

THE ETHIC OF INFORMED CONSENT:

PHRONESIS AND CARING

**A Thesis Submitted to the College of
Graduate Studies and Research
in Partial Fulfillment of the Requirements
for the Degree of Master of Arts
in the Department of Philosophy
University of Saskatchewan
Saskatoon**

by

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Fall 1996

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ABSTRACT

The purpose of this thesis is to consider the problems associated with the concept of informed consent to treatment from the perspective of two theories: Aristotelian virtue ethics and a contemporary ethic of caring.

The theory and practice of informed consent to treatment is an important issue in contemporary medical ethics. Informed consent requires a relationship between doctor and patient based on dialogue and trust. Unfortunately, this relationship is too often undermined by authoritarian practices on the part of the medical profession. I shall examine the problems that this raises by means of an analysis of the concept of phronesis in Aristotle and from the perspective of the ethic of caring developed by Nel Noddings.

The presented integration of these two very different ethical theories provides a possibility for more inclusive understanding of the problem of informed consent and establishes a base for further study in this area.

ACKNOWLEDGEMENTS

This thesis was only made possible through the active cooperation of a large number of people. Foremost among these is my husband, Howard, who patiently read, reread, and edited many pages of this manuscript. He also gave me unwavering encouragement and support as well as the occasional prod when I needed it.

Most sincere thank you to Dr. Kevin Corrigan, my thesis supervisor, who provided advice, feedback, and ongoing support for this endeavour. He encouraged me to think deeply and critically about my research, introduced me to new ways of interpreting the world, and helped me to express complex thoughts clearly and concisely. I will always be grateful for his patience and understanding and for his dedication to this research during his sabbatical.

A very special thank you is due to Dr. David Crossley, who always read the drafts of my thesis promptly and with diligence, care, and insightful comments.

I also wish to thank Dr. Rudy Krutzen, the other member of my thesis committee, as well as Dr. Esther Grogin, the external examiner, for their support. Thanks are also due to the staff of the St. Thomas More College for their ongoing support and advice.

DEDICATION

This thesis is dedicated to my husband, Dr. Howard R. Woodhouse for his encouragement, support and belief in my work.

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1. THE PROBLEM OF INFORMED CONSENT TO TREATMENT

The concept of informed consent to treatment is poorly understood by both health care professionals and the general public. By and large, the general public is unaware of either its meaning or the rights to which it entitles them in their relationship to doctors and other health care professionals under Canadian law (The Canadian Nurses Association, 1991, p.3; The Royal College of Physicians and Surgeons, 1987, p.9; Kluge, 1992, p. 113; Rozovsky & Rozovsky, 1990, p.1; Rozovsky, 1993, p.19). The medical profession is characterized by its tradition of values such as the unquestionable trust that the patients must place in doctors and the expectation that they will follow their orders. In the last decade there has been an increased awareness within the medical profession itself that it is necessary to abandon the unquestioned paternalism of the past (The Royal College of Physicians and Surgeons, 1987, p.9). The change of direction away from the well-established value of paternalistic trust between the patient and doctor was initiated by the legal doctrine of Informed Consent giving the patient a right to participate in the medical

decision-making process (114 D.L.R.(3d),1980,p.13). Theoretically, the right to informed consent presents no problems. In reality, however, many doctors and other health care professionals view the concept of informed consent to treatment as a mere formality of obtaining a patient's signature on a 'consent' form and disregard the idea that patients have the right to receive all reasonable information when making a choice regarding medical treatment (Katz, 1984, pp.59-60; Kluge, 1992, p.131; R.C.P.S. 1987; Rozovsky, 1993, p.19). The doctor has a responsibility that such communication takes place within the limits of what the normal reasonable person can be expected to understand. While the purpose of my thesis can readily be described as critical analysis of the process of informed consent as it takes place in the doctor-patient relationship, it is by no means a condemnation of doctors or other health care professionals.

Consent to treatment within the medical context is defined as a prerogative of patients to decide about their medical treatment (The Royal College of Physicians and Surgeons of Canada, 1987, p.9). It is an integral part of a fiduciary relationship based on understanding and effective communication between patient and doctor or other health care professionals. The fiduciary relationship means that the doctor or health care professional is expected to act in

the best interest of the patient. The principle of autonomy which defines the fundamental right to self-determination for all persons emerged to counter-balance medical paternalism and became the foundational concept of informed consent. However, that does not require that the doctor is obliged to do whatever the patient demands. The mean between excess and defect in patient-doctor relationship is best described as shared responsibility. The signed consent form represents nothing more than evidence of consent and cannot be considered consent itself (Rozovsky, 1989, p.1). The consent form on its own is not the actual consent process but rather evidence that the patient agreed to the operation or surgical procedure (e.g. hip replacement or pacemaker insertion), but it is not evidence that the patient knew what the procedure was or that s/he was properly informed. If the mere signing of a form is no substitute for the kind of interpersonal understanding and open dialogue between patient and health care professionals that forms the basis of the consent process, what in fact constitutes informed consent to treatment?

The theory and practice of informed consent to treatment is a contentious issue in both contemporary medicine and law (Canadian Medical Protective Association, 1981, p.39; Katz, 1984, pp.2-3; Miller, 1980, p.2100; Rozovsky 1993, p.20; The Royal College of Physicians and

Surgeons of Canada, 1987, p.9). In the first section of this chapter I will explain the origins of informed consent to treatment as an essential prerequisite to the provision of medical services. The nature and extent of doctors' duty to provide relevant medical information to their patients so that their consent to treatment is informed will be analysed by means of the landmark 1980 decision of the Supreme Court of Canada, Reibl vs. Hughes (Dominion Law Reports, (3d), 1980), The Canadian Law of Consent to Treatment (Rozovsky & Rozovsky, 1990) and Canadian Medical Law (Sneiderman, Irvine and Osborne, 1989). I shall then define the process of informed consent to treatment and its criteria as the individual's right to self-determination reflected in the contractual relationship between an individual and the health practitioner.

I will address the problem of informed consent to treatment in the second section of this chapter and highlight the following ethical issues. First, the present character of the relationship between doctor and patient tends to reduce the question of informed consent to mere formality and, moreover, it portrays patients as unable and unwilling to make medical decisions (Canadian Medical Protective Association, 1981, p.41; Katz, 1984, pp. xix; 59; Rozovsky & Rozovsky, 1990, pp.1-14; Rozovsky, 1993, p.19). Second, the kind of knowledge applied by the doctor must be

more than scientific and technical in nature. Practical knowledge, as the excellence of practical thinking in terms of the particular patient, combined with a sufficient understanding of the situation in terms of the patient's lifestyle, profession, and economic considerations, must be included as an essential element of the doctor-patient relationship, since the treatment of the patient as a person must be conceived as a foundation of the medical profession itself (Benner, P., Wrubel, J., 1989, pp. 1-8; Bok, 1980, pp. 238-241; Katz, 1984, p.xx; Kluge, 1992, p. 119; Noddings, 1984, pp. 3-6). Finally, I shall discuss the notion of caring in doctor-patient relationships as a foundation of informed dialogue that respects the rights and needs of both sides.

1.1 The Process of Informed Consent to Treatment: An Essential Pre-requisite to Medical Care

Within the context of Canadian law (Supreme Court of Canada, *Reibl vs. Hughes*, 1980; *Hopp vs. Lepp*, 1980) the right to make an informed decision about one's own health belongs inherently to the individual. The law on informed consent to treatment in Canada is represented by the Supreme Court decision in the case of *Reibl vs. Hughes* (Dominion Law

Reports (3d), 1980; Kluge, 1992, p.116; Sneiderman, Irvin and Osborne, 1989, p.49).

The plaintiff, Mr. Reibl, of Hungarian origin, aged 44, sought medical treatment for persistent headaches in the spring of 1969. Upon initial examination by Dr. Szabo, also of Hungarian origin, it was discovered that the plaintiff had high blood pressure and was given a prescription for certain medication. Since there was no improvement, Dr. Szabo recommended that the plaintiff be admitted to the hospital for a complete check-up. While in the hospital, it was discovered (by Dr. Orr, a specialist in endocrinology) that the plaintiff also had diabetes. Following the stay in the hospital, the plaintiff went back to work (Ford Motor Company) although he still suffered from headaches. In February 1970, Dr. Szabo again recommended that the plaintiff be admitted to the hospital. After a series of tests and strict diet the headaches diminished. However, the plaintiff's continuing high blood pressure was an ongoing concern to both Dr. Orr and Dr. Szabo.

With Dr. Szabo's concurrence, Dr. Orr brought in Dr. Hughes, a neurosurgeon and the defendant in this case. The defendant ordered an arteriogram to confirm the diagnosis of blockage in the left carotid artery of the plaintiff's neck. This test showed a significant narrowing of the left carotid artery leading to the brain allowing only 15% of blood flow.

The plaintiff's condition, in the view of the defendant, was not related to his high blood pressure and at the present time was not causing any detectable neurological problems. However, the defendant suggested that the plaintiff undergo surgery to remove the blockage in order to prevent a risk of death or stroke caused by the reduced blood supply to the brain. The risk involved was about a 10% possibility of a stroke in each year the plaintiff lived in this condition. There were also risks of death and stroke involved if the plaintiff were to undergo remedial surgery, but these were not disclosed to the plaintiff. The plaintiff, who possessed an inadequate knowledge of English and believed that the proposed surgery would also eliminate both his high blood pressure and headaches, agreed to the surgery which was performed by the defendant. Consequently, the plaintiff suffered a massive stroke which left him paralysed on the right side of his body and impotent (114 D.L.R. (3d), 1980, pp.1-2, 17-18; Sneiderman, Irvine and Osborne, 1989, pp. 49-50).

The Supreme Court declared that the legal obligation to provide sufficient information concerning treatment is part of the doctors' obligation of care to their patients (114 D.L.R. (3d), 1980, p.2). The liability in this case was based on a breach of the doctor's duty to provide relevant medical information to his patient and a demonstrable causal

link between the breach of this duty and the patient's injury (114 D.L.R. (3d), 1980, p.32; Sneiderman, Irvine and Osborne, 1989, p.49). The doctors' duty to provide relevant medical information (known as the 'duty of disclosure') includes both answering patients' questions and volunteering information about the nature of the proposed treatment, material risks, alternatives, and the consequences of inaction.

The Supreme Court rejected the previously established 'professional standard' of disclosure of risks described by the Ontario Court of Appeal as¹:

..."the manner in which the nature and degree of risk is explained to a particular patient is better left to the judgement of the doctor in dealing with the man before him" (114 D.L.R., (3d), 1980, p.12).

In this professional standard of disclosure the doctor was only required to disclose information that a similarly placed doctor under comparable circumstances would have disclosed. There were two major problems with this standard. First, it emphasized professional opinion while diminishing the principle of autonomy of patients. Second, professional expertise also determined whether or not there had been a breach of duty of disclosure. As Chief Justice Bora Laskin pointed out:

To allow expert medical evidence to determine what risks are material and, hence, should be disclosed and, correlatively, what risks are not

material is to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there has been a breach of that duty (114 D.L.R. (3d), 1980, p.13).

Rejecting the previously established professional standard², The Supreme Court pointed out that the issue under consideration was a different issue from that involving the question whether or not the doctor acted according to applicable professional standards:

What is under consideration here is the patient's right to know what risks are involved in undergoing or foregoing certain surgery or other treatment (114 D.L.R. (3d), 1980, p.13).

In other words, informed consent essentially requires that the patients know³ what risks are involved in the proposed medical treatment thus allowing them to control their health care and make their own health-care decisions. Consequently, dealing with the issue of causation (casualty or wounded person requirement), the Supreme Court adopted an 'objective reasonable person' standard as the proper disclosure of risks and benefits regarding the proposed treatment as well as any special considerations affecting the particular patient. Again, in the words of Chief Justice Laskin:

I think it is the safer course... to consider objectively how far the balance in the risk of surgery or no surgery is in favour of undergoing surgery. The failure of proper disclosure ... becomes therefore very material. And so too are any special considerations affecting the particular patient. For example, the patient may

have asked specific questions which were either brushed aside or were not fully answered or were answered wrongly...[The] objective standard would have to be geared to what the average prudent person, the reasonable person in the patient's particular position, would agree to or not agree to, if all material and special risks of going ahead with the surgery or foregoing it were made known to him [or her]. Far from making the patient's own testimony irrelevant, it is essential to his case that he put his own position forward (114 D.L.R. (3d), 1980, p.16).

In other words, the objective reasonable person standard sets out the duty of the doctor to disclose, unasked, sufficient medical information that a reasonable person in the patient's particular position might want to know. The duty of the doctor to disclose sufficient medical information is defined in legal terminology as a 'disclosure standard'. Moreover, the mention of 'the patient's particular position' not only reflects the needs of our multicultural society but also suggests an element of subjectivity with respect to the patient's culture, religion, age, profession and other variables (Kluge, 1992, p.118).

By giving consent to treatment, an individual enters into a contractual relationship with health care professionals. The individual agrees to submit to a specific medical, diagnostic or surgical procedure/treatment which will be carried out by health care professionals. In turn, health care professionals, including doctors, nurses, special care aides, physiotherapists, and medical or X-ray

technologists agree to perform the specific procedure or treatment within the limitations set down by both parties. Despite the fact that it is not usually thought of as a 'consent contract', the authorization for treatment is precisely that. Moreover, just as in other contracts there are specific considerations for both parties entering into such a contract. In the case of patients, there is an obligation to provide the doctor with all relevant information regarding their condition and the restriction on their freedom to pursue normal lifestyles for a particular period of time. In the case of health care professionals, there is the obligation to provide all pertinent data about diagnostic and therapeutic procedures in anticipation of monetary gain arising from providing care even if provincial health insurance programs 'pay' for their services. There is a financial consideration "which follows from the agreement to submit to and to provide treatment" (Rozovsky, 1990, p.1). Moreover, the results of research conducted over the past twenty years concluded that fee-for-service as a method of payment to doctors increased overall costs of health care in Canada by 20 to 40 percent without any significant benefit to patients; in other words, "the payment is a piecework, the more a doctor does, the more he or she makes" (Rachlis, 1994, p.54). Consequently, monetary considerations follow from the 'consent contract' in which one party

submits to, and the other provides, treatment. Finally, while there are many types of contracts, the 'consent contract' is based on what is known as a 'fiduciary' relationship. Such a relationship reflects health care professionals' duty to act in a way that benefits patients. Therefore, health care professionals are required by consent contract to act in ways that best serve the interests of their patients (Kluge, 1992, pp. 114,121; Rozovsky, 1990, p.2).

A consent contract based on the special relationship of trust between patient and health care professionals can only be achieved by the completion of a proper 'consent process'. As stated earlier, this consent process involves more than securing a signature on a consent form. It requires clear and open communication between the patient and the health care professional, a communication evidently based on an ongoing relationship of trust between both parties. Moreover, patients may voluntarily and competently waive their right to informed consent in full or in part, in which case the doctor should provide whatever treatment she believes to be in the patients' best interests (Kluge, 1992, p.113; R.C.P.S., 1987, p.9).

If the patient is both mentally and legally capable of consenting to treatment, the consent process for elective procedures should take place in the following manner to be

recognized as informed and valid. It is initiated by the patient's illness or injury. The proper documentation of the patient's history, including the signs and symptoms of the disease, as well as all concerns expressed by the patient are obtained. The diagnosis and care plan is proposed by the doctor (or other health care professionals) and disclosed to the patient. The proper disclosure will include the following information:

- a) nature and purpose of any proposed surgery, diagnostic intervention or treatment;
- b) the probable risks and benefits of this proposed intervention including material and special risks with consequences of death or paralysis;
- c) reasonable alternatives to treatment if any exist;
- d) the impact of treatment on the patient's lifestyle;
- e) economic considerations (is the proposed treatment covered by the provincial health insurance program?);
- f) the consequences of refusing the surgery, diagnostic intervention or treatment;
- g) who is to perform the procedure (including medical residents and interns in teaching hospitals).

Any authorization is specific to the procedure(s) to be performed. The patient must have an opportunity to ask questions and receive answers that he/she understands. Moreover, there should be no misrepresentation of material information described as "risk information which would influence a person's consent to treatment" concerning risks which may materialize and their consequences (Rozovsky &

Rozovsky, 1990, p.8). The question of what risks a patient would regard as material could be determined without the patient's special knowledge of medical science because the doctor's explanation must be in lay terms and not in medical-scientific jargon. Moreover, the doctors must also take into account the strengths and weaknesses of their patients. This may require spending a certain amount of time to get to know the patients, to guide them to recognize the unrealistic expectations from more realistic ones, and to accept that:

The fact that a doctor makes a reasonable recommendation regarding treatment does not necessarily mean that the reasonable person in the patient's position would accede to it (Rozovsky & Rozovsky, 1990, p.9).

Both parties should strive for agreement on the proposed treatment; however, as I mentioned earlier, competent patients may refuse the treatment or even waive their right to informed consent. The fact that informed consent is a right does not mean that every patient must exercise it (Kluge, 1992, p.113). Sometimes, in the doctor's opinion, the disclosure of information may harm the patient. As Kluge points out, "in these sorts of cases it is tempting to argue that the patient should not be told the truth even though otherwise (as a competent person) he or she be entitled to it." (1992, p.128). In the realm of ethics this privilege of a doctor to withhold information from a patient is called a

therapeutic privilege. At this point, we must ask the question whether it is the information itself which may cause harm to the patient, or the manner in which such information is presented? Conversation between doctor and patient has never been an important part of any medical curriculum and as a result, while the technical competence of doctors has steadily increased, their ability to converse with empathy, compassion and diplomacy has not been enhanced by formal instruction (Katz, 1984, p.152). Finally, the authorization for treatment obtained from the patient shall be free of undue influence and coercion. Only under the above conditions of proper disclosure of information will the patient have an opportunity to reflect and ask questions before consenting to any proposed treatment.

If the consent to treatment is to be considered valid, there are several criteria which must be met. The patient must be legally competent to consent to treatment and possess the mental capacity to authorize the care. Mental capacity is usually defined as the intellectual ability to reach a reasoned choice about the proposed treatment. Therefore, for purposes of consent to treatment, patients under psychiatric care, involuntary patients in a mental health institution or persons under the influence of drugs or alcohol are presumed mentally capable of giving consent. However, such a presumption can be invalidated by adequate

proof that the individual in question cannot exercise his/her thought processes to reach a decision regarding the proposed treatment. In such cases, the evaluation is carried out by professional assessment criteria and judged on a case-by-case basis (Rozovsky, 1990, pp. 5-7). The law in Canada presumes that all patients (including children) are legally competent to consent to treatment unless such presumption is removed by provincial legislation, judicial orders or a court order (Rozovsky, 1990, p.3). The Royal College of Physicians and Surgeons of Canada defines competent patients as "those who can make rational decisions about their medical care" (September, 1987). Similarly, in the Ontario Legislature Bill 109: The Consent to Treatment Act, which passed third reading and received Royal Assent on December 10, 1992, a mentally competent person is defined as:

... capable of consenting to treatment if he or she can understand the information relevant to making the decision and can appreciate the consequences of a decision or lack of decision. Like common law, the act deals with mental capacity on a case by case basis, without reference to age (Highlights of the Acts, Ontario, 1992, p.3).

Mental competency is defined as being able to understand the information relevant to making the decision about proposed treatment and the mentally competent person has the capacity to make choices and to formulate requisite judgements about those choices. In other words, a competent person has the

ability to engage in a rational process of making decisions. There is sometimes a tendency to judge persons either wholly competent or wholly incompetent. However, this trend has been changing, and it is now recognized that:

For example, if a person is under a guardianship order that removes his right to negotiate real estate or banking transactions, it does not automatically follow that the person cannot consent to care. Much would depend on provincial legislation as well as the scope of the specific guardianship order (Rozovsky & Rozovsky, 1990, p.3).

Under these conditions, where persons are seen as having capacity in some situations but not in others, it is important to recognize the need for an open dialogue between the patient and the health care professional. Only under these conditions can health care professionals "keep in mind that it is the patient and not the guardian or the author of the legislation who is to receive care" (Rozovsky & Rozovsky, 1990, p. 5).

Theoretically, a consent contract based on the special relationship of trust between patients and health care professionals is achieved by the completion of the 'consent process' as I mentioned above in this section. In practical terms, however, consent is generally perceived as a threat to the medical profession (CMPA, 1981, p.39; Katz, 1984, p. viii; Miller, 1980, p. 2100) or "as a mere formality—a paper exercise" (Rozovsky, p.19, 1993). Patients have been, and generally are, excluded from participation in the decision-

making process that fundamentally affects their health and lives. Including patients in the decision-making process is a difficult requirement for doctors to understand unless they have learned how to communicate via informed dialogue that respects the rights and needs of both sides (Katz, 1984, p.viii). With the rapid development in both medical science and technology there is a general consensus among doctors that medical knowledge cannot be properly understood by the patients. I shall turn now to discuss the problems of consent to treatment as reflected in the current consent practices of both doctors and other health care professionals.

1.2 The Problem of Informed Consent to Treatment: Current Consent Practices

In this section I will first analyse the impact of the Supreme Court decision on various professional documents published by the health care professionals themselves. Second, I will discuss the issue of patients' autonomy and comprehension as it relates to their communication with doctors and other health care professionals. The scientific and technical knowledge acquired by both theoretical studies and clinical practice of medicine does not equip the doctors with the ability to participate in a meaningful dialogue

with their patients. I will argue that the communication between doctors and patients must be based on a different kind of knowledge, namely, the practical knowledge or moral discernment defined by the Aristotelian concept of phronesis. Third, I shall discuss the concept of caring as both an inherent aspect of the doctor-patient relationship and a foundation to informed dialogue that respects the rights and needs of both sides.

The 1980 Supreme Court of Canada decision of Reibl v. Hughes influenced the content of various professional documents published by the health care professions themselves. The Canadian Medical Association's Code of Ethics (April, 1990) lists twenty four 'Responsibilities to the Patient' the ethical physician should recognize. It is puzzling, to say the least, that the actual recognition of a patient's right to participate (via disclosure procedure) in the process of consent to treatment is recognised only as a subsidiary choice for an ethical physician who:

will, when the patient is unable to give consent and an agent of the patient is unavailable to give consent, render such therapy as the physician believes to be in the patient's interest (CMA, 1990).

This statement is the only place in the Code of Ethics where the actual word 'consent' is written (in the text). Consequently, it appears that the notion of the process of consent to treatment has not yet found a place within the

Code of Ethics of the Canadian Medical Association. However, this is not to say that the physicians, their governing body, The Royal College of Physicians and Surgeons of Canada, their Provincial Associations and the Canadian Medical Protective Association are not interested in the issue of consent to treatment.

In 1981, one year after the Supreme Court of Canada decision Reibl v. Hughes, the General Counsel of the Canadian Medical Protective Association Mr. Charles F. Scott, Q.C., in his opening remarks at the eightieth annual meeting of the association informed members that:

No legal event in the last fifty years has so disturbed the practice of medicine as did the decision of the Supreme Court of Canada in Reibl v. Hughes. Our final court of appeal has changed the obligations of Canadian doctors in what they must tell their patients (CMPA, 1981, p.39).

Indeed, the doctrine of "informed consent" raised strong opposition from the medical profession who used paternalistic arguments such as the concern that the disclosure standard would harm the patients by the actual disclosure of "excessive and potentially harmful revelations" (CMPA, p.39, 1981, Miller, p.2100, 1980) or that the disclosure of material information is unnecessary and irrelevant because doctor and patient share the same interest, namely, the patient's best interest (Katz, 1984, p.x). Moreover, it was suggested that the law of informed

consent to treatment is "an attempt by lawyers to restructure the physician-patient relationship in a way detrimental to both physicians and their patients" (Miller, 1980, p.2100) in which the well-established doctor-patient relationship situates doctor and patient as unequal bargaining partners in a contract for services where the doctor's special knowledge creates the advantage. In this sense, doctors argued, informed consent is meant to "force them to give the patients knowledge that will make them equal bