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MEDICINA NEI SECOLI ARTE E SCIENZA, 13/1 (2001) 187-197
Journal of History of Medicine

Articoli/*Articles*

CLINICAL BIOETHICS. IDENTITY, ROLE, AIMS

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SUMMARY

Clinical bioethics may help ethics to pay deeper attention to the real phenomena of the moral life, with the aid of the psychological tradition, particularly of the psychoanalytic lesson. If we focus on the concrete moral experience of the patient, we recognize that rational justification of moral judgements (that is ethics) does not apply principles in a syllogistic way, but makes abstraction from a living emotional world, which is more rich and concrete than the theoretical precepts and axioms used.

A forgotten soul of ethics

Clinical bioethicists run several risks to meet with a disappointment, when they try to apply some spreading ethical concepts to bedside situations[1].

We have in mind, first of all, the emphasis on *autonomy*. Contemporary bioethics, especially in the anglo-analytical stream, has described a moral agent that does not exist in the real world: an isolated, atomistic individual, who looks for and implements the (presumed) best decision, in an impersonal nowhere place, hidden behind a veil of ignorance, free from passions, affections, traditions, relevant relationships. The so-called autonomous person tries to follow coherently a detached, intellectual reasoning, aimed to maximize benefits and minimize evils for all or to reach the largest consent among himself[2] and the other rational, autonomous subjects.

Little attention is paid to the real phenomena of the moral experience, to the symbols of good that make the history of my life

Key words: Clinical bioethics - Autonomy - Consent - Psychoanalysis - Moral philosophy

my moral history, to the emotional turbulences (like the sense of guilt) that give birth to and accompany one's own personal ethical conflicts. Little importance is given to the signs of the mutual interpersonal dependency that in childhood has marked once forever and that everyday marks one's own moral attitude. A dependency that does not lead to heteronomy, but instead to the only kind of autonomy one can build and enjoy[3].

We would rather agree with the psychoanalytic observation that a person is really autonomous if he can hear the voices of as more as possibile characters of his inner theatre, if he is not afraid of listening to the different and even opposite claims made by the strolling players, who constitute the pluralism of his internal moral world[4]. These are characters who need to be understood, mutually translated, emotionally felt, before making the final ethical decision, before giving the main chair (using a political metaphor) to one of them. The moral decision cannot be really yours if one party is sent off your mental assembly without respecting the right of the opposition. We would therefore maintain that such characters are looking for an author, who can recognize them, dialogue with them, bind them into the narrative unity of a moral history[5]. In other word the ideal of mental *integration* seems to be more realistic and fundamental than the abstract request of *autonomy*.

Let us consider for example the statement that *patient's rationality* is a necessary condition of his/her *informed consent*. In biomedical ethics *competence* is more than one of the elements of informed consent: it is the mental precondition of apprehending information and acting voluntarily.

> *Judgments of competence and incompetence [...] often apply to a limited range of decisionmaking, not to all decisions made by a person[...]. The same person's ability to make decisions may vary over time, and he or she may at a single time be competent to make certain practical decisions but incompetent to make others*[6].

It is therefore interesting to look for the methodology you have to follow in order to recognize that one person is competent to make a certain decision and that he has to be respected as an autonomous moral agent. If you follow a *result standard*,

you fall into a morally biased attitude (we may call it a paternalistic one[7]) because -in the result standard- you judge at first that a decision is irrational, or bizarre from your point of view (someone deciding to refuse lifesaving transfusion, or to be inseminated by a turkey-basket) and then you come to the conclusion that the subject is incompetent.

The only way out is to follow a *process standard:* you confine yourself to evaluate the consistency, solidity and emotional integrity of the request and of the reasoning that supports the request. You deal with the process, whatever result might come out. If the process is good, the person has to be judged competent, whatever he/she decides.

Now, what kind of formal evidence of competence you have to perceive? We would answer: evidences that the subject

- is able to comprehend the importance and to weigh the seriousness of the alternatives of actions he is facing and is able to reason about the means-to and the consequences-of such actions;
- is able to appropriate, process and work out new informations, to deepen or modify his thoughts, if new data come up (differently from psychopathological delusions of persecutory or grandiose kind);
- is able to base his reasoning on moral values he shows to trust, i.e. values that are *his* own values;
- is able to express, in a sufficiently organized speech, reasons which have internal coherence and do not contradict each other in different close occasions and dot not contradict manifest non-verbal actions, omissions, parapraxis, or lapsus enacted by the patient;
- is able to express *emotions*, feelings, affections, traits of mood which correspond to the intellectual reasons and which are in concordance to the idea enunciated (we have some element to doubt the soundness of a consent given by a patient who declares to be happy and peaceful with regard to his decision to be operated, but who, at the same time, cries and curses with violence).

As you can see, implementing and evaluating a process standard require that patient and doctor know, understand and trust

each other. That is the reason why we affirm that the contractual version of the *physician-patient relationship*, a version endorsed by the main (theoretical) bioethical stream, suffers from a rationalistic bias and promotes an educational framework, in the medical schools, that is widely useless or misleading in the clinical practice.

In fact physician's duty cannot be limited to check that a patient's inform request exist, that it is documented and valid from a bureaucratic point of view and to execute it, once it is ascertained that someone will pay for it. Only if a physician takes in account both *the emotional and the cognitive elements of the consent*, he can take as valid or not the explicit statements of the patient. We all know that behind the conscious reasons there are unconscious ones, that are not necessarily irrational and that may be in conflict with the former. A physician is not a psychoanalyst; nevertheless he should possess the human virtues and the psychological skills, that enable him to give his patient the time, information and the other general conditions of a daily well-made decision. He has to respect the psychological resistances, so far as they work and they sustain an explicitly well articulated choice, so far as -for istance- splitting and projection do not disturb too much a dialogical therapeutic covenant.

These bioethical observations in the clinical setting and the disappointment *at the bedside*, we mentioned before, led us (as clinical bioethicist) to rethink the roots and the developments of the discipline itself, bioethics, with the suspect that something important of its *original soul* has been lost and in the hope that a fruitful aid could be got from other domains, particularly from the psychological tradition.

Take again for example the topic of informed consent. In psychoanalysis the conflict about informed consent is not a step to be watched *before* the treatment starts. It is rather a symbol of patient's mental integration; it is the sign of the inner struggle that has to be analyzed and treated, so that at the same time psychoanalysis improves personal integration and strengthens the consent of the patient. There is a virtuous circle between the effectiveness of analysis and the validity of the consent to it, so that paradoxically only at the end of the analysis the consent

may be expressed at the highest level of certainty and with the least contradiction. We might call this consent a *continuing or on-going consent* (*an evolving contract*[8]) in the sense that the consent to psychoanalysis is continuous and can be reaffirmed or taken away in every moment. Obviously such a consent cannot be implemented in those medical situations, when a decision (yes or no) has to be taken before an intervention, that will determine permanent consequences. Anyway, the psychological skills and competencies seemed to be rich enough to offer useful corrections in several occasions to some bioethical abstractions.

For this reason we began to explore the relationship between the *two disciplines* and we found out several *intriguing bridges*. As Bernard Williams has written, contemporary ethics needs a moral psychology[9]. On the other hand, Hinshelwood has written that *psychoanalysis needs moral philosophy* and that: *issues in the nature of mind and professional ethics cannot be separated*[10]. We then started thinking that a deeper analysis should be directed to the preconditions of this mutual enrichment. What kind of practice is psychoanalysis or psychotherapy to dialogue with ethics and to give it help and to receive help from it? We seem to know what ethics is: it is philosophy, moral philosophy. But what is psychotherapy?

Reflecting upon this question, we have been perceiving and denouncing several ambiguities related to the nature of the psychological practice. How can a *psychiatrist* present himself as a scientist, if he knows that his practice is deeply value-laden and not at all morally neutral? How can a *psychotherapist* inform his patient that the value of psychotherapy -as Hinshelwood has written[11]- is knowledge about oneself and is not happiness? That it is investigation of one's own moral system of values and it is a practice of a moral life and a maturational endeavour and it is not a scientific cure[12]? That the psychotherapeutical aims are not exactly the removal of symptoms but the scrutiny of a meaning for life and the achievement of a fuller, more free experience? How can a contemporary *psychoanalyst* deal with the evidence that he works with moral categories and that the socalled technical rules are in a sense moral prescriptions? How can be

defended in a consumer society the Freudian notion that the essence of psychoanalysis is not therapy, but truth-searching?

We have also been finding out some confusion in the common selfrepresentation of psychological practices and suspected that psychotherapy had in a sense confiscated tools, skills and domains that are properly ethical, with the result that the philosophical search for a meaning (the meaning of living, of dying, of procreating) had been transformed and reduced to the search of an internal psychological wellbeing, a sedate, domesticated, comfortable escape from conflicts. One example of this ambiguity is the notion of *counselling*: you can hear speaking of moral counselling, genetic counselling, psychological conselling, pastoral counselling. But what is it meant by that? We guess that counselling is nothing else than applied ethics, if counselling requires the analysis of the moral pro-and-con argumentations in face of a dilemma, if it requires the balancing of the moral values at stake, if it pushes you to understand the meaning of your faith (religious or secular), in cases when your desire collides with a normative interdiction.

In other words we wonder whether psychoanalytical work deserves the title not only of ethically connoted practice, as it happens for other professional care activities (whose decisions and operations raise delicate moral questions) but also, at least for certain aspects, the title of moral practice or *applied ethics*[13] or process of moral education.

On the other hand, we had and still have the impression that clinical bioethics needs *psychological tools*, if it has to interpret the human meaning of a medical decision. These conceptual and emotional tools and virtues like compassion are not a only features of the good physician, but also qualities of the bedside ethicist, when he helps the physician and the patient to discover what is the good clinical solution.

When we realized that clinical bioethics, in applying ethics, makes use of both philosophical concepts and psychological skill, an historical memory crossed our mind. One of the founders of The Hastings Center is Willard Gaylin, a still active private psychiatrist in Manhattan and a known writer[14]. In a recent article he underlines that psychotherapy is value laden and

the therapist is always directing, advising and introducing values in the relationship[15]. Therefore, we would say, he needs philosophical knowledge to critically evaluate the moral dimensions of his work. This observation closely mirrors our convinction that the bedside practice of clinical bioethics is laden with psychological dilemmas and has to be performed with interpersonal skills[16]. Gaylin is not the only scholar who kept alive an *original stream of bioethics* focused on the concrete moral experience of the patient and of the caregivers, when affection, reasoning, desire and will intermingle and mould the ethical decision. Eric J. Cassell's *Talking with Patients*[17] is another brilliant example of this perspective.

In such a theoretical vein, the present article makes some preliminary steps in order to raise the question of the nature of clinical bioethics itself, specifically of its epistemological status and of the relationship between philosophy and other disciplines (humanities and particularly psychology).

Which Application of Ethics?

Clinical bioethics is the ethics applied to the problems in dealing with clinical cases, and it is therefore the reflection made regarding the moral dilemmas, which result when we have to take a decision relating to the wellbeing of one or more patients. The following questions serve as paradigms of the contents (substantive ethics): *What is the best (in a moral sense) thing to do here and now for this patient?* or *What clinical decision best promotes the patient's good in this situation?* To understand the epistemological statute of this application we must preliminarily define the terms in use[18].

First of all we adopt the definition of *ethics as the rational justification of moral judgements.* Everyone evaluates, expresses judgements on what is good or bad in particular circumstances, makes choices suitable for promoting what seems to be the prominent value or what is most just in certain conditions. Ethics corresponds to the attempt to account for what the moral agent has decided or put into practise.

Such an attempt can be acted upon in different directions. A widespread manner of presenting the function of *philosophical*

ethics consists of identifying this in clarifying concepts, making reasoning more coherent and consistent, and defending appropriate criteria to motivate practical decisions. This foundation, as it proceeds, necessarily becomes more extensive and universal, and at the same time loses specification. In biomedical ethics this happens when we justify a therapeutic decision based on a behavioural rule, when we support the rule on the basis of principles and finally when we anchor such principles to fundamental ethical theories. Utilitarianism, Kantianism, personalism, contractualism, and libertarianism - to name but a few examples - offer each one precisely an axiomatical framework from which one extracts the criteria for solving particular moral questions. It is maintained that the aspiration of philosophical ethics is to find the most simple, clear, comprehensive, complete and coherent general theory in order to set against a background and solve the maximum number of specific dilemmas. The fecundity of the theory would actually be verified based on its flexibility in applying to specific cases[19].

In search of a valid certainty we thus progress from cases to theory. Reciprocally we extract back from the theory applicable consequences relative to concrete cases; consequences which, if unsatisfactory to us, make us suspect the validity of the theory itself. This equilibrium or reflecting circle shows us immediately the complexity of applied ethics and therefore also the complexity of clinical bioethics. In fact we must ask ourselves what type of application is in use. To begin to reply, we could firstly recognize that the *application* is a richer activity than the mere syllogistic deduction, since this application is not to deduce from known premisses, conclusions so logically convincing and sure as those premisses. Rather it is question of using a necessarily abstract principle with the purpose of creating order among complex realities which are therefore always richer than the initial principles.

It is exactly for this reason that the validity of an ethical theory is verified (as previously acknowledged) based on the fecundity of its application to particular cases. This phenomenon is very different from what would happen if the deduction followed a syllogistic model. For these reasons we have maintained

that in the application there is a *rebounding* of the rule from reality, into which it falls, to the theory from which it originates[20]. This *rebounding* is such that the deformation stamped or conveyed from reality to the rules may result in the modification of this same theory.

Commenting on a text by St. Thomas Aquinas (*Summa Theol.* I, II, q.94, a.4), a neoscholastic scholar stated:

> *Speculative knowledge is always related to necessary truths, whilst practical reason must apply more general precepts to particular cases which are always more complex than the types of conduct to which the universal precepts refer. Therefore, while in speculative knowledge there is an identical truth (est eadem veritas) in the universal precepts and conclusions (in the axioms and theorems) [...], in practical knowledge 'truth or practical rectitude is not the same in particular conclusions, but only in the more universal principles, and even when it is the same, it is not known equally to all*[21].

In our opinion the complexity of the ethical application has been misunderstood from the theoretical approach, which has opposed deontological and teleological positions, without using an adequate phenomenological reconstruction of the symbolic quality of the moral experience. A quality which, as we will demonstrate in the following article, can instead be more correctly defined from a *hermeneutical approach*.

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2. Not to burden the text with the double reference he/she, his/her and so on, we shall use only the male pronouns, aware as we are of the risk of sexism.
3. The opposite of autonomy [...] is *not* dependency but *heteronomy*, write HOLMES J., LINDLEY R., *The Values of Psychotherapy*. London, Karnac Books, 1998, p.7. The practice of applied ethics today deals mostly with abstract theories of action, balancing-procedures among general principles, detached views from nowhere places and impersonal techniques of justifications. A rationalistic attitude undervalues what actually moves people to act, i.e. motives and passions: *It treats the rational content of speech and argument without regard to the engaged concerns that incite both speech and action. It by and large ignores mores and customs, sentiments and at-*

titudes, and the'small morals' that are the bedrock of ordinary experience and the matrix of all interpersonal relations. It by and large ignores real moral agents and concrete moral situations, preferring the abstraction of the hypostasized 'rational decisionmaker' confronting the idealized problem needing to be solved [...] Though originally intended to improve our deeds, the reigning practice of ethics, if truth be told, has, at best, improved our speech. See: KASS L.R., *Practicing Ethics:Where's the Action?* Hastings Center Report; 1990; 20,1: 5-12. See also the comment by HAMEL R., in Bull. Park Ridge Center, 1990; 42-43.

4. HINSHELWOOD R.D., *Therapy or Coercion? Does Psychoanalysis Differ from Brainwashing?* London, Karnac Books, 1997.
5. We are thinking of LUIGI PIRANDELLO's play *Sei personaggi in cerca d'autore* (1921), of course.
6. BEAUCHAMP T.L., CHILDRESS J.F., *Principles of Biomedical Ethics*. 2nd ed., New York-Oxford, Oxford Univ. Press, 1983, pp.72 foll..
7. We prefer to use *paternalism* only in a disparaging sense, as an attitudine always wrong, because the powerful partner (the parent, the physician, the psychoanalyst) takes advantage of his position to prevent and stop the development of the weak partner (the child, the patient) towards the ownership and exercise of power, autonomy, culture. The so-called weak paternalism, that may be morally justified, deserves -in our opinion- the title of good *parental* responsibility. In some situations the stronger covenanter has not only the right, but the duty to treat the partner *as a child*, that is to treat him as a good father or mother would do. The duty is to use his power to represent, defend and help the weaker agent to acquire or to regain his voice, rights and strenght. In other words to become in an actual and developed way what he is germinally from the beginning: a person having a dignity which is equal with every other person.
8. In HOLMES J., LINDLEY R., see ref. 3.
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19. On the relationships between theories, considered judgements and moral decisions, see again *Principles of Biomedical Ethics*. By BEAUCHAMP T.L., CHILDRESS J.F., New York - Oxford, Oxford University Press, IV ed., 1994, in the pages concerning

specification, generalization, reflecting equilibrium. BEAUCHAMP T.L., *Principles and'Principlism'*. In: AA.VV., *Le radici della bioetica*. Milano, Vita e Pensiero, 1998, pp. 47-59, writes: Principles, in the *prima facie* conception, should be understood less as norms that are *applied* and more as guidelines that are *interpreted and made specific* for policy and clinical decision making (p.55). The *specification* of the principles is defined (quoting Richardson and De Grazia): *the progressive filling in and development of the abstract content of principles, shedding their indeterminateness and thereby providing action-guiding content* (p.55). We personally agree with many of the criticisms of *principlism* expressed by hermeneutical ethics, for example by LEDER D., *Toward a Hermeneutical Bioethics*. In: DUBOSE E.R., HAMEL R., O'CONNELL L.J. (edited by), *A Matter of Principles? Ferment in U.S. Bioethics*. Valley Forge, Trinity Press International, 1994, pp.240-259.

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