16 (April 22-29, 1992), pp. 2221-2226.

The purpose of this chapter is to present an analysis of the key elements of several authors' attempts at a solution to difficulties in the physician-patient relationship. The first part of the chapter will provide a synopsis of Dr. Jay Katz's work on conversation. This will be followed by Dr. H. Brody's development of Katz's conversation model. From there we will discuss Dr. E. Pellegrino and Dr. D. Thomasma's attempt to blend virtues, principles and duties. The chapter concludes with a synopsis of the key elements of the work of Dr. R. Charon and Dr. W. F. May and their focus on the role of narrative in ethics. These authors are important in terms of the purpose of this thesis because they focus on the relational structure between physician and patient.

## 2.1 Conversation and Consent: The Contribution of Dr. J. Katz

In his book the *Silent World of Doctor and Patient,* Katz begins by reiterating that, historically, physicians have excluded their patients from decision making and focussed rather on a misguided belief that silence reassures and encourages a patient's faith and hope. Katz's basic position on informed consent is that, while it was a necessary legal corrective to a medical problem, it has been largely misunderstood by physicians and also insufficiently developed.

> In fact, precisely because of the appeal's strange and bewildering novelty, physicians misinterpreted it as being more far-reaching than courts intended it to be . . . Physicians did not realize how much their opposition to informed consent was influenced by suddenly

> encountering obligations divorced from their history, their clinical experience, or medical education. Had they appreciated that even the doctrine's modest appeal to patient self-determination represented a radical break with medical practices, as transmitted from teacher to student during more than two thousand years of recorded medical history, they might have been less embarrassed by standing so unpreparedly, so nakedly before this new obligation. They might then have realized that their silence had been until most recently a historical necessity, dictated not only by the inadequacy of medical knowledge but also by physicians' incapacity to discriminate between therapeutic effectiveness based on their actual physical interventions and benefits that must be ascribed to other causes. They might also have argued that the practice of silence was part of a long and venerable tradition that deserved not to be dismissed lightly. They might at least have pleaded for time, because before they could embrace the unaccustomed obligation to talk with their patients, many problems required intensive study.[2]

Katz's model for informed consent is one which is grounded in the development of a relationship between the physician and patient. While Katz does not set out what an ideal model of informed consent would look like, he proposes that earned trust, through conversation, must provide the foundation for informed consent. The relationship between silence and abandonment is one of the major themes of Katz's work on informed consent.

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[2] Katz, *The Silent World of Doctor and Patient*, p. 3. See also A.S. Kessel, "On Failing to Understand Informed Consent," *British Journal of Hospital Medicine* 52, 5 (September 1994), pp. 235-238. Not only does Kessel share Katz's opinion on the relationship between informed consent and the doctor-patient relationship, he also holds the opinion that the medical profession seems to have been incapable of understanding that such a relationship exists. "Ian Meisel also echoes this view, in "A 'Dignitory Tort' as a Bridge between the Idea of Informed Consent and the Law of Informed Consent,' *Law, Medicine and Health Care* 16, 3-4 (Winter 1988), pp. 210-218.

## 2.1.(a) Silence and Abandonment

Katz provides an excellent synopsis of this history of silence in *The Silent World of Doctor and Patient* from the time of ancient medicine until the present day. He notes that the only specific advice on conversation in the Hippocratic Oath "speaks against disclosure,"[3] and notes that physicians of ancient Greece would have found the notion of shared decision making unnecessary "because they viewed doctor and patient as united through *philia,* friendship, which made their objectives one and the same."[4] Similarly, Socrates believed that conversations between physicians and patients were "meant to reinforce therapeutic effectiveness"[5] while conversations between physicians and patients in the medieval period served "the purpose of offering comfort, reassurance and hope, and of inducing patients to take the cure."[6]

In seventeen-century medicine, we begin to see a slight shift in perspective with the notion espoused by De Sorbière that "some patients had the capacity to listen to their doctors, and on the basis of what they heard, to make their own choices."[7] During the age of enlightenment Katz points to another shift from *philia* to reason, with the concomitant recognition that the interests of the physician and the

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[3] Katz, *The Silent World of Doctor and Patient*, p. 3.

[4] Katz, *The Silent World of Doctor and Patient*, p.6.

[5] Katz, *The Silent World of Doctor and Patient*, p.6.

[6] Katz, *The Silent World of Doctor and Patient*, p.7.

[7] Katz, *The Silent World of Doctor and Patient*, p.12.

patient might not be the same. However, as Katz points out, the focus here was more on manipulating the therapeutic relationship for therapeutic ends, rather than encouraging patients to share in decision making.

We see in nineteenth-century medicine, with Thomas Percival's work in medical ethics, an attempt to address the needs of patients. While Percival writes, "Every case, committed to the charge of a physician or surgeon should be treated with attention,"[8] the issue of the patient's right to choose did not receive mention. As a result, "the retreat from conversation was total."[9] It was not until the early 1900's, with physicians like Dr. Richard C. Cabot, that we see the beginning of the notion that in fact lying and lack of disclosure destroys trust and the ensuing call to engage physicians in dialogue with their patients. However, at that time, there were still no steps taken to urge physicians to make joint decisions with their patients.

As mentioned previously, it is Katz's opinion that this situation of silence was not promulgated out of malice on the part of physicians who wished to deceive their patients, but rather out of a desire to protect them and to encourage hope and trust.

> The history of the physician-patient relationship from ancient times to the present bears testimony to physicians' caring dedication to their patients' physical welfare. The same history, by its account of the silence that has pervaded this relationship, also bears testimony to

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[8] C. Leake, ed., *Percival's Medical Ethics* (New York: Robert Krieger Publishing Company, 1975), as cited in Katz, *The Silent World of Doctor and Patient*, p. 17.

[9] Katz, *The Silent World of Doctor and Patient*, p. 18.

> physicians' inattention to their patients' right and need to make their own decisions. Little appreciation of disclosure and consent can be discerned in this history except negatively.[10]

However, Katz's position holds that, in fact, faith, hope and reassurance are more radical determinants of health than is a patient's self-determination. While patients since the time of Hippocrates have been asked to trust their doctors, it is only recently, perhaps due to the arrival of the legal doctrine of informed consent, that physicians have been asked to trust their patients by having conversations with them about their treatment options. However, as Katz points out

> . . . the idea that conversation will lead to mutually satisfactory decisions is not one of human beings' most abiding convictions . . . We have paid little attention to how to communicate better with one another . . . the newly imposed legal requirement of informed consent — the dual obligations to inform patients and to obtain their consent — is only modern proof that trust in the professional is no longer viewed as sufficient protection of the integrity of the physician-patient relationship. Instead, the idea of informed consent suggests that trust must be earned through conversation. [11]

In search of a more adequate solution, Katz notes that it is first necessary to understand that the fears and misunderstandings of physicians are rooted in the previous longstanding history. Only when this has been addressed can we begin to develop a new model of informed consent, one that is grounded in trust and developed through conversation. Unlike prior moments in history, in which there

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[10] Katz, *The Silent World of Doctor and Patient*, p. 28.

[11] Katz, *The Silent World of Doctor and Patient*, p. xiv.

were struggles between competing groups like homeopaths and allopaths, it is no longer sufficient for a patient to trust a physician based on reputation. Of this earlier time Katz writes,

> Since the public could not distinguish between the qualified and unqualified on the basis of formal training, patients wisely preferred to trust reputation as transmitted by word of mouth. [12]

Today, however, informed patients require their own experience of trust before they can trust going forward. Katz proposes that it is only through conversation that this trust can be developed.

### 2.1.(b) Trust and Conversation

Katz's new model of trust demands that both the patient and the physician reflect internally on choices before they act on them externally. While the duty to reflect is a crucial part of each party's autonomy, it is the physician's obligation to instigate the process of reflection. Reflection is the prerequisite for conversation.

For conversation to be meaningful, Katz proposes that we must differentiate between trust that is blind and trust that is earned following an acknowledgment that one does not hold all of the answers. He suggests that the proponents of informed consent and patient self-determination have not appreciated or fully understood the

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[12] Katz, *The Silent World of Doctor and Patient*, p. 35.

difficulties in expressing uncertainty; neither have the opponents of informed consent fully appreciated that disclosure and consent do not undermine trust.[13]

However, as he points out, it is inordinately difficult for a physician to live with uncertainty, let alone disclose it to a patient. Only if we "distinguish knowledge from ignorance and uncertainty,"[14] can we begin to have the possibility of engaging in meaningful conversations with patients. Interestingly, Katz notes that the difficulties intrinsic to joint decision making in informed consent are but examples of the reality that we can never really know ourselves, let alone another.

> . . . human beings remain strangers to one another. One can only know and understand another to a limited extent. But the problem runs even deeper. One can only understand oneself to a limited extent. The latter impediment powerfully reinforces the former, making it even more difficult to know another.[15]

While Katz's synthesis of the history of silence is foundational to his work, it is this author's opinion that the area which offers the greatest hope for a new model of consent, one which closely aligns with the hypothesis of this thesis, lies in Katz's

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[13] Further to this notion of the relationship between disclosure, consent and trust, Katz writes in *The Silent World of Doctor and Patient*, p. xv, "Disclosure and consent only banish unilateral, blind trust; they make mutual trust possible for the first time."

[14] Katz, *The Silent World of Doctor and Patient*, p. xvii.

[15] Katz, *Silent World of Doctor and Patient,* p. xviii. For another interesting perspective on Katz's work on human development as it relates to decision making, see Dean M. Hashimoto and Mark E. Haddad, "Professor Katz's Study of Human Relationships," in *Law, Medicine and Health Care* 16, 3-4 (Winter 1988), pp. 160-66.

account of the psychological and existential vagaries that underlie the difficulty in conversations with patients. In his final chapter, entitled "The Abandonment of Patients: A Final Argument Against Silence" in *The Silent World of Doctor and Patient*, Katz addresses the fear of death that seems to underlie medical paternalistic authoritarianism and which in turn causes physicians to turn away from the suffering and dying patient.

He clearly articulates the importance of both a rational and emotional component to decision making. In keeping with this perspective, Katz is critical of Kant's attempt to limit autonomy to rationality and points to Freud's work on primary and secondary processes as providing a starting point for understanding the impact of the psyche on autonomy.

> The importance psychoanalysis attributes to the unconscious also suggests that we become 'freer' only if we acknowledge that unconscious motivations influence the decisions we make and then explore the sources of these motivations or at least appreciate the influence of such hidden forces on thought and action . . . Thought and action are influenced by the simultaneous operation not only of conscious and unconscious forces but also of rational and irrational determinants . . . Rationality refers to the impact on thought and action of consciousness, reality needs, time perspectives, varied and subtly blended emotions, realistic expectations, necessary postponements of gratifications, reflective thought prior to action, and regard for facts. Irrationality refers to the impact on thought and action of unconscious impulses and ideation, fantasies, timelessness, concreteness, unmodulated emotions, confusions of past and present

> realities, unattainable and infantile conceptions and disregard of facts.[16].

However, Katz is not suggesting that irrational thoughts are pathological, or that the irrational is inferior to the rational; rather he proposes that they both impact the conversation model he is proposing and therefore must work together. Not only must the patient and physician become aware of those psychological factors which influence his/her decision making, but so too must they become aware of the influences which the other is experiencing. Only in doing so can they first recognize and then address the issue of doubt and uncertainty. Katz addresses what he calls the "contrary assumption" that only patients are influenced by irrational thoughts.

> The contrary assumption that doctors' but not patients' contributions to any conversation are influenced largely by rational (personal and professional) considerations, has made self-reflection by physicians and even searching conversation between physicians and patients — from which *both* can learn — largely irrelevant. If physicians and patients recognize that physicians' communications are also affected by unconscious and irrational determinants, the parties' perceptions of one another and conversations between them would be decisively affected.[17]

However, like John Stuart Mill, Katz notes that humans are fallible and psychologically fragile; therefore reflective conversation must be imposed by the physician as a corrective to poor choices.[18]

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[16] Katz, *The Silent World of Doctor and Patient*, p. 115-16.

[17] Katz, *The Silent World of Doctor and Patient*, p. 122.

[18] In support of Mill, Katz writes in *The Silent World of Doctor and Patient*, p. 123, "(Mill) may

In summary, Katz provides an excellent understanding of the history of silence that has effectively resulted in the psychological abandonment of the patient. His vision is one which offers a new model of consent, grounded in trust and developed through conversation. However, he does not lay out what this model will look like in practice. This is perhaps the greatest limitation of his work and one which has received some criticism relative to the legal perspective and within a cultural milieu which unfortunately sees juridical interventions occurring more and more frequently.[19]

In particular, Howard Brody, director of the Center for Ethics and Humanities in the Life Sciences, Michigan State University, has addressed this issue and added a corrective to Katz's work which he believes is more compatible with the legal requirements of informed consent.

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have realized that human beings' psychological functioning needed nurture and support in the service of 'freedom of action.' That amount of intrusion, that degree of paternalism, he tolerated, indeed advocated . . . Mill viewed this imposition of dialogue as a necessary corrective to the uncompromising demand for liberty of action."

[19] Robert Burt, who is a colleague and friend of Jay Katz, supports his work, particularly his discussion of the existential situation. However he writes in "Uncertainty and Medical Authority in the World of Jay Katz," *Law, Medicine and Health Care* 16, 3-4 (Winter 1988), pp. 190-91, "This new phenomenon is the increased reliance on declaratory proceedings where judges resolve physicians' uncertainty about their authority either to provide or to withhold specific treatments."

## 2.2 Transparency and Consent: The Contribution of H. Brody

While Brody recognizes the limits of the law and some of the negative impact that an overemphasis on the law has exerted on the legal doctrine of consent, he maintains that any rearticulation of the doctrine must be compatible with legal requirements. As a result, from a practical perspective, he believes that Katz's conversation model will not work.

> I will maintain that accepted legal standards, at least in the form commonly employed by courts, send physicians the wrong message about what is expected of them. An alternative standard that would send physicians the correct message, a conversation standard, is probably unworkable legally. As an alternative, I will propose a transparency standard as a compromise that gives physicians a doable task and allows courts to review appropriately.[20]

Brody sees informed consent as inseparable from a patient care model, and good medical practice. In fact, if a physician is incapable of informing patients adequately and gaining their consent, he believes that he/she is as unfit to practice medicine as if he/she lacked a clinical skill.[21] However, he also sees a model of consent which is non-medical and legalistic as destructive of good patient care. He shares Katz's views on the current situation in which

> Physicians typically underestimate patients' desire to be informed and overestimate their desire to be involved in decision making. Physicians

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[20] Howard Brody, "Transparency: Informed Consent in Primary Care," *Hastings Center Report* 19, 5 (September/October 1989), p.5.

[21] Brody, "Transparency," p. 5.

> may also view informed consent as an empty charade, since they are confident in their abilities to manipulate consent by how they discuss or divulge information.[22]

Brody's focus in this article is on the primary care situation, rather than tertiary care. In primary care, he proposes that there are many more opportunities for the process of consent to occur over an extended period of time, and many more occasions in which a patient may change his/her mind. As a result, reforming the present model of consent is crucial to primary care since it is likely a part of the "daily practice of medicine."[23]

However, there has been a move away from the community practice standard, which instructs physicians to behave as other physicians in his/her own specialty behave, regardless of the impact on the particular patient, to the more acceptable and less paternalistic reasonable practice standard which focusses on what a reasonable patient may need to know in order to make a decision. This has resulted in a belief that it is more important to document the content of the information disclosed to the patient, rather than the patient's response to the information. Not only is this unworkable in the primary care setting, in which the number of possible procedures is more numerous and the amount of time allotted to each patient is considerably less than in the tertiary care setting, it also adds another

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[22] Brody, "Transparency," p.5.

[23] Brody, "Transparency," p.5.

difficulty to the already poorly understood legal standards for disclosure in the doctrine of consent. While Brody believes that Katz's conversation model provides

> . . . an approach to respect for patient autonomy that can be readily integrated within primary care practice . . . one cannot tell in advance how the conversation is going to turn out. One must follow the process along and take one's clues from the unfolding conversation itself.[24]

Since, according to Brody, there are no exact rules for the successful conversation, it follows that physicians must rely on their own intuitions in order to ascertain when a conversation has or has not been successful in terms of the obligations of informed consent. In this sense, informed consent is more than a stating of information: it becomes a participatory process which is "located within the context of the everyday relationship between physician and patient, albeit with a renewed emphasis on patient participation."[25] However, while conversation is crucial, Brody notes,

> . . . the conversation metaphor does not lend itself to ready translation into a legal standard for determining whether or not the physician has satisfied her basic responsibilities to the patient. There seems to be an inherently subjective element to conversation that makes it ill-suited as a legal standard for review for controversial cases.[26]

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[24] Brody, "Transparency," p. 7.

[25] Brody, "Transparency," p. 7.

[26] Brody, "Transparency," p.7.

While no doubt both physician and patient are good judges of the success or failure of a conversation around consent, Brody proposes that this is not the case if juries are asked to deliberate on whether or not a conversation successfully executed the legal requirements of consent. It is because of the conversation standard's inability to meet legal standards for approval that Brody finds the conversation model inadequate and posits his transparency standard as a way of operationalizing it.

> According to the transparency model, the key to reasonable disclosure is not adherence to existing standards of other practitioners, nor is it adherence to a list of risks that a hypothetical reasonable patient would want to know. Instead, disclosure is adequate when the physician's basic thinking has been rendered transparent to the patient. If the physician arrives at a recommended therapeutic or diagnostic intervention only after carefully examining a list of risks and benefits, then rendering the physician's thinking transparent requires that those risks and benefits be detailed for the patient. If the physician's thinking has not followed that route but has reached its conclusion by other considerations, then what needs to be disclosed to the patient is accordingly different. Essentially, the transparency standard requires the physician to engage in the typical patient-management thought process, only to *do it out loud in language understandable to the patient.*[27]

Brody's transparency standard would require that the physician begin the conversation with the patient by sharing his/her thoughts, then encouraging questions and ascertaining the level of involvement that the patient wishes to have in treatment decisions and finally, facilitating that involvement. He suggests that this

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[27] Brody, "Transparency," p.8.

transparency standard would preclude the need to divulge every possible risk or alternative to a patient, unless the patient requested that information. In fact, according to Brody, this is much less likely to happen if the physician shares how he/she reached his/her own conclusion on the topic. He proposes that "if the patient is told precisely the grounds on which the physician has made her recommendation, and then asked the same question, the response is more likely to be individualized and meaningful."[28] In the event that a case goes to court to determine whether or not a risk should have been disclosed to a patient, the transparency standard would reorient the questioning of the physician to an investigation of whether or not he/she felt that a particular risk was a relevant consideration in providing his/her recommendation to the patient, rather than whether or not a reasonable patient should have been informed of a particular risk. It is Brody's opinion that not only is the quality of conversation improved by using the transparency standard, but that physician liability is also reduced.

However, Brody's primary intent is not to reduce negligence findings, but rather to improve the process of informed consent. Brody is clear that the risks to his transparency approach are as yet unknown and may in fact prove to be deleterious. While he is also unsure as to whether or not it is possible for a physician to share his/her thought process with patients, he urges that his standard be judged not

[28] Brody, "Transparency," p. 8.

against ideal medical practice, but against current medical practices and the message that this model will offer to physicians. Rather than operating under the notion that one can only protect oneself legally by disclosing all possible risks to a "reasonable patient," the transparency standard urges physicians to engage in conversations with patients in a way which encourages their input. More importantly, it urges physicians to be as open as possible with their patients in sharing how they reached their medical judgment and recommendation for treatment.

Brody's model of consent builds on Katz's conversation model by adding this notion of concretely articulated transparency and openness to the therapeutic alliance and to discussions surrounding informed consent. In this way, the benefits of conversation are combined with the legal requirement for disclosure of information, with the result that patient care is improved. Both Katz's model and Brody's vision demand a high level of comfort with both rational and emotional elements of all concerned. Although, in this author's opinion, both models depend on this recognition and nurturing of these dual aspects of decision making, this is an area which neither author, particularly Brody, has developed. Both demand a reorientation also to the development of personal characteristics of the physician. This is in keeping with the notion of medical professionalism which authors like

Pellegrino and Thomasma have focussed on in their work on virtue, principles and duty.

## 2.3. The Synthesis of Virtue, Principles and Duty: The Contribution of E. Pellegrino and D. Thomasma

Pellegrino and Thomasma have contributed much to the debate on the limits of principle-based approaches to ethics. Their work focusses on the patient who suffers through illness and the physician who enters into the therapeutic relationship with him/her. However, for the purposes of this thesis, this section will focus on their work on the role of virtue in medical practice, since it is here that we most clearly see their position on the relationship between physician and patient.

Pellegrino and Thomasma propose that principle-based approaches to ethics are inadequate in large part as a result of their lack of development of the moral character of the agent or person engaged in making moral choices,

> Recently, principle-based ethics has come under fire for its almost formulaic approach to ethics. Based, as it is, on the application of autonomy, beneficence, and justice to individual cases, this form of ethics fails to take into sufficient account the character of the agent, as well as the nuances of real life that situate and define the moral quandary.[29]

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[29] Edmund D. Pellegrino and David C. Thomasma, *The Virtues in Medical Practice* (New York: Oxford University Press, 1993), p. xi.

However, they offer the opinion that, although they are insufficient on their own, principle-based approaches have merit and are necessary in that they provide standards against which to measure action.[30] However, in order to be a more accurate guide to moral living, they must be complemented by a virtue-based ethic, since ". . . the way principles are selected, interpreted, ordered in relation to each other, and applied, is dependent on the character of each participant in a clinical activity."[31] Neither principle-based approaches nor virtue-based approaches are complete on their own: they both have different emphases and are complementary.[32] Pellegrino and Thomasma's approach is different from other attempts to address virtue in medical ethics in that

> The other efforts link virtue theory with principle-based theories without moving through the virtue of prudence, that is, establishing right reason in action, recta ratio agibilium, as St. Thomas called it. More important, other theories neglect the intrinsic relationship between prudence, the other virtues, and the nature of medicine and professional dedication.[33]

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[30] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. xi.

[31] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. xi.

[32] Pellegrino and Thomasma refer to Tom Beauchamp in *The Virtues in Medical Practice*, p.14, who writes in "What's So Special About the Virtues?" in Shelp, ed., *Virtue in Medicine*, p. 310, " . . . no duty-based theory need deny the importance of virtues and any viable theory of principles of duty, in my judgment, will include an account of virtue. You can't have one without the other."

[33] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. xii.

Their book, *The Virtues in Medical Practice*, provides a teleological perspective to ethics in that it takes the Aristotelian and Thomistic approach to the practice of medicine by "relating the virtues of medicine as a practice to the ends of medicine."[34] They argue that

> . . . the moral essence of a health profession is the special relationship that sickness and the response to illness creates between healer and patient . . . For that reason, the virtues that interest us in this book are those that arise from the caring bond (which includes healing, caring, and curing) and the public trust implied by the commitment to care for another — faith and healing, trust, hope, compassion, courage, fidelity and the like.[35]

In attempting to link principle, duty and virtue-based ethics, Pellegrino and Thomasma urge a refocussing on the moral agent who is a "constant factor in the implementation of the moral act."[36] Their view is of medicine as a moral community, whose source for centuries was the character of the physician. For Pellegrino and Thomasma, virtues play an essential role in ethics and medicine since no matter how many policies or theories one has in place, if the "individual physician, as well as the patient, is not habitually disposed toward the good and generally to be trusted, terrible consequences occur in medicine and medical practice, from outright fraud to

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[34] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. xii.

[35] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p.xii.

[36] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p.xii.

direct harm to patients."[37] However, they continue to reiterate the limits to any one system of moral analysis. Whether it is principlism, virtue, casuistry or narrative, none is sufficient on its own. They constantly return to the moral character of the agent who interprets principles in accordance with his/her own particular circumstances.

> A moral decision is not a decision about a principle, but about the relationship of circumstances, intentions, and ends to a principle . . . The virtue of prudence, that is, practical wisdom, enables us to arrive at the right and good ordering of principles and concrete facts in particular cases. Nowhere is this truer than in medical decisions, since each person's experience of illness is unique and its relationship to moral principle is far from indisputably evident.[38]

However, their position is that good intentions and character do not suffice to ensure that choices are good. At most, they can ensure that intentions are good. The moral quality of acts will depend upon

> . . . the way intentions, circumstances, and acts relate to each other. Moral principles are the benchmarks against which we may assess the moral quality of these relationships. A complete moral theory must, at a minimum, tie some conceptual knots between duty, principles, and virtue.[39]

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[37] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p.13.

[38] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 23.

[39] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 21.

It is the relationship between these three that grounds Pellegrino and Thomasma's work on virtue. In referring to Hume, who defined virtue as a "quality of the mind agreeable to or approved by everyone, who considered or contemplates it,"[40] the writers make the point that while virtues evoke a feeling or "sentiment of approbation in others,"[41] it is through an experience of actions that virtue itself is initially perceived. The feeling, which is evoked by the action, is then confirmed through reflection and judgment as good.[42]

This is consistent with Beauchamp's and Childress' views that every principle has a corresponding virtue.[43] While Pellegrino and Thomasma find Beauchamp and Childress' work in this area compatible with their own position on the relationship between virtue and principles, they propose the need for a more precise concept which links the two. Their work on the medical virtues of compassion, intellectual honesty and benevolence attempts to provide this precision.

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[40] David Hume, *An Enquiry Concerning the Principles of Morals*, edited by J.B. Schneewind (Indianapolis: Hackett, 1988), p. 68., n.50, as cited in *The Virtues in Medical Practice*, p. 24.

[41] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 24.

[42] This is an area of Pellegrino and Thomasma's work which although not explicitly articulated in their writings, is consistent with Bernard Lonergan's work on cognition, feelings and value, which will be discussed in Chapter Three of this thesis.

[43] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 3d ed. (New York: Oxford University Press, 1989), p.379.

They define compassion as "the capacity of physicians to feel something of the unique predicament of the patient, to enter into the patient's experience of illness, and, as a result, to suffer vicariously the patient's anxiety, pain, fear (and so on)."[44] In their view, the physician can only heal the patient when he/she has compassion for him/her and makes congruent the patient's wishes as to what should be done, with what he/she is proposing medically. Without this subjective component, medicine is limited to fulfilling only the function of providing a technical response to a biological disorder.

Intellectual honesty is defined as a requirement to "disclose accurately to your patient and colleagues the extent of your knowledge and ignorance."[45] While compassion evokes a feeling in response to a concrete action, the authors contend that, in part, intellectual honesty can be perceived through actions alone. However,

> We could not be honest unless we possessed the virtue of honesty, the habitual disposition not to deceive, or to move positively to reveal what we know and do not know about the clinical situation — diagnosis, treatment, prognosis, and so on.[46]

Finally, in their discussion of benevolence, the authors note that this virtue need not necessarily be linked to its corresponding principle of beneficence. They

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[44] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 25.

[45] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 25.

[46] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 25-26.

provide the example of the physician, who not liking his/her patient, may wish to harm them, but does not do so for fear of lawsuits, reprisals, etc. While he/she may not feel benevolently toward that patient, he/she nonetheless upholds the principle of beneficence in an objective sense, by behaving in a good manner toward them. This dichotomy is not something that Pellegrino or Thomasma supports. To the contrary, they propose the ideal physician as one who is virtuous, as opposed to one who merely upholds principles and carries out the duties intrinsic to medicine. As they point out

> The importance of virtue as Beauchamp and Childress suggest, is that in any given case, the virtuous physician is more likely to act according to right principles . . . Thus the virtuous physician is one who can be trusted to act rightly in whatever circumstance he encounters. If the physician has the master virtue to prudence, she can more rightly adjust the deeper and genuine meaning of principles to the particularities of the case in question by seeing more clearly what compassion, wisdom, courage, and justice require in this case and in these circumstances. A truly satisfying conceptual linkage between virtues and principles is difficult to discern. But we know that we want a physician who is virtuous in the sense of possessing the virtues specific to achieving the ends of medicine. [47]

### 2.3. (a) Internalizing the Good: Linking Principles and Virtues

In attempting to create this formal linkage between principles and virtues, the authors note that two of the three ways in which they can be linked are inadequate,

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[47] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 26.

i.e., added on after the fact or by substituting one for the other. Those who support "adding on" virtues to principles suggest that, after first determining which acts are morally right and therefore desirable, it is only a matter of instilling the desire for the morally correct act by adding rules and/or incentives that support the right acts. Examples of this can be seen in countries like Singapore with its preponderance of laws complete with swift and heavy penalties. On the other hand, those who advocate for the substitution model suggest that once the truth has been fully integrated into each citizen of society, then the principles no longer are necessary. Against this model Pellegrino and Thomasma write,

> . . . virtue cannot substitute for moral principles. One reason is that virtues can impel us to right and good acts only generally and for the most part . . . Another way of putting this is that there is no metaphysical certitude in moral matters. So the second reason virtue cannot substitute for moral principles is that human experience demonstrates all too well that not all human beings are at the same level of moral development. National guidelines, public moral policy, and moral rules are necessary to establish a minimum expectation of everyone. This is especially important in health care, where so much care involves strangers who do not know one another, much less one another's values. [48]

A third model which the authors suggest holds more hope is one which mediates between virtues and principles. When conflicts arise among competing principles, the person of virtue mediates between and finds a method of applying

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[48] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 27.

them, "through internalization of the good as proposed by those principles."[49] In fact, this is in keeping with Bernard Lonergan's notion of the appropriation of truth which he notes occurs in both the volitional and cognitive realms. The role of affectivity and emotions is crucial here in that "virtues are incrementally more powerful dispositions to strike a balance between the two extremes."[50] Relative to the role of emotions and decision making, the authors use the example of the virtue of compassion, to show the way in which feelings and virtues can mediate conflict.

> . . . compassion would allow the physician to achieve a balance between the extremes of withdrawal from the patient's plight, on the one hand, and over engagement in the patient's life, on the other.[51]

Crucial therefore is the intent of the moral agent who is making those choices among various goods. With experience and eventually conscious choice, the agent habitually becomes oriented toward the good which then in turn orients his behaviour toward choices for the good. When one's heart and mind are focussed in the direction of the good, one's nature as a moral being is confirmed. Pellegrino and Thomasma make it clear, however, that without principles, and rules which guide those principles, virtue alone is not sufficient. Neither are principles nor rules sufficient on their own. However, the virtues provide the

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[49] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p.27.

[50] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 28.

[51] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 28.

> . . . conditions of possibility for the implementation of principles and moral rules. This is the essential linkage hinted at by Ingelfinger's intuition, that without the virtuous agent, no amount of rule making will ever change the behaviour of individuals. Simply put, internalization of the right and the good through training and disposition will not only ensure application of the meaning of moral rules to life circumstances, but will also lead to refinements of the moral principles, and even to new moral theories that will try to resolve the new issues of the day.[52]

While Pellegrino and Thomasma are advocating for a development of ethics in the relationship between principles and virtues, they note that human experience, both as individual experience and as the moral experience of communities, will impact the way in which this occurs. However, they are not implying that moral rules necessarily become so inculturated in any particular environment that they cannot be extrapolated for use in another. What it means for the authors lies in the form of a question that asks whether or not there "are indeed inherent human propensities, inclinations, disinclinations, that transcend history and culture." [53] However, what is clear for both Pellegrino and Thomasma is that the character of the moral agent, who operates within a particular community, is crucial.

While the authors describe medicine as a moral community, they note that this community is changing. They suggest that this change is perhaps in response to

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[52] Pellegrino and Thomasma, *The Virtues in Medical Practice,* p. 28.

[53] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 29. Pellegrino and Thomasma go on to say that "Movement in both directions, toward the universal moral rules and toward a universal human nature, will always be problematic from the point of view of the formal linkage of virtues with principles."

technological developments and patients' expectations. As a result, they note that there appears to be a conflict between those physicians who hold to the notion of a profession with the ensuing sense of personal accountability to a higher moral standard and those who hold that the moral expectations of physicians should be the same as any other person.

> What is most distressing is the pervasive conviction that the citadel of ethics has already fallen, that it is no longer possible to be an ethical physician, and that the only choices are capitulation, accommodation, or early retirement, with warnings to one's children not to enter the fallen city. Those who would resist feel powerless, alone, and abandoned by the profession. They justifiably complain that others cannot expect them to be sacrificial lambs trying to reverse the inimical forces arrayed against traditional medical ethics today.[54]

In order to combat this malaise, the authors suggest that the notion of a moral community be reawakened, and healed. Their sense is that physicians are already part of a moral community, albeit one which has remained latent at best, or distorted at worst. As a result of this moral community, physicians have collective, as well as individual, moral obligations to protect the welfare of sick persons in a world that increasingly treats medicine as a commodity, a "political bauble, an investment opportunity, or a bureaucrat's power play."[55]

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[54] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 32.

[55] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 32.

As a result, the medical profession has a collective responsibility to protect the sick and vulnerable. The authors propose that there must be a return to this sense of medicine as a moral community, one whose focus is on the healing relationship between the patient and the physician. This human relationship between physician and patient is characterized and defined by issues of vulnerability and inequality, the fiduciary nature of the relationship, the nature of medical decisions, the characteristics of medical knowledge and moral complicity.[56]

Given the inequality produced by the vulnerability of the experience of illness, the physician has an obligation to protect. As a result of this vulnerability, the patient is forced to trust his/her physician, who in turn promises to help, by virtue of the knowledge he/she possesses and the oath that he/she takes on becoming a physician. This is grounded in a belief that,

> trust is ineradicable, despite the fact that some ethicists today would do away with it by substituting the contract model.[57]

### 2.3. (b) Beneficence-in-Trust and The Virtues

Pellegrino and Thomasma suggest grounding the telos of medicine in the relationship between physician and patient and the virtues that are required for

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[56] Pellegrino and Thomasma, *The Virtues in Medical Practice*, pp. 41-44.

[57] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 43.

healing. They suggest that if principlism is to survive, it must be grounded in the physician-patient relationship, or in the internal morality of medicine since,

> It is oriented to the ends and purposes of the relationship. It is the degree to which decisions and actions of the moral agents — physicians and patients — approximate these ends that determines whether they are right and good. Briefly, the ends of medicine are ultimately the restoration or improvement of health and, more proximately, to heal, that is, to cure illness and disease or, when this is not possible, to care for and help the patient to live with residual pain, discomfort, or disability. There are many decisions along the way to these ends, but in each decision there is a fusion of technical and moral elements.[58]

When this occurs, beneficence is a requirement of the practice of medicine, one in which respect for autonomy and justice is obligatory since the physician owes the patient faithfulness to the trust which has been given to him/her. Pellegrino and Thomasma place a strong emphasis on a reorienting of the principle-based approach to bioethics to one which focusses on obligations to sick persons. Here the primary principle becomes

> . . . beneficence in trust - that is, beneficence that encompasses the patient's complete well-being, and not simply his medical well-being . . . This form of beneficence cannot obtain if we violate autonomy, justice, truth-telling, fidelity to trust, or promise keeping.[59]

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[58] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 52.

[59] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 53.

This notion of beneficence is capable of becoming a guide to action, one which is grounded in the humanity of each of the participants in the therapeutic alliance. Rather than autonomy-based models of contract and consumer which the authors believe are detrimental to a patient's well being, in that they tend to ignore the reality that the patient is not an equal bargaining partner due to his/her vulnerable status, Pellegrino and Thomasma propose a model based on trust between the physician and patient. Like Katz, whose conversation model is grounded in trust, Pellegrino and Thomasma's work on virtue, which focusses on the patient-physician relationship, is dependent on fidelity to trust, one of the eight virtues which they discuss.[60]

> Trust is ineradicable in human relationships. Without it we could not live in society or attain even the rudiments of a fulfilling life. Without trust we could not anticipate the future and we would therefore be paralyzed into inaction. Yet to trust and entrust is to become vulnerable and dependent on the good will and motivations of those we trust. Trust, ineradicable as it is, is also always problematic.[61]

The patient's trust of the physician is, in fact, an act of faith in the benevolence and character of the physician. Such trust, however, is a forced

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[60] The eight virtues which Pellegrino and Thomasma discuss in *The Virtues in Medical Practice*, are fidelity to trust, compassion, phronesis, justice, fortitude, temperance, integrity and self-effacement. They note that these are not all of the virtues in medical practice but that they, in the interest of time and space, have left out others like intellectual honesty, humility and therapeutic parsimony.

[61] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 65. The authors note that trust becomes more difficult in illness with the increasing vulnerability of the patient.

experience in that the patient only seeks out the physician when he/she is in need of help and has little or no choice but to trust.

> When a patient consults a physician, he or she does so with one specific purpose in mind; to be healed, to be restored and made whole, i.e., to be relieved of some noxious element in physical or emotional life which the patient defines as dis-ease - a distortion of the accustomed perception of what is a satisfactory life . . . At the point when this perception leads to the *need* to be healed, the person becomes a *patient* . . . The patient, then, is a suffering person who enlists the physician's aid in regaining a former state or a more optimal one.[62]

This ethics of trust obliges the physician to enter into a relationship with the patient in order that he/she might begin to understand what the patient's wishes might be. This clearly transcends the limits of a contractual model of physician/patient relationship which focusses on rights and obligations. Rather it demands a relationship between both who see each other as "gift" with the ensuing obligations that this implies. Relative to the issue of informed consent, an ethic of trust obliges the physician to

> . . . present clinical data as free as possible of personal or professional bias. Fidelity to trust precludes manipulation, coercion, or deception in obtaining consent. It requires assisting patients to perform the calculus of effectiveness, benefit, and burden as carefully

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[62] Edmund D. Pellegrino and David C. Thomasma, *A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethic of the Healing Professions* (New York: Oxford University Press, 1981), pp. 122-3.

> as the situation permits. It is here that other virtues intersect, virtues such as intellectual honesty and humility.[63]

Against a paternalistic approach, they argue that if the patient is competent, he/she must be allowed to make choices even if those choices are not what we think are good for him/her.

> The traditional stance of benevolent authoritarianism in the patient-physician encounter is increasingly under scrutiny and challenge. More patients want full disclosure of the therapeutic alternatives. Legal opinion is unanimous in requiring informed consent not only in experimental procedures but in the ordinary therapeutic encounter.[64]

Coercion, manipulation and misinformation on the part of the physician are violations of the integrity of the patient.

> Only the patient can free us of the obligation to abide by her choices by giving us a mandate to make decisions for her if she feels emotionally or intellectually overwhelmed by the complexity of the choices. But even in the act of yielding up her prerogative, the patient exercises her freedom by choosing not to make a choice. The physician can never presume to usurp that prerogative. The freedom to choose, and to be responsible for the outcome of those choices, is the ground upon which any reasonable notion of autonomy and beneficence is built.[65]

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[63] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 76.

[64] Pellegrino and Thomasma, *The Philosophical Basis of Medical Practice*, p. 160.

[65] Edmund D. Pellegrino and David C. Thomasma, *For The Patient's Good: The Restoration of Beneficence in Health Care* (New York: Oxford University Press, 1988), p. 81.

For the authors, beneficence in trust becomes the ordering principle that mediates between conflicting principles and values, in particular between autonomy and paternalism.

> We call this sort of beneficence, one that encompasses several other ethical principles, *beneficence-in-trust*. By beneficence-in-trust we mean that physicians and patients hold 'in trust' (Latin, *fiducia* ) the goal of acting in the best interests of one another in the relationship. In the main, the patient's fulfilment of this trust resides in carrying out the negotiated plan for his or her health. The burden of trust more often belongs on the physician, who must act in the best interests of the patient under the conditions we have already discussed, including social conditions.[66]

In providing guidelines for addressing specific values, the authors abstain from giving explicit rules. While their work in this regard may appear to be vague at first glance, it in fact is much more effective than a stance which is limited to a rule-based approach. The completeness of their position rests on their careful working out of a fourfold hierarchy of values which all relate to the patient's good as a way of resolving conflict between competing values and principles. [67] The physician is obligated to promote all four components of the patient's good if he/she is to enter into a relationship with the patient. He/she is obliged to foster the

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[66] Pellegrino and Thomasma, *For The Patient's Good*, pp. 54-5.

[67] This opinion is supported by Erich H. Loewy, "Beneficence in Trust," *Hastings Center Report* 19, 1 (January/February 1989), p. 43.

> (1) ultimate good — that which constitutes the patient's ultimate standard for his or her life's choices, that which has the highest meaning for her; (2) biomedical good — that which can be achieved by medical interventions into a particular disease state; (3) the patient's perception of her own good at the particular time and circumstances of the clinical decision and how she prefers to advance her own life plan; and (4) the good of the patient as a human person capable of reasoned choices.[68]

In this way, an ethic of trust, grounded in the virtue of the physician, transcends principle and duty-based approaches to ethics. While this framework demands a "reconciliation between autonomy and beneficence,"[69] it also depends on the formation of character and a return to professionalism, since "virtue is best taught by practice"[70] and by modelling teachers who themselves are virtuous.

### 2.3. (c) The Relationship Between the Virtues and Theology

The authors are adamant in their stance that philosophical bioethics is insufficient on its own. They propose that Christian theological ethics provides a necessary corrective in the sense that it links ethics with a source for the meaning of human life. It is a necessary supplement to philosophical ethics if a complete medical morality is to be found."[71] While the authors' notion of beneficence in trust is pivotal

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[68] Pellegrino and Thomasma, *For The Patient's Good*, pp. 76-7.

[69] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 77.

[70] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 77.

[71] Edmund D. Pellegrino and David C. Thomasma, *Helping and Healing: Religious Commitment in Health Care* (Washington, D.C.: Georgetown University Press, 1997), p. 129. David Thomasma has also written on the relationship between human dignity and medicine in David C. Thomasma, "The Basis of Medicine and Religion: Respect for Persons,"

to their understanding of the role of virtue in medical practice, beneficence like justice depends on love.

> Charity is the first principle of Christian justice. It could be similarly argued on philosophical grounds that justice is ultimately rooted in benevolence and beneficence. In this way, love can be the first principle of naturalistic and of Christian ethics.[72]

Not only does beneficence in trust have an affective component, so too does the virtue of compassion which the authors discuss depend in large part on affective development.

Compassion, which is a virtue that is central to the practice of medicine, is a

> . . . compound of affect, attitude, word, gesture, and language . . . it encompasses a moral and an intellectual component. Compassion, like other virtues, is related to emotional states out of which it may emerge and with which it may be expressed. But virtues are more than emotions. . . A good physician does not just apply cognitive data from the medical literature to the particular patient by reason of a catalog or "cook-book" of indications. Rather, the good physician cosuffers with the patient.[73]

While there is an affective component to all of the virtues,[74] affect is not enough for moral development. The authors note the need for intellectual

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in *Hospital Progress* 60, 9 (September 1979), pp. 54-57.

[72] Pellegrino and Thomasma, *Helping and Healing*, p. 149.

[73] Pellegrino and Thomasma, *The Virtues in Medical Practice*, pp. 79-80.

[74] Robert C. Roberts, "Emotions Among the Virtues of the Christian Life," *The Journal of Religious Ethics* 20 (1992), pp. 37-68. Roberts argues on p. 37 that in every system of virtues ". . . be it Christian, Aristotelian, Stoic, Humean utilitarian . . . the emotions play an especially central role."

development in the development of the character of the virtuous physician. Cognitive and affective development are necessary in order to best heal the patient and must be kept in balance.

> To carry out this cognitive function of the virtue of compassion requires, paradoxically, a certain *épоche*, a suspending of the attachment that the affective component requires, so that we may objectively stand back and measure, weight, feel, test, question, — in short, uses the tools of medical diagnosis to define the predicament and to symbolize it in appropriate language. The physician's effort should be to shape treatment recommendations to accommodate all those things — persona, emotional, and social, as well as physical — that makes *this* illness a unique experience for *this* person. Compassion, thus, has an objective component that can be ascertained by the methods of medicine and grasped cognitively and that, together with the moral component, makes it a virtue.[75]

While it is not enough for a physician to be a master of technical skills, neither is it sufficient to feel compassion for his/her patient. In fact, compassion demands competence, in that "nothing is more inconsistent with compassion than the well-meaning, empathetic, but incompetent clinician. Compassion must co-exist with competence"[76] if the patient is to be healed.

The need to balance and properly use the virtues in order to heal the patient, demands phronesis, which is the "intellectual virtue that disposes us habitually to

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[75] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 80.

[76] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 83.

attain truth for the sake of action, as opposed to truth for its own sake."[77] However, they note that the concept of prudence is more complete in that it

> . . . takes into account the full breadth of Aristotelian phronesis, but in addition, its discerning capacity extends to the supernatural virtues of faith, hope, and charity — as well as to the moral and intellectual virtues recognized by Aristotle.[78]

They note that for Aquinas, prudence was the

> . . . capstone virtue, the link between the intellectual, moral, and supernatural virtues. It was the indispensable connection between cognition of the good and the disposition to seek it in particular acts.[79]

It is the authors' view that, given the reality of the daily practice of medicine, in which principles often appear to conflict with values, and issues of trust, respect and loyalty are challenged, it is the virtue of prudence that mediates the struggle. Without it, the role of clinical judgment becomes obsolete and medical decisions are based purely on an analysis of outcomes. Not only is the virtue of prudence mandatory for the practice of medicine, but also for the purpose of this thesis, which is to develop a model of consent in which emotions and intellect play a part. While Pellegrino and Thomasma do not clearly articulate or develop the role that emotions play in medical decision making, their work on virtue has a strong affective

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[77] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 84.

[78] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 85.

[79] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 84.

component. In particular, in their discussion of the virtue of prudence, we see a link between the intellect and affect in the process of decision making, with their statement that

> It may be that prudence, besides linking the intellectual and moral virtues, may link the emotions with the virtues, perhaps closing the gap between cognition of the good and motivation to do the good. Prudence has this possibility, since it combines reason with disposition.[80]

We see a further evidence of the relationship between affect and virtue in the authors' discussion of the virtue of justice. They note that their notion of justice is transformed by a theory of the virtues. While contemporary theories of justice describe it as

> . . . a claim we have on the community — compliance with which is an obligation of communal living. In its highest expressions, it might be justified as owed to humans because they are worthy of respect and dignity. On the view of the virtues, however, justice has its deepest roots in love; it is an extension of the charity we should show to others. Not to do justice would be to relapse into self-interest, to turn from love of the other to love of self. Love testifies that the claims of others upon us are the claims of our brothers and sisters in a community of compassion and care. By that fact, individuals are entitled to be loved, especially in health care settings. Love generates and transmutes . . . It is not only knowledge that generates justice, as in Plato or Aristotle, but the loving concern of the community of care itself.[81]

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[80] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 90.

[81] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 95.

The authors point out that, in becoming aware of the call to love and in responding to this call, medicine is transformed from a profession to vocation. No doubt this notion of justice is difficult, particularly in a medical environment which places such a strong focus on individual autonomy and at the same time operates within a situation with limited resources, gate keeping and increasing longevity. However, as James Drane says,

> It is one thing to cultivate the urge for fairness; another to know what fairness is. All virtue involves the use of prudence and intelligence because virtues are refinements of human persons who cannot help but be in the world in an intelligent way. There is no such thing as blind virtue or ignorant virtue or unconscious virtue.[82]

Pellegrino and Thomasma are of the opinion that coping with this situation requires the virtue of fortitude or moral courage, particularly with regard to feelings of fear and confidence. They define fortitude as the

> . . . virtue that renders an individual capable of acting on principle in the face of potential harmful consequences without either retreating too soon from that principle or remaining steadfast to the point of absurdity . . . Physicians need fortitude to do the right thing when it is required and expected of them, given their role in life.[83]

The authors note that, in the current medical milieu, with its movement to two-tier medicine and third-party providers, and in a society in which increasing poverty,

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[82] James Drane, *Becoming a Good Doctor: The Place of Virtue and Character* in *Medical Ethics* (Kansas City, MO: Sheed & Ward and The Catholic Health Association, 1988), p. 106.

[83] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 111.

individualism and depersonalization coexist, the physician requires fortitude to advocate for those vulnerable members of society who fall through the cracks of the health care system and are devalued by the same society of which they are a part.

This call to action on the part of the physician also requires the virtue of temperance, which in its role as a moderator of desires, is also equated with wisdom. Increasing advances in technology and the basic human propensity to take charge, present a significant challenge to the practice of medicine. As a result, temperance is necessary in order to be able to relinquish control and to avoid "playing God." In these instances we see the necessary relationship between the virtues in that the limiting of medical treatment, particularly in the dying patient, will depend on the virtues of temperance, fortitude, prudence and justice. [84] As a result of the virtue of temperance, there is an acute necessity for the physician to have "exquisite knowledge,"[85] not only of the physical condition and needs of the patient, but also of his/her values in order that he/she may assess the quality of a variety of outcomes in relation to those values. The authors define temperance as

> . . . the constant disposition of physicians toward responsible use of power for the good of their patients, avoiding, on the one hand, underuse of technology and other interventions, with its consequent

[84] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 122.

[85] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 122.

> abandonment of patients, and, on the other, overuse of interventions and technology.[86]

While we see with the virtue of temperance in relation to medical decisions about futility, a further example of the relationship between the virtues, we see with the virtue of integrity and its subsidiary, intellectual honesty, a description of the ideal person who integrates all of the virtues.

> To say that someone possesses integrity is to claim that person is almost predictable about responses to specific situations, that he or she can integrate all the virtues into a whole and can prudentially judge the relative importance in each situation of principles, rules, guidelines, precepts, and the other virtues in reaching a decision to act. Clearly, a virtuous physician and a virtuous patient, working in a concert of interests that is the doctor-patient relationship, must possess this virtue to bring about the healing aim of the relationship. [87]

**2.3.(d) The Virtues and Personal Authenticity**

Pellegrino and Thomasma note that, in spite of the current focus on autonomy, the concept of integrity is more crucial to the development of the human person. However, both autonomy and integrity are related to trust, which is the prerequisite for both. While in law, the principle of autonomy develops out of the notion of privacy, both are expressed most clearly in the legal doctrine of informed consent, which

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[86] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 122.

[87] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 127.

> . . . has become the central requirement of morally valid medical decision making. For consent to fulfill the claims of human beings to self-governance, it must be based on sufficient information to make a reasoned choice and must be free of coercion or deception. The procedures surrounding informed consent are designed to facilitate the capacity of rational beings to make judgments of what they consider best, rather than what the physician or any other person might consider best for them.[88]

The authors offer the opinion that integrity demands that all parts of human personhood maintain a correct order in relation to the whole. Neither the intellect, nor affect, nor bodily functions take precedence over the others, although at different times and in different situations, each may be expressed more than others. However, all must be in keeping with the good of the whole person. In illness, bodily needs take precedence over other aspects of the person with the result that there is a disunity in the whole.

> This ontological assault of illness is aggravated by the loss of certain specific freedoms which we identify as peculiarly human. The patient is no longer free to make rational choices among alternatives. He lacks the knowledge and the skills necessary to effect a cure or to gain relief from pain and suffering. Voluntary or not, the patient is forced to place himself under the power of another person, the health professional, who has the knowledge and the skills which can heal — but also harm. This involuntary need grounds the axiom of vulnerability from which follows the obligations of the physician.[89]

Similarly, illness challenges personal values which may appear to conflict with the values of family, friends, of physicians. It is as a result of the potential for

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[88] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 129.

[89] Pellegrino and Thomasma, *The Philosophical Basis of Medical Practice*, p. 208.

disunity in the person, that the physician is under a greater obligation to heal or make whole. The obligation to heal is pivotal to the covenantal aspect of the Hippocratic oath since

> Restoration of the integrity of the person is the moral basis of any genuinely holistic medicine.[90]

It is within this understanding of integrity, that Pellegrino and Thomasma express the view that the moral claim for autonomy is derived from the "fundamental claim for preservation of the integrity of the person."[91] While privacy and autonomy are necessary for integrity, they are not sufficient. The preservation of autonomy also depends on the character of the physician, who in fidelity to the issue of trust in the healing relationship, interprets and applies the principle of autonomy.

> Clearly, no contract, law, or abstract ethical principle can eradicate the need for trust, just as it cannot be eradicated from all other human relationships. The present emphasis on autonomy has been extremely significant in reducing the grosser violations of the integrity of persons. But the physician's responsibility for safeguarding the patient's autonomous wishes still depends strongly on his character.[92]

As a result, the physician must be a person of integrity if he is to restore the patient to integrity or wholeness. With this notion of autonomy, neither the patient

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[90] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p 130.

[91] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 131.

[92] Pellegrino and Thomasma, *The Virtues in Medical Practice*, p. 132.

nor the physician makes decisions in isolation from the other, but rather in conversation with the other.

Pellegrino and Thomasma have suggested a renewal of a virtue-based approach to ethics, one which complements but does not supplant principlism. In their discussion of the virtues in medicine, one gets a glimpse of their view that feelings and intellect must work together if one is to foster virtue. This is the strength of their work, in that it is an area of thought which clearly underlies their writing. However, the weakness of their position lies in the fact that they do not take the further step of distinguishing between those feelings which are positive influences on character and those that are not. Neither is the role of feelings as they relate to decision making, and in particular, informed consent (which is a specialized form of decision making) and human authenticity developed.

In several places in their work, Pellegrino and Thomasma reinforce the importance of a relationship of trust, as a model for the physician-patient relationship. Their position is that neither a contract model, nor a consumer model in which patients purchase services, is consistent with the characteristics of a therapeutic relationship grounded in beneficence-in-trust and in the virtues. While their work does not develop the relationship between physician and patient in terms of a covenant, it alludes to it in several places throughout their writings. This is an

area of thought which has been well developed by William F. May and serves as a necessary complement to their work on an ethics of virtue.

## 2.4. Feelings and Ethics: The Contribution of R. Charon and W. F. May

May's work on covenant uses literature to provide an analysis of images and their impact on the narrative story of life. As Lawrence J. Schneiderman writes in his article "In Medicine, Linking, Metaphors and Numbers,"

> Great literature, for example, if nothing else, can teach physicians to tolerate ambiguity, help connect them to the historical past as well as to their own spiritual and emotional presence, reawaken sensibility that has been scorched by overexposure, and reestablish the kinship of mortality between physicians and patients.[93]

William F. May uses literature to draw out the main thesis of his work, which revolves around the premise that current images of the physician as Parent, Fighter, Technician and Teacher are inadequate — what is required is an image of the healer as covenanter. The use of literature, which May invokes, has been a recent addition into medical school curricula,[94] and an understanding of its framework is crucial to an understanding of May's message. Here, the work of Rita Charon provides a necessary prior step to understanding the contribution which May makes

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[93] Lawrence J. Schneiderman, "In Medicine, Linking, Metaphors and Numbers" *Hastings Center Report* 14, 3 (June 1984), p. 41.

[94] Rita Charon et al., "Literature and Medicine: Contributions to Clinical Practice," *Annals of Internal Medicine* 122, 8 (April 15, 1995), pp. 599-606.

to the field of medical ethics. As a result, the first part of the following section begins with a brief synopsis of Rita Charon's views on the contribution of literary approaches to medicine. Following this will be a discussion of May's particular use of a literary approach.

### 2.4. (a) Literature and Medicine: The Contribution of R. Charon

Charon notes that when students enter medical schools, they bring with them a complex set of experiences "in the conflicts between identity and objectivity."[95]

> If they have read fiction, witnessed drama, watched films, they have had experience in taking on another's point of view. They may have labelled a film 'sentimental' because it tried cheaply to enlist them on a purely emotional level. They may have labelled another 'cerebral' because it didn't allow its characters to move through a genuine range of feelings. They have had experience in identification with a character while preserving their objective stance. Writing fiction calls forth this power of simultaneous identification and distance.[96]

While Charon is not writing explicitly about informed consent in this context, her notion of the importance of simultaneous identification and distance and the unity of emotions and intellect in human nature is crucial to the work of this thesis. Charon's work involves teaching physicians to imagine the lives of their patient through writing their story. In writing and imagining what the patient is

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[95] Rita Charon, "To Render the Lives of Patients," *Literature and Medicine* 5 (1986), p. 64.

[96] Charon, "To Render the Lives of Patients," p. 65.

experiencing, Charon believes that physicians become connected with the patient's feelings and with the meaning of illness to their lives.

> The act of writing leads both to empathy and to objectivity, and gives experience to the writer in an oscillation between the two, similar to the oscillation that occurs when a physician or student cares for a patient . . . The writer can use the objectivity as food for the empathy and vice versa, and can experience them not as conflicting but as dual aspects of the same task. They need not cancel each other out.[97]

Charon's work on literature and medicine focusses on helping physicians to understand not only their patient's feelings, but also their own. Only by humanizing medicine in this way does it become reoriented to its proper task of healing. Only by understanding their patient's suffering can physicians "accompany patients through illnesses with empathy, respect and effective care."[98] Charon proposes using literary methods as a way of teaching physicians how to listen and understand diagnosis and treatment decisions from the patient's point of view. In so doing, she notes that the therapeutic alliance is strengthened and physicians and patients are able to make decisions oriented toward a common goal.

In her work, Charon notes that patients often believe that their physician does not really understand how they feel. This leads to a sense of alienation and impedes the patient's ability to engage in discussions about his/her illness and treatment.

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[97] Charon, "To Render the Lives of Patients," p. 65.

[98] Charon et al., "Literature and Medicine," p. 599.

Literary accounts of illness bridge this gap between the "humanistic content of ordinary medical encounters as well as the hypothesis-generating and ratifying processes that constitute diagnostic reasoning"[99] and in so doing strengthen the relationship between the physician and the patient.

Charon notes in fact that narrative and literary methods are already embedded in the medical interview.

> Evaluating patients requires the skills that are exercised by the careful reader; to respect language, to adopt alien points of view, to integrate isolated phenomena (be they physical findings or metaphors) so that they suggest meaning, to organize events into a narrative that leads toward their conclusion, and to understand one story in the context of other stories by the same teller. To make sense of clinical information, physicians rely on skills that belong to the narrative sphere of knowledge. Unlike logico-scientific knowledge, narrative knowledge configures singular events befalling human beings or human surrogates into meaningful stories.[100]

Charon's focus on literary methods and narrative is an attempt to help physicians develop the skills necessary for the imagination to understand feelings and meanings around illness. Hers is an attempt to help physicians to recognize "their affective selves."[101] Charon notes that narrative ethics

> . . .offers the kind of knowing that the German neo-Kantians called *Verstehen* — a powerful, concrete, rich sense of the feelings, values,

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[99] Charon et al., "Literature and Medicine," p. 601.

[100] Charon et al., "Literature and Medicine," p. 601.

[101] Charon et al., "Literature and Medicine," p. 602.

> beliefs, and interpretations that make up the actual experience of the sick person . . . Narrative skills can help the clinician to be sensitive to moral questions as they occur, to integrate questions about values and beliefs into the routines of medical care, and to make contact with the conflicts, tragedy, humor, irony, and ambiguity that contribute to each human life.[102]

Crucial to Charon's work is an understanding that the moral sense resides in the creative faculties as opposed to reason. "Attainment to the right and the good is attained by imaginatively rendering, for oneself, the situations of others."[103] For Charon, only literature is capable of adequately addressing the "complex resonance of human choice and human desires."[104]

What Charon has found in her work is that physicians, "*by inspecting the narrative frames of their medical actions*, find ethically appropriate solutions to their clinical dilemmas."[105] In summary, Charon believes that the field of literature and medicine is capable of developing necessary "skills in the human dimensions of medical practice."[106] These skills require a development of the affective component of human personhood and the ensuing ability to empathize and respect patients. While Charon and William F. May have not written collaboratively, it is this author's

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[102] Charon et al., "Literature and Medicine, " p. 602.

[103] Charon et al., "Literature and Medicine," p 602.

[104] Charon et al., "Literature and Medicine," p. 603.

[105] Rita Charon, et al., "Literature and Ethical Medicine: Five Cases From Common Practice," *The Journal of Medicine and Philosophy* 21, 3 (June 1996), p. 246.

[106] Charon et al., "Literature and Medicine," p. 599.

view that Charon's notion of narrative and her view of the role which feelings play in medicine is aligned with May's use of narrative and images in his discussion of the covenantal aspect of the physician-patient relationship.

### 2.4.(b) The Notion of Covenant: The Contribution of W. F. May

Medicine today has become focussed on the rational and intellectual with its emphasis on outcomes, quantification and replication. As a result, the role of the humanities has been ignored, as has the role which the imagination can play in medicine. We have seen that Rita Charon's work on narrative ethics places a strong emphasis on the role which emotions and the imagination have in medicine: so too is William F. May's work grounded in the creative acts of the imagination and in feelings.

While bioethics over the last twenty-five years has focussed on the ordering of principles and the development of rules, such development is in May's view inadequate, in that it has "not offered much insight into those ordeals confronting patients (and sometimes practitioners) that do not wholly admit of solution."[107] May believes that these problems need to be faced, rather than solved, since

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[107] William F. May, "On the Many Voices of Bioethics," *Hastings Center Report* 24, 3 (May/June 1994), p. 26 .

> Moral reflection about such events does not simply trace back to a brace of sometimes conflicting principles; it forces meditation on the human condition; it probes one's deepest convictions; it may even unsettle one's habits; it asks of the agent the mobilization of resources, some of them already in place but untested; others, as yet, unbidden.[108]

While the question of the meaning of illness and human suffering demands an approach that transcends any one ethical system, "the success or failure of every system depends partly upon the habits of heart of the citizenry."[109] It is from within this literary and narrative framework, with its focus on feelings, that May offers his notion of the covenantal relationship between physician and patient. Regarding the image of covenant May writes,

> That image appears early in the Western theological tradition. It centers in the covenants between God and humankind, which the Scriptures gather up into a canon, and which are designated the Old and New Covenants. But the image itself also springs from ancient political precedent in the treaties between political powers and in the vows of marriage, friendship, and the professional relationship.[110]

In his book, *The Physician's Covenant: Images of the Healer in Medical Ethics*, May notes that his work

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[108] May, 'On the Many Voices of Bioethics," p. 27.

[109] May, "On the Many Voices of Bioethics," p. 27.

[110] William F. May, *The Physician's Covenant: Images of the Healer in Medical Ethics* (Philadelphia: Westminster Press, 1983), p. 23.

> . . . takes a different tack. It explores rather the pervasive role of images, particularly of metaphors, in understanding the healer's role and defining his or her tasks.[111]

May's view is that the humanities offer the possibility of exploring the relationship between values and meaning and the role which imagery places. The image which preoccupies May's work is that of the healer as covenanter. However, this image, while necessary, is not sufficient: one needs the clarification and completion which the images of the healer as parent, fighter, technician and teacher provide. His book attempts to place each of these images within the context of the Western biblical tradition which

> . . . affirms the holy of holies to be creative, nurturant, and donative, rather than destructive. It does not deny the reality of disease, suffering, and death but puts them in the context of a power that transcends them. God ultimately encompasses disease and death.[112]

**2. 4.(b)(i) Necessary But Insufficient Images**

For May, the image of the healer as parent portrays the physician as one who is known by the family personally and in fact assumes the role of father in the family unit. As parent, he/she suffers with the patient and has compassion for him/her. As opposed to the philanthropist, the physician as parent always involves some measure of self-expenditure. However, May notes that this image has declined in modern

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[111] May, *The Physician's Covenant*, p. 116.

[112] May, *The Physician's Covenant*, pp. 32-33.

society with a shift from a familial to a contractual model. He writes that the major differences in these models are the notions that

> The first type of social organization derives community from origins (family, church, and nation); the second type bases community chiefly on shared ends (of workplace, interest groups, and free associations). The first derives largely from the fate of birth; we inherit it. The second emerges from shared goals; society chooses it. The first orients to the past; it relishes permanence. The second orients to the future; it adapts to the contingent.[113]

It is May's position that the transient nature of today's life transforms the image of the physician as parent, and encourages contractualism. Today's physicians and patients are strangers who "exchange services for money; they do not face a crisis as surrogate family members."[114] However, the image survives, albeit in the modified form of managerialism or puppeteerism, in which there is a "behind the scenes management of. . . (patients') . . . lives"[115] by physicians, with the result that the best of the image is destroyed and the worst is kept. While the anti-paternalists oppose this distorted image, anti-paternalism too has negative implications for the practice of medicine and the relationship between the patient and the physician. This is particularly evident relative to informed consent, according to May.

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[113] May, *The Physician's Covenant*, pp. 42-43.

[114] May, *The Physician's Covenant*, p. 43.

[115] May, *The Physician's Covenant*, p. 43.

His views are that "anti-paternalism can increase paternalism by shifting the burden of proof from the physician and forcing the patient to prove his/her competence."[116] What results is a reinforced paternalism, one which encourages paternalists to justify their interventions by

> . . . appealing to the patient's relative incompetence, the minimal nature of the deprivation to which the patient is subjected, and the great evil from which he or she will be protected — but also by appealing to the positive goods to which the paternalistic intention will lead.[117]

Not only do anti-paternalists fail to promote the patient's good when they override his/her autonomy, they also fail when they take a minimalist approach and focus only on the patient's right as a decision maker. In his discussion of paternalism and anti-paternalism and the distortion of the image of the physician as parent/healer, we see an underlying position that points to the limits of a model focussed too strongly on reason, rights and the law.

> Autonomists fail to serve the patient's good if they do not engage in the hard work required to assist the patient in making better decisions and developing the habits of good health. The overbearing paternalist hardly qualifies as the moral ideal, but neither does the take-it-or-leave-it dispenser of technical services. Informing the patient, persuading the patient, and helping the patient to live with the

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[116] May, *The Physician's Covenant*, p. 54.

[117] May, *The Physician's Covenant*, p. 60.

> consequences of disturbing information takes time and patience, and sometimes even the persistent love of a parent.[118]

However, in spite of its limitations, May's position is that the image of the physician as healer, while flawed, is attempting to articulate the necessity "for a compassionate, sometimes, sacrificial, authoritative, and nurturant devotion to another's good."[119]

May's discussion of the image of the physician as fighter focusses on the notion that medical technology should be used like weapons of war in the fight against disease by the physician/fighter who is specially trained in using medical paraphernalia to combat disease. However, here again the patient suffers, this time as a result of an overindulgence in the fight against disease and death.

> The machine becomes autonomous. Instead of the machine serving the patient's life and assisting that person's recovery so as to permit him or her once again to serve others, the patient serves the machine. The patient becomes a demonstration of the potency of the machine and the virtuosity of the medical team.[120]

Underlying the success of this image is the notion that death must be avoided at all costs, and that suffering is ultimately evil. However, in May's opinion, this negative approach to suffering and death results in either a vitalist perspective, one which holds life as sacred no matter what the quality, or the opposing perspective

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[118] May, *The Physician's Covenant*, pp. 61-62.

[119] May, *The Physician's Covenant*, p. 62.

[120] May, *The Physician's Covenant*, p. 65.

which maintains that only a life of good quality is worthwhile. Underlying both perspectives is a belief that life is a good created by humankind, rather than God, and the notion that God cannot transcend disease, suffering and death. Against this position, May writes that a Christian theological perspective

> . . . prohibits a commitment to an unconditional fight against death. The medical profession ought not to define itself wholly by the effort to prolong life at any cost. The profession should be free to respond to patients' requests to cease and desist in the medical struggle when the patient has fought the good fight and finished the course and medical resistance can no longer serve his or her health.[121]

Rather than a medical model which focusses on maximal treatment, May proposes one whose goal is to provide optimal care. However, May's view of optimal care is one which argues against the image of the physician as fighter and medicine as focussed on a war against disease.

> Full throttle efforts to cure or to keep alive may in fact neglect the patient, gagging that person with the irrelevant, while denying what he or she truly needs. It may overlook the patient's real condition and wants.[122]

As a result of this position, May proposes that

> . . . the issue of informed consent poses more deeply the question of the human possibility for dignity, humility and courage in facing

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[121] May, *The Physician's Covenant*, p. 73.

[122] May, *The Physician's Covenant*, p. 76.

> death; knowledgeable consent to procedures that may go awry rests on a willingness at some level to face one's own dying.[123]

The image of the physician as fighter leads to another image which May discusses and ultimately finds inadequate — the physician as technician. Here, the notion of excellence in one's technical performance can be traced back to the Hippocratic tradition in which love of humanity justified love of one's art. Here May refers to the Spanish historian of medicine, Pedro Lain Entralgo, and his notion of the relationship between *philanathropia* and *philotechnia.*[124] While the written codes of the modern medical guild also subordinate love of one's art to love of humanity, May proposes that, in reality, philanthropy tends to be subordinated to competence. He suggests that underlying this may be an unwritten motivating factor that attempts to protect the physician from over-involvement with his/her patient.

> Under these circumstances, a code that centers in technical performance serves an invaluable psychological function. It does not encourage personal involvement with the patient; and it helps free the physician from the destructive consequences of involvement. [125]

May calls for a balancing of the technical and cognitive aspects of medicine with the creative and affective components. Not only must the healer diagnose and attempt to cure a disease, so too must he/she treat the illness of which "disease

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[123] May, *The Physician's Covenant*, p. 78.

[124] May, *The Physician's Covenant*, p. 92.

[125] May, *The Physician's Covenant*, p. 97.

forms but a part."[126] In order to do so and to return the patient to wholeness, however, the patient must "accept some responsibility for a unitary, comprehensive, and concrete governance of his or her life and health."[127] He notes that

> Studies have shown that patients will not accept this responsibility as readily unless they, to some degree, share in the physician's knowledge and understanding. In effect, the physician cannot engage in artistic reconstruction unless the patient personally internalizes the need to resculpt his or her life.[128]

The quest for healing and for wholeness, according to May, requires that the physician and patient enter into a covenantal relationship with each other. However, while May's work on moral theory focusses more on the notion of covenant and virtue than on obligation and principles, he does not propose that a virtue-based ethics is devoid of principles or the element of obligation. [129]

### 2.4.(b)(ii) Covenant, Contract or Philanthropy

May's position on the image of the physician as covenanter grounds his view of covenantal ethics which places "human givers in the context of a primordial act of

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[126] May, *The Physician's Covenant*, p. 104.

[127] May, *The Physician's Covenant*, p. 105.

[128] May, *The Physician's Covenant*, p. 105.

[129] See William F. May, "The Virtues in a Professional Setting," in K.W.M. Fulford et al., eds., *Medicine and Moral Reasoning* (New York, NY: Cambridge University Press, 1994), pp. 75-90.

receiving a gift not wholly deserved which they can only assume gratefully."[130] The three elements of covenant which are crucial to an understanding of May's work on the physician's covenant are gift, response and a set of ritual and moral obligations which are connected with the promise. May notes that the primary religious covenant focuses on the following: "first an original gift between the soon-to-be covenanted partners (the deliverance of the people from Egypt); second, a promise based on the original or anticipated gift (the vows at Mt. Sinai)."[131]

While the notion of covenant takes its roots in the biblical context, it also figures prominently in the Hippocratic tradition in which the physician has first a duty to his/her patients, secondly a "covenantal obligation to one's teacher and his family; and third, sets both within the context of an oath to the gods."[132] It is the sense of indebtedness, or responsiveness to gift, which the physician owes to his/her teacher that provides the foundation for May's use of the image of physician as covenanter. Compared to this are the duties which the physician provides to the patient and which, rather than being grounded in a sense of indebtedness in

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[130] May, *The Physician's Covenant*, p. 108.

[131] May, *The Physician's Covenant*, p. 108

[132] May, *The Physician's Covenant*, p. 109. The duties to patients include a set of prohibitions and positive injunctions, and are philanthropic in nature; the covenantal obligations to one's teacher and his family are of a filial nature.

response to a gift, arise either out of a misguided sense of philanthropy, or out of a focus on a contract or services in return for payment.

May believes that these two positions, contract and philanthropy, arise in part out of the detachment of the Hippocratic Oath from the religious vow of promises to the gods. It is the notion of indebtedness to humanity as a response to indebtedness to God which is crucial to May's notion of the physician as covenanter. As a result, his perspective is that philanthropy succumbs to the "conceit of philanthropy, when it assumes that the professional's commitment to patients is a wholly gratuitous, rather than a responsive act."[133] In fact, May suggests that the profession of medicine owes a large debt to the community and to patients. Not only is the physician a benefactor, he/she is also "a beneficiary"[134]in the sense that he can neither learn how to practice medicine, nor continue to practice medicine without the patient. Physicians do not act primarily as

> . . . godly benefactors but as those who, first and foremost, benefit. The human activities of healing, teaching, parenting, and the like, do not create — that is God's work — but from beginning to end,

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[133] May, *The Physician's Covenant*, p. 112. May is critical of this notion of philanthropy as wholly gratuitous, which he finds condescending. He voices the opinion on p. 113 that "the code offers the picture of a relatively self-sufficient monad, who out of the nobility and generosity of his disposition and the gratuitously accepted conscience of his profession, has taken upon himself the noble life of service." This for May is a false posturing which is entirely out of keeping with the reality of the profession of medicine which in fact owes a great deal to patients.

[134] May, *The Physician's Covenant*, p. 115.

> respond. Only within a fundamental responsiveness do professionals undertake their secondary little initiatives on behalf of others.[135]

While pragmatism falls prey to conceit and therefore is inadequate, the notion of the physician as contractor, while limited, has some obvious benefits that May outlines, particularly in the area of informed consent.

> First, it breaks with more authoritarian models (such as parent or priest) . . . It emphasizes informed consent rather than blind trust; it encourages respect for the dignity of the patient, who does not, because of illness, forfeit autonomy as a human being; it also encourages specifying rights, duties, conditions, and qualifications that limit the contract. In effect, it establishes some symmetry and mutuality in the relationship between doctor and patient as they exchange information and reach for an agreement, tacit or explicit, to exchange goods . . . Second, a contract provides for the legal enforcement of terms on both parties and thus offers each some protection and recourse under the law to make the other accountable under the contract. Finally, a contract does not rely on the pose of philanthropy or condescend as 'charity.' It presupposes frankly that self-interest primarily governs people.[136]

However, although it has these merits, May believes that the notion of contract is, on its own, insufficient to fully describe the ideal relationship between doctor and patient. His belief stems primarily from the fact that contract "suppresses the element of gift in human relationships."[137] While this appears to contradict May's criticism of philanthropy, it is, in fact, entirely consistent with his view that it is

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[135] May, *The Physician's Covenant*, p. 116.

[136] May, *The Physician's Covenant*, p. 117.

[137] May, *The Physician's Covenant*, p. 118.

pretentious of physicians to see themselves as sole givers.[138] Not only does contract fail to address the notion of gift, it tends towards minimalism in the sense that it limits duties to the specifications of a contract, rather than to the larger sense of professional obligation. While contracts are external to the parties involved, covenants address a deeper personal reality and are therefore both internal to and constitutive of human relationships. Interestingly, May notes that not only do contracts often produce a minimalistic approach to medicine, they can have the opposite effect, in that they are conducive to the practice of both a defensive and a maximalistic medicine.

> Under the pressure of fear of disease and death, patients often push for the maximum in tests and procedures, and physicians often yield to (or exploit) these fears, because they fear malpractice suits. Paradoxically, contractualism tempts the doctor simultaneously to do too little and too much for the patient — too little in that one extends oneself only to the limits the contract specifies, and too much in that one orders procedures that are useful in pampering the patient and protecting oneself, even though the patient's condition does not demand them. The emphasis on self-interest in contractual decisions provides the link between these apparently contradictory strategies of too little and too much. The element of gratuitous service vanishes.[139]

The key elements of May's vision of covenant lead to a covenantal ethics that is both responsive and gratuitous. May notes, however, that at first glance, response

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[138] William F. May, "Code, Covenant, Contract, or Philanthropy," *Hastings Center Report* 5, 6 (December 1975), pp. 29-38.

[139] May, *The Physician's Covenant*, pp. 122-23

to debt and gratuitous service may appear contradictory. However, it is his view that this is due to the fact that "we have abstracted the concept of covenant from its original context within the transcendent."[140] Only within the context of transcendence do these principles operate synergistically. All human actions are at their deepest level, responses to the wholly gratuitous nature of God. Without this connection, illness and suffering become unbearable and death becomes the greatest tragedy. Technical proficiency, contract and philanthropy flourish within this existential abyss since they provide the means for avoiding connections with patients. They become ways in which

> . . . healers, beset by pain, pettiness, and suffering, shield themselves from patients and their perishing life. Professionals who prize technique alone find in their technique a protection against the terrible disorder of war, disease, and death and their emotional reaction to it. The philanthropist solves the problem of neediness by adopting the pose of the self-sufficient giver who extends a hand while figuring out how to wriggle free. Philanthropy offers a doctrine of love without ties. It deteriorates into condescension, not because philanthropists harbor a conviction of their ultimate superiority to petitioners, but because they fear that they will drown in a sea of need if they step down from their promontory. Contractors, similarly, seek to solve the problem of perishing by keeping their commitments limited. Thus, code, philanthropy, and contract, within the context of death, are all devices for evading ties. All have in common a fear of perishing, of drowning in the plight of the other.[141]

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[140] May, "Code, Covenant, Contract, or Philanthropy," p.35.

[141] May, *The Physician's Covenant*, p. 128.

The image of the physician as covenanter requires an emotional maturity and sense of transcendent indebtedness, in order for the physician to be able to engage with and be present to the patient with compassion, while at the same time maintaining whatever emotional distance is necessary in order to heal. However, May is not proposing that covenantal fidelity alone is sufficient. In fact, without proficiency, the notion of the physician's covenant dies.

> A rather sentimental existentialism unfortunately assumes that it suffices morally for human beings to be 'present' to one another. But in crisis, the ill person needs not simply presence but skill, not just personal concern but highly disciplined services targeted on specific needs. Covenantal ethics, then, must include rather than exclude the interests of the unwritten codes of the profession in the refinement of technical skills.[142]

May offers the example of truth telling in order to show a covenantal ethic at work. In drawing the distinction between telling the truth and being true, he makes the point that medical ethics limits truth telling to descriptive speech, which characterizes a given condition in the world, i.e., "you have cancer," rather than a "being true" which takes the form of performative speech. Performative speech changes the world by introducing an element which would not be there apart from the speech, i.e., "I promise you I will not abandon you while we treat your cancer." Promises, which are an example of performative speech, provide a much more

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[142] May, *The Physician's Covenant*, p. 136.

expanded notion of truth for the patient, whose greatest fear is abandonment. Here the physician offers the patient not just technical ability and proficiency, but also fidelity. May links the notion of promise to healing in noting that

> . . . the virtue of fidelity begins to affect the resolution of the dilemma itself. Perhaps more patients and clients could accept the descriptive truth if they experienced the performative truth. The anxieties of patients in terminal illness compound because they fear that professionals will abandon them.[143]

This position is borne out in numerous articles[144] which speak paradoxically of those situations in which the patient, who in struggling with a decision, turns to the physician for guidance, and waives the right to informed consent by asking the physician to make a decision for him/her. While these situations are extremely difficult for most physicians, it is this author's opinion that, in these cases, abrogating the responsibility to make a decision is an abandonment of the patient, who in fact is exemplifying in practice what Pellegrino and Thomasma are suggesting in the abstract, namely that beneficence-in-trust, can take the form of a capable patient requesting that a physician make the decision, in his/her best interests.

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[143] May, *The Physician's Covenant*, pp. 142-3.

[144] See William F. Young Jr., "Change of Shift," *Annals of Emergency Medicine* 30, 2 (August 1997) ,pp. 350-1. See also Lewis S. Solomon, "Informed Consent" [letter], *Journal of Medical Ethics* 17, 1 (March 1991), pp. 45-6; Richard C. McMillan, "Responsibility 'to' or 'for' in the Physician-Patient Relationship," *Journal of Medical Ethics* 21, 2 (April 1995) pp. 112-15.

Not only is the content of performative speech important, but so too the timing of when one tells the truth, crucial. Again, this requires that the physician knows and understands the patient's fears and dreams, and his/ her feelings about illness and death. In this way, the notion of truth "expands beyond decision bits and raises the question of the healer's readiness to accept his or her role as teacher in the therapeutic enterprise."[145]

For May, it is not enough to disclose facts and heal specific disease processes, the physician as covenanter must teach the patient how to transform his/her habits, and dispositions in order to promote a healthy life style.

> When physicians issue prescriptions wordlessly, opaquely, without an earnest effort to clarify and persuade, they do not play God; they usurp another kind of privilege, high handed, arrogant, and ultimately obtuse. One thinks of Kierkegaard's characterization of the demonic state in the *Concept of the Dread*. He describes it as 'shut-upness, 'a dreadful taciturnity, unrevealing, unhelpful, withdrawn, and cruelly destructive to those who need a healing word.[146]

May's vision of the physician as covenanter demands that he/she engages in conversations with patients, both in order to heal and also to teach. While he opposes a wordless paternalism which abandons patients to fear, he also suggests that the telling of truth often requires finesse rather than bluntness and immediacy. He prefers a more subtle indirect approach, particularly to the disclosure of bad

[145] May, *The Physician's Covenant*, p. 144.

[146] May, *The Physician's Covenant*, p. 152.

news. This, he argues, allows death to be treated "decorously as a sacred event,"[147] while at the same time respecting reality. Here May is not suggesting that the use of indirect language should be used as

> . . . an excuse for delivering signals so remote as to evade or mislead. At its best, indirect discourse verbally respects rather than avoids reality . . . So also we need not dwell directly on the subject of death interminably or avoid it by a condescending cheerfulness wholly inappropriate to the event. Still, two human beings can acknowledge death, if ever so indirectly, and hold their ground before it until parted.[148]

Obviously this is best done before a crisis erupts, when the physician and patient can share their views on future possibilities. While not articulated in terms of an advance directive, this is in essence what May is alluding to — a series of conversations regarding one's future wishes, placed within the context of one's life.

Finally, May discusses the physician as covenanter, and therefore teacher, in the context of a covenantal ethic in which the institution bears some responsibility for the delivery of care.

> . . . the notion of covenant also permits one to set professional responsibility for this one human good (health) within social limits. The professional covenant concerning health should be situated within a larger set of covenant obligations that both the doctor and patient have toward other institutions and priorities within the society at large. The traditional models for the doctor/patient relationship (parent,

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[147] May, *The Physician's Covenant*, p. 164.

[148] May, *The Physician's Covenant*, p. 164.

> friend) tend to establish an exclusivity of relationship that obscures those larger responsibilities . . . one must think about the place held by the obligation to the limited human good of health among a whole range of social and personal goods for which men are compacted together as a society. [149]

He notes that, at the very least, a covenantal ethic must deal with the responsibilities of both physicians and the institutions within which they work. Every health care institution must be clear on its primary mission, which is to heal patients, and therefore, must place an emphasis on fulfilling that mission. Every other purpose is secondary to this. Only a covenantal ethic is capable of focussing hospitals on this primary function.

> The military image subverts the primary end of health to a subordinate and merely *contributory* purpose; the fight against death. The image of the physician as technician elevates a merely *instrumental* good to a final good . . . The parental image, meanwhile, tends to substitute somewhat *covert* purposes for the primary end of a health care institution . . . covertly the hospital and staff also function as rubber gloves to insulate the society from the shock of disease and death. In a sense, these institutions perform a paternalistic function, not simply for inmates but for the society at large.[150]

Within a covenantal ethic, the primary goal of the hospital is not to prevent death, or protect against suffering, or perfect the techniques of professionals — its primary goal is to heal. As was previously noted, in carrying out this function,

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[149] May, "Code, Covenant, Contract, or Philanthropy," p. 36.

[150] May, *The Physician's Covenant*, p. 172.

hospitals need to distinguish between "maximal treatment and optimal care."[151] Within this focus, the teaching of patients will focus on preventative medicine and rehabilitation. More importantly, May reminds us that health is only one good among many and, in fact, is, in and of itself, not the highest good. Neither institutions nor physicians have "a moral warrant in a health-obsessed age to bloat this good beyond its place in human affairs."[152] May cautions health care professionals against taking themselves or the good of health too seriously. Rather, given that disease and suffering are not ultimate, he urges

> . . . a deeper ease which would allow us to relieve distress but with a final metaphysical nonchalance. Only from that nonchalance can we relieve distress vigorously while accepting, without complacency, the moral limits upon our struggle against death.[153]

May's work on covenant is a treatise on the relationship between physician and patient. It focusses on a shared responsibility for health and healing, one which, in this author's opinion, depends both on the creative and the affective as well as the cognitive and scientific. Both are necessary; neither are sufficient on their own. However, May places this notion of covenant within the larger covenant which humankind shares with God, and therefore the notion of gift, and receptivity and

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[151] May, *The Physician's Covenant*, p. 173.

[152] May, *The Physician's Covenant*, p. 175.

[153] William F. May, *The Patient's Ordeal* (Bloomington: Indiana University Press, 1991), pp. 198-99.

response to that gift are crucial. Healing, ultimately, can only occur as a result of the creative act of God. The strength of May's work lies in his position on the relationship between physician and patient as one of gift and response. Like the authors previously mentioned, he speaks about the need for conversation, trust and virtue. Of particular note here is his view that the image of the physician as covenanter requires an emotional maturity. However, the weakness of his work lies in the same area as doės the other authors. May does not develop what this emotional maturity consists of or how to develop it. Neither does he speak of the relationship between emotional maturity and decision making.

In conclusion, this chapter has attempted to provide the key elements of the work of six authors, Katz, Brody, Pellegrino, Thomasma, May and Charon. As noted in the introduction, we have focussed on these authors because they have attempted to address difficulties in discussions between physicians and patients by looking at the structure of the relationship in the therapeutic alliance.

While Katz notes that informed consent is a necessary legal corrective to a medical problem, he believes that it has been insufficiently developed. He proposes that earned trust, through conversation, must provide the foundation for informed consent. His model of trust demands reflection on the part of both physician and patient, particularly as they struggle to deal with the psychological and emotional trauma of making decisions in the face of medical uncertainty. His work provides an

invaluable contribution to the discussion on informed consent by noting that it is only through trust and conversation that truly informed consent can occur. While Katz acknowledges that feelings are present in the process, it is this author's opinion that his work is incomplete in this regard in that he does not proceed with concrete suggestions for how to carry out discussions around informed consent. Neither does he discuss how feelings function in discussions between physician and patient.

While Brody shares Katz's view that a legalistic reduction of informed consent is detrimental to good patient care, he is critical of the notion that physicians must rely solely on their own feelings and intuition in order to determine if a conversation has been successful in terms of the legal obligations of informed consent. While he speaks about the need for conversation, he notes that there must be a more objective measure of the success of a conversation than how one feels about it. His transparency standard, in fact, is an attempt at operationalizing Katz's conversation model in a way that meets legal standards for approval. In so doing, Brody improves on Katz's conversation model by encouraging openness and trust in both physician and patient, who both must share their thoughts and feelings about the way each is coming to make decisions. However, while Brody acknowledges the existence of feelings and the need for reason in decision making, he too does not discuss what role each plays in the process, either in terms of the interaction between feelings and reason, or their evaluation. Neither does he offer any suggestions for

understanding how one in fact comes to an authentic decision. As such his model, like Katz's, is limited.

Throughout Pellegrino and Thomasma's work, we see a focus on the importance of the development of the moral character of the person who makes moral choices. Their work on virtue is a teleological approach which links the virtues of the practice of medicine to the ends of medicine. The authentic human being is one who aspires to virtue. Like Katz's conversation model and Brody's transparency standard, Pellegrino and Thomasma speak of the importance of a trusting relationship between healer and patient. Unlike Katz or Brody, however, their notion is grounded in a commitment to care for another as part of a moral community. Beneficence-in-trust is the focus of their work on the place of virtue in medical practice. While these authors speak often of the importance of feelings or affect in the development of virtue, they, like Katz or Brody, do not discuss the relationship between feelings, virtue and decision making. While Pellegrino and Thomasma speak of some of the virtues, such as compassion, as having an affective component, and the need for intellect and feelings to work together in fostering virtue, it is this author's opinion that they do not adequately develop what these relationships entail or how they develop. The closest they come to discussing the relationship between feelings and intellectual and moral growth is in their discussion of the virtue of prudence which they posit may link emotions with the virtues, thereby

combining reason with the desire to do good. In this sense, while they have gone much further than either Katz or Brody in this area, their work is also incomplete in that it does not develop the way in which feelings, reason or virtue function in decision making.

While Katz, Brody, Pellegrino, and Thomasma each in their own way speak of the importance of a relationship of trust between physician and patient and either implicitly or explicitly acknowledge the presence of feelings in this relationship, Rita Charon advances the discussion a further step with her work on literature and medicine. Here we see an attempt to connect the physician with how the patient is feeling through the writing and imagining of the patient's story. Charon furthers the discussion on the role of feelings in the therapeutic alliance in that she moves beyond an acknowledgment of feelings to an attempt to provide a concrete method which might bridge the gap between diagnostic reasoning and the human encounter in medicine. However, her work falls short of providing a way of understanding precisely how feelings might contribute to or impede medical decision making.

Finally, in May's discussion of the notion of a covenantal approach to the therapeutic alliance, we see an approach which is grounded in the creative acts of the imagination and a particular notion of covenant. The three elements of covenant which are crucial to May's work are the notions of gift, response and the connection of rituals and moral obligations to the response. One's indebtedness to

humanity arises out of a response to indebtedness to God. Against a disconnected philanthropy which offers love without ties and therefore collapses into condescension, May offers a notion of covenant which operates within the context of transcendence. While May himself does not explicitly state how feelings function in this model, it is this author's opinion that May's work is heavily dependent on feelings in the sense that the obligation to respond to others is ultimately a desire to respond to God. Throughout his work we see allusion to this notion: however, it is never really developed. In this way, while he contributes to the discussion, it is this author's opinion that further development is necessary.

One sees common threads in the work of Katz, Brody, Pellegrino, Thomasma, Charon and May. These threads provide the basis for developing an improved model of consent. Conversation, trust and transparency are mandatory if one is to engage in the process of informed consent. This process demands more than an intellectual understanding of the legal requirements of consent, or the mastering of a technical skill, but the full and authentic engagement of the virtuous physician who desires to both heal and cure. It demands the development of a covenantal approach to the therapeutic alliance, rather than a contractual model that reduces both parties to the limits of rights and obligations. Rather, it requires a vision of the "other" as a person to whom one is indebted as part of a moral community. Ultimately, this vision of covenant and of healing is grounded in the creative act of

God. Conversation, trust, virtue and covenant are the crucial elements in these authors' work and provide some of the data from which to begin to develop an improved model of informed consent. As we have seen, feelings are implicit in all of these elements. However, while Katz, Brody, Pellegrino, Thomasma, Charon and May each in their own way either explicitly or implicitly alludes to the importance of feelings in the therapeutic alliance, and therefore informed consent, they do not develop how feelings actually function in the process of knowing, either how or why they assist decision making or impede it. Similarly, while each speaks about the importance of the authentic or virtuous human person who makes decisions, they do not develop the relationship between those decisions and authenticity.

As a result, while their work offers a valuable contribution to the work at hand, several questions remain. Precisely how do feelings function in decision making? Do all feelings assist in making good decisions? What is the relationship between feelings, decision making and human authenticity? While no doubt the discipline of psychology speaks of the significance of feelings it does not develop precisely how feelings operate in knowing, and therefore, in making decisions about one's health. Similarly, while we will speak of the lessons from psychiatry relative to informed consent in Chapter Four of this thesis, the psychiatry experience also does not develop the role of feelings in decision making. It is here, in this author's

opinion, that the work of Bernard Lonergan can provide some insight and to which the following chapter turns.

# Chapter Three
# The Role of Feelings in Bernard Lonergan's Cognitional Structure[1]

At the outset of this work, it was stated that the legal doctrine of informed consent is an overly bureaucratic, impersonal, legal document which fails to adequately consider the highly personal nature of the physician-patient relationship. As we have seen, fostering the health of the relationship between physician and patient is crucial if we are to begin to transform the nature of the present model of consent. The previous chapter has been an attempt to provide several suggestions from different authors on improving the therapeutic alliance. What has become evident in this discussion is that these suggestions share common perspectives on the importance of conversation, trust, transparency and covenant.

Even more crucial in terms of this present work is the notion that each of these common perspectives has a strong affective component. However, what has also become evident is that there is lack of clarity about the relationship between how feelings operate in models of decision making and consent that focus on conversation, trust, transparency and covenant. Neither is it clear how feelings and decision making relate to personal authenticity. It is this author's opinion that if we are to attempt to improve the present model of consent, we not only have to begin

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[1] This author's Master's thesis, "Affectivity, Bias & Grace: The Role of Feelings in Bernard Lonergan's Notion of the Subject" (University of Montreal, 1995), provides the basis for much of this chapter.

with understanding and improving the relationship between physician and patient, we must also dig deeper into this relationship and try to understand the operation of feelings in their conversations about decision making.

The intent of this chapter is to look at Lonergan's work in an attempt to clarify the questions which were left at the end of the second chapter: "Precisely how do feelings function in decision making?" "Do all feelings assist in making good decisions?" "What is the relationship between feelings, decision making and human authenticity?"

While considerable attention has been given to Bernard Lonergan's writings in the areas of cognitional analysis, epistemology and method, there has been significantly less focus on the contribution that his work might make to the area of ethics or moral theology. During a lecture given at Milltown Park in Dublin in 1971, when asked whether he thought a systematic moral theology was possible, Lonergan replied that he would emphasize feelings in attempting to develop such a theology.[2] However, it must be noted at the outset that Lonergan is concerned with the concrete rather than the abstract and, as a result, the starting point which is implicit in all of his work is the operation of the human subject. Perhaps nowhere is this more clear than in his study of feelings. This area of his work is most clearly articulated in

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[2] Question number 23, posed following the lecture entitled "Institute on Method in Theology," Tuesday August 10, 1971, Milltown Park, Dublin. While this lecture has not been published, a transcript taken from tape is available at the Lonergan Institute in Toronto.

*Insight: A Study of Human Understanding*[3] as well as *Method in Theology*.[4] However, it is only in *Method* and later writings that the important link is made between values and feelings where the stance taken is one in which values are apprehended by feelings.[5] This places Lonergan within the ongoing debate between those who would advocate for the primacy of reason and argue against the intrusion of emotion in ethics and moral theology, and those who attribute value to the role that emotions or feelings play in this area. A number of authors have interpreted Lonergan's philosophy on the role of feelings in ethics. In reading their work, one recognizes that there are conflicting interpretations of how feelings operate in the cognitional process. However, for the purposes of this thesis and the relationship between

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[3] Bernard Lonergan, S.J., *Insight: A Study of Human Understanding*, Volume 3 of *Collected Works of Bernard Lonergan*, edited by Frederick E. Crowe and Robert M. Doran (Toronto: University of Toronto Press, 1992).

[4] Bernard Lonergan, S.J., *Method in Theology* (London: Herder and Herder, 1973).

[5] See Mark Doorley, *The Place of the Heart in Lonergan's Ethics: The Role of Feelings in the Ethical Intentionality Analysis of Bernard Lonergan* (Lanham MD: University Press of America, 1996); Patrick Byrne, "Analogical Knowledge of God and the Value of Moral Endeavor," *Method: Journal of Lonergan Studies* 11, 2 (1993), pp. 103-35; Neil Ormerod, "Lonergan and Finnis on the Human Good," in William J. Danaher, ed., *Australian Lonergan Workshop* (Lanham, MD: University Press of America, 1993), pp. 199-210; David Oyler, "The Cognitive Functions of Feelings," *Method: Journal of Lonergan Studies* 7, 1 (1989), pp. 31-50; Bernard Tyrell, "Feelings as Apprehensive-Intentional Responses to Values," *Lonergan Workshop* 7 (1988), pp. 331-60; Kenneth Melchin, "Ethics in Insight," *Lonergan Workshop* 8 (1990), pp. 135-47; Kenneth Melchin, "Moral Decision Making and the Role of the Moral Question," *Method: Journal of Lonergan Studies* 2, 2 (1993), pp. 215-228; Michael Vertin, "Judgments of Value, for the Later Lonergan," *Method: Journal of Lonergan Studies* 13, 2 (1995), pp. 221-48 for recent work in this area.

feelings and value in Lonergan's work, we will rely heavily on the work of Walter Conn and his "middle of the road" approach.

In an attempt to address the questions that have been raised in the previous chapter, this chapter will proceed in the following way. As we have noted above, any interpretation of Lonergan's thought must have as its starting point a discussion of the human person, who for Lonergan is the human subject. The importance of beginning a discussion of Lonergan's work from this anthropological perspective is reinforced by Lonergan scholars like Robert Doran in *Theology and the Dialectics of History*.

> The notion of the subject constitutes both the central and foundational position in Lonergan's work and achievement. From the position on the subject all else derives: proximately and quite directly, positions on being and objectivity, then on meaning and value, and on philosophical and theological method; more derivatively a metaphysics, an ethics, and both a philosophical and Christian systematic theology.[6]

As a result, the first part of this chapter will begin with a discussion of the characteristics of this subject. However, this section will not attempt to provide an exhaustive presentation of Lonergan's notion of the human subject. Rather, the

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[6] Robert Doran, *Theology and the Dialectics of History* (Toronto: University of Toronto Press, 1990), p. 19.

focus will be the role which feelings play relative to the human subject who desires to know and to be authentic in his/her decision making.[7]

Many who read Lonergan's work in *Insight* become discouraged in struggling through the first five chapters dealing with the evolution of mathematics and physics. While this difficulty usually is somewhat relieved with the reading of the sixth chapter on common sense, this relief is short lived when one is faced with another challenge that in my view surpasses the difficulty in arithmetic comprehension. In this chapter, it becomes clear that Lonergan's primary intent in this and other of his writings is to call the reader to a personal transformation, that is, to authentic subjectivity and self-appropriation.

This is particularly clear in Lonergan's work in *Understanding and Being*, which begins from the point of self-appropriation, a focus which is continued throughout the book. Here he articulates the three components of the process of self-appropriation which serve to further reinforce the fact that he is not proposing an abstract set of principles, but rather an engagement of the subject in a way that is distinctly tangible.

> First of all, self appropriation is advertence — advertence to oneself as experiencing, understanding, and judging. Secondly, it is

[7] For a more general presentation of this topic see Bernard Lonergan, "The Subject," The Aquinas Lecture, Marquette University, March 3, 1974. This lecture was later published in Bernard Lonergan, A *Second Collection*, edited by William F. J. Ryan, S.J., and Bernard J. Tyrell, S.J. (London: Darton, Longman & Todd, 1974), pp. 69-86.

> understanding oneself as experiencing, understanding, and judging. Thirdly, it is affirming oneself as experiencing, understanding and judging. The analysis of knowledge, then yields the three elements: experience, understanding, judging.[8]

With this focus on the authenticity of the human subject, Lonergan is proposing a concrete method which is oriented towards an understanding of the act of understanding, or "insight into insight." While this method moves beyond the level of theory, it does not discard theory. Rather, it uses theory in order to express the self-knowledge and self-constitution of the human person. In this sense, it is a deeply existential approach to the human subject.

In attempting to provide some clarity on the question relative to which feelings assist decision making, and which don't, and why, we will proceed with an analysis of Lonergan's work on the negative function of feelings as present in bias. This will be followed with a discussion of the positive function of feelings and the relationship between feelings and value.

Finally, in attempting to provide some clarity around the relationship between feelings, decision making and human authenticity, the chapter will conclude with a discussion on Lonergan's work on decision making, human authenticity and the need for ongoing conversion.

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[8] Bernard Lonergan, *Understanding and Being*, edited by Elizabeth A. Morelli and Mark D. Morelli (Toronto: University of Toronto Press, 1990), p. 33.

## 3.1 Characteristics of the Human Subject

Before beginning this discussion on the characteristics of the subject, one should note that Lonergan's position on this issue underwent development from his early work in *Insight* in the early 1950's, to his later writings such as "Healing and Creating in History,"[9] in 1975. During this time Lonergan's position on the subject became more and more differentiated and eventually included the positions on the subject as a knower, the subject as an historical and existential agent, the subject as a lover, and finally, the subject as a participant in healing and creating. In laying out these four positions or stages, this author is borrowing from the categories which Robert Doran sets out in *Dialectics*. As Doran points out these four stages are,

> . . . not separate and discrete units of thought, but intimately related moments in the organic unfolding of a consistent and ever more comprehensive understanding of the elusive and polymorphic reality to which each of us is ever present in all of our waking and some of our sleeping hours, but which, by virtue of an immanent law, always escapes complete objectification: namely, the subject as subject.[10]

This section will provide a summary of these four positions which comprise the characteristics of the human subject.

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[9] This 1975 lecture was published as Bernard Lonergan, S.J., "Healing and Creating in History," *A Third Collection: Papers by Bernard Lonergan*, edited by Frederick E. Crowe (New York: Paulist Press, 1985), pp. 100-9.

[10] Doran, *Dialectics,* p. 20.

### 3.1.(a) The Subject as a Knower

In Chapter Eleven of *Insight*, the reader is asked to affirm that he/she is a knower, in the sense that he/she moves through three levels which Lonergan proposes are involved in all instances of knowing: the level of experience, the level of understanding, and the level of judging. A further development of this process takes place in *Method*,[11] in which a fourth level of decision becomes part of the operations involved in cognition.

The level of experience consists of all of the operations of sense which function in making us capable of attending to data and being receptive to events. In order to be clear on what functions are included in this level, one needs to point out that Lonergan uses the word "experience" in a double way. In one instance, it refers to the passive state of being receptive to data, particularly the data of sense. However, it is also used to refer to all of the qualities of human activity. This stance provides further evidence that emotions or feelings are not confined to the experiential level, but are inseparable from every level of Lonergan's cognitional structure.

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[11] See Lonergan, *Method*, pp. 13-20 for a complete discussion of the place of the level of decision in Lonergan's transcendental method.

On the level of understanding, our intellect comes into play in providing us with all of the tools necessary for comprehension. This includes not only the asking of questions but also the imaging that facilitates understanding, as well as the conceptualizing and formulation of what in fact we have come to understand.

The level of judgment consists of all of the actions which we as rational agents utilize in order to prove the truth or falsity of our understanding. Not only does this include reflection on the method we will use to determine truth as well as the gathering of further evidence that may be required, but also the very act of judging itself.

Finally, on the level of decision, we exercise our capacity as responsible agents in choosing or refusing to act on what we have determined to be truth or value. This involves a series of activities which include deciding which courses of action are feasible and among those, which are best. Finally, a decision is reached and one pursues a particular course of action to its completion.

This process involves more than just seeing or taking a look, but judging oneself to be a knower. As well, we also recognize that consciousness is not precisely the same on all four levels. The significance of this difference, in terms of consciousness at each of the levels, is important in that it is constitutive of the character of the subject who acts on each of these levels. As we move from

experiencing to understanding to judging and finally to deciding, the stakes become higher, since more of ourselves is involved.

> This can be seen perhaps most vividly in the increasing responsibility we feel when we must acknowledge failure at the various levels. To acknowledge that we haven't noticed something that others have noticed is generally an easy admission to make; to acknowledge we haven't understood something that others have understood hits closer to home; to acknowledge that our judgment has been wrong is an even more personal admission of some failure in ourselves; and to acknowledge that one has chosen, embraced, or done what was evil addresses the core of who one is. But it is not the possibility or reality of failure which is our real concern at this point but rather the fact that as we move from level to level it is a fuller self of which we are aware and the awareness itself is different. As we consciously move from level to level, not only are our operations different, we ourselves are different. In fact, there is a dual creation in anything we engage in. We not only create relationships or objects, we create ourselves in so doing.[12]

For example, on the first level of experience, we are empirically conscious, and as a result the questions that we ask, such as "What is it?" or "Why?" are clearly incapable of being answered by "yes" or "no." However, on the second level of understanding, in asking the question "Is it so?," we are asking questions for intelligence that can in fact be answered affirmatively or negatively in that they terminate in judgement. On the third level of judgment, our rationality enters the picture in our attempts to verify if something is really true, to reach the absolute that

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[12] Vernon Gregson, "The Desire to Know: Intellectual Conversion," in Vernon Gregson, ed., *The Desires of the Human Heart* (New York: Paulist Press, 1988), p. 20.

makes it impossible for that which we say "is" to also be "is not."[13] Finally, on the level of decision we make a choice as to whether or not to operate in accord with the norms which have become evident in the movement through the levels of experience, understanding and judging.

While it is possible for the question of truth to be addressed prior to the answering of questions for understanding, such knowing is nothing more than arrogance. As a result of this stance, the self-affirmation of the knowing subject is constitutive of him/her as well as being a self disclosing act. Lonergan's objective in Chapter Eleven of *Insight* is primarily to bring the subject to an understanding of what he/she is doing when he/she is knowing. Why is doing a particular thing knowing? Finally, what precisely does one know when one does this particular thing? In *Method*,[14] Lonergan discusses these three questions which are involved in the self-affirmation of the knower in terms of cognitional theory, epistemology and metaphysics. However, understanding is not enough. It is only through one's own experience, understanding and judging, and an understanding of that experience, understanding and judging, that one is asked to affirm that experience, understanding and judging are mandatory.

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[13] Relative to the issue of consciousness as it relates to the affirmation of the subject as one who knows, Lonergan writes in *Insight*, p. 352, "'I' has a rudimentary meaning from consciousness, and it envisages neither the multiplicity nor the diversity of contents and conscious acts but rather the unity that goes along with them."

[14] Lonergan, *Method*, p. 25.

Several questions arise as a result of the above discussion. Again in remaining true to Lonergan's method, the first question that needs to be addressed is one which arises on the levels of experience and understanding. This is a question which asks, "Is it true?" In other words, could this method be disproved or revised? Secondly, on the levels of judging and deciding, there is the question of value, in which one asks, "Is it worthwhile?" One could ask if Lonergan's method, like other methods that involve a turn to the subject, does not fall prey to the pitfalls of subjectivism and relativism. While the question "Is it worthwhile?" is not limited to the issue of subjectivism, for the purposes of this chapter, this is the difficulty which the question of worth will address. For Lonergan, the answer to this question lies in the fact that the relationship between the desire to know and the human subject provides the groundwork for the notion of objectivity.

Some of the implications of these questions, "Is it true?" and "Is it worthwhile?," will now be addressed in the following three sections on the possibility of revision, objectivity and subjectivity, and the desire to know.

### 3.1.(a) (i) Possibility of Revision

In discussing the question whether or not this account is descriptive or explanatory, Lonergan notes that it is explanatory in that it separates distinguishing stages in the cognitional process which are defined by their relationship to one

another, rather than by their relationship to us. However, it is not an abstract notion, nor is it hypothetical as it derives its meaning from our self-appropriation and the elements in this are verifiable, in the measure that one knows when one has insight. In speaking of the possibility of revision of this method, Lonergan draws our attention to the fact that this account of self-knowledge is unable to be revised, since any attempt at revision will involve the very steps in this theory of knowing that are the focus of the revision itself. In other words, it will involve data that are intelligent, insight, conception, verification, grasp of the virtually unconditioned, etc. In this way, while future progress in self-knowledge will enhance this pattern, or provide it with further conclusions, any attempt at revision will be unable to step away from this pattern.

### 3.1.(a) (ii) Objectivity and Subjectivity

In Lecture Seven of *Understanding and Being*, "The *A Priori* and Objectivity," Lonergan provides a clear summary of his work in *Insight* relative to the problem with the notion of objectivity. In *Understanding and Being*, he notes that this problem comprises three aspects. The first of these involves the question of a starting point, the second is concerned with one's perception of what knowing is, and the third appertains to the relationship between truth and fact.

The question of starting point concerns whether one should base one's notion of objectivity on the study of cognitional process, and from that move to a metaphysics of the object, of the knower and the knowing,[15] or if one should start with the metaphysics of the object and then proceed to an understanding of the metaphysics of the knower and then the act of knowing. Lonergan's response to this issue is that it does not constitute a serious problem. It does not matter where one begins. What counts is that one terminates the circle in a way that is complete.[16] In other words, one can finish the circle with a brief account of knowledge and metaphysics, in a way which would be incomplete, or one could finish the circle with an extensive account of one or both elements, in a way that would be increasingly correct and comprehensive. This stance provides a further example that Lonergan views the process of knowing as an ongoing one which is never finalized.

The second aspect of the problem of objectivity relates to one's view of the process of knowing. Here Lonergan notes that different answers will result in different interpretations and criticisms of Kant.[17] Lonergan's position on Kant is one

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[15] See Lonergan, *Understanding and Being*, p. 177.

[16] See Lonergan, *Understanding and Being*, p. 178.

[17] See Lonergan, *Understanding and Being*, p. 179. Relative to these interpretive differences, Lonergan writes, "Thus de Tonquédec holds that what is wrong with Kant is his ideal of pure reason and the categories of understanding; Kant should be content with intuition, and put more stress on it. Maréchal, however, criticizes Kant for putting too much stress on intuition and not enough on judgment."

which recognizes that knowing can result from intuitions which produce concepts. However, Kant does not recognize judgment; neither does he make an apprehension of the unconditioned a key point. As a result, Lonergan holds that Kant's judgment that knowledge can only reach phenomena is only true if one accepts the truth of the judgment as being fundamental to Kant's position. This is precisely what Kant does not do, and as a result, Lonergan concludes that Kant's position is incongruous with his theory.[18]

One sees the introduction of a similar contradiction into the subject, when a pragmatic approach is taken to life. While such an approach, which measures life by results, may contain an

> . . . implicit appeal to the virtually unconditioned . . . it is 'by the way'; it is inconsequential; it is not our actual way of living. There is a contradiction within the subject. There is a dynamic of events in human development; it is animal, intelligent, and rational. Consequently, the weight that can be carried by the rational part of man is a variable, but we are always living. To meet the problem, one must shift one's basis.[19]

The "shift" which Lonergan is proposing is one in which the subject moves from an animal to an intelligent level and finally to a rational level. This shift from intelligent to rational is a philosophical occurrence in that it is the shift from

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[18] Lonergan's position on Kant is complex, and is not the focus of this section. However, it is significant in that it provides a good example of the impossibility of revision of the method which Lonergan is proposing.

[19] Lonergan, *Understanding and Being*, pp. 179-180.

essentialism to existentialism, "to a position which makes truth dominant and operative in a fundamental way in one's philosophy."[20]

This brings us to the final difficulty which Lonergan addresses relative to the issue of objectivity, that is, one that involves the cognitional problem of truth and fact. This is crucial for his notion of authenticity and its relationship to judgment, since truth is reached by the study of facts, in which the subject adverts to the conflict between the theories that he holds and his/her operations in knowing and doing. In this instance, the judgment of oneself as a knower, is a judgment of fact, one which begins on the level of experience, but is not content to rest on this level. One is driven to understand, to reflect, judge and finally to act. In this sense, fact combines

> . . . the concreteness of experience, the determinateness of accurate intelligence, and the absoluteness of rational judgment. It is the natural objective of human cognitional process. It is the anticipated unity to which sensation, perception, imagination, inquiry, insight, formulation, reflection, grasp of the unconditioned, and judgment make their several, complementary contributions.[21]

The self-affirmation of the knower, as a judgment of fact, results in the dignity of the human person. This is in direct opposition to the position of the relativist, who takes the position that human knowing is a theory, one in which there can never be any correct judgments.

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[20] Lonergan, *Understanding and Being*, p. 180.

[21] Lonergan, *Insight*, p. 355.

From this discussion of the problems relating to objectivity, one comes to an understanding of Lonergan's position that "genuine objectivity is the fruit of authentic subjectivity."[22] It is only when we use all of our cognitional capacities, and allow our desire to know to take control, that our judgments can be considered to be objective. In other words, on the subjective side, one has a desire to know, which involves understanding and judgment, while on the objective side there exists "a universe of being whose reality corresponds to the totality of true judgments — knowing everything about everything."[23] Lonergan further clarifies the relationship between objectivity and authentic subjectivity in noting that self-appropriation is capable of orienting inquiry. In discussing the self that is to be appropriated, as one which develops, he notes that there are differences in the self which lead to asking which self it is that we will in fact appropriate.

### 3.1. (a) (iii). The Desire to Know

While the previous sections have focussed on the subject as a knower, for Lonergan, this subject is unthinkable without the notion of desire. In fact it is the notion of desire as well as the objects of desire that are crucial to an understanding of Lonergan's work, particularly his position on the human subject. Bernard

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[22] Lonergan, *Method*, p. 292.

[23] Lonergan, *Understanding and Being*, p. 182.

Lonergan speaks of objectivity as being the result of an authentic subjectivity. This authentic subjectivity is comprised of inquiry that is intelligent, reflection that is critical, and judgments that are true. Authentic subjectivity allows the desire to know to be pure, detached and disinterested. When one raises questions for intelligence and reflection, one is in fact asking, "What is being?" The object of knowing, proportionate being,[24] i.e., being which is proportionate to our knowing, is reached in stages when one moves through the levels of experience, understanding, judging and deciding.

Not only is the body erotic, so too is the spirit. In our desire to know we are expressing a desire for what is beautiful, comprehensible, true, and valuable. If objectivity is the result of authentic subjectivity,[25] in which the desire to know is unfettered, then there is an absolute objectivity to every authentic judgment as a result of the subject's having grasped the fulfilment of its particular conditions. In this sense, it becomes a virtually unconditioned in that the conditions for its achievement have been comprehended. The absolute nature of true judgments in this sense is an accomplishment of self-transcendence. As well, it is in the act of judging that absolute objectivity is found, in that one arrives at a virtually

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[24] See Lonergan, *Insight*, p. 676. Lonergan defines "proportionate being" as being that which is proportionate to our knowing.

[25] See Lonergan, *Insight*, p. 404.

unconditioned. In making such a judgment, one moves into a realm in which one becomes aware of the self as well as the objects of knowing. In this way, absolute objectivity provides a bridge between the subject and the object.

For Lonergan, the ground of objectivity lies in the "unfolding of the unrestricted, detached, disinterested desire to know."[26] It avoids an obscurantism which conceals truth because of its unrestricted nature. The detachment that is part of the pure desire to know stands in opposition to blockages of the cognitional process that arise from other human desires. As a result of its disinterested nature, it is opposed to "the well-meaning but disastrous reinforcement that other desires lend cognitional process only to twist its orientation into the narrow confines of their limited range."[27] This quotation raises some important questions. The first concerns which human desires inhibit cognition or limit its orientation? Secondly, what impact would such desires have relative to the relationship between feelings and values? Thirdly, how does one avoid falling prey to those desires which impede true judgments? The first question will be addressed in the section on "The Dialectic of the Dramatic Subject," particularly in the section on "Dramatic Bias."

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[26] Lonergan, *Insight*, p. 404.

[27] Lonergan, *Insight*, p. 404.

The second question underlies the issues which are dealt with in the section on "Feelings and Value." Finally, the question of avoidance will be the starting point for the discussion of grace in the section on "Universal Willingness."

One cannot over-emphasize the importance which the notion of desire has in Lonergan's work. As Vernon Gregson has noted, it is the desires and longings we have for what is true, valuable, beautiful, and of ultimate value which are the core of our humanity. Lonergan's work is a "grammar of those desires . . . [it] is not only a theory about human desire . . . but it is also and especially an invitation to name our own desires."[28] Most importantly, the motivation for the naming of those desires is the strengthening of one's freedom to choose that which is good.

### 3.1. (b) The Subject as an Historical and Existential Agent

The notion of the subject as an historical and existential agent presents a shift in Lonergan's thinking, one which can be dated to the post-*Insight* years 1964-1965. During this time two significant themes emerged: "the primacy of the fourth level of human consciousness, the existential level, the level of evaluation and love; secondly the significance of historical consciousness."[29] While there is an emphasis in A

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[28] Gregson, "The Desire to Know," pp. 16-17.

[29] Introduction by William F.J. Ryan, S.J., and Bernard J. Tyrell, S.J., in *A Second Collection*, pp. vii-viii. For further elaboration on this point see Lonergan, *Insight*, pp. 237-244, in which Lonergan discusses "Intersubjectivity and Social Order," "The Tension of Community" and "The Dialectic of Community."

*Second Collection* on the subject as an intersubjective being, one needs to be clear that this is not a reversal of Lonergan's position in *Insight*. One sees in his early writings the foundation for the basis of his later work, in which the focus is not on individualism, but intersubjectivity and the subject as one who is engaged in history in the lecture "Natural Right and Historical Mindedness."[30]

Lonergan begins by noting that not only are men and women responsible for their own lives, they also share a collective responsibility for the world in which they live. While the notion of natural right was the product of the ancient Greek world, 19th-century historical thought placed a focus on human historicity. Lonergan's intent in the preparing of this lecture was to attempt to unite these two components. Foundational to this attempt is the perspective that "nature is given man at birth. Historicity is what man makes of man."[31] In order to understand the human person, one must study his/her history since it is through history that man and woman are made. In this sense we see that history and historicity are "related as object to be known and investigating subject."[32] While an Aristotelian perspective would focus on the characteristic of man/woman as one who raises and answers questions,

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[30] This lecture was later published in Lonergan, *A Third Collection*, pp. 169-183.

[31] Bernard Lonergan, "Natural Right and Historical Mindedness," in Longeran, *A Third Collection: Papers by Bernard Lonergan,* edited by Frederick E. Crowe, S.J. (New York: Paulist Press, 1985), p. 170.

[32] Lonergan, "Natural Right and Historical Mindedness," p. 171.

Lonergan notes that an exclusive focus on intellectual satisfaction would be an erroneous notion of what the human spirit desires.

With this in mind, Lonergan points out that not only are there questions for intelligence and reflection, but also questions which have practical, interpersonal and existential proportions. In three relatively short paragraphs on one page of "Natural Right and Historical Mindedness," one sees a summary of what has been referred to by many who study Lonergan, as the second phase of his thought on the human person.

In these few paragraphs, we are able to discern the key elements of this development in his thinking, in which he focusses on moral self-transcendence, the role of feelings, their relationship to a hierarchy of values, judgments of value, and decisions.[33]

While the elements of feelings, moral transcendence, a scale of values, judgments and decision are all contained in this pivotal passage, one must be aware that these issues are not missing from his earlier works, neither has his position on knowing, which is articulated in *Insight* been reversed. What is of crucial significance is that these existential characteristics arise in a way which constitutes a discrete or separate level of consciousness.[34]

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[33] See Lonergan, "Natural Right and Historical Mindedness," p. 173. These paragraphs will be quoted in section 3.3 (a) of this thesis, "Feelings and Value in Post-*Insight* Texts."

[34] See Doran, *Dialectics*, pp. 26-30, for an excellent discussion of this development in

For Lonergan, the movement to the question "Is it worthwhile for us?" from the question "Is it worthwhile for me?" is an example of how human meaning evolves through human collaboration. Men and women are to be known not only through their nature but also in their historicity, concretely as well as abstractly. For Lonergan, the source of natural right is intrinsic to human intelligence. However, it is within the context of the freedom which is operative within an environment of personal relations that Lonergan finds the correlation between the social order and the organization of consciousness. It is to be found in communities where persons are bound together by the common good of order in which common needs are met.[35]

However, Lonergan notes that human participation and cooperation in such communities is animated by feelings and desires which respond to values. The self-transcending subject is intellectually transformed and therefore capable of making the distinction between the world of immediacy and the world mediated by meaning, morally capable of acknowledging the distinction between satisfactions and values, and affectively ordered to being committed to love. Since every person is an embodiment of natural right as well as historically constituted, he/she is constantly revealing his/her natural tendency to be open to friendship.

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Lonergan's thought.

[35] See also Lonergan, *Method*, pp. 49-50.

### 3.1. (c) The Subject as Lover

The subject of love is first introduced in Chapter Four of *Method,*[36] with the notion of falling in love with God. This chapter provides the major locus for his position on love, one which undergoes further development in later writings. As Robert Doran points out, the unique and unifying theme in Lonergan's book *A Third Collection*, which is comprised mostly of his post-*Method* writings, is the discussion of love.

While Doran speaks of this position on love as constituting a fifth level of consciousness, this is not universally accepted among Lonergan scholars. In fact, it constitutes one of the most active internal debates in Lonergan studies at the present time. A discussion on this issue clearly transcends the scope of this work. However, for the purpose of this analysis of the characteristics of Lonergan's subject, it does not impact the validity of describing him/her as one who loves, since there is ample evidence for this perspective throughout Lonergan's later works, and Lonergan himself refers to it as a fifth stage in self-transcendence. However, whether it constitutes a fifth level of consciousness remains a question for this author as for others who study Lonergan's work.[37]

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[36] See Lonergan, *Method,* pp. 101-124.

[37] For an excellent presentation of this topic, see Michael Vertin, "Lonergan on Consciousness: Is There a Fifth Level?," in *Method: Journal of Lonergan Studies* 12 (1994),

However, in "A Post-Hegelian Philosophy of Religion" in *A Third Collection*, Lonergan reinforces the importance of being in love by noting that human development becomes

> . . . a successful way of life only when we really are pulled out of ourselves as, for example, when we fall in love, whether our love be the domestic love that unites husband and wife and children, or the love of our fellows whose well-being we promote and defend, or the love of God above all in whom we love our neighbour as ourselves.[38]

The significance of the subject as one who loves becomes clearer in that Lonergan views self-transcendence itself as reaching its pinnacle not in righteousness,

> . . . but in love and, when we fall in love, then life begins anew. A new principle takes over and, as long as it lasts, we are lifted above ourselves and carried along as parts within an ever more intimate yet ever more liberating dynamic whole.[39]

For Lonergan, just as the question of God is implied in all of our questions,

> . . . being in love with God is the basic fulfilment of our conscious intentionality. That fulfilment brings a deep-set joy that can remain despite humiliation, failure, privation, pain, betrayal, desertion . . . Being in love with God, as experienced, is being in love in an unrestricted fashion. All love is self-surrender, but being in love with

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pp. 1-36.

[38] Bernard Lonergan, "A Post-Hegelian Philosophy of Religion," in Lonergan, *A Third Collection: Papers by Bernard Lonergan*, edited by Frederick E. Crowe and Robert M. Doran (Toronto: University of Toronto Press, 1992), p. 208.

[39] Lonergan, "Natural Right and Historical Mindedness," p. 175.

> God is being in love without limits or qualifications or conditions or reservations. Just as unrestricted questioning is our capacity for self-transcendence, so being in love in an unrestricted fashion is the proper fulfilment of that capacity.[40]

This notion of being in love with God as the basis for transformation of knowing and loving is pivotal to Lonergan's notion of the human person. However, while it forms the basis for his anthropological stance in terms of human authenticity and self-transcendence, it is primarily a theological assertion prior to its being an anthropological statement, in that it operates from within the framework that views the human person as the "image of God" and the relationship between man, woman and God as having ramifications for one's status as a human being.[41]

Perhaps more significantly, it says that the human person can only be accurately understood as he/she relates to God. This further reinforces Lonergan's perspective that authenticity does not ultimately depend on human achievements.

### 3.1. (d) The Subject As a Participant in Creating and Healing

As mentioned in the above section of this thesis, Lonergan speaks of grace as a "being in love with God" and it is this notion of the human subject as one who loves because he/she is first loved, which leads us to the final development of

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[40] Lonergan, *Method*, pp. 105-106.

[41] For an excellent discussion of this perspective see Richard M. Gula, S.S., *Reason Informed by Faith: Foundations of Catholic Morality* (New York: Paulist Press, 1989).

Lonergan's work on the human subject. In *Third Collection*, Lonergan makes the distinction between two different kinds of human development. In the discussion of the subject as one who knows we have seen that there is a development from

> . . . experience, to growing understanding, from growing understanding to balanced judgment, from balanced judgment to fruitful courses of action, and from fruitful courses of action to the new situations that call forth further understanding, profounder judgment, richer courses of action.[42]

Lonergan refers to this stage as part of a creative developmental process which moves from "below upwards."[43] However, he also speaks of another process, one which moves from above downwards, and whose proximate cause is falling in love. Lonergan refers to this stage as one of healing, one which is crucial in that it transforms one's capacity for self-appropriation in the sense that it is the act of falling in love that releases the desire for what is intelligible, true, being and the good. He describes this process of healing in "Natural Right and Historical Mindedness" as follows:

> But there is also development from above downwards. There is the transformation of falling in love: the domestic love of the family; the human love of one's tribe, one's city, one's country, mankind; the

[42] Lonergan, "Healing and Creating in History," p. 106.

[43] Lonergan, "Healing and Creating in History," p. 106. See also Doran, *Dialectics*, p. 176, for a further development on this aspect of Lonergan's thought.

> divine love that orientates man in his cosmos and expresses itself in his worship."[44]

In conclusion, the human subject exists as a collection of characteristics which are integrated into one unity-identity-whole, which for Lonergan clearly is in the "image of God." As one who desires to know, the subject moves through the levels of experience, understanding and judgment to action. In the affirmation of oneself as a knower, character is created. As one who loves, the subject reaches the pinnacle of self-transcendence and the realization that such self-transcendence is not wholly dependent on his/her own actions. As an historical and existential agent there is recognition that one's temporal nature carries with it a collective responsibility to the world. There is also the recognition that cultures are not static and that the present exists in tension with the past and the future. Of particular importance is the introduction of the notion that Lonergan views feelings as relating to value and self-transcendence. Finally, the subject as one who not only is involved in creating, but also is in need of healing, points out that inherent in our natures as having been created in the image of God is the invitation to participate in communion with others. In fact it is only in doing so, that we reach fulfilment.

We see in all of these characteristics, as well as in all of the levels of experience, both an affective as well as rational component that not only are

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[44] "Healing and Creating in History," p.106.

constitutive of the human subject but bear both a symbiotic and synergistic relationship to each other. This is the result of the fact that the dynamism of the process of self-transcendence is driven by desire, and this is the same throughout all of the stages of self-transcendence.

### 3.2 The Negative Function of Feelings: Dialectical Tension in the Subject and Bias

Lonergan's position on the human subject is not as neat a package as the previous section might appear to point out. In fact, Lonergan is constantly alluding to the fact that the subject bears a fragility which impacts his/her every action. While he discusses this fragility in various contexts, it is in his treatment of bias that we get a clear sense of both the reasons for this fragility, as well as the consequences of it. The purpose of this section is to discuss Lonergan's notion of bias, which is not a preference of character, but rather a "block or distortion of intellectual development,"[45] one which excludes or represses not only insights but also further questions which insights might have produced.

In this discussion, one gets a clear sense that, for Lonergan, human authenticity is never some "pure and serene and secure possession."[46] The "authentic" human subject does not rest in a stable, or permanent state of self-

[45] Lonergan, *Method*, p. 231.

[46] Lonergan, *Method*, p. 110.

transcendent bliss, but constantly struggles through many crises in the process of self-appropriation, in which success and failure are intimately connected.

This section will begin with a discussion of the dialectic of Lonergan's subject and the implications this has in terms of the desire to know, self-transcendence and bias. This is followed by a discussion of each of the four types of bias — dramatic bias, egoistic bias, group bias and finally general bias — with the focus being on dramatic bias. It will conclude with a brief discussion of what the affective component of these biases might be. Robert Doran's work on the psyche, as the locus of feeling, will serve as a clarification of Lonergan's own thought in this section.

This section will not provide an exhaustive treatment of Lonergan's position on dialectic, or bias. Rather, as in the previous section, the topic of feelings will provide the focus for this discussion and will drive the treatment of both of these issues in this chapter.

### 3.2. (a) The Dialectic of the Dramatic Subject

Lonergan speaks of the process of self-transcendence as being one which drives the cognitional process from "sense and imagination to understanding, from understanding to judgment, from judgment to the complete context of correct judgments that is named knowledge."[47] However, as we will see in the section

[47] Lonergan, *Insight*, p. 372.

below, the subject is a combination of dialectical tensions, which provide a conduit for bias. As a result, the desire to know involves the subject in an ongoing battle for authenticity.

However, although involving the subject in an existential conflict, as was pointed out in the discussion of the "desire to know," Lonergan describes the desire for knowledge itself as being pure, as well as unrestricted, detached and disinterested.

The desire is pure, in that one does not know it by the "misleading analogy of other desire, but by giving free rein to intelligent and rational consciousness."[48] It desires to know and to understand intelligently and reasonably, to distinguish between questions that are sound and those that are meaningless or illegitimate. In this sense, it is different from all other desires. In being driven by this powerful desire, one is held by the fascination of the question and engaged in the search for solutions. The pure desire to know involves the

> . . . absorption of investigation, the joy of discovery, the assurance of judgment, the modesty of limited knowledge. It is the relentless serenity, the unhurried determination, the imperturbable drive of question following appositely on question in the genesis of truth.[49]

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[48] Lonergan, *Insight*, p. 373.

[49] Lonergan, *Insight*, p. 373.

In this quotation, one understands that, for Lonergan, the objective of the pure desire is a desire for what is to be known, an orientation to that which is not yet known. Ultimately it is a desire for "being."

The desire to know is unrestricted in the sense that it strives to understand completely even those things which appear to lie outside of its seemingly limited horizon. In this way, the unrestricted nature of the desire to know is constitutive of being, since being is comprised of that which can be grasped intelligently and professed reasonably. While the desire to know grounds enquiry, one cannot separate the notion of being from the process of cognition. It is the "supreme heuristic notion,"[50] in that it is intended in all questions for understanding and all acts of judging.

Thirdly, the desire to know is not only pure and unrestricted, but also disinterested and detached, in that it meets all questions and further questions fairly, in a manner devoid of self-interest and manipulation.

However, as Lonergan notes in his section on genetic method in Chapter Fifteen of *Insight*

> . . . it is difficult for man, even in knowing, to be dominated simply by the pure desire, and it is far more difficult for him to permit that detachment and disinterestedness to dominate his whole way of life. For the self, as perceiving and feeling, as enjoying and suffering,

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[50] Lonergan, *Insight*, p. 380.

> functions as an animal in an environment, as a self-attached and self-interested centre within its own narrow world of stimuli and responses. But the same self as inquiring and reflecting, as conceiving intelligently and judging reasonably, is carried by its own higher spontaneity to quite a different mode of operation with the opposite attributes of detachment and disinterestedness. It is confronted with a universe of being in which it finds itself, not the centre of reference, but an object co-ordinated with other objects and, with them, subordinated to some destiny to be discovered, or invented, approved or disdained, accepted or repudiated.[51]

With these words, one again understands that Lonergan's notion of the human person is one in which there is a recognition that authenticity is never achieved without struggle. Since this situation is the result of a tension which exists in the very make-up of the person, the struggle for self-transcendence and authenticity is on-going and authenticity itself is never a permanent possession.

Lonergan refers to this situation as the result of the "dialectic of the dramatic subject." The notion of dialectic is a major organizing theme in *Insight*. Since *Insight* is concerned with the self-appropriation and authenticity of the human person, ultimately one must understand the notion of dialectic in order to understand Lonergan's position on the subject.[52] In *Insight*, Lonergan discusses dialectic as involving a tension in the subject. He describes this tension as being between neural demands and the censorship. The censorship is exercised by the intellect and the

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[51] Lonergan, *Insight*, p. 498.

[52] See also Doran, *Dialectics*, pp. 67-68, for a brief discussion of the place of dialectic in Lonergan's work.

imagination, which together select and arrange materials constructively, resulting in insight.

However, often there is a breakdown in this relationship between censorship and the neural demands and as a result censorship becomes repressive, rather than constructive. Lonergan notes however, that this tension between the censor and neural demands is really a tension between the pure desire and the sensitive psyche which are "the unfolding on different levels of a single, individual unity, identity, whole."[53] As a result, the tension is unavoidable since the human subject is a combination of opposites, that is, both psyche and intellect. He refers to this condition as an instance of the "law of limitation and transcendence"[54] and notes that it is this law which constitutes every moment of authentic development in the world.

Lonergan describes this law as being one of a tension between the subject as he/she is and the subject as he/she could be. As was noted in the section above, it is this tension which provides a point of vulnerability for bias.

Robert Doran expands on this relationship between the psyche and intellect, in noting that the data of consciousness is in fact twofold and that

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[53] Lonergan, *Insight*, p. 499.

[54] Lonergan, *Insight*, p. 497.

> . . . at least an implicit correctness on one set, the intentional or spiritual, is necessary for the correct negotiation of the other set, the psychic . . . there are two distinct sets of data of consciousness, the data of intentionality and the data of the psyche and the latter set, the sensitive experience of the movement of life, changes with the performance of the operations through which direction in that movement is found.[55]

One of the implications of this situation is that the precariousness of affirming oneself as a knower is a result not only of inaccurate perceptions of what knowledge is, but also of the psychic factors which need to be averted to, if one wishes to expand one's horizon or outlook in moving to a higher viewpoint. Doran notes that Lonergan accounts for the transformative power of intentionality on the psyche as resulting from a "vertical finality toward participation in the life of the spirit . . . [where] finality is a relationship of orientation to an end higher than that resulting from what a thing is."[56]

> Such vertical finality is another name for self-transcendence. By experience we attend to the other; by understanding we gradually construct our world; by judgment we discern its independence of ourselves; by deliberate and responsible freedom we move beyond merely self-regarding norms and make ourselves moral beings . . . Within each individual vertical finality heads for self-transcendence.[57]

[55] Doran, *Dialectics*, pp. 46-47.

[56] Doran, *Dialectics*, p. 47.

[57] Bernard Lonergan, "Mission and the Spirit," in *A Third Collection: Papers by Bernard Lonergan*, edited by Frederick E. Crowe (New York: Paulist Press, 1985), pp. 29-30.

The psyche has this finality, both as an instrument of insight, in that images are required for insight, as well as acting as a participant in the functioning of insight. This results in the achieving of a higher integration of neural processes, as well as a gaining of order and unity. Robert Doran writes that this higher integration is "effected by the intentional processes of question and answer and by the experience of falling in love. The science of intentionality thus gives us the lead as to what it is to be well, even psychologically or affectively well."[58]

We see therefore that not only do our intentional operations have a constitutive effect on our feelings, but that our feelings impact the performance of those operations. In other words, the movement of the psyche must act in symbiosis with the self-transcendence of intentional operations if those operations are to proceed smoothly. In this way, the psyche participates constructively in terms of the dialectic of the subject in that it allows experience to occur for its own sake.

### 3.2. (a) (i) Bias

However, not only can insight be desired, it can also be unwanted and refused. Lonergan refers to this situation as a "flight from understanding."[59] The consequences of this refusal are grave in that not only is one misunderstood by

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[58] Doran, *Dialectics*, p. 48.

[59] Lonergan, *Insight*, p. 5.

others, but more importantly, he/she is incomprehensible even to himself/herself. We see in Lonergan's discussion of the "flight from understanding" that it is not to be viewed as a "peculiar aberration that afflicts only the unfortunate or the perverse."[60] Rather, it is the result of an incomplete development in the process of cognition. In the following discussion of bias, it is important to remember that the struggle for authenticity is not restricted to certain individuals, but is a universal condition with no anthropological boundaries. In this disussion, the impact of feelings on cognition will be discussed relative to their ability to exert a somewhat negative force in the development of insight.

### 3.2 (a) (ii) Dramatic Bias

Lonergan's notion of dramatic bias is the most developed of all the types of bias and will therefore be given extensive treatment here. It is important also due to the fact that it is in this type of bias that we get the clearest picture of the deleterious effect which feelings can exert on the cognitional process. In dramatic bias one sees that

> . . . the incomprehension, isolation, and duality rob the development of one's common sense of some part, greater or less, of the corrections and the assurance that result from learning accurately the

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[60] Lonergan, *Insight*, pp. 5-6.

> tested insights of others and from submitting one's own insights to the criticism based on other's experience and development.[61]

In other words, not only is insight refused, but the further questions which would arise from insight, are also excluded. Lonergan refers to this aberration, which results in incomprehension and isolation, as a "scotosis" and the blind spot that results from it as a "scotoma."[62] As well, he also notes that it operates on an unconscious level, where it arises in the censorship which controls the surfacing of psychic contents.

While Lonergan does not himself provide specific examples of such bias, nor elaborate at any great length on the experiential causes of this bias, others like Vernon Gregson and Robert Doran do, and as mentioned previously, this author would suggest that one can find a firm ground for their views in Lonergan's writings. We see in Gregson's writings that he views dramatic bias as being caused by

> . . . a major trauma to our physiological/psychological constitution. Anything touching the trauma is so emotionally loaded that one avoids dealing with it.[63]

This avoidance takes several forms. For example, although unwanted insights may occasionally continue to arise, as mentioned above, there can be an exclusion of the further relevant questions which pertain to that insight, thereby effecting a

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[61] Lonergan, *Insight*, pp. 214-215.

[62] Lonergan, *Insight*, p. 215.

[63] Gregson, "The Desire to Know: Intellectual Conversion,", p. 31.

stalemate in the subject's development. Again, this exclusion of further questions occurs on an unconscious level. One can perhaps see a parallel to this in the unconscious avoidance of specific situations that is often manifested by victims of post-traumatic stress disorder. For those people, not only are further questions excluded, but situations which would provoke those questions and insights that might arise from them, are also unconsciously avoided. As well, the subject who is affected by this bias is often capable of brushing aside any unwanted insights by labelling them as irrational, or having no basis in fact, in order to avoid facing something that is undesirable. He/she may also attempt to avoid any critical reflection entirely, by recoiling in horror from certain insights or by an emotional reaction of pride or distaste.

Lonergan speaks of these as "inverse phenomena" and notes that

> Insights that expand the scotosis can appear to lack plausibility; they will be subjected to scrutiny; and as the subject shifts to and from his sounder viewpoint, they will oscillate wildly between an appearance of nonsense and an appearance of truth.[64]

In this way, although the scotosis remains unconscious, it will undergo various crises, which in turn will produce states of "obscurity and bewilderment, of suspicion and reassurance, of doubt and rationalization, of insecurity and disquiet"[65] in the

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[64] Lonergan, *Insight*, p. 215.

[65] Lonergan, *Insight*, p. 215.

subject. In other words, it is important to understand that while the memory of a traumatic event may in fact be attempting to resurface, the subconscious defence mechanisms are still also capable of being more or less in control, and it is this that leads to oscillations in the subject, of the dichotomies of suspicion and reassurance, etc., of which Lonergan speaks.[66]

In other words, it appears that, at its most efficient, and prior to the oscillation that Lonergan notes occurs when the scotosis itself is subject to crises, the scotosis effectively results in the repressing of the images and their affects, which occur prior to, and are mandatory for, attaining insight. However, at the same time, the scotosis allows into consciousness those images that support the scotoma itself. This inhibition operates differently on the image than it does on the affect. Since insight is into images and not into affects, for insight to be prevented, it is the image that will have to be prevented. However, as Doran points out, since it is easier to repress images than feelings,

> . . . the affective component becomes dissociated from its imaginal apprehensive correspondent, and attaches itself to other and incongruous images, that is, to those that *are* allowed to emerge into consciousness. The result is a cumulative departure from coherence, a progressive fragmentation of sensitive consciousness.[67]

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[66] For an excellent discussion of scotosis, see Lonergan, *Insight*, p. 216.

[67] Doran, *Dialectics*, p. 60.

When this occurs, it may however be possible to investigate the association paths, that is, from the incongruous to the original affect, thereby concluding that some form of repression is exerting an influence on the original image and its affect. One finds numerous examples of this in cases of adults who were abused as children.

Similarly, we see that emotional triggers can be found in specific words, smells or looks, which all have become disassociated from the original image through repression. In this way, we see that while certain things may be completely innocuous or insignificant for one person, for one who is afflicted with dramatic bias, they are terror-filled reminders of past traumas to which he/she often reacts with inappropriate anger or fear, or with strong defence reactions such as complete emotional, verbal or physical withdrawal.

However, it is important to point out that such occurrences indicate that a personality is now struggling towards psychic healing. These disassociated recollections and images are part of the healing process, in that they constitute part of the psyche's effort to assimilate the traumatic event into their lives. However, such a process is far from easy and there are numerous relapses to old patterns of behaviour. Lonergan points out in this regard that "insights are unwanted not

because they confirm our current viewpoints and behaviour, but because they lead to their correction and revision."[68]

Not only does dramatic bias result in a differentiation of the persona and the ego, but also, more importantly, this differentiation effectively defeats the attempts of the dramatic actor to perform smoothly, since the split between the ego and persona impedes the concentration of higher level functions, thereby permitting the feelings of the ego or shadow to slide into the persona's performance.[69] We see, therefore, that dramatic bias has many far-reaching consequences, from this differentiation of the persona and ego, to the alternation of suspicion and reassurance, doubt and rationalization that was previously mentioned. We have also seen that it undermines the development of common sense, in that the developing scotosis interferes with the images that are necessary for insights.

In the above section on the "Dialectic of the Dramatic subject," it was noted that it is the vertical finality towards participation in the spiritual that accounts for the transformative power of intentionality on the psyche. The psyche has this finality, both as an instrument of insight, in that images are required for insight, but it also acts as a participant in the functioning of insight, thereby achieving a higher integration of neural processes as well as gaining order and unity. Again this higher

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[68] Lonergan, *Insight*, p. 217.

[69] Lonergan, *Insight*, p. 217.

integration is the result of both the question-and-answer process of intentionality as well as the experience of love. In this way, the science of intentionality provides insight into psychic and affective well being. This provides further evidence of the fact that not only do intentional operations have a constitutive effect on our feelings, but also that feelings impact the performance of those operations.

### 3.2. (a) (iii) Egoistic Bias

Lonergan refers to egoistic bias as a distortion in the development of intelligence, which results from the refusal to ask the further questions which would lead to the good of order. Instead egoism chooses only those goods which are relative to its own desires. While even in neurotic bias, which is largely unconscious, the subject experiences a feeling of unease relative to his/her actions, this is more so with the egoist since the impetus to choose oneself over others is conscious.

However, it must be stated that the egoist is not deficient in the sense of the disinterestedness or detachment required for intelligence. Quite the contrary, he/she has fine-tuned the capacity to solve problems. Neither can one accuse the egoist of allowing the process of knowing to be negatively impacted by desires or fears. He/she is the "cool schemer, the shrewd calculator, the hardheaded self-seeker."[70] However, with the egoist's refusal to allow further questions to arise that might have

[70] Lonergan, *Insight*, p. 245.

the potential of altering his/her understanding but might not be self-satisfying, there arises an "incomplete development of intelligence."[71] While egoism has the courage to think for itself, it does not move from the initial impetus provided by desires and fears, to the self-denial required for the desire to know to flourish. This results in the reduction of the self-correcting process of knowing, to a paying of lip-service and a position of narcissism which isolates the subject from the larger community.[72] This is an important point relative to the role of feelings and intentionality.

Lonergan is not saying that egoistic bias is devoid of an affective component, since all knowledge springs from the desire to know. However, he is saying that just as inquiry is arrested at a certain point, so too are the desires which provoke it. In this bias, intellect and feelings function to support a static position, rather than operating within the heuristic structure of knowing, which moves to a higher viewpoint. As well, since the neural manifold and the environment of the subject have a symbiotic relationship, in that operations of cognition have an influence on the desire to know from which they emanate and vice-versa, then egoistic bias has the potential to distort not only the perspective from which operations of intentionality function, but also the way in which the subject experiences his/her environment and

[71] Lonergan, *Insight*, p. 245.

[72] Gregson, "The Desire to Know: Intellectual Conversion," p. 32.

relates to others within that environment. As we shall see further on, egoistic bias will have a significant impact on the relationship between values and satisfaction.

### 3.2. (a) (iv) Group Bias

Whereas individual bias is characterized by a subject who is indifferent to his/her community, group bias is supported by intersubjective feeling. Lonergan, in discussing the dialectic of community, notes that there is both the operation of practical intelligence as well as human intersubjectivy.[73] While it is part of the human condition to desire to exist in unity with others in a relationship of love and support, the problem arises when a group can no longer see beyond its own self-interest to the good of society, and to its place within that society. In other words, with group bias, there exists a distortion between intersubjectivity and practical intelligence, in which the goods of society are displaced as a result of the group's limited horizons.

> Just as the individual egoist puts further questions up to a point, but desists before reaching conclusions incompatible with his egoism, so also the group is prone to have a blind spot for the insights that reveal its well-being to be excessive or its usefulness at an end.[74]

Not only does this bias have implications for the individual, but obviously for the whole social order. Since the advantage of one group is often disadvantageous

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[73] Lonergan, *Insight*, pp. 247-248.

[74] Lonergan, *Insight*, p. 248.

to another, the inner functioning of groups often takes the form of a reactive posturing, which is focussed on self-protection, or offensive mechanisms which attempt to displace other groups. A stratification of society ensues, with the development of distinct and separate classes, and practical intelligence is no longer the desire to know "being" but the desire to know only those things which fall within the horizons of the group.[75] Further, the social order

> does not correspond to any coherently developed set of practical ideas. It represents the fraction of practical ideas that were made operative by their conjunction with power.[76]

As a result of the struggle between the dominant and the repressed groups of society, violence and further decline ensue. While individual bias can be dealt with on a small scale, group bias, which is distinct in its social characteristic, results in massive consequences. One only has to look to Northern Ireland and South Africa for but two examples of the effects of group bias. Similar to the situation with egoistic bias, group bias will have a fundamental influence on the relationship between values and satisfaction, which will be discussed further on in this chapter.

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[75] Relative to the impact of the stratification of society, Lonergan writes in *Insight*, p. 249, that "the new differentiation finds expression not only in conceptual labels but also in deep feelings of frustration, resentment, bitterness, and hatred."

[76] Lonergan, *Insight*, p. 249. Further to this Lonergan writes "the sins of group bias may be secret and almost unconscious. But what originally was a neglected possibility, in time becomes a grotesquely distorted reality."

### 3.2. (a) (v) General Bias

Lonergan refers to this bias as both "general bias" as well as the "bias of common sense," in that it involves the tendency to settle for short-term, "quick fix" solutions to even the most complex problems. As with the other forms of bias, its presence points to the fact that the problems of the world are often beyond the ability of man/ woman to cope, a condition which is the result of the tension between our status as physiological beings, and our existence as intelligent actors.

This accounts for the fact that we as humans regularly fail in our attempts to structure our lives in harmony with some accepted standard of intelligence. This occurs in large part because the development of intellect, which is concerned with choosing what is worthwhile, occurs at a slower pace than our physiological needs. As a result, there is a tendency to settle for what is immediate and gratifying, rather than choosing what is valuable or worthwhile.[77] This lag in development bears an important relationship to common sense which is concerned with the concrete and particular. However, not only does it not concern itself with reaching universal and abstract laws, but it also proposes that such knowledge is merely speculative and therefore irrelevant.

> Every specialist runs the risk of turning his specialty into a bias by failing to recognize and appreciate the significance of other fields.

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[77] Lonergan, *Insight*, p. 250.

> Common sense almost invariably makes that mistake; for it is incapable of analyzing itself, incapable of making the discovery that it too is a specialized development of human knowledge, incapable of coming to grasp that its peculiar danger is to extend its legitimate concerns for the concrete and the immediately practical into disregard of larger issues and indifference to long-term results.[78]

As a result, there is again a desecration of the transcendent orientation of one's very being, with the result that insight no longer heads for its ultimate object, which is the valuable, but stops short at an apprehension of truth. This is a significant point in that it is on the level of value — that is, on choosing what is worthwhile — that one's intentionality reaches its objective. This does not undermine the importance of truth, but rather emphasises the relationship between authenticity and decision.

For Lonergan, knowing involves both a decision as to what is valuable, as well as an understanding of the value of the actions which will lead to value. The historical consequences of this are significant in terms of what Lonergan refers to as the "longer cycle of decline," in which societies become corrupt and history is no longer constituted by meaning. Lonergan views the cycles of progress and decline as operating on an individual as well as a social level.

> But as individuals not only develop but also suffer breakdowns, so too do societies . . . Progress proceeds from originating value, from subjects being their true selves by observing the transcendental precepts, Be attentive, Be intelligent, Be reasonable, Be responsible . . .

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[78] Lonergan, *Insight*, p. 251.

> Progress, of course, is not some single improvement but a continuous flow of them . . . But precepts may be violated . . . Common sense commonly feels itself omnicompetent in practical affairs, commonly is blind to long term consequences of policies and courses of action, commonly is unaware of the admixture of common nonsense in its more cherished convictions and slogans . . . Decline has a still deeper level. Not only does it compromise and distort progress. Not only do inattention, obtuseness, unreasonableness, irresponsibility produce objectively absurd situations . . . A civilization in decline digs its own grave with a relentless consistency. It cannot be argued out of its self-destructive ways . . . As self-transcendence promotes progress, so the refusal of self-transcendence turns progress into cumulative decline. [79]

We see here that the growing irrelevance and negation of the detached and disinterested desire to know produces a subject who has ceased to be open to higher viewpoints, and is also distorted in terms of the experiential foundation from which he/she operates. The narrowing of his/her experiential scope becomes cumulative and, with time, both the possibility for change and the need for change are rejected. As a result of individual unauthenticity, society and history are no longer constituted by meaning.

### 3.2. (a) (vi) Affective Component of Bias

As we have discussed in a previous section, the law of limitation and transcendence relates to bias in that when bias is absent, and this tension is in equilibrium, then the neural manifold is the source of limitation, while transcendence has its roots in the constructive censorship. However, when the tension is in

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[79] Lonergan, *Method*, pp. 52-54

disequilibrium, then several possibilities may exist. If the tension is displaced in the direction of neural demands, then limitation will predominate over transcendence resulting perhaps in depression, or "too little possibility."[80] However, there may also be a revolt of neural demands against a repressive censor resulting in schizophrenia. As well, if the tension is skewed towards the censorship, then transcendence will predominate over limitation. Finally, if the source of limitation is the repressive censor, then the distortion will result in exaggerated humility.

In all of these instances, it is obvious that a disturbance in the tension that exists between limitation and transcendence "invites the reversal that comes from the exercise of the claims of the opposed principle."[81] It is also clear that there can be no development in the subject without this tension between limitation and transcendence being maintained. Lonergan speaks of the admission of this tension into consciousness as pertaining to the "law of genuineness," one which is necessary for development.

> . . . It is the necessary condition of the harmonious cooperation of the conscious and unconscious components of development. It does not brush questions aside, smother doubts, push problems down, escape to activity, to chatter, to passive entertainment, to sleep, to narcotics. It confronts issues, inspects them, studies their many aspects, works out

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[80] Doran, *Dialectics*, p. 180.

[81] Doran, *Dialectics*, p. 180.

> their various implications, contemplates their concrete consequences in one's own life and in the lives of others. [82]

In this discussion, one understands that genuineness does not avoid inquiry, but rather confronts it, analyses it and becomes aware of the consequences that certain questions might have for one's life. However, even if there is a failure in genuineness, the tension, while displaced, can never be escaped. In other words, one must be clear that it is the displacement of the tension and not the tension itself, which is at the root of all bias.

As Doran points out, the "orientation of the censorship against insight can be rooted in either of its constitutive elements."[83] In each case of bias, although for different reasons and in varying degrees, "the psyche's aesthetic liberation from the neural undertow that would permit it to collaborate with intelligence in admitting into consciousness images for insight is impaired."[84]

For example, in general bias, which sees common sense as omnipotent and tends to settle for quick-fix solutions to even the most difficult problems, the root lies in unconverted human intelligence. In group bias, which seeks to direct development to its own benefit, there is a dominance of intersubjective spontaneity over the development of intelligence. With regard to the individual bias of the egoist,

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[82] *Insight*, p. 502.

[83] Doran, *Dialectics*, p. 180.

[84] Doran, *Dialectics*, p. 182.

who uses his/her intelligence to reach self-serving insights, we see that such an attitude interferes with common sense's social obligations, as well as with the intersubjective factor of psychic spontaneity. Finally, as we have seen, dramatic bias is "an interference of more primitive elemental affect with the constructive function of the censorship."[85]

It would appear therefore, that all of these biases have inherent in them problems of both intellectual as well as psychic underdevelopment. It would also appear that psychic underdevelopment is more pronounced as one moves from individual, to group, to dramatic bias, in the sense that dramatic bias is less available for control by consciousness than is individual bias. General bias, while having an obvious affective component in that it arises from within the subject who is a unity of both intellect and psyche, is, however, in its roots, an intellectual block and not a psychic difficulty. This in fact is the position taken by Doran. While the present author is in agreement with Doran's stance, one needs to be clear that Lonergan's insistence on the unity of psyche and intellect presupposes that there must be an affective component to all bias. There are numerous examples in *Insight* that would support this view.

> Nor are the pure desire and the sensitive psyche two things, one of them 'I' and the other 'It'. They are the unfolding on different levels of

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[85] Doran, *Dialectics*, p. 182.

> a single, individual unity, identity, whole. Both are 'I' and neither is merely 'It.'[86]

In summary, Lonergan's vision of the subject is one in which the dialectical tension between intellect and psyche, results in the possibility of his/her falling prey to bias. As a result, not only is the subject fragile and far from being self-assured, but the process of self-transcendence itself is full of crises and struggles. In discussing the four types of bias, one recognizes that each has both an affective as well as intellectual component. However, the affective dimension becomes greater as one moves from individual, to group, to dramatic bias. General bias, while rooted in the intellect, nonetheless is in some sense still affected by the psyche, in that it arises from within the dialectic of the human subject. What also becomes significant is that Lonergan views "knowing" in its ultimate sense as involving a choice for what is valuable.

However, as mentioned briefly in the previous section of this chapter, values are first apprehended not by the intellect, but by feelings. Since the intellect cannot be separated from the human subject, who is a unity of both affect and intellect, the question arises as to the relationship between intellect and feelings as they relate to values. It is towards an understanding of this relationship that the following part of this chapter now turns.

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[86] Lonergan, *Insight*, p. 499.

## 3.3. The Positive Function of Feelings: Feelings and Value

As we have seen in the earlier parts of this chapter, the authentic human subject is one who is driven to go beyond him/herself, in his/her desire to know. This dynamism which involves the whole person who struggles for self-transcendence, has been referred to as being "affective at its very core."[87] In *Method*, Lonergan writes,

> Because of our feelings, our desires and our fears, our hope or despair, our joys and sorrows, our enthusiasm and indignation, our esteem and contempt, our trust and distrust, our love and hatred, our tenderness and wrath, our admiration, veneration, reverence, our dread, horror, terror, we are oriented massively and dynamically in a world mediated by meaning.[88]

What is made clear in these words is the notion that knowing is inseparable from feelings. In fact, it is feelings that provide the momentum for all cognitional operations. Human discovery is affect laden in the sense that it carries with it an experience of joy.[89] While Lonergan's early works discuss feelings primarily in the context of the interference they can effect on knowing, his later works have

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[87] Walter E. Conn, "The Desire for Authenticity: Conscience and Moral Conversion," in *Desires of the Human Heart*, p. 40.

[88] Lonergan, *Method*, p. 31.

[89] See Conn, "The Desire for Authenticity," p. 40. Conn writes, "We cannot imagine the experience of discovery apart from the enthusiastic anticipation that precedes it, the ecstatic excitement that accompanies it, or the joyful satisfaction that follows it."

developed the notion of feelings more positively, in that they are discussed in terms of the notion of value.[90] While this development corrects a perception that Lonergan's work on cognition in *Insight* largely ignored the aspect of feelings, one must be clear that in making this move Lonergan did not abandon the intellect in favour of a focus on feelings.

There could be a tendency in highlighting the positive role which feelings play in Lonergan's later writings, to over-correct, in the sense that the role of the intellect becomes subordinated to feelings. While this section is focussed on the positive function of feelings, it is neither attempting to suggest that feelings take priority over intellect, nor to limit everything to the level of affect. To do so would be an inaccurate reading of Lonergan's work. Rather he has placed both within the dynamism of the human subject's desire for the true and the good.

The purpose of this present section is to address the question, "How are feelings related to values?" Underlying this issue is the larger question which asks, "What effect does the relationship between feelings and value have relative to the authentic development of the subject and his/her struggle for what is good or valuable?" At the outset, it must be noted that this is an area of Lonergan's thought that has not undergone substantial systematic analysis. Robert Doran, Frederick

[90] For an excellent summary of the history of the development of this aspect of Lonergan's thought, see Walter Conn "Bernard Lonergan on Value," *The Thomist* 40 (1976), pp. 243-257, particularly pp. 247-249.

Crowe and Walter Conn,[91] however, have each in their own way developed a particular aspect of Lonergan's notion of feelings and value and as a result they will serve as valuable secondary sources in this section.

There is also an added difficulty in the relationship between feelings, values and the human subject, one that relates to the fact that there is a degree of linguistic imprecision in Lonergan's work on feelings. While one must be clear that Lonergan did not relinquish the basic structure of his work in *Insight*, in the sense that feelings are treated from within the same context of the desire for self-transcendence as is his work on cognition, his language and use of concepts relative to feelings and values is in need of clarification and refining.

### 3.3. (a) Feelings and Value in Post-*Insight* Texts

In the section entitled "The Subject as an Historical and Existential Agent," we alluded to a passage contained in "Natural Right and Historical Mindedness," in which the "second phase" of Lonergan's view of the human person was laid out. Crucial to this development of the notion of the subject is the discussion of feelings

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[91] Robert Doran and Frederick Crowe are excellent guides in this field. As has been previously stated, Doran's work on the psyche serves to clarify some of Lonergan's work on feelings. Frederick Crowe's writings on Lonergan's notion of value, particularly in Frederick E. Crowe, S.J., "An Exploration of Lonergan's New Notion of Value," *Science et Esprit* 29 (1977), pp. 123-143; also Frederick E. Crowe, S.J., "An Expansion of Lonergan's Notion of Value," in *Lonergan Workshop*, 7 (1987), pp. 35-57, relates the notion of value to the development of the human subject.

and values. It is necessary to cite this passage in its entirety at this point, since it contains all of the key elements of the development of Lonergan's notion of feelings as they relate to values and the subject's struggle for self-transcendence.

> It remains that the successful negotiation of questions for intelligence and questions for reflection is not enough. They do justice to sensitive presentations and representations. But they are strangely dissociated from the feelings that constitute the mass and momentum of our lives. Knowing a world mediated by meaning is only a prelude to man's dealing with nature, to his interpersonal living and working with others, to his existential becoming what he is to make of himself by his own choices and deeds. So there emerge questions for deliberation. Gradually, they reveal their scope in their practical, interpersonal, and existential dimensions. Slowly they mount the ladder of burgeoning morality. Asking what's in it for me gives way to asking what's in it for us. And both of these queries become tempered with the more searching, the wrenching question. Is it really worthwhile?
>
> It is a searching question. The mere fact that we ask it points to a distinction between feelings that are self-regarding and feelings that are disinterested. Self-regarding feelings are pleasures and pains, desires and fears. But disinterested feelings recognize excellence: the vital value of health and strength; the communal value of a successfully functioning social order; the cultural value proclaimed as a life to be sustained not by bread alone but also by the word; the personal appropriation of these values by individuals; their historical extension in progress; deviation from them in decline; and their recovery by self-sacrificing love.
>
> I have called the question not only searching but also wrenching. Feelings reveal values to us. They dispose us to commitment. But they do not bring commitment about. For commitment is a personal act, a free and responsible act, a very open-eyed act in which we would settle what we are to become. It is open-eyed in the sense that it is consciously a decision about future decisions, aware that the best of plans cannot control the future, even aware that one's present

> commitment however firm cannot suspend the freedom that will be exercised in its future execution.[92]

At the beginning of this passage, we are again confronted with an awareness that for Lonergan, one cannot stop with questions for intelligence or reflection: ultimately, the question of value arises. These questions of value, which Lonergan refers to as "wrenching," drive the process of self-transcendence and involve the subject in the difficult procedure of deliberation. We are again reminded that self-transcendence involves the dynamism of the whole person in a way that is neither tranquil, nor absolute. There is the ever present possibility of failure. This possibility exists because feelings are not only disinterested, but also self-regarding. Lonergan elaborates on the distinction between the different types of feelings in *Method*, in the discussion of feelings as non-intentional states or trends, and feelings as intentional responses to value.

### 3.3. (a) (i) Non-Intentional States and Trends vs. Intentional Responses

Lonergan's position on the relationship between values and feelings is laid out in *Method*, in which he suggests that, "Intermediate between judgments of fact and judgments of value lie apprehensions of value. Such apprehensions are given in feelings."[93] However, while he gives credit to feelings as vehicles for reaching value,

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[92] Lonergan, "Natural Right and Historical Mindedness," p. 173.

[93] Lonergan, *Method*, p. 37.

he does not assume that feelings are an unambiguous source of such values. His position in this area is derived from the phenomenological analysis of Dietrich von Hildebrand and Max Scheler.[94]

In drawing a distinction between non-intentional states and intentional responses, Lonergan notes that non-intentional states are comprised of instances of fatigue, anxiety, bad humour, while the trends are urges such as thirst, hunger and sexual discomfort. While the states have causes, the trends have goals. However,

> . . . the relation of the feeling to the cause or goal is simply that of effect to cause, of trend to goal. The feeling itself does not presuppose and arise out of perceiving, imagining, representing the cause or goal. Rather, one first feels tired and, perhaps belatedly, one discovers that what one needs is a rest. Or first one feels hungry and then one diagnoses the trouble as a lack of food.[95]

Values are not apprehended in either states or trends but in intentional responses. We see again with this stance further evidence of the move which Lonergan wished to make, from an approach grounded in faculty psychology, to one based on intentionality.

> I wished to get out of the context of a faculty psychology with its consequent alternatives of voluntarism, intellectualism, sentimentalism,

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[94] Lonergan refers to the importance of von Hildebrand's writing relative to this aspect of his own writing in *Method*, p. 31, note 2. Here he refers us to Dietrich von Hildebrand's *Christian Ethics* (New York: David McKay, 1953), as well as to Manfred Frings, *Max Scheler* (Pittsburgh: Duquesne University Press, 1965).

[95] Lonergan, *Method*, p. 30.

> and sensism, none of which has any serious, viable meaning, and into the context of intentionality analysis that distinguishes and relates the manifold of human conscious operations and reveals that together they head man towards self-transcendence.[96]

Intentional responses, unlike non-intentional states or trends, do not relate merely to ends and causes, but to the object which is intended and apprehended.

> The feeling relates us, not just to a cause or an end, but to an object. Such feeling gives intentional consciousness its mass, momentum, drive, power. Without these feelings our knowing and deciding would be paper thin.[97]

However, since feelings arise in a non-systematic way, values cannot be apprehended in every intentional response. Feelings therefore are ambiguous in their ability to apprehend value, in the sense that while the satisfying and the valuable do sometimes coincide, it is often the case that what is satisfying is not oriented to value.

> Feelings that are intentional responses regard two main classes of objects: on the one hand, the agreeable or disagreeable, the satisfying or dissatisfying; on the other hand, values, whether the ontic value of persons or the qualitative value of beauty, understanding, truth, virtuous acts, noble deeds. In general, response to value both carries us towards self-transcendence and selects an object for the sake of whom or of which we transcend ourselves. In contrast, response to the agreeable or disagreeable is ambiguous. What is agreeable may very well be what also is a true good. But it also happens that what is a true good may be disagreeable. Most good men have to accept

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[96] See Lonergan, *A Second Collection*, p. 170.

[97] Lonergan, *Method*, pp. 30-31.

> unpleasant work, privations, pain, and their virtue is a matter of doing so without excessive self-centred lamentation.[98]

We are reminded that self-transcendence is more often than not a painful journey, and that the manner in which feelings are discerned is a difficult procedure. However, when feelings do respond to value, we catch a glimpse of the possibility of being moved to self-transcendence in such a way that our whole being is awakened. The significance of the movement of our whole being relates to Lonergan's notion that knowing is knowing value, and when one knows value, one is moved at the core of one's being to the potential for moral self-transcendence.

Another problem arises with Lonergan's recognition that although disinterested feelings do relate to values, there are several types of values, for example the vital values, social values, and personal values referred to in the above quotation. Lonergan makes the distinction between these different kinds of values in *Method*, pp. 31-32, in the discussion of the development of values according to an ascending hierarchy.

### 3.3. (a) (ii) Hierarchy of Values

Lonergan's analysis of feelings and values makes the crucial point that feelings not only respond to value, but do so in agreement with an ascending scale

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[98] Lonergan, *Method*, p. 31.

of preference. As a result, he makes the distinction between vital, social, cultural, personal and religious values and arranges their development in an ascending order.

> Vital values, such as health and strength, grace and vigor, normally are preferred to avoiding the work, privations, pains involved in acquiring, maintaining, restoring them. Social values, such as the good of order which conditions the vital values of the whole community, have to be preferred to the vital values of individual members of the community. Cultural values do not exist without the underpinning of vital and social values, but none the less they rank higher. Not on bread alone doth man live. Over and above mere living and operating, men have to find a meaning and value in their living and operating. It is the function of culture to discover, express, validate, criticize, correct, develop, improve such meaning and value. Personal value is the person in his self-transcendence, as loving and being loved, as originator of values in himself and in his milieu, as an inspiration and invitation to others to do likewise. Religious values, finally are at the heart of meaning and value of man's living and man's world.[99]

One sees in this passage, the notion that feelings and values develop in a way that is closely intertwined. In other words, while feelings develop relative to this ascending scale of values, the developing values themselves only become apparent in feelings.[100] These feelings respond to values according to the hierarchical structure of values, with religious values evoking the fullest affective response. However, one must also remember that, "Values after all, are not purely rational,

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[99] Lonergan, *Method*, pp. 31-32.

[100] See Conn, "The Desire for Authenticity," p. 41, for another discussion of Lonergan's notion of a hierarchy of values.

abstract realities; they are rooted in our feelings at the depths of our psyche."[101] As a result, values, in their dependence on feelings, not only share the strengths of feelings, but also their limits.

However, once feelings have arisen, they can be substantiated by approval or diminished by negation. As a result, while feelings are central to one's consciousness as a moral agent, it is through the discrimination of feelings that their status as vehicles for value lies. It is important to note, however, that not only will reinforcement or curtailment encourage "some feelings and discourage others but that such actions will also modify one's spontaneous scale of preferences."[102] In this way, feelings are capable of shaping new horizons, in that they drive the cognitional process and provide it with its momentum. They are transcendental in the sense that they intend the unknown which is contained in one's questions.

As a result, Lonergan draws our attention to the need to foster an environment of discernment and taste in which one can enhance his/her apprehension of values in feelings, thereby giving rise to self-transcendence and authenticity. The process of understanding, deliberation and judgment is therefore crucial and is related to the transcendental notion of value.

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[101] Conn "The Desire for Authenticity," p. 42.

[102] Lonergan, *Method*, p. 32.

### 3.3. (b) Transcendental Notion of Value and Its Relationship to the Dynamism of the Subject

Having clarified the difference between feelings which are non-intentional and therefore do not relate to value and feelings which are intentional responses to value, as well as the hierarchical structure of values themselves, we now turn to a discussion of how values relate to the desire of the subject for self-transcendence.

With the eruption of the question "Is it worthwhile?" one is oriented towards value rather than being. Not only does consciousness tend towards cognitional self-transcendence, but also towards moral self-transcendence when one makes a decision. However, the desire for value is driven by the same desire as is the desire for understanding. In other words, understanding, judging and deciding are all part of the desire for the intelligible or real, the true, and the good. One recognizes, therefore, that there exists a correlation, or relationship between the unity of the dynamism of the subject and the transcendentals. As a result, an understanding of the transcendentals, in particular, the transcendental notions, is fundamental to an understanding of this association.

Lonergan speaks of the sources of meaning as being conscious acts with intended contents, whether they occur in the dream situation or on any of the levels of consciousness. The transcendentals play a crucial role relative to meaning, in that they are the very

> . . . dynàmism of intentional consciousness, a capacity that consciously and unceasingly both heads for and recognizes data, intelligibility, truth, reality, and value.[103]

They are *a priori* because they go beyond what we know, to seek what we do not know yet. They are unrestricted because answers are never complete and so only give rise to still further questions. They are comprehensive because they intend the unknown whole or totality of which our answers reveal only part. So intelligence takes us beyond experiencing to ask what and why and how and what for. Reasonableness takes us beyond the answers of intelligence to ask whether the answers are true and whether what they mean really is so. Responsibility goes beyond fact and desire and possibility to discern between what truly is good and what only apparently is good. So if we objectify the content of intelligent intending, we form the transcendental concept of the intelligible. If we objectify the content of reasonable intending, we form the transcendental concepts of the true and the real. If we objectify the content of responsible intending, we get the transcendental concept of value, of the truly good.[104]

One recognizes again Lonergan's notion that the true, the real and the good are intended in every question which the subject poses in his/her desire to know

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[103] Lonergan, *Method*, p. 73.

[104] Lonergan, *Method*, pp. 11-12.

everything there is to know about that which is not yet known. However, he makes a crucial clarification between the transcendental concepts of the true, the real and the good and the transcendental notions in his discussion of the relationship between the two and the dynamism of the subject. He notes that while the objectification of intelligent intending results in the transcendental concept of the intelligible, and the objectification of reasonable intending results in the transcendental concept of the real, and finally the objectification of responsible intending results in the transcendental concept of the truly good, or value, it is the prior transcendental notions which constitute the dynamism of the subject's desire to know those concepts. It is these notions which

> . . . constitute the very dynamism of our conscious intending, promoting us from mere experiencing towards understanding, from mere understanding towards truth and reality, from factual knowledge to responsible action. That dynamism, so far from being a product of cultural advance, is the condition of its possibility; and any ignorance or error, any negligence or malice, that misrepresents or blocks that dynamism is obscurantism in its most radical form.[105]

One is again aware of Lonergan's viewpoint, that the fundamental moment in the notion of being is constituted by the capacity for wonder which is part of human nature. Intelligence is the natural capacity to ask questions of an unlimited nature,

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[105] Lonergan, *Method*, p. 12.

that is, about being. In this way we see that being itself, which is the object towards which our knowing moves, is both universal and concrete.

As has been noted several times in this section, Lonergan views feelings as being capable of apprehending value, and therefore as also having the capacity to transform the human subject, in that it is through feelings that the transcendental notion of value drives the subject toward a full realization of the good. Significantly, we see again that desire is at the centre of the drive towards a realization of the good.

However, any action, whether it be of a group or an individual, is a finite good in that it is open to criticism and carries with it a set of risks and alternatives. What becomes clear, therefore, is that while the transcendental notions function to advance the subject to consciousness, and while feelings can apprehend value, authenticity is achieved only after the process of deliberation, when one makes a decision for the valuable. In other words, we eventually

> . . . reach the point where we discover that it is up to ourselves to decide for ourselves what we are to make of ourselves, where we decisively meet the challenge of that discovery, where we set ourselves apart from the drifters.[106]

In referring to the need to separate ourselves from the "drifters" we again recognize the emphasis which Lonergan places on the role of decision in the process

[106] Lonergan, "A Post-Hegelian Philosophy of Religion," p. 208.

of self-transcendence. However, while the making of a choice is an exercise of liberty, in the sense of self-determination and not indeterminism, the process of deliberation itself cannot be considered decisive. In other words, liberty is only achieved when the subject terminates the process of deliberation by an act of judgment in which he/she chooses a particular course of action and proceeds to carry out that action.

In summary, this section has provided an analysis of the relationship between feelings and values. It has begun by drawing a distinction between non-intentional states or trends and intentional responses. As we have seen, non-intentional states such as fatigue, anxiety or bad humour, etc., and trends such as thirst or hunger, do not provide a vehicle for the apprehension of value. Conversely, intentional responses relate us to an intended object and it is these types of feelings which provide intentional consciousness with its drive. As a result of our feelings, we are oriented in a world mediated by meaning. However, as we have noted, feelings arise non-systematically and are therefore ambiguous in that they do not always respond to value. In fact, they relate to two quite different classes of objects, that is, to both the agreeable or disagreeable, as well as the satisfying or dissatisfying. While that which is agreeable may also be that which is true, the opposite may also be the case. As a result, the possibility of bias is always present.

As well, we have pointed to another difficulty in the relationship between feelings and values, one which arises as a result of the recognition that, while feelings do respond to value, they do so in agreement with a scale of preference. Discrimination of feelings becomes crucial, therefore, in attempting to discern value. As a result, while response to value is constitutive of the subject in that he/she catches a glimpse of what it is to transcend his/herself, Lonergan again reminds us that self-transcendence is a process involving much struggle.

While all of these relationships are animated by feelings, they bear the same fragility as the human subject does. The inevitability of failure is omnipresent and changes in direction are always mandatory if true development is to occur. None of these changes, nor the choices that are constitutive of them are easy. However, it is precisely through those choices and the changes they effect that human character develops. As we have suggested, implicit to all such development is need for healing and the question of God, and of grace.

## 3.4. Feelings, Decision making and Healing: Towards Personal Authenticity

The intent in these final pages is to lay out Lonergan's perspective of the relationship between feelings, decision making, healing, grace and personal authenticity. This relationship is crucial to the development of an improved model of informed consent, which will be the focus of the final chapter of this dissertation.

However, this section will not purport to provide an exhaustive analysis of Lonergan's theology of grace: such a discussion would be the subject of a further study.[107] Rather, it will serve to point to key elements in Lonergan's writings, which have been alluded to in previous chapters of this thesis, that provide the structure in which this further development could take place.

### 3.4.(a) The Healing Vector and the Creative Vector

During the period between 1974 to 1977, there was a development in Lonergan's thought in which two distinct ways of human development "each with its own dynamism but each also complementary to the other, came sharply into focus."[108] As noted above, Lonergan describes these two ways in terms of a development from below upwards, or a creative vector, and a movement from above downwards, or a healing vector. One sees, in the following passage from "Questionnaire on Philosophy," the complementarity of these two movements.

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[107] For a discussion on Lonergan's treatment of grace, see Bernard Lonergan, "St. Thomas's Thought on *Gratia Operans, Theological Studies,* 2 (1941), pp. 289-324 and 3 (1942). These articles later appeared in the collection Lonergan, *Grace and Freedom*, edited by J. Patout Burns (N.Y.: Herder and Herder, 1970). For a discussion on the influence of Aquinas on Lonergan's perspective of grace, see Patrick E. Byrne, "Thomistic Sources of Lonergan's World View," *The Thomist*, 46 (1982), pp. 108-145. See also Bernard Lonergan, *Verbum: Word and Idea in Aquinas*, ed., David B. Burrell, C.S.C. (Notre Dame: University of Notre Dame Press, 1967).

[108] See Crowe, "An Expansion of Lonergan's Notion of Value," pp. 35-57, relative to this development.

> [H]uman development occurs in two distinct modes. If I may use a spatial metaphor, it moves (1) from below upwards and (2) from above downwards.
>
> It moves from below upwards inasmuch as it begins from one's personal experience, advances through ever fuller understanding and more balanced judgment, and so attains the responsible exercise of personal freedom.
>
> It moves from above downwards inasmuch as one belongs to a hierarchy of groups and so owes allegiance to one's home, to one's country, to one's religion. Through the traditions of the group one is socialized, acculturated, educated.[109]

The upward movement affirms the general principle of the dynamic movement from experience, to understanding, to reflection, to judgment. This movement, which constitutes Lonergan's position on human knowing, has been outlined throughout the previous sections of this chapter and, as noted, is the central theme in *Insight*. As has been discussed, the dynamism of this movement is the result of the eros of the human subject who is driven by the desire to know.

While the movement from below upwards has been given extensive treatment by Lonergan, as well as others who have developed his work, the movement from above downwards has received less attention. It was previously noted that the movement from above involved a development in the human subject, one which was effected by the transformative power of love. In "Natural Right and Historical

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[109] Lonergan, "Questionnaire on Philosophy," in *Method: Journal of Lonergan Studies* 2, 2 (1984), p. 10, cited in Crowe, "An Expansion of Lonergan's Notion of Value," p. 37, with Crowe's correction of a minor misprint.

Mindedness," one finds further evidence of this relationship between affectivity and human development. Here Lonergan notes that

> . . . the handing on of development may be complete or incomplete. But it works from above downwards: it begins in the affectivity of the infant, the child, the son, the pupil, the follower. On affectivity rests the apprehension of values. On the apprehension of values rests belief. On belief follows the growth in understanding of one who has found a genuine teacher and has been initiated into the study of the masters of the past. Then to confirm one's growth in understanding comes experience made mature and perceptive by one's developed understanding.[110]

Of significance in the above passage is the notion that not only can feelings apprehend value, but also that the affectivity which begins in the infant is continued in the apprehension of values and can result in belief as well as a development of understanding. One also recognizes that, while the subject in *Insight* functions as one who operates through the asking of questions, and in this way participates in the upward movement, the dynamism of love which is operative in the downward movement is intersubjective rather than subjective. Frederick Crowe makes a crucial point relative to this notion of intersubjectivity in drawing our attention to the point that, as a result of the fact that "We are 'we' before we are 'you' and 'I',"[111] there

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[110] Lonergan, "Natural Right and Historical Mindedness," p. 181.

[111] Crowe, "An Expansion of Lonergan's Notion of Value," p. 42.

exists a significant difference in the way in "modes of operation as the two dynamisms move us in opposite directions from level to level."[112]

Further clarification of this difference is found in Lonergan's Fourth Chapter on "Religion" in *Method*, in which he notes that, while unrestricted questioning constitutes the capacity for self-transcendence, being in love with God in an unrestricted manner is the fulfilment of that capacity. However, such fulfilment is

> . . . not the product of our knowledge and choice. On the contrary, it dismantles and abolishes the horizon in which our knowing and choosing went on and it sets up a new horizon in which the love of God will transvalue our values and the eyes of that love will transform our knowing.[113]

In this description of religious love as a dynamism which reorients one's horizon, and yet is not the product of knowing, one sees an analogous movement to that of the description of the healing vector above, which involves a movement from affectivity to values, to judgments to mature experience. While the creative vector is a movement in which our capacity for self-transcendence is shown, it is in the healing vector that we see that capacity becoming an actuality.

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[112] Crowe, "An Expansion of Lonergan's Notion of Value", p. 42.

[113] Lonergan, *Method*, pp. 105-06.

However, of crucial importance to an understanding of the healing vector is Lonergan's position both in *Method* and *Philosophy of God, and Theology*. Here he notes that the source of this downward movement is the gift of God's love.

> I have argued that it is this gift that leads men to seek knowledge of God. God's gift of his love is God's free and gratuitous gift. It does not suppose that we know God. It does not proceed from our knowledge of God. On the contrary I have maintained that the gift occurs with indeed a determinate content but without an intellectually apprehended object. Religious experience at its root is experience of an unconditioned and unrestricted being in love. But what we are in love with, remains something that we have to find out.[114]

In this quotation we see not only that the gift of God's love is the source of our ability for self-transcendence, but also that it requires reception and response from the subject. As a result, Lonergan is not proposing that the fragility of the human subject is erased by the offering of grace. Just as the desire to know while pure, detached and unrestricted is still susceptible to bias, so too is the desire for God subject to the frailty of the human subject's ability to receive the offering of God's love. Just as "knowledge makes a slow, if not bloody entrance"[115] into man/woman's world, so too does the offering of grace threaten the "stability" of the fragile subject, in the sense that in the profound and passionate encounter with the

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[114] Bernard Lonergan, *Philosophy of God and Theology* (London: Darton, Longman and Todd, 1973), pp. 50-51.

[115] Lonergan, *Insight*, p. 210.

divine,[116] one is faced with difficult questions and ultimately with the need to make a decision. Questions arise such as "Will I love him in return, or will I refuse? Will I live out the gift of his love, or will I hold back, turn away, withdraw?"[117] In response to this difficulty, Lonergan proposes that the answer lies in a higher integration, or a "universal antecedent willingness." As we will see below, his notion of "universal willingness" is closely related to the integrity and unity of the dialectic of the human subject and also to the role which grace plays in the struggle for authenticity and self-transcendence.

### 3.4.(b) Universal Willingness

While Lonergan's notion of personal authenticity is in some ways a process in which the subject creates him/herself, he makes the point throughout *Insight* that sustained self-transcendence is the result of an arduous developmental process, whose solution lies in a higher integration. However, as Robert Doran has noted "nobody is a self-starter. Integrity is ultimately a function of divine grace."[118]

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[116] For a discussion of the passionate aspect of God's love, see Rosemary Haughton, *The Passionate God* (London: Darton, Longman & Todd Ltd., 1981).

[117] Lonergan, *Method*, p. 116.

[118] Doran, *Dialectics*, p. 186.

Lonergan refers to this higher integration as a "universal antecedent willingness," a state in which one is capable of making decisions without persuasion. As such, it is a habitual openness to the desire for the intelligible, the true, the good and for "being" itself. In other words, one sees that, in the creative vector, universal willingness is an openness towards terminal value, and in the healing vector, it is an openness towards love, of one's fellow human being and ultimately towards God.

In elaborating on the relationship between the creative vector and universal willingness, Lonergan begins by pointing out that rather than being separated from intellect, universal willingness is a function of intellect itself.

> For unless one's antecedent willingness has the height and breadth and depth of the unrestricted desire to know, the emergence of rational self-consciousness involves the addition of a restriction upon one's effective freedom. In brief, effective freedom itself has to be won. The key point is to reach a willingness to persuade oneself and to submit to the persuasion of others. For then one can be persuaded to a universal willingness; so one becomes antecedently willing to learn all there is to be learnt about willing and learning and about the enlargement of one's freedom from external constraints and psychoneural interferences. But to reach the universal willingness that matches the unrestricted desire to know is indeed a high achievement, for it consists not in the mere recognition of an ideal norm but in the adoption of an attitude towards the universe of being, not in the adoption of an affective attitude that would desire but not perform but in the adoption of an effective attitude in which performance matches aspiration.[119]

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[119] Lonergan, *Insight*, pp. 646-647.

While this passage is from *Insight* and does not speak about value, it is significant in that it anticipates Lonergan's later development of the notion that feelings are capable of apprehending values. Of particular importance is the fact that even in his earlier writings, Lonergan places a great deal of importance on performance, or the carrying out of an action, and that such behaviour is inseparable from the desire of the human subject. This is in keeping with his later writing in which he proposes that, while feelings are important, they only bear fruit following the process of judgment when one follows a particular course of action, thereby reaching a terminal value.

Lonergan proceeds with his discussion of universal willingness and the relationship to the creative vector by referring to universal willingness as providing the means by which one is freed from bias. Lonergan first draws our attention to the need for a higher integration, or a universal willingness, in his discussion of the relationship between the integrity of the dialectic of the human person and the threefold development of his/her components, that is, the body, the psyche and the intellect.

> Organic, psychic, and intellectual development are not three independent processes. They are interlocked, with the intellectual providing a higher integration of the psychic and the psychic providing a higher integration of the organic . . . Hence a single human action can involve a series of components: physical,chemical, organic, neural, psychic, and intellectual . . . [however] unless one asks the further questions, one remains with the insights one has already, and

> so intelligence does not develop . . . one develops through functioning.[120]

In this explanation we again see Lonergan's notion of the human person as being pivotal to an understanding of universal willingness, in that development occurs as a result of the heuristic structure of knowing, which involves the unity of the human person. The notion of the subject's unity is significant in terms of universal willingness since personal integrity involves maintaining the dialectic of the subject in a creative tension. However, as was noted in the section on the "Dialectic of the Dramatic Subject", it is particularly difficult to maintain the tension which exists between the psyche and the intellect in equilibrium. As was also recorded in this chapter, Lonergan views this tension as being the result of the law of limitation and transcendence, and has noted that what is needed is a higher integration in order that neither of these two components dominates the other thereby giving rise to bias. In this instance, the higher integration, or universal willingness required is one of genuineness in which the subject admits the tension between limitation and transcendence into consciousness.[121] This genuineness of which Lonergan speaks is

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[120] Lonergan, *Insight*, pp. 494-495. One needs to be clear here that while Lonergan's discussion of organic, psychic and intellectual development involves a process in which the intellectual is a higher integration of the psychic, he is not denying the importance of the role which feelings play relative to cognition.

[121] See Doran, *Dialectic*, p. 9.

the "necessary condition of the harmonious cooperation of the conscious and unconscious components of developments."[122]

Through a position of genuineness, the subject participates authentically in the world. Relative to the creative vector, this authentic participation is manifested in a willingness to operate from within a position of openness to the pure, detached and disinterested desire to know.

Having examined the relationship between universal willingness and the creative vector, we now turn to an analysis of the connection between the healing vector and universal willingness. As with the creative vector, there exists a similar emphasis on the importance of the unity of the human subject in Lonergan's discussion of universal willingness as it relates to the healing vector. In this instance, universal willingness, rather than being an openness to the pure desire to know, is an openness to mystery and love. Here the unity of psyche and intellect is articulated in terms of spiritual and material being and a stance of openness to mystery and to love.

We find clarification of this relationship between the human person as a unity of spirit and matter and the orientation to mystery and love in Lonergan's discussion of the notion of "being." As we have noted previously,[123] the object of the pure

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[122] Lonergan, *Insight*, p. 502.

[123] See the section of this chapter entitled, "The Desire to Know."

desire to know is "being," that is, what we can know through the answers to our questions. However, given the fact that the desire to know as unrestricted will always produce further questions, it is not through one's answers that one knows "being," but through the further questions that such answers provoke. It is in this sense that Lonergan discusses "being" in terms of a "known unknown," and as a result notes that, while self-knowledge may be explicit, it cannot bypass this sense of mystery. It is this unavoidable existence of mystery which demands the involvement of both the operations of intellect as well as the psyche.

Lonergan's position on the relationship between the two vectors and universal willingness is clear. Unless the movement from below upwards is met by a complementary movement from above downwards, universal willingness and therefore human development will be unattainable. However, we must remember that what is crucial to this position is Lonergan's view that universal willingness is not something which is effected by the subject. The movement from above downwards is one in which grace operates to effect the various conversions, or the changes in direction that are required for self-transcendence. However, as with the treatment of Lonergan's notion of grace, the following discussion will be limited to the relationship between feelings and conversion as it relates to the development of the human subject. A complete discussion of Lonergan's treatment of conversion would require further treatment.

### 3.4.(c) Conversion

Lonergan speaks of conversion as being more than a change or development; it is rather a "radical transformation on which follows, on all levels of living, an interlocked series of changes and developments."[124] As such, it involves a movement from a previous perspective to a new way of being. When this way of being is lived it

> . . . affects all of a man's conscious and intentional operations. It directs his gaze, pervades his imagination, releases the symbols that penetrate to the depths of his psyche. It enriches his understanding, guides his judgments, reinforces his decisions.[125]

In other words, one who is converted not only understands differently, but apprehends differently and relates to others in a new way. As a result there is a transformation of both the subject as well as the world within which he/she lives. Such a transformation has far reaching effects, in that what begins as a profoundly intimate and personal experience can also become communal and finally historical. In *Method*, Lonergan speaks of conversion as being intellectual, moral, and religious

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[124] Lonergan, *A Second Collection*, pp. 65-66. See also Lonergan, *Method*, p. 130. Here Lonergan elaborates on the transformation of the subject and his/her world, by noting that "Normally it is a prolonged process though its explicit acknowledgment may be concentrated in a few momentous judgments and decisions. Still it is not just a development or even a series of developments. Rather it is a resultant change of course and direction. It is as if one's eyes were opened and one's former world faded and fell away."

[125] Lonergan, *Method*, p. 131.

and writes that "while each of the three is connected with the other two, still each is a different type of event and has to be considered in itself before being related to others."[126] In *A Third Collection* he adds affective conversion to this list and notes that it too is related to the other three.

### 3.4.(c) (i) Intellectual Conversion

Lonergan's position on intellectual conversion is intimately connected to his position on knowing, and therefore to the "subject as knower." As we have seen, Lonergan views knowing as a set of operations in which the subject moves from the level of experience, to understanding, to judgment and finally to decision. Intellectual conversion is an acceptance of the fact that one knows in this way. As such, it is a

> . . . radical clarification and, consequently, the elimination of an exceedingly stubborn and misleading myth concerning reality, objectivity, and human knowing. The myth is that knowing is like looking, that objectivity is seeing what is there to be seen and not seeing what is not there, and that the real is what is out there now to be looked at . . . Knowing, accordingly, is not just seeing; it is experiencing, understanding, judging, and believing.[127]

As we have noted earlier, the criteria for objectivity is not comprised of what can be observed, but rather results from an awareness of the movement past

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[126] Lonergan, *Method*, p. 238.

[127] Lonergan, *Method*, p. 238.

experience, to understanding, judging and deciding. Similarly, reality is more than what is seen: it too is what is understood, judged and decided upon. Lonergan clarifies what he means by intellectual conversion in drawing the distinction between the naive realist, the empiricist and the idealist.

> The naive realist knows the world mediated by meaning but thinks he knows it by looking. The empiricist restricts objective knowledge to sense experience; for him, understanding and conceiving, judging and believing are merely subjective activities. The idealist insists that human knowing always includes understanding as well as sense; but he retains the empiricist's notion of reality, and so he thinks of the world mediated by meaning as not real but ideal.[128]

Contrary to this, Lonergan proposes the position of the critical realist as one who can acknowledge the world to be mediated by meaning and to be real. However, he/she is capable of this acknowledgment only by virtue of his/her position that knowing, as experiencing, understanding, judging, and deciding, is a process of self-transcendence. We are again reminded of the position discussed in the section "Objectivity and Subjectivity," in which it was noted that Lonergan views objectivity as being the result of authentic subjectivity. Only in using all of our capacities as a subject, only by giving free reign to our desire to understand and our desire for what is true, in a way that is free from bias, can objectivity be obtained. Intellectual conversion is the acceptance that this is true.[129]

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[128] Lonergan, *Method*, pp. 238-239.

[129] Gregson, "The Desire to Know," p. 27.

### 3.4.(c) (ii) Moral Conversion

In the section on "The Subject as an Historical and Existential Agent," it was noted that moral development is not an easy task.[130] It is, in fact, inordinately difficult to effect a change in our horizons, and therefore the way in which we live. Moral conversion requires that the subject respond to those feelings which are indicative of value in a way which causes her/him to act in accordance with those values. In its essence, moral conversion is a change in the

> . . . criterion of one's decisions and choices from satisfactions to values . . . [it is the] time for the exercise of vertical freedom . . . [for] opting for the truly good, even for value against satisfaction when value and satisfaction conflict. Such conversion, of course, falls far short of moral perfection. Deciding is one thing, doing is another . . . One has to keep scrutinizing one's intentional responses to values and their implicit scales of preference.[131]

As we have previously discussed, one creates oneself through actions and when those actions are the realization of the dynamism of the human spirit, actions are authentic. As a result, not only do we do what we please, but also what is

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[130] See also Lonergan, *Method*, p. 268, for further clarification on this point and the importance of decision in the development of authenticity.

[131] Lonergan, *Method*, p. 240. Of significance here is the importance of community in effecting moral conversion. Lonergan writes "one has to remain ready to learn from others." In this sense, we see that universal willingness has a social component, as it must, since man/woman is a social being.

valuable and good. In this sense, the moral agent is one who is both practical and existential.

> By his own acts the human subject makes himself what he is to be, and he does so freely and responsibly; indeed he does so precisely because his acts are the free and responsible expressions of himself . . . Just as the existential subject freely and responsibly makes himself what he is, so too he makes himself good or evil and his actions right or wrong.[132]

As a result of moral conversion, there is not only a decision for the valuable over the merely satisfying, but as well a concomitant growth in knowledge, since both the true and the good are inseparable parts of the heuristic structure of knowing of which decision is a part. However, the problem of moral impotence is only partially addressed by an experience of moral conversion. In other words, it requires confronting the invitation which moral conversion offers, that is, to a dedication to becoming a source of love which is committed to true value. As a result, moral conversion presupposes a significant level of affective development, or affective conversion, in that it can only be understood in terms of the context of one's personal apprehension and choice of values which receive initial presentation through feelings. This demands that one become an "ever more authentic source of love dedicated to the ever greater realization of true value."[133] In other words, it is

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[132] Lonergan, *A Second Collection*, pp. 79 and 83.

[133] Conn, "The Desire for Authenticity," p. 52.

only through the reality of love that one is capable of attaining and/or sustaining moral self-transcendence. But first that love must be perceived, and this requires that one must first be open to others.

We see here again the existential component of the notion of universal willingness. Receptivity to others, and ultimately to God, is the key to moral conversion, and for Lonergan, this has, as its source, affectivity.

### 3.4.(c)(iii) Affective Conversion

Lonergan's discussion of affective conversion does not occur in *Insight* or *Method*. In fact, it appears only once in his published writings, in *A Third Collection*, within a discussion of the dialectic of history. In discussing the enlightenment and emancipation he writes,

> Again, as always, emancipation has its root in self-transcendence. But in the contemporary context it is such self-transcendence as includes an intellectual, a moral, and an affective conversion . . . [A]s affective, it is commitment to love in the home, loyalty in the community, faith in the destiny of man.[134]

While Lonergan has not written on affective conversion, other than in the above context, the link which he makes between this and other conversions and his notion of self-transcendence provides the background from within which to develop

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[134] Lonergan, "Natural Right and Historical Mindedness," p. 179.

a position on affective conversion. As such, I would propose that the position which Lonergan takes relative to self-transcendence as reaching its peak when one falls in love is crucial to an understanding and development of his notion of affective conversion.

This is an area of thought which has not been as thoroughly worked out as others. However, we will borrow heavily from Robert Doran's work in *Dialectics* in which he does develop Lonergan's statement on affective conversion, albeit mainly in terms of psychic conversion. As such he is clear that his use of the term psychic conversion is not what Lonergan means by affective conversion. While one must be careful not to confuse Doran's psychic conversion with Lonergan's affective conversion, Doran's work does provide markers which serve to keep this distinction clear.[135]

Lonergan perceives affective self-transcendence occurring only when one acts for others as well as for one's self. Subsequently, when a person falls in love, this love is not limited to a specific act or group of acts, but to a dynamic state of being in love. It is this state that provides the foundation for affective development. In other

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[135] Doran, *Dialectics*, pp. 9, 52, 59, 85-90, He writes on p. 9, "What I mean by psychic conversion is not what Lonergan means by affective conversion. Lonergan's affective conversion is the fruit in part of psychic conversion, since psychic conversion makes available materials that need to be transformed if one is to be in love in an unqualified fashion."

words, while the transcendental notions are constitutive of our capacity for self-transcendence, this capacity is realized only when one falls in love.

> Then one's being becomes being-in-love. Such being-in-love has its antecedents, its causes, its conditions, its occasions. But once it has blossomed forth and as long as it lasts, it takes over. It is the first principle. From it flows one's desires and fears, one's joys and sorrows, one's discernment of values, one's decisions and deeds.[136]

As was noted previously, while moral conversion results in a willingness to meet certain issues, it is affective conversion which transforms the person, thereby making him/her capable of responding in a way that involves decision and commitment.[137] One can never overemphasize the importance that decision and praxis have in Lonergan's work. While the adoption of a converted affective stance is mandatory, it is insufficient unless it is met with adequate operation.

Further clarification is also required relative to Lonergan's use of the phrase "falling in love." While he does differentiate between different kinds of love, and his view of love is one which is benevolently directed towards another, one needs to recognise that Lonergan is not using the term in a sentimental fashion. As we have seen, his interpretation of the role of feelings is one in which they discern value. For Lonergan, the notion of love is one which includes not only passion, in the sense that

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[136] Lonergan, *Method*, p. 105.

[137] See also Walter Conn, *Christian Conversion: A Developmental Interpretation of Autonomy and Surrender* (New York: Paulist Press, 1986).

it derives from the drive of the spirit towards self-transcendence, but also has as its correlative, commitment.

In other words, while affective conversion therefore is the reorientation of one's feelings at the most profound interior level of the person, it must be matched by reflection and ultimately action.[138] In a sense, it must be a fully human response, which requires an exercising of all of the characteristics of human agency, that is, knowing, loving, and acting in the world as an existential and historical agent. However, such an attitude of self-giving love is, as we have seen, not always the normal course of events. In fact, human experience tells us that love is often distorted in the sense that it is self-oriented rather than self-giving. We are again reminded that authenticity is never a secure or serene possession, that while the transformation of feelings in affective conversion provides the human subject with the possibility of sustaining self-transcendence, human development cannot be the result of human efforts alone: it is fundamentally a gift. As a result, one recognizes that affective transformation depends on religious conversion. In other words, just as moral conversion depended on affective conversion, both are ultimately dependent on religious conversion. It is only through God's grace that the transformation of the human subject can occur.

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[138] This notion of love being comprised of both passion and commitment is well articulated by Walter Conn, in *Christian Conversion*, pp. 149-150.

### 3.4.(c) (iv) Religious Conversion

In the section on "Subject as a Participant in Creating and Healing," we discussed Lonergan's notion of the subject as one who came into being only when he/she fell in love. However, as has been noted repeatedly throughout this chapter, Lonergan's vision of the human subject is one which never attempts to bypass his/her humanness, and therefore the fragility of his/her very being. In addressing the difficulty faced by the human subject relative to self-transcendence, Lonergan reiterates the view that the solution is to be found in a "supernatural" or transcendent form.

However, the transcendent nature of the solution which Lonergan proposes, that is divine grace, does not render that solution as being outside the nature of the subject. In fact, precisely the opposite is the case. As we have seen, Lonergan's method places God firmly within the horizon of the subject, since the question of God is implicit in every attempt of the human spirit to transcend itself, and therefore in every question that she/he poses.[139] Only if we refuse to allow the desire to know to be consciously reflected upon can we ignore questions relative to God.[140]

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[139] Lonergan, *Method*, p. 103. "The question of God, then, lies within man's horizon."

[140] See also Denise Lardner Carmody, "The Desire for Transcendence: Religious Conversion," *Desires of the Human Heart*, p. 59. Lardner Carmody takes a similar position to Lonergan relative to the relationship between the desire to know and transcendent being.

Similarly, if the love of family, friends and neighbour are consummations of the human subject's capability for affective self-transcendence, then the love of God is the ultimate ground of self-transcendence.

> I have conceived being in love with God as an ultimate fulfilment of man's capacity for self-transcendence; and this view of religion is sustained when God is conceived as the supreme fulfilment of the transcendental notions, as supreme intelligence, truth, reality, righteousness, goodness.[141]

It is as a result of this position that Lonergan can speak of religious conversion as an otherworldly falling in love. Such otherworldly love however has no conditions, qualifications or reservations. Lonergan relates self-transcendence and God's love to religious experience in that

> All love is self-surrender, but being in love with God is being in love without limits or qualifications or conditions or reservations. Just as unrestricted questioning is our capacity for self-transcendence, so being in love in an unrestricted fashion is the proper fulfilment of that capacity.[142]

It is a dynamic state which is "prior to and principle of subsequent acts."[143] Relative to Christianity, it is a gift in which the love of God "flood[s] our hearts through the Holy Spirit given to us."[144]

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[141] Lonergan, *Method*, p. 111.

[142] Lonergan, *Method*, pp. 105-106.

[143] Lonergan, *Method*, pp. 240-241.

[144] Lonergan, *Method*, p. 105.

Religious conversion, as a total being in love, is the ground of all self-transcendence, and sublates intellectual, moral and affective conversion. As such, moral conversion "goes beyond the value, truth to values generally . . . [thereby] promot[ing] the subject from cognitional to moral self-transcendence."[145] Similarly, religious conversion sublates moral, in that while our questions and decisions reveal our capacity for self-transcendence, this capacity reaches its fulfilment[146] when "religious conversion transforms the existential subject into a subject in love, a subject held, grasped, possessed, owned through a total and so an other-worldly love."[147] However, fulfilment is not the result of man's choice or knowledge.

> On the contrary, it dismantles and abolishes the horizon in which our knowing and choosing went on and it sets up a new horizon in which the love of God will transvalue our values and the eyes of that love will transform our knowing.[148]

However, while religious conversion sublates affective, and affective sublates moral, and moral sublates intellectual, Lonergan is not implying that there is a progression which begins from intellectual conversion and moves to moral, then to affective and finally to religious conversion. Rather, he notes,

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[145] Lonergan, *Method*, pp. 241-242.

[146] See Lonergan, *Method*, p. 106.

[147] Lonergan, *Method*, p. 242.

[148] Lonergan, *Method*, p. 106.

> On the contrary, from a causal viewpoint, one would say that first there is God's gift of his love. Next, the eye of this love reveals values in their splendour, while the strength of this love brings about their realization, and that is moral conversion. Finally, among the values discerned by the eye of love is the value of believing the truths taught by the religious tradition, and in such tradition and belief are the seeds of intellectual conversion.[149]

In this passage, one finds further clarification of Lonergan's position on the relationship between the healing vector and the creative vector which was discussed earlier on in this chapter, in which it was noted that it is through the introduction of God's love that the capacity for self-transcendence becomes an actuality. Prior to man/woman's ability to understand, or to decide, is the gift of love which is the ground of every instance of authenticity. This experience of a mysterious and uncomprehended God is the essence of human existence, without which the human subject cannot be authentic.

In that it appears that the introduction of grace might create a momentary disequilibrium in the tension between limitation and transcendence, in the direction of the transcendent pole, one could suggest that religious conversion is an example of bias. This suggestion might have credibility if grace were viewed as an act rather than a state. However, while it appears that grace is initially operative on the level of affect, it is also operative in terms of the subject's cooperation or response to the gift of love. As we have seen in the discussion of universal willingness, grace produces a

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[149] Lonergan, *Method*, p. 243.

state in which the subject is habitually open to allowing the desire to know and to love free reign. In distinguishing between operative and cooperative grace, Lonergan writes,

> . . . since the days of Augustine, a distinction has been drawn between operative and cooperative grace. Operative grace is the replacement of the heart of stone by a heart of flesh, a replacement beyond the horizon of the heart of stone. Cooperative grace is the heart of flesh becoming effective in good works through human freedom. Operative grace is religious conversion. Cooperative grace is the effectiveness of conversion, the gradual movement towards a full and complete transformation of the whole of one's living and feeling, one's thoughts, words, deeds, and omissions.[150]

This passage is crucial in terms of clarifying the relationship between feelings and grace. In discussing operative grace as a "replacement of the heart of stone by a heart of flesh," and cooperative grace as a transformation of living and feeling, one gets the sense that there is a critical difference in the way in which feelings operate relative to the different operations of grace. As was noted above in the discussion of universal willingness, grace results in a habitual openness to making decisions without persuasion. This is perhaps most clearly illustrated in *Method*, in the discussion of development and failure relative to the "human good." Here Lonergan writes,

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[150] Lonergan, *Method*, p. 241. While we see that the gift of God's love necessarily involves an initial disruption in the tension between limitation and transcendence, since it operates on the level of affect, it also reestablishes the tension between the two in that the subject is led to co-operate with that gift.

> In the measure that one's love of God is complete, then values are whatever one loves, and evils are whatever one hates so that, in Augustine's phrase, if one loves God, one may do as one pleases, *Ama Deum et fac quod vis*. Then affectivity is of a single piece.[151]

What becomes apparent in the above passages, relative to the difference in the operation of feelings in the two types of grace, is the notion that Lonergan views feelings as having already been transformed in operative grace. However, with cooperative grace, his view is one in which feelings are still in the process of undergoing development. While religious love is the offering of a new beginning in which one's vertical finality is reorganized and feelings are converted in such a way that one exists in the dynamic state of being in love with a being who is neither given nor understood, there is still the need for response. Operative grace, while providing the source for self-transcendence, only becomes effective with the participation of the human subject who cooperates in allowing the continued development of his/her entire being, both feelings as well as intellect.

As a result, we see that while God's unrestricted love operates initially on the level of affect, it only becomes effective with the subject's assent. Such assent allows the feelings which were already transformed by operative grace to continue developing with the cooperation of the subject. We see therefore that Lonergan's notion of grace does not provide a "sure-fire" solution to the possibility of human decline.

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[151] Lonergan, *Method*, p. 39.

In conclusion, the purpose of this chapter has been to analyze Lonergan's work on feelings in an attempt to answer the questions which had been raised in the previous chapter: "Precisely how do feelings function in decision making?" "Do all feelings assist in making good decisions?" "What is the relationship between feelings, decision making and human authenticity?"

In attempting to address these questions, the chapter began by looking at Lonergan's work on the characteristics of the human subject, which, as we have pointed out, is the starting point for all of his work. In doing so, we came to know that the subject is a multi-faceted being who is a knower, an historical and existential agent, a lover, and a participant in healing and creating. For Lonergan, the human person is a unity-identity-whole who exists in the "image of God." As one who knows, he/she moves through the levels of experience, understanding, judging and deciding in every act of authentic knowing. All attempts at revising this pattern are unable to step away from the pattern, and in this sense, Lonergan's position on knowing is incapable of revision. Only when we use all of our cognitional capacities and give free reign to the desire to know are our judgements said to be objective. This desire to know is ultimately a desire for the beautiful, the comprehensible, the true and the good. In affirming oneself as a knower, character is created. As one who is an historical and existential agent, the human person shares a collective

responsibility for the world in which he/she lives. His/her participation in friendship as part of a community is animated by feelings and desires which respond to values.

Of crucial importance here is not only that feelings relate to values, but also to self-transcendence. As one who loves, the human subject only develops fully when he/she is pulled out of him/herself, that is, when he/she falls in love with another. Most important to Lonergan's position on love is the belief that the human person can only be accurately understood as he/she relates to God. Authenticity ultimately does not depend on human achievements.

Finally, the human subject is not only involved in creating, but also dependent on healing. In all of these characteristics, there is both an affective and rational component. As has been stated, these components are constitutive of the human subject and exist in a symbiotic as well as synergistic relationship. This is the result of the fact that the process of self-transcendence is driven by feelings.

Given this understanding of the human subject, the chapter proceeded with an attempt to understand the specific way in which feelings operate in knowing. Here we began with a discussion of the negative function of feelings as present in bias. Lonergan's position on the human subject is not as neat a package as one might think. Throughout his work, he constantly alludes to the fragility of the human subject, whose desire to know involves him/her in an ongoing battle for authenticity. A tension exists in the very makeup of the human person who not only desires to

choose that which is valuable, but at the same time is confronted with a desire for the satisfying or pleasurable.

While value and satisfaction may not be mutually exclusive, in many instances, they confront each other. As a result, not only can insight be desired, it can also be unwanted and refused. This "flight from understanding" takes several forms. In Lonergan's work on bias, we get a sense of the negative function of feelings. In dramatic bias not only is insight blocked, but also the questions which might lead to insight are subconsciously avoided. This bias is often the result of trauma. As a result of this trauma, subconscious feelings interfere with the images that are necessary for insight.

In egoistic bias, there is a distortion in the development of intelligence. Here one only makes self-satisfying choices and excludes those questions which relate to the good of order.

In group bias, one sees a similar distortion of knowing in which intersubjective feeling precludes the asking of questions for intelligence. As a result, the group can not see past its own self-interest.

Finally, with general bias, one chooses quick fix solutions to even the most complex problem. Again, as with the other biases,we see the tendency to settle for what is immediate and gratifying rather than what is valuable or worthwhile. As we have pointed out, all of the biases have both an affective as well as an intellectual

component. However, what became clear at this point is that while Lonergan perceives feelings as capable of negatively influencing knowing, he also believes that feelings are capable of relating to value. In furthering the discussion on which feelings assist in making good decisions, the chapter next turned to a discussion of the relationship between intellect and feelings as they relate to values. Of crucial importance here was the notion that knowing is inseparable from feelings. In fact, it is feelings which provide the momentum for all operations of cognition.

However, in making the distinction between those feelings that are intentional responses to value and those that are non-intentional trends, it became clear that, for Lonergan, all feelings do not relate to value. In fact, feelings are ambiguous in their ability to apprehend value. Only those feelings that are disinterested relate to values, and these do so according to an ascending scale of preference.

This discussion has been focussed on addressing two of the questions that were posed in the previous chapter, i.e., "Precisely how do feelings function in decision making?" and "Do all feelings assist in making good decisions?" The chapter concluded with an attempt to lay the foundation for addressing the remaining question, which was posed in Chapter Two of this thesis: "What is the relationship between feelings, decision making and human authenticity?"

We have laid this foundation in the section on the transcendental notion of value and its relationship to the dynamism of the subject. Here, it was pointed out

that feelings, in their capacity of apprehending value, have the capacity to transform the human subject. Through feelings, the transcendental notion of value drives the subject toward a full realization of the good. However, it is only through decision and action that knowing is reached. Only in making choices for that which is good and valuable does one constitute him/herself as a person of authenticity. In making good choices, we become better people. As human people, we have the capacity and the freedom to become what we habitually choose and do. However, as Lonergan notes throughout all of his work, the human person is a fragile being for whom self-transcendence is never a serene possession. As a result, sustained self-transcendence in choosing and in doing the good can only be the result of divine grace, in order to effect the various conversions which are necessary for authenticity.

Further discussion is required in this regard relative to the significance of the act of judgement and secondly the ways in which these acts of judgment are constitutive of personal authenticity. This discussion will be best furthered in the next chapter as it relates to the kinds of decisions and judgements one sees in a concrete situation like those involving informed consent. Here again, Lonergan's work on values and the human good will provide us with insight.

Again, it is worth reiterating that in this author's opinion, Lonergan's vision of the human person as one whose desire to know is driven by feelings, and who struggles to make authentic decisions, is capable of providing the foundation for a

model of consent, one which pulls together the threads which were offered by Katz, Brody, Pellegrino, Thomasma, Charon and May.

## Chapter Four
## Towards An Improved Model of Informed Consent

Before proceeding to introduce this fourth and final chapter, it is perhaps helpful to summarize what has taken place to this point. In the introduction, the question was raised as to the role feelings might play in decision making and in particular in a specialized aspect of decision making, i.e., informed consent.

The second question which derived from this, asked what informed consent would look like in practice if we allowed the participation of feelings. In attempting to address this issue, Chapter One began with a discussion of the historical development of the legal doctrine of informed consent, and three models of consent which attempt to articulate the values embedded in the legal doctrine. Here it was shown that there has been an ensuing shift in values which are connected to the doctrine. It was noted that while the litigation process has shaped the legal doctrine of informed consent, the courts' decisions have in fact failed to meet the law's commitment to the values underlying the doctrine.

In discussing the values of well-being and self-determination, it became apparent that, while in theory these are compatible, in reality they often conflict. As a result, it was noted that the values, like the doctrine itself, may not be absolute. So too did our discussion of three theories of consent, the patient benefit theory, the

social benefit theory and the self-determination theory show that each have their own limits. Since each of these models depends on the capacity of the patient who gives consent to both understand and appreciate, the two necessary requirements for capacity, this chapter focussed next on the difficult area of determining capacity, and on three common proposals which attempt to set the necessary criteria for such determinations, an outcomes-based model, a patient status model and a model based on the patient's ability to function as a decision maker.

Not only did it become clear that there are critical flaws in the outcome-based model and in the patient status model, the functional ability model, which appears the most sound, in that it is situation and patient-specific and therefore does not exclude a large segment of the population, is also in need of rehabilitation. There is a serious difference of opinion about what constitutes incapacity. Most pressing is the need to resolve the debate over the roles which reason and emotions play in assessing the capacity of a particular patient to make a particular decision in a particular situation. The chapter concluded with a summary of the difficulties which exist in the practical application of the process of informed consent and spoke of the need to improve the relationship between the physician and the patient.

This prior step is mandatory if one is to begin to improve the legal doctrine of informed consent, which depends so heavily on the relationship between physician

and patient. Chapter Two provided a synopsis of such attempts at addressing the difficulties in the physician-patient relationship, by looking at selected writings of Dr. Jay Katz's work on conversation, Dr. H. Brody's development of Katz's conversation model, and Dr. E. Pellegrino and Dr. D. Thomasma's attempt to blend virtues, principles and duties. It also looked at the writings of Dr. R. Charon and Dr. W. F. May and their work on narrative approaches to ethics.

For Katz, earned trust through conversation must provide the foundation for informed consent.

While Brody agrees with the need for conversation, he believes that one needs more than an intuition or feeling about the success of particular conversation, and so he proposes a transparency standard as a way of operationalizing Katz's model. Only in this way does he believe that the conversation model meets legal standards for approval. He, like Katz, encourages openness and trust in both physicians and patients, whom he believes must share their thoughts and feelings about the way each is making decisions.

Pellegrino and Thomasma attempt to improve the therapeutic alliance by focussing on the development of the moral character of the person who makes moral choices. They, like Katz and Brody, speak of the importance of trust. However, unlike either Katz or Brody, they ground their notion of trust in an

intersubjective model, beneficence-in-trust, which views trust as a commitment to care for others who are also part of a moral community. They speak of the need for intellect and feelings to work together in fostering virtue, particularly in their discussion of the virtue of prudence which they propose links emotions with the virtues. In making this connection, they link reason with the desire to do good.

With Rita Charon's work on narrative approaches to ethics, we see an acknowledgment of the role of feelings which she suggests might bridge the gap between diagnostic medicine and the human endeavour in medicine.

Finally, with William F. May's work on the therapeutic alliance, we get a picture of his attempt to ground a relationship of covenant within the context of transcendence. Ultimately, it is this author's opinion that May's work, like the others, is heavily dependent on feelings in the sense that the obligation and desire to respond to others arise out of a desire to respond to God.

Several common threads are evident in the work of the above authors. As has been noted, these threads provide the basis for developing an improved model of consent. Conversation, trust, transparency, virtue and covenant are mandatory if one is to improve on the present model of consent. As has been noted, this requires more than an intellectual assent to a rationalistic model. Rather, it requires the full

engagement of both physician and patient, who each desires to do good and to make the right choice.

However, while each of these authors focusses in his/her own way on the relational aspect of the therapeutic alliance, the most crucial aspect of their works in terms of the focus of this thesis, is what, in this author's opinion, is implicit and sometimes explicit in each of their works: i.e., the impact of emotions on decision making. While all of their works depend in varying degrees on both intellect and affect and comment on the potentially positive as well as negative impact of emotions, none offers an attempt to understand how, in practice, emotions might relate to decision making and human authenticity.

Several questions arose as a result of this discussion: "Precisely how do feelings function in decision making?" "Do all feelings assist in making good decisions?" "What is the relationship between feelings, decision making and human authenticity?"

Chapter Three called on the work of Bernard Lonergan to provide insight into these questions and their potential answers. Given that the development of the human subject and his/her struggle for self-transcendence is the central theme in all of Lonergan's works, this chapter began with a discussion of the characteristics of

the human subject, who journeys through the levels of experience, understanding, judgment and decision, in a desire to know.

This chapter noted that, for Lonergan, there is both an affective as well as rational component of the operations of the authentic human person. In the affirmation of oneself as a knower, character is created. As one who loves, the subject reaches the peak of self-transcendence and also the recognition that such a process is not wholly dependent on his/her actions. Here we affirmed the fact that self-transcendence is never a secure or serene possession.

The section on bias discussed the basis for this difficulty, which lies in the dialectical tension between intellect and psyche and provides the conduit for bias. In the discussion of bias, we laid out the potentially negative function of emotions according to Lonergan. In each of the four types of bias, an affective component was involved. This section also discussed the notion that knowledge involved choosing what was worthwhile, and that value could be apprehended in feelings.

In the discussion of the potentially positive function of values, we clarified the relationship between feelings and values. Of primary significance here was the notion that feelings are capable of apprehending value according to a scale of preference, and that the actions of choosing and exercising choice were constitutive of the human subject as a moral agent. Feelings, therefore, in their ability to

apprehend value, have the capacity to transform the human subject. In fact, it is through our feelings that the transcendental notion of value drives us towards a realization of the good. However, Lonergan is quick to point out that, while the intending of value is a step in the right direction, it is only through making choices for that which is good, that one constitutes him/herself as an authentic human being. Of importance here was the recognition that values play a role in decision making. However, values, as apprehended by the feelings of the human subject, carry with them the same frailty as the subject. Running through this chapter was the common theme of the fragility of the human subject, who is involved in the never-ending struggle for personal authenticity. The final part of this chapter situated feelings and individual fragility in the context of the need for ongoing conversion and Lonergan's notion of grace as a "falling in love with God."

This section did not purport to provide an exhaustive analysis of Lonergan's theology of grace, but rather pointed to key elements in Lonergan's writings in which the human subject is transformed by love. What became clear here was that feelings play a decisive role in the conversion and development of the fragile human person, whose struggle for authenticity is never a secure or serene possession.

The objective of this final chapter will be to synthesize Lonergan's theological anthropology and cognitional structure, with key elements of the work of Katz, Brody,

Pellegrino, Thomasma, Charon and May, in an attempt to develop a practical and more authentically human model of consent, one which might enhance human flourishing. This model will include the function of both feelings and intellect.

The first section will begin by discussing consent as a process rather than an event; a process which demands an overall relational framework involving conversation, trust, transparency, virtue and covenant between health care provider and patient, within which discussions of consent could take place. From there it will lay out a specific process for consent, one which is consistent with Lonergan's cognitional structure in which the fragile human subject moves through the levels of experience, understanding, judging and deciding in a never-ending struggle for that which is true, good and real in decisions about his/her health care.

Throughout this section, we will argue that, in order for a patient to both understand and appreciate (the two elements which are legally required in order for a person to be found capable of making a decision under present Ontario legislation), attention must be paid not only to what he/she thinks about the diagnosis, prognosis and treatment, but also and equally, to how his/her feelings about the disease, prognosis and treatment relate to the values which he/she holds. We will argue that not only do feelings play a crucial role in understanding, as Lonergan suggests, they in fact provide the possibility for the second legal criteria for

valid consent, appreciation. The second section of this chapter will argue that when consent is seen as a process rather than an event, when the therapeutic alliance is grounded in trust, transparency, virtue and covenant, when there is an acknowledgment and encouragement of the role of both reason and feelings, informed consent can in itself be beneficial. Here, we will cite some data from psychiatry which suggests that informed consent may be an effective therapeutic tool in promoting a patient's psychic healing.

Finally, the chapter will conclude with a discussion of the theological significance of an improved framework for consent. This section will focus on completing a response to the third question which was raised in Chapter Two, i.e., "What is the relationship between feelings, decision making and human authenticity?" Here we will take up the foundations which were laid in the previous chapter on Lonergan's work, in which we discussed the transcendental notion of the good. At this point, we will proceed with a discussion of the significance of acts of judgment in informed consent and the ways in which judgments and decisions about one's treatment might be constitutive of personal authenticity.

## 4.1 Consent as Process vs. Event

In looking at various models of consent, one realizes that consent can be viewed either as a moment in time, one which focusses on the signing of a form, or as a process involving ongoing decision making. What has become evident in our discussions to this point, is the sense that dialogical models of consent like Katz's, and covenantal and virtue-based models of the physician-patient relationship, such as Pellegrino, Thomasma and May propose, demand the latter model, rather than the former. There are serious problems with the event model, as several authors have pointed out. This section will draw on the work of Paul Appelbaum, Charles W. Lidz and Alan Meisel,[1] who, in this author's opinion, have provided the most complete discussion of the strengths and weaknesses of both of these models.

> In the event model, informed consent is not directly concerned with improving the quality of the decision-making process or the patient's comprehension of treatment; rather, the emphasis is on the physician's provision of the information that a hypothetically rational person would want.[2]

Not only does most medical care involve many decisions, it also involves making these decisions over various points in time in response to changing

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[1] Paul S. Appelbaum, Charles W. Lidz and Alan Meisel, *Informed Consent: Legal Theory and Clinical Practice* (New York: Oxford University Press, 1987), pp. 151-174.

[2] Charles W. Lidz, Paul S. Appelbaum, and Alan Meisel, "Two Models of Implementing Informed Consent," *Archives of Internal Medicine*, 148, 6 (June 1988), p.1386.

conditions and treatment modalities. In treating illness, the physician gathers medical data on an ongoing basis, attempts to understand the data in order to make a judgment about diagnosis and prognosis, and then together with the patient makes a decision about which treatment to start. This is a further example of the unrevisable nature of human knowing of which Lonergan speaks.

The movement from experience, to understanding, judging and decision is in fact embedded in the process model of informed consent. With each new piece of information, the process begins anew. Contrasted with this, however, is the event model in which both the physician and patient wait to gather all of the information and then make a judgment. Here the patient is completely left out of the process, while the physician does the work-up. This becomes problematic in terms of the legal requirement of informed consent, since

> . . . the evaluation may be difficult to separate from treatment (e.g., a trial of antibiotics is both diagnostic and therapeutic) and presents risks and benefits of its own, these decisions are precisely the kind in which patient involvement is anticipated by the idea of informed consent.[3]

Even in those instances where only a single medical decision needs to be made, the event model's presupposition that a decision is made at a particular moment in time, once all of the evidence has been accumulated, has been shown to

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[3] Appelbaum, Lidz and Meisel, *Informed Consent*, p. 154.

result in the patient's feeling that there is nothing left to decide. In other words, when the patient is excluded from the process up until the point of decision making, without engaging in the process of experience, understanding and judging, on the grounds that the time has not yet come for a decision, not only does he/she become isolated, but "the goal of patient participation that underlies the idea of informed consent will be subverted."[4]

Even more crucial, the event model actually appears to impede the patient's ability to understand and appreciate, in that it forces the patient to make a decision that not only is in a rush but more importantly forces him/her to come to a judgement in a way which is contrary to how he/she authentically comes to know. In so doing, not only is the patient's anxiety heightened, but the decision itself may be more prone to the various biases, or blocks to understanding, which were addressed in Chapter Three of this thesis. This model actually encourages human inauthenticity. As a result,

> The event model inhibits precisely the kind of understanding participation on which the idea (although perhaps not the legal doctrine) of informed consent is based. Numerous studies show poor patient understanding and limited retention of information provided in physician disclosures and consent forms. This problem is at least in

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[4] Appelbaum, Lidz and Meisel, *Informed Consent*, p. 155.

> part a reflection of the failure of the educational function in an event model.[5]

Not only does the event model run counter to the ideals of informed consent, it also encourages a fracture in the physician-patient relationship which should be grounded in conversation, trust, transparency and covenant. In this model, both physician and patient recognize that the patient is not truly a participant in treatment decisions and therefore cannot ever truly understand his/her options. As a result, many physicians reject the whole idea of informed consent as being an impossible ideal.

> It seems farcical to spend time talking with patients in detail about some of the least important decisions that need to be made — in the sense of having been preordained by other events — when the earlier, more influential decisions have been made by physicians alone. It seems a waste of time to present patients with elaborate consent forms when they so rarely seem to understand the information critical to a decision. In short, the event model perpetuates a view of informed consent as something detached from the unique rhythm of the clinical setting — something imposed on medicine by an uncomprehending legal system.[6]

Unlike the event model, the process model views medical decision making as a continuous process, one in which information flows freely from physician to patient and back. Again, it is this author's opinion that this model is grounded in the same

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[5] Appelbaum, Lidz and Meisel, *Informed Consent*, p. 155.

[6] Appelbaum, Lidz and Meisel, *Informed Consent*, p. 155.

way as Lonergan's cognitional structure is, i.e., on the authentic human subject's pure, disinterested and detached desire to know.

This model proceeds from the level of experience, in which the physician discloses all of the relevant facts about his/her diagnosis and prognosis. From here, both physician and patient engage in the process of understanding the various alternatives in order to judge which treatment is most acceptable and finally arrive at a decision.

This model has several benefits, in that not only does it conform to the legal requirements of informed consent, it also promotes the underlying values and ideals of informed consent. However, the ongoing sharing of information in this model demands not only the kind of cognitive structure which Lonergan proposes, in which emotions and reason function together in arriving at decisions,[7], but also the kind of relationship between physician and patient that Katz, Pellegrino, Thomasma, and May propose. Such a relationship is dialogical and transparent, grounded in trust

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[7] While the role of emotions in process models of informed consent has not been the focus on writings on informed consent, some authors like Julia E. Connelly, suggest that physicians be at least aware of their patients' feelings about values. Not only does she support Appelbaum et al.'s position on the merits of the process model in Julia E. Connelly, "Informed Consent: An Improved Perspective," *Archives of Internal Medicine*, 148, 6 (June 1988), pp, 1266-1268, she writes on p. 1267, that the process model encourages physicians to be ". . . acutely aware of feelings and other nonverbal expressions. Sensing anger, anxiety, depression, or fear during a clinical encounter, they have the courage to inquire about the source of the feelings, and the expertise to handle the ensuing situation appropriately."

and the virtues, in which the patient and physician together enter into a covenant focussed on care and healing. However, the challenge is to develop a model of consent in a way that is capable of being implemented in today's medical environment, enhances the physician-patient relationship and still meets the necessary legal requirements of the doctrine. It is towards articulating the steps in this new model of consent that we now turn.

While the following section may look like a "how-to manual," it is not intended to diminish the academic rigor of this discussion on informed consent, but rather to support the prior discussions of the first three chapters with some practical suggestions that might help physicians in their relationships with patients, particularly as they relate to feelings and informed consent.

These practical suggestions arise from this author's experience over many years, first as a hospital chaplain and then as a bioethicist working in the clinical setting. As such, they come out of an experience with the suffering and struggle of many patients and physicians to whom a deep gratitude is owed. All cases and/or examples have been disguised to protect the privacy of individuals.

This new model of consent will follow Lonergan's cognitional structure in which the patient moves from experience, understanding, and judging to deciding.

In doing so, it will also focus on meeting the legal requirements of valid consent which were set out in Chapter One of this thesis.

Given the importance of the intersubjective relationship between physician and patient, the first step will focus on establishing a covenant between the two.

The second step will involve the level of experience, which will focus on the sharing of information about diagnosis, prognosis, and the risks and benefits of various treatments.

The third step will involve the level of understanding, which will focus on helping a patient to understand and appreciate the two legal requirements for valid consent.

The fourth step will involve the level of judging, which will focus on helping a patient to select a plan of treatment.

Finally, the fifth step in our new model of consent will involve the level of deciding. Here we will focus on helping the patient to act on his/her choice by agreeing to treatment or by signing a consent form.

### 4.1. (a) Establishing a Covenant in the Therapeutic Alliance

This must be the first step in any authentic model of consent that recognizes and accepts the intersubjective nature of the human person. Ideally, this should be

done when the patient is in good health. The situation that we present will focus on those more or less ideal cases in which a hospitalized patient is in a non-emergency situation and has some time to make a decision. Certainly there are differences between the emergency situation and the non-emergency situation. However, the author suggests that the model proposed here for these ideal situations might serve as a reference for the non-ideal situations, in that it focusses on providing a way of relating to people who are ill and who are faced with making decisions about their treatment. As such, it is an attempt to develop a basic attitude towards the informed consent process.

In the hospital, even in those non-emergent situations, the patient more often than not has never met the physician and is now attempting to cope with illness and perhaps death, in the face of a total stranger in whom he/she is expected to place his/her trust. This is an abnormal situation that demands explicit statements about what each both hopes for and can reasonably expect from the other. Ideally this very first meeting is not the time or place for bombarding the patient with terrifying possible diagnoses.

This is an instance in which the possibilities of bias are omnipresent. Since the overwhelming emotional state of the patient is often one of fear and anxiety to one degree or another, this should not be the place to begin a discussion of the risks and

benefits of various treatment. It is the rare patient who is able at this point to focus on the pure desire to know that is required in order to make an authentic decision. Rather, before one can enter into the sharing of facts, the patient and physician must enter into an experience of each other. As has been pointed out throughout this thesis, this is both a cognitive as well as affective exercise.

However, it is in fact emotions that provide the first opportunity to enter into the narrative of the patient's life, an entrance which is mandatory to the covenantal relationship and any ensuing decision making.[8] From the first visual impression of the physician, the patient is hoping that this is someone he/she can trust to help him/her. It is important that the physician physically enter the room, sit down so that eye contact can be made, and then introduce him/herself before beginning any conversation.

Even the emergency situation has the possibility of a brief introduction by the physician. A simple statement such as, "I am Dr. Smith and I will be caring for you right now," is possible even in the most critical cases and should be clearly stated to the patient.

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[8] See Julia Connelly, "Emotions, Ethics, and Decisions in Primary Care," *The Journal of Clinical Ethics* 9, 3 (Fall 1998), pp. 225-234. Connelly argues on p. 226, that physicians "must develop self-awareness to recognize emotions in a clinical interaction, and the skills needed to help patients express their emotions and tell their stories."

While many physicians are concerned that this will take "too much time," time spent here will pay off a hundred-fold later. The physician should acknowledge to the patient that he/she is there to work together with him/her in order that he/she might get well, if that is possible. The notion of working together places the relationship within its proper framework, that is, of beneficence-in-trust. It neither behaves paternalistically towards the patient, nor abandons them to make decisions without guidance. It is the first step in establishing a covenantal relationship, based on mutual trust and ongoing dialogue.

As part of this initial conversation, there should be an understanding and acceptance of each other's roles. Crucial to this discussion is addressing the issues of trust, disclosure of information and abandonment. Patients need to know two major things: one, that they will have all of the information that they want to have about their test results, diagnosis and prognosis, and, secondly and more importantly, that they will not be abandoned to make these decisions on their own. Avoiding abandonment does not mean to imply that a physician should stay on a case, when he or she is not the appropriate person, i.e., when the patient's condition requires further expertise; however, it does imply that the method of transference or sharing of care be discussed with the patient in advance of its occurring.

This is particularly crucial in large tertiary care centers, in which there are many people involved in the care of a single patient. The initial conversation between treating physician and patient should address this issue so that the patient knows that their care is being coordinated by one person. So too should each consultant introduce themselves to the patient as someone whom their physician has asked them to see.[9] Avoiding abandonment also implies that the physician provides guidance on treatment decisions. Unfortunately, in today's legalistic climate, with its focus on patient autonomy, many physicians are reluctant to give an opinion to their patients as to which treatment they think is best. Not only is this an abrogation of professional responsibility, it effectively results in the isolation of the patient who is left to make decisions in a vacuum.

Physicians and patients need to discuss the process by which both will share decision making and commit to carrying out that process to the best of their ability. No doubt this requires the virtues of which Pellegrino and Thomasma speak, and that arise from the trust which the patient places in the physician's commitment to care. Again, this demands the kind of transparency of thought and word that Brody

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[9] See Appelbaum, Lidz and Meisel, *Informed Consent*, pp. 157-158, for a discussion of this issue. Here the authors note that "Patients are understandably bewildered, not knowing why the examination is being conducted or who ordered it. They do not know whether the consultant is someone who can present new information to them or will make treatment decisions." Many patients have expressed to this author in various ways, the sense that they feel that they have lost control of their own bodies when unknown physicians enter into their room and proceed to examine them without any introductions.

speaks of. In every clinical encounter, both physician and patient need to be able to express what their concerns and needs are in a way in which the other is capable of understanding. Without this transparency, there can be no full expression of any of the virtues, in particular beneficence in trust.

These suggestions seem simple and in fact they are; however, in practice, these first steps in establishing the covenant between physician and patient are often neglected. It is this author's opinion that unless the relationship is clear from the very beginning, it will be difficult for consent to be anything more than

> . . . empty ritual in which patients are presented with complex information that they cannot understand and that has little impact on their decision making.[10]

### 4.1.(b) Experience: Sharing the Facts in The Process of Informed Consent

Only after these very rudimentary efforts have been made to establish the basic groundwork for a covenantal relationship between physician and patient can the process of informed consent continue. This second step involves the level of experience, with its focus on the sharing of information about diagnosis, prognosis, and the risks and benefits of various treatments.

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[10] Charles W. Lidz, Paul S. Appelbaum, and Alan Meisel, "Two Models of Implementing Informed Consent,"pp. 1385-1389.

In order for consent to be valid, as we have noted earlier, it must relate to a diagnosis, and then to a specific treatment or plan of treatment. As a result, one must begin on the level of experience, in which there is a sharing of facts and data about the patient's illness. Here, however, one needs to be cognizant that there are different perceptions of what the facts are. The patient may perceive the facts of his/her illness quite differently than does the physician. In recognizing this, however, one must then proceed to provide as complete an accounting as possible of the medical facts of a case. These constitute the medical indications.

Given the criteria that are set out in the Consent to Treatment Act,[11] that a patient must understand and appreciate the risks and benefits of a particular treatment that is being offered for his/her particular disease, it is crucial that this conversation begins with the patient's experience of his/her illness.

If one looks at the work of Jonsen, Siegler and Winslade,[12] in which the authors propose beginning with the gathering of data in resolving ethical dilemmas, one sees an excellent example of Lonergan's cognitional structure at work. For Jonsen et al., the facts of a particular medical situation include medical diagnosis,

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[11] See Chapter One of this dissertation.

[12] Albert Jonsen, Mark Siegler and William J. Winslade, *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine* (New York: McGraw-Hill Health Professions Division, 1998).

prognosis, patient or surrogate notions of quality of life, and contextual circumstances like family dynamics and religion.

Although not articulated in Lonergan's terms, Jonsen et al. in fact propose that one must begin on the level of experience, in which facts are shared, before one can move to understanding, judgment and decision. For both Jonsen et al. and Lonergan, these facts have a cognitive as well as affective dimension, which includes not only diagnosis and prognosis, but how patients and families feel about their illness and quality of life in light of their own context and values.

However, rather than a blow-by-blow accounting of symptoms and medical history, as is typically the case in these types of discussions, what is more helpful, after the physician has shared the diagnosis and prognosis, is a discussion about how the symptoms of the disease have impacted the daily life of the patient. This type of discussion is supported by Appelbaum et al. Here these authors suggest that process models of consent encourage patients to participate in defining their problems, and that patients are more likely to be ". . . disturbed by interferences with their daily lives than by underlying pathologic processes." [13] They suggest that when physicians recognize this, they are more likely to ask the appropriate questions to elicit a patient's values and preferences. They reject a model in which physicians

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[13] Appelbaum, Lidz and Meisel, *Informed Consent*, "Defining the Problem," pp. 160-162.

control patient care, one in which patients respond to physicians' questions about their problems.

Rather, they suggest that patients perceive that it is difficult to hold the attention of physicians, and as a result, the conversation quickly erodes into monosyllabic responses about details regarding bodily functions, rather than how they feel their lives have changed as a result of their problems.

This initial conversation about how patients perceive their illness is crucial to fulfilling the first basic legal requirement of consent, i.e., that the patient understands and appreciates his/her diagnosis. In other words, the patient must understand that he/she is ill and in need of treatment. One cannot begin a discussion of the risks and benefits of chemotherapy vs. surgery in a patient with lung cancer who has not yet come to understand that his/her symptoms, while perhaps bearable, are the result of a diagnosis of cancer, which if untreated, will result in metastases and ultimately death. The crucial facts at this point are the diagnosis and prognosis. When patients are given the time to tell physicians what they understand and feel about their diagnosis and prognosis, both patient and physician come to a better understanding of each other's perceptions of both disease and timeliness of treatment. The following case illustrates this point.

> Mr. P. arrived at the emergency department with acute abdominal pain. On examination he was diagnosed as having a blockage of his

> small intestine due to a large malignant tumor. When surgery was proposed to remove part of his intestine, he refused to enter into the conversation, and subsequently refused treatment.

Mr. P.'s physician was concerned that Mr. P. was struggling with his diagnosis of cancer and continued the conversation with her patient. Rather than pushing him further to engage in a conversation about the risks and benefits of surgery, she wisely engaged in a different kind of conversation in order to help Mr. P. make an informed decision. This conversation focussed not on assessing risks and benefits of surgery, but rather on Mr. P.'s emotions about his diagnosis. What emerged from this discussion was the fact that Mr. P. was so traumatized on hearing that he had cancer that he was incapable of even hearing the facts about the risks and benefits of surgery. This case points out the potential for emotions to negatively impact decision making on the first level of experience, due to dramatic bias. However, rather than resulting in a "knee jerk" finding of incapacity due to the inability to engage in the conversation required to understand and appreciate risks and benefits of treatment, this physician was willing to enter into the discussion about how Mr. P. "felt" about the information he was receiving. Physicians must learn to engage not only in the intellectual discussion of diagnosis, risks and benefits, but also the discussion of how patients feel, particularly when it is clear that emotions are negatively impacting hearing the facts. This is particularly so with regard to Charon's work on narrative ethics. In telling the story of the impact of illness on

one's life, emotional issues are addressed. This in turn leads to an enhanced relationship between physician and patient.

It is impossible to expect a patient to begin the process of understanding the risks and benefits of various treatment options if he/she is paralyzed by terror of disease and death. If these fears are not discussed at this point, many patients are incapable of starting the process of understanding and appreciating the consequences of their less-than-informed choices or refusals. Listening to a patient's feelings at this point can help the physician to understand the patient's hopes and expectations for life. Feelings, as Lonergan suggests, can provide insight into the values which a particular patient holds. Whether a patient is most concerned about pain control, length of life, ability to interact with loved ones, ability to work, etc., provides us with crucial information as to how a patient views vital, social, cultural, personal and religious values. An understanding of the importance that the patient places on each of these values is crucial to helping a patient make an informed choice.

Only after discussing the facts of diagnosis and prognosis can one move to sharing another set of facts — i.e., the facts surrounding the risks and benefits of various treatments. Again, as with the discussion of diagnosis and prognosis, the discussion of risks and benefits should be placed within the context of how those

risks and benefits relate to the patient's particular values. In other words, the sharing of the various risks and benefits of a particular treatment should address how the risks and benefits might impact health and strength, or vital values, one's engagement in the community, or social values, those things which are traditionally important, or cultural values, one's relationship with loved ones, or personal values, and finally, one's sense of life's meaning, or religious values.

How the patient defines his/her problem in light of these values is more important than the details of a particular pathological process. Since the human person is multifaceted, so too must the information transcend the biological. If we are to expect the patient to understand and appreciate, we must be willing to accept that understanding and appreciation is more than an ability to comprehend pathology and assess percentages of risks and benefits. As a result, we must be willing to enter into the deeper discussion, one which shares the medical facts of a case in light of how those facts might impact patients' lives and values. In fact, if we do not address the facts in this way, we cannot move to the next stage of the informed consent discussion in which the patient struggles with understanding the choices before him/her.

The following case study provides an excellent if somewhat painful example:

> Susan, a 35-year-old woman has been diagnosed with end stage ovarian cancer with metastasis to lung, bone and brain. Her

> prognosis is grim. She is in severe pain and short of breath. Neither radiation, surgery, nor chemotherapy can offer her any chance of survival. Her life expectancy is less than one month. Her physician orders a continuous morphine drip to relieve pain. However, Susan's situation is unusual in that the level and type of sedation she requires to alleviate her pain renders her unconscious. She states that she feels out of control and frightened that she can no longer speak to her family.

While Susan's situation is unusual and extraordinarily difficult for all involved, it provides an excellent example of the importance of discussing risks and benefits of treatment in light of a patient's stance on the various values of which Lonergan is speaking. Susan would rather suffer pain than lose her ability to interact with others. This is not to suggest that pain control be withheld in the terminally ill in order to fulfill a greater good, in this instance, social value. It is merely saying that, in this particular case, this is what the patient wants.

However, Susan's case does point out the importance of listening to how patients see their choices in light of their value preferences. Unless we discuss risks and benefits of treatments in a way which is relevant to a patient's life, we run the risk of plunging people into situations which are incompatible with who they are as people and how they wish to live their lives. In sharing the facts of a case, physicians must understand how the patient feels about the facts of diagnosis, prognosis, and risks and benefits of treatment if they are to help them understand the risks, benefits

and alternatives to various treatments and eventually to make a judgment about which option to choose.

### 4.1(c) Facilitating Understanding: Understanding and Appreciation

While Lonergan notes that emotions can function negatively, as is the case with dramatic bias, all emotions provide insight into the human person and therefore require attention. They are of crucial importance in helping to clarify what the goals of treatment are. It is mandatory that these goals be clear before one begins to assess the risks and benefits of treatment, since such assessments must include how a particular treatment might help a patient to reach his/her goal. This third step will involve the level of understanding that will focus on helping a patient to understand and appreciate, the two legal requirements for valid consent.

No doubt one of the greatest handicaps to the discussion about what patients understand is impatience, particularly on the part of the physician who understandably is anxious to get on with treatment. Here, the possibility of the bias of common sense[14] is something to be avoided. This is not the time or place for "quick fix" solutions, particularly since the patient is prone to dramatic bias at this point. Here the prevalent emotion on the part of the patient is often one of fear and

[14] See Chapter Three of this dissertation.

avoidance of pain and unpleasantness. Denial is ever present and is a sign of the patient's attempt to protect him/herself against difficult choices.

At this point, transparency is mandatory and the patient must be encouraged to share his/her thoughts and feelings. The patient should be helped to ask questions, which may or may not include inquiries about second opinions and the competence of the physician. While egoistic bias on the part of the physician is a threat here, this situation requires humility and a willingness to admit prognostic uncertainty. Here, too, the patient needs to be encouraged and helped to imagine and understand how various options might impact his/her life.

Questions posed to the patient such as "What are you hoping for?" can lead this discussion.[15] Again, the physician must remain patient in hearing what may be repetitive questions and perhaps a desire for unrealistic goals. It is crucial that the desire for an unrealistic goal be addressed by the physician in a way which does not destroy hope. This is an area which demands attention to the patient's feelings and requires sensitivity and patience on the part of the physician.

Again, as with the level of experience and the sharing of the medical facts of the case, assessing understanding must take into account the patient's wishes in light

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[15] For a discussion of how to ascertain the needs and goals of a patient, see Appelbaum, Lidz and Meisel, *Informed Consent*, p. 163. Here the authors note that when a patient's hopes are not congruent with medical outcomes, they must be ". . . made aware of the divergence and more realistic goals suggested."

of how he/she perceives meaningful life and its contextual presentation. While the focus should remain on what the patient wants, his/her contextual situation must be taken into account. However, while it may be important to ascertain what the rest of the family wants in terms of treatment, etc., one should be careful here to avoid the pitfalls of group bias which ignores the needs of the patient in favor of the needs of the group. While the consequences for the group are important, they should not be the driving force behind decisions which affect the life or death of an individual. The following case provides an example of group bias in medical decisions:

> Mrs. Jones is 58 years old and widowed. She has suffered a debilitating stroke affecting her brain stem. She is unable to swallow or breathe on her own. She is ventilated and being fed by G tube. All medical opinions state that she will never recover any degree of consciousness. Her family notes that Mrs. Jones would likely not want to live in this state. However, they want to continue life-sustaining treatment indefinitely. Further discussion reveals that they know they are "being selfish," but they just can't let her die. She is their mother and they need her.

Cases like the above are difficult and require serious consideration. However, in Mrs. Jones case, her surrogates are not making decisions according to what their mother would have wanted but rather according to their own needs. While such grief reactions are understandable, they cannot drive decisions about a patient's life. The family needs further support in order to make the decision that their mother would have wanted.

The legal requirements of informed consent are that a patient must be capable in order to make decisions, i.e., he/she must be able to both understand and appreciate his/her disease, prognosis and risks and benefits of all treatments, including no treatment. However, as was mentioned in Chapter One, too much attention is placed on the cognitive aspect of understanding. Here again, Lonergan's vision of the unity of the human person is crucial.

As one who is a combination of affect and intellect, these two components must participate equally in discussions of consent, because to do otherwise would result in a fragmentation of the unity of the person. This depends on an understanding that emotions can play a positive role in capacity. This is especially so when capacity is viewed as more a matter of practical reasoning rather than theoretical. [16]

In fact, as mentioned previously, authors like Louis Charland argue that appreciation, one of the requirements of valid consent, has "important emotive components that are seldom sufficiently recognized or acknowledged."[17] While the

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[16] See Louis C. Charland, "Is Mr. Spock Mentally Competent? Competence to Consent and Emotion," *PPP* 5, 1 (March 1988), pp. 67-81. See also B. Freedman, "Competence, Marginal and Otherwise," *International Journal of Law and Psychiatry*, 4 (1981), pp. 53-72. Freedman argues on p. 64, ". . . reasons consist of premises that argue towards a practical conclusion."

[17] Louis C. Charland, "Appreciation and Emotion: Theoretical Reflections on the MacArthur Treatment Competence Study," *Kennedy Institute of Ethics Journal* 8, 4 (1999), pp. 359-376.

requirement of understanding in informed consent has both cognitive and affective components, this is even more so when one looks at the appreciation requirement of valid consent. With this requirement, the patient must be capable of appreciating that the facts they have been given are related to their own circumstances.

In other words, appreciation requires that a patient recognize that the diagnosis of cancer, for example, applies to them, as do the risks and benefits of various treatments. More importantly, not only does the patient need to appreciate that the diagnosis and treatment applies to him/her, he/she must also recognize that the information has personal meaning and significance. How the patient assesses the various options available requires again that they be evaluated in light of one's own values and beliefs. Feelings as indicators of value therefore play a pivotal role in appreciation. The following case provides an example:

> Mr. Brown is a 30-year-old actor with bilateral testicular cancer. His surgeon advises removal of both testes and chemotherapy. Mr. Brown is terrified of death, and also disfigurement. When asked what his hopes are, he repeatedly states that he wants to live and to get married to his fiancé.

While Mr. Brown understands the diagnosis and risks of treatment, he, more than anyone, acutely appreciates that whatever he chooses will have an impact on his life. While he is therefore capable of making a decision, he needs help in order

to address his feelings of fear, shame and hope, in order that he can fully appreciate how each possible treatment will alter his life.

Again, as with the level of experience in which the physician shares the facts of the case and discusses this in light of a patient's feelings and thoughts, on this level of understanding in which the patient is being helped to comprehend the various options in light of his/her own value system, feelings play a crucial role. This is also true with the next stage of the process in which the patient is being asked to select a treatment plan.

### 4.1(d) Judging: Facilitating and Helping a Patient to Select a Plan of Treatment

This fourth step involves the level of judging which focusses on helping a patient to make a choice by selecting a particular treatment, including perhaps no treatment at all. At this point in the process of informed consent, the patient is being asked to choose which treatment is most likely to help him/her achieve the goal that best fits with his/her values and beliefs. However, the ability of a patient to make a choice at this point is heavily dependent on how the process has gone so far. Here the patient is required to make a choice and abide by it.

This does not mean that further questions might not arise, or that the patient might not change his/her mind. In fact, a process model of consent accepts that

further questions are unavoidable and, as a result, judgments too may change. However, if the patient is asking the same question repeatedly in spite of many attempts to address it, it may be an indicator that he/she is incapable of understanding or appreciating.

The types of questions that the patient asks will help guide the physician in understanding what the block to judgment is and whether or not bias is operating. If the questions focus on what the disease is, then the patient is asking questions on the level of experience. He/she may require more facts about the pathological process. If the questions focus on how a treatment will really impact one's life, then the patient is asking questions on the level of understanding. He/she may require more assistance in attempting to imagine and conceive of the impact of various treatments in light of his/her personal values.

Often, patients have difficulty imagining how a particular treatment might impact their lives, especially if they have never experienced the treatment before. Here the physician can provide invaluable guidance. When the physician understands the patient's values and expected goals, he/she can provide information to questions that the patient may never have thought of. This is crucial if consent is to be informed.

However, sometimes, in spite of repeated attempts at sharing the facts and attempting to assess risks and benefits, the patient is unable to make a decision. At this point, one needs to make a final assessment of where the block to knowing is occurring and what is causing it. Is it a failure of intellect and/or feelings which is making the patient incapable of understanding and appreciating?

While capacity is assumed unless we have reason to question it, when there is a question about capacity, it must be addressed. Again, in assessing whether or not a patient is capable of making a judgment, care must be taken to assess ability in light of the specific treatment being offered. This harkens back to the need to apply the functional model of assessing capacity as was discussed in Chapter One of this thesis. If the patient is cognitively able to reason and deliberate but is being blocked by bias from doing so, every attempt must be made again to resolve what may be the negative function of feelings. Given the multifaceted nature of the human person, it may be helpful to suggest to the patient that counsel be sought from family, friends, clergy and/or psychiatry, in fact anyone whom the patient will allow to help him/her through the ordeal of illness.

This approach is much more conducive to healing than one that immediately leaps ahead to a finding of incapacity and seeking consent from the appropriate substitute decision maker. This should only be sought when all other attempts have

been made to help the patient make his/her own choice. If, at that point, the patient is found to be incapable of making a particular decision, for whatever reason, consent should be sought from the appropriate substitute.

At some point in the process where the patient is being asked to make a choice, he/she may ask the physician what he/she thinks should be done. It is this author's belief that a model of consent based on conversation, transparency, virtue and covenant, requires that the physician give an opinion, especially when he/she is requested to do so. To do otherwise abandons the patient and is antithetical to a covenantal approach to consent. In giving his/her opinion, the physician should be transparent about the process by which he/she arrived at the judgment and should speak about how his/her thoughts and feelings impacted the process. This provides not only the requested opinion, but also models the movement from experience, to understanding, judging and deciding. Only after all of these issues have been addressed can we complete the process of consent by moving to the level of decision in which the patient or substitute, if the patient is incapable, carries out the action of signing the consent form and/or agreeing verbally to treatment .

### 4.1. (e) Decision: Agreeing to Treatment and/or Signing the Consent Form

Finally, the fifth step in our new model of consent involves the level of decision. Here we will focus on helping the patient to act on his/her choice by agreeing to treatment or by signing a consent form. This is the final step in the process of informed consent. Here, the patient is asked to agree to a particular treatment and in some instances, to sign a consent form. Whether or not a signature is required will be determined by various laws and/or hospital policies.

However, what is of importance here is not whether or not a patient signs a form, but rather that the process which has been undertaken so far becomes concretized by a decision to act. A patient's signature on a consent form is stating that he/she has been given the information that he/she requires in order to make a decision about treatment and that he/she has agreed to that treatment.

The signature implies that there is understanding and appreciation of and agreement to the proposed treatment. The signature expresses the judgment that this is what the patient is choosing. Unfortunately, in too many cases, the focus of informed consent is placed on the signing of this form, rather than on the process that it is attempting to concretize.

While the intent of this present work is to focus on the process of consent, the natural and mandatory conclusion of the informed consent process is that the

patient's choice moves to the level of decision in which he/she agrees to treatment, and/or to sign the consent form in those instances where written consent is required. Of crucial importance here is that the preceding steps should be taken as close as possible to agreeing to treatment or to signing of the form. If this is not possible and significant time has elapsed, there should be a review of the process at the time of signing or agreement. If this is occurring at the same time as the preceding conversation, then obviously there is no need to repeat the conversation. Similarly, if this is occuring close to the time of the preceding steps, there may be no need to go over the same issues, unless the patient desires or requires it. One need simply confirm that the patient understands and appreciates what he/she is consenting to and that there are no further questions.

One cannot overestimate the importance of having this discussion prior to the patient's entry into the operating room in the case of surgical procedures. The process of consent which is being proposed here is not conducive to eleventh-hour conversations when the patient is en route to surgery, unless there is no choice due to emergency.

This model of consent then moves from the level of experience, in which facts are shared, to understanding, in which various treatments are assessed in light of one's values, to judgment, in which a treatment is selected which is consistent with

one's values and on to decision, in which a consent form is signed. As such, it is consistent with Lonergan's notion of knowing and also meets the legal requirements for informed consent. With the focus on the role of feelings as well as intellect, it provides a concrete method of assessing both understanding and appreciation. In doing so, it puts into practice what Katz, Brody, Pellegrino, Thomasma, Charon and May have been suggesting. Conversation, transparency, virtue, narrative and covenant are embedded in Lonergan's method given his view of the human subject as intellectual, affective, historical and existential, and both capable of creating and in need of healing. As such, it is a model of consent which expands on the present limited legalistic structure.

While it is this author's opinion that it meets the legal requirements of consent, of further importance in terms of the present work is the impact that it could have in terms of individual authenticity and human flourishing. Literature from psychiatry provides some clues into how consent might in and of itself be therapeutic. It is towards this brief discussion that the present work turns.

## 4.2 Beyond the Patient Benefit Theory: Consent as Therapeutic — The Psychiatry Experience

Given the enormous degree to which emotions impact decision making, and the fact that the discipline of psychiatry depends heavily on the strength of the therapeutic alliance in working through emotional issues, it is not surprising that some authors[18] have suggested that informed consent might actually be therapeutic in the psychiatric milieu. They suggest that the strengths of informed consent lie in its intersubjective nature, particularly the participation of the patient, and sharing of feelings in transference and counter-transference.[19] However, this is only so if informed consent is seen as a process involving trust between physician and patient. Consent, if seen as a "coming together," is healing in part because it demands intersubjective feeling.

> Implicit in the definition is a community of feeling, a shared trust which goes beyond a mere explicit contractual agreement.[20]

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[18] The author expresses gratitude to a psychiatry resident, who as part of her practicum in clinical ethics with this author, did a review of informed consent in the practice of psychotherapy. As far as the author is aware, this paper is as yet unpublished. Lisa McMurray, "Informed Consent in the Practice of Psychotherapy: A Review," 1998. In this paper, McMurray argues that while the literature is weak, it appears that informed consent does no harm and in fact might be beneficial to the patient.

[19] J. Marta and F. H. Lowy, "Le consentement éclairé; un atout pour la psychothérapie?" *Canadian Journal of Psychiatry,* 38 (October 1993), pp. 547-551.

[20] Allen R. Dyer and Sidney Bloch, "Informed Consent and the Psychiatric Patient," *Journal of Medical Ethics* 13, 1 (March 1987), p. 13.

In psychiatry, more so than perhaps any other medical specialty, beneficence-in-trust is crucial. Given the challenges to autonomy of some patients who may be having difficulty in making decisions, the physician encourages the patient throughout the healing course of therapy. Of importance here is the recognition that in some instances in psychiatry there exists a dilemma between respecting autonomy and acting paternalistically in order to protect incapable patients and perhaps society from harm. It is as a result of this dilemma that the fiduciary principle, or partnership, becomes even more crucial in psychiatry.

It is this notion of partnership that some authors believe grounds the therapeutic alliance and provides the best approach to informed consent.[21] Just as the relationship between therapist and patient changes with the changing needs of the patient, so too should the process of informed consent recognize that while each party has a shared goal — to understand what the patient needs and wants, communication between the two may have different levels of meaning requiring recognition and exploration. However, this ongoing process of assessing the needs of the patient increases the responsibility of the therapist, thereby strengthening the therapeutic relationship. As a result, informed consent becomes therapeutic in and of itself.

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[21] Dyer and Bloch, "Informed Consent and the Psychiatric Patient."

One sees this principle of partnership in action in Coyne and Widiger's[22] "participatory model of psychotherapy" in which they advocate for sharing information with patients, including the sharing of uncertainty as part of the process of therapy. They also argue for transparency on the part of the physician in the sharing of the personal values of the psychiatrist, given that the patient may both consciously and/or unconsciously be influenced by the values of the psychiatrist. This arises out of their belief that the patient has a right to know the values of the psychiatrist in order that he/she might recognize the potential for undesired influences. However, as Pellegrino and Thomasma propose, this reinforces the need to foster the virtue of humility on the part of the psychiatrist, who must be willing to share his/her personal feelings and values.

It appears that the use of informed consent in psychiatry might provide another opportunity for enhancing the therapeutic alliance, and that this is what makes informed consent therapeutic. It appears that the stronger the relationship between physician and patient, the greater the chances of healing might be. In fact, some studies[23] show that patients trust their physicians more and therefore are more

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[22] J.C. Coyne and T.A. Widiger, "Toward a Participatory Model of Psychotherapy," *Professional Psychology* 9 (1978), pp. 700-710.

[23] See T. Sullivan, W. L. Martin and M. M. Handelsman, "Practical Benefits of an Informed Consent Procedure: An Empirical Investigation," *Professional Psychology — Research and Practice* 24, 2 (1993), pp. 160-63.

willing to see them and to refer others to them, if they have engaged in this type of model of informed consent.

What we see in psychiatry is further evidence that the elements which we have laid out so far in our model of consent are ones which are at the forefront in the psychiatric experience of consent. The sharing of uncertainty, the importance of trust and communication, the need to foster virtue, the willingness to engage in a changing process according to the needs of the patient and the openness to enter into a two-way discussion of feelings and personal values not only are crucial elements of a new model of consent, but in fact provide an opportunity for healing.

In psychiatry it appears that the benefits of consent may derive in large part from the relational structure of therapy, which includes discussions focussing on the need for ongoing development in sharing feelings, thoughts and struggles. In fact, what the psychiatric model is describing is encompassed in Lonergan's work on the importance of conversion which was described in Chapter Three of this thesis.

However, while the psychiatric model suggests that consent can be therapeutic in terms of psychic healing, it remains to be seen if consent can be conducive to human authenticity in a broader perspective. Given the importance of the acts of judgment and decision which we have alluded to in Chapter Three in our discussion of the work of Bernard Lonergan, in which Lonergan notes that

authenticity is only achieved when one makes a decision for the valuable, it is important that we return to a discussion of his work in this regard. This is especially so given that the final two steps in our model of consent involve judgment in which a patient selects which treatment he/she desires and decision in which the patient signs the consent form or verbally agrees to treatment. In turning towards a discussion of the theological significance of an improved model of consent, we will therefore focus on the relationship between human authenticity, and the significance of the acts of judging and deciding.

### 4.3. Consent and the Authenticity of the Human Person: Theological Significance of an Improved Model of Consent

As was reinforced above, for Lonergan, it is only through judgment and decision or action that one constitutes him/herself as a person of authenticity. In attempting to analyse this relationship, this section will begin by discussing Lonergan's work on values and the human good. It will begin by summarizing his work on judgments of value and then conclude with a discussion of terminal values and the structure of the human good.

**4.3.(a) Judgments of Value**

Lonergan points out that, while value is a transcendental notion, the mere intending of value is just that, intending; it is still not knowing. Only in decision and action is knowing reached. Following the apprehension of value in feelings and the asking of questions for personal deliberation, there arise both judgments regarding values and finally decisions regarding courses of action. When one makes a judgement regarding a value that has first been perceived in feelings, one confirms or denies that something is or is not good, or that one good is more important than another. As we have noted previously, for Lonergan, the objectivity of any given judgement is maintained in as much as it proceeds from an authentic self-transcending subject.[24] However, the fullness of moral self-transcendence is not reached in knowing, but in doing, since it is possible to know what is right and yet not do it. The repercussion of this self-contradiction is the destruction of one's moral being. On this relationship between judgment, action and moral self-transcendence, Lonergan writes,

> Still, if he knows and does not perform, either he must be humble enough to acknowledge himself to be a sinner, or else he will start destroying his moral being by rationalizing, by making out that what truly is good really is not good at all. The judgment of value, then, is

[24] Not only does Lonergan relate this notion of objectivity to authentic subjectivity, he also makes the point in *Method*, p. 37, that the truth or falsity of judgments "has its criterion in the authenticity or lack of authenticity of the subject's being."

> itself a reality in the moral order. By it the subject moves beyond pure and simple knowing. By it the subject is constituting himself as proximately capable of moral self-transcendence, of benevolence and beneficence, of true loving.[25]

In summary, then, one notes that there are three components which come together in Lonergan's notion of judgments of value,

> First, there is knowledge of reality and especially of human reality, Secondly, there are intentional responses to values. Thirdly, there is the initial thrust towards moral self-transcendence constituted by the judgment of value itself. The judgment of value presupposes knowledge of human life, of human possibilities proximate and remote, of the probable consequences of projected courses of action.[26]

It is both through the development of knowledge, as well as the development of moral feeling, that the existential discovery is made that one has the potential to become a moral being. However, it is through the process of deliberation and judgment that a choice for a particular value is made. In making this choice, one both realizes his/her potentiality and also constitutes him/herself as a person of authenticity.[27]

In other words, it is ir: those moments whereby one chooses a particular good, that he/she moves towards fulfilment. Lonergan refers to this process as

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[25] *Method*, p. 37.

[26] *Method*, p. 38.

[27] See *Method*, p. 39, for further elaboration on Lonergan's notion of the fragility of the human subject and the drive for authenticity.

being the "making .of man, his advance in authenticity, the fulfilment of his affectivity, and the direction of his work to the particular goods and a good of order that are worthwhile."[28]

Lonergan describes these particular goods, or values which are chosen as "terminal values," and as having a particular place in the larger structure of the human good. One must be aware that here, as in previous discussions, Lonergan recognises that the choice for value is comprised of both an intellectual and affective component, and that this has its basis in his notion of the dialectic of the human person, as one who struggles for self-transcendence.

### 4.3.(b) Terminal Values and the Structure of the Human Good

Lonergan's introduction of the terms "terminal values" and "originating values" may seem at first somewhat confusing, since these terms do not appear in his list of values as being comprised of vital, social, cultural, personal and religious. However, this confusion is easily overcome in his discussion of "The Human Good" in *Method*. Here he makes the distinction between terminal values and originating values by noting that

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[28] *Method*, p. 52.

> Terminal values are the values that are chosen; true instances of the particular good, a true good of order, a true scale of preferences regarding values and satisfactions by their good choices. Correlative to terminal values are the originating values that do the choosing; they are authentic persons achieving self-transcendence. Since man can know and choose authenticity and self-transcendence, originating and terminal values can coincide. When each member of the community both wills authenticity in himself and, inasmuch as he can, promotes it in others, then the originating values that choose and the terminal values that are chosen overlap and interlace.[29]

Terminal values then, are goals that are realized in the process of judgment and action. Lonergan situates these values or goods within the larger structure of the human good and notes that they are "at once individual and social."[30] As individuals, we have the ability and the desire to reach a particular good, i.e., a particular object or action which addresses a particular need at a particular time and place. However, since individuals do not function in a vacuum, but within society as a whole, such operations often take the form of cooperation of a number of human subjects operating within a larger framework such as the family, society and education, the law, the economy, or the church, etc. The capacities of individuals to perform operations require specific skills that are related to their role within a given institution, or are specific to a given task.

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[29] *Method*, p. 51.

[30] *Method*, p. 47.

As well as the institutional component of cooperation, there is the concrete way in which cooperation occurs, and it is this that Lonergan refers to as the good of order. While it is separate from cases of particular goods, it is nonetheless related to them in the sense that it "regards them, however, not singly and as related to the individual they satisfy, but all together and as recurrent."[31] However, the good of order is not a utopian system, but rather the concrete functioning or non-functioning of a series of "if—then" relationships, which both direct the subject who carries them out as well as organizing the operations themselves. As a result, one should not limit the good of order to its institutional basis, since it is the result of many dimensions of human living. In other words, the good of order is dynamic in the sense that it

> . . . orders the dynamic unfolding of desires and aversions, but also in the sense that it itself is system on the move. It possesses its own normative line of development, inasmuch as elements of the idea of order are grasped by insight into concrete situations, are formulated in proposals, are accepted by explicit or tacit agreements, and are put into execution only to change the situation and give rise to still further insights.[32]

However, Lonergan is quick to point out that this description only catches a glimpse of the unfolding of social development, which would be simply a matter of intellectual development, if the human psyche did not make its contribution. Since

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[31] *Method*, p. 49.

[32] *Insight*, p. 620.

the human subject is a unity of intellect and psyche, this impacts the course of societal development, in that it, like he/she, does not possess authenticity purely or serenely. In those particular moments when we do decide in favour of terminal values, not only do we fulfil our needs, but more significantly, we create ourselves as originating values and become vehicles for the human good. Again, we see the focus on the subject who in choosing the true good rather than the apparently good,

> . . . is achieving moral self-transcendence; he is existing authentically; he is constituting himself as an originating value, and he is bringing about terminal values, namely a good of order that is truly good and instances of the particular good that are truly good. On the other hand, in so far as one's decisions have their principal motives, not in the values at stake, but in a calculus of the pleasures and pains involved, one is failing in self-transcendence, in authentic human existence, in the origination of value in oneself and in one's society.[33]

One is once again aware of the importance of the process of deliberation in terms of making decisions that are not only self-constituting, but also constitutive of society. As well, there is a recognition that liberty is also operative within an environment of personal relationships in which people are bound by a common good of order, related by obligations to each other and therefore others' expectations of them. Most significantly in terms of this present work, is Lonergan's view that,

[33] *Method*, p. 50.

> . . . these relationships normally are alive with feeling. There are common or opposed feelings about qualitative values and scales of preference. There are mutual feelings in which one responds to another as an ontic value or as just a source of satisfactions. Beyond feelings there is the substance of community. People are joined by common experience, by common or complementary insights, by similar judgments of fact and of value, by parallel orientations in life. They are separated, estranged, rendered hostile, when they have got out of touch, when they misunderstand one another, when they judge in opposed fashions, opt for contrary social goals. So personal relations vary from intimacy to ignorance, from love to exploitation, from respect to contempt, from friendliness to enmity. They bind a community together, or divide it into factions, or tear it apart.[34]

Terminal values then, as values which are chosen, operate on the levels of reflection, judgement, deliberation and choice. As such, they are valid moments of both the particular good and the good of order. In other words, terminal values are the good as an object of one's rational choosing. As originating from an authentic subject who deliberates, chooses and acts, they are driven by the feelings that are part of that subject's environment and they respond to those feelings intersubjectively and individually in opting for a true good.

Authenticity is not reached in the intending of value, but only after a process of deliberation that results in judgment and action. In our discussion of the subject who reaches moral self-transcendence through the operation of decision and action, we have discussed the object of that operation, or terminal value, and have placed this value within the larger structure of the human good. As we have shown, the

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[34] *Method*, pp. 50-51.

human good is comprised of three goods: the particular good, the good of order, and terminal value, which is the pinnacle of all other goods. The human subject is related to these goods in that he/she is the authentic person who is involved in the action of choosing a particular good. Terminal values therefore share common features with the subject, in that they relate to both the social as well as the individual, have a psychic as well as intellectual component, and are oriented towards freedom in the sense that the subject exercises his/her liberty in the acts of choosing and executing his/her choice.

Lonergan's notion of this relationship between judgments, decisions and authenticity provides us with further insight into the theological significance of our improved model of consent. Given the nature of medical decisions, it would appear that this process of informed consent provides an invaluable opportunity for making choices which might be constitutive of human authenticity. In making medical decisions, the patient has the ability to directly influence oneself, one's family, and the society in which he/she lives. These decisions will ultimately impact on one's understanding of God. In our proposed model of informed consent, the purpose has not been to engage in a theoretical reflection about various pathologies or methodologies, but to assist the authentic human subject to make a decision for that which is true and good and real.

In conclusion, this chapter has synthesized Lonergan's theological anthropology and cognitional structure with key elements of the work of Katz, Brody, Pellegrino, Thomasma, Charon and May in an attempt to develop an improved model of consent. We began with an analysis of the limits of an event model of consent and spoke of the need to develop a process model. From there we laid out a process which is consistent with Lonergan's cognitional structure and vision of the human person as a combination of intellect and affect in which the patient moves through the levels of experience, understanding, judging and deciding.

The first step in our process set out the need for establishing a covenant in which the physician and patient enter into an experience of each other and come to understand their respective roles and responsibilities.

From there we moved to the next step, the level of experience in which the patient is asked to share his/her story about the impact an illness has on his/her life. It was noted that it is within this context that the facts of the case should be shared in terms of diagnosis, prognosis and risks and benefits of various treatment. We noted the need for patience and recognition of how bias could be operating on this and every level.

Following the level of experience in which facts are shared, we moved to the next level of understanding, in which the physician assists the patient in asking

questions for clarification in an attempt to conceptualize how his/her illness and the various treatments which are being proposed might impact his/her life Of importance here is the directive to contextualize the discussion within the particular value system of the patient. We noted that while the legal requirements of consent mandate that the patient be able to understand and appreciate, the emphasis has historically been placed on the intellectual aspect of understanding with insufficient focus on the more affective aspects of appreciation. We argued that since feelings are accurate indicators of a patient's capacity to appreciate, this level of understanding should pay particular attention to both what a patient thinks about what he/she understands, and also to what he/she feels about what he/she is grappling with. Following the sharing of facts and attempting to understand, we moved to the third step, which focussed on the level of judgment in which the patient selects a plan of treatment. Here the patient is required to make a choice that is consistent with his/her own values. Of importance here is the need to help the patient make a judgment, having understood and appreciated the impact that the judgment will have on his/her life. Only after these three steps have been taken, can we move to the level of decision in which the patient agrees to treatment and/or signs the consent form. At each of the levels, we discussed the potential for feelings to negatively or positively impact the process.

Having laid out our new model of consent, we asked the question as to the impact the model might have in terms of individual authenticity and human flourishing. We cited some lessons from psychiatry which suggested that informed consent might be therapeutic. Here the importance of partnership was noted, one which was consistent with our notion of covenant. The literature from psychiatry also suggested that it was important to focus on the role which feelings and values might play in the consent conversation. Of particular note was the suggestion that the therapeutic value of consent in psychiatry appeared to arise out of the key elements which we have put together in our new model — trust, transparency, covenant and the importance of feelings in coming to understand.

This brought us to our final discussion as to the theological significance of our model of consent in terms of personal authenticity. Given the position on knowing that was laid out in Chapter Four, in which it was noted that authenticity is reached in moments of judgment and action, this section focussed again on the work of Bernard Lonergan relative to judgments and the human good.

Here it became clear that in moving from experience and understanding and judging to acting on what one has judged as being valuable, one advances in authenticity. Again it was noted that the process of making a choice for value demands the engagement of both intellect and affect. Not only does the choice of a

particular good, or "terminal value," have significance in terms of individual authenticity, but it also is constitutive of human flourishing. From a theological perspective, our model of consent was shown to have the potential to be transformative of society as well as the individual.

We conclude the chapter with a reminder that while the strength of our model lies in its focus and trust in the authentic human subject who desires to know, it shares the fragility of the human subject for whom knowing and therefore authenticity is never a "secure or serene possession."

# Conclusion

This thesis began with a discussion of the problems in the legal doctrine of informed consent. It was noted that while this doctrine arose out of the realization that it was unethical to exclude the patient from choices concerning his/her treatment, the legal doctrine of informed consent has become an overly rationalistic and impersonal legal tool. Not only does the focus on reason and the law fail to adequately consider the highly personal nature of the physician-patient relationship, it has significant implications for the authenticity of the human person, since the process of consent touches the entirety of the human subject as a person endowed with freedom, rationality and feelings. As mentioned previously throughout this thesis, the decisions that we make contribute to who we become as human persons. This is perhaps no more evident than in making decisions about one's health. The decisions made by patients who are ill have more than a scientific impact on their lives. They impact on one's family and friends, one's work and ultimately on the meaning of one's life.

The objective of this thesis has been to develop a practical model of informed consent, one which includes feelings in the process of decision making in the way in which Bernard Lonergan suggests. In doing so, our intent was not to develop a theory of informed consent, neither was it to produce a model that was reduced to a

checklist. Rather, it was to develop a practical approach to consent which could be applied in the day-to-day struggles that patients face in making medical decisions. It is a desire to make a difference in the lives of patients that has provided the impetus for this work. While the model is grounded in theory, it is unique in that it provides a theological approach to consent that is consistent with the legal requirements of the doctrine of consent and also builds on the theories and work of contemporary philosophers and physicians who are engaged in the field of clinical ethics. Such an approach is somewhat foreign to medicine, although not unacceptable in this author's opinion.

The model that we have proposed engages the patient in the movement from experience, to understanding, and finally to judgments and decisions throughout the process of informed consent. As such, it operates in a way that is consistent with how the patient comes to know. In fact, it is this author's opinion that in many instances in which there are conflicts and perhaps even threats of lawsuits in medicine relative to issues surrounding informed consent, these often result from bypassing the way in which we as individuals come to know. While this happens for many reasons, the outcome is almost universally the same. The patient feels abandoned, and the physician feels compromised and ill at ease with the way things have gone. Neither is comfortable with the outcome and neither is comfortable with the process.

However, given the pressure to reduce cost per weighted case and average length of stay, many physicians sadly resort to rushing through human moments that, if nurtured, would save much more time and anguish later on.

This model, which includes conversation, trust, transparency, and virtue, and therefore allows for the participation of both feelings and intellect, addresses the multifaceted nature of the human person who exists as a knower, lover, existential being, and one who is capable of creating but also in need of healing. As we have shown, this model does not necessarily translate into spending inordinate or fruitless amounts of time with patients. However, it does provide a unique opportunity for a fully integrated approach to human knowing and authenticity in making medical decisions.

Ultimately, the decision for authenticity lies with the patient, who is free to make both choices which are constitutive of authenticity as well as choices which are not. Authenticity like knowing is never secure or serene. Religion and the profession of healing share the premise that human life is at once fragile and perfectible. Growth in virtue and health requires awareness of life's finitude and perfectibility and, at the same time, demands an affirmation that happiness and well-being are ideal aims for individuals. Such growth rests upon the altruistic assumption that human beings can help each other to improve. It is significant to note that the

earliest priests were also medicine men.[1]

It is this author's view that the model that has been proposed here may actually ease the struggles of both patient and practitioner who together engage in often painful dialogues about life and death. In fact, the author's clinical experience with hundreds of patients and physicians has provided the opportunity to observe flaws in the present legalistic model of consent and in an "unscientific" way to test the model that is proposed in this thesis. It appears to work. However, at the present time, the author is engaged in taking the next step that derives from this thesis. She is in the process of developing a research study whose purpose is to more scientifically assess the merits of the model in the clinical situation.

Not surprisingly, given that our model is grounded in the way in which human subjects come to know and be known, it has shown the potential to work both in terms of the validity of the consent, and in terms of enhancing the authenticity of both patient and physician. However, it requires courage and the virtues that the various authors have spoken of.

It is not easy to share one's hopes and fears with another, particularly when the stakes are as high as they are in health care. The universal willingness of which Lonergan speaks and which is mandatory for this model to work will result in a degree of vulnerability in which each person allows the other to enter into his/her

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[1]David Thomasma, "The Basis of Medicine and Religion: Respect for Persons," *Hospital Progress* 60, 9 (September 1979), pp. 54-57, 90.

world. This is the opposite to the stance of so-called medical objectivity, which is so often misconstrued as aloofness and coldness on the part of physicians. However, as the author has observed in hundreds of situations, it is exactly this kind of process which results in healing, even when there is little hope for medical success.

Given that the human person is forever fragile and in need of healing by others and also God, this model of consent is not a perfect system. However, its strength lies in its focus and trust in human experience. In looking at the total structure of the encounter in informed consent, it moves beyond the limits of principlism and a rights-based approach, to one which judges authentic decisions as those which are directed towards the human good. Ultimately, however, it rests on a hope and trust in divine grace.

This is perhaps one of the greatest challenges that the model faces. Is it possible for a model, which is grounded in faith, to be accepted in what is for the most part a secular environment? Certainly it is a concrete challenge which this author faces in teaching medical residents and physicians on how to approach the issue of consent. While there is support and evidence that the model does in fact work in the clinical situation, and agreement in the academic environment that it could make sense as a theory of consent, it is somewhat of a challenge when one begins to answer the questions of medical students as to where they can read more about the "desire to know," which is such a crucial element of the model.

Historically, this has not been a topic for most medical journals. This question has rested for the most part with theology. Ultimately, its answer lies in God. However, this answer presents a challenge to many people in health care. Does this mean that the model is irretrievably flawed? This author does not believe that it does. In fact, it is here in this author's opinion, that the greatest challenge of the model may provide the greatest possibility for further development and collaboration between science and theology.

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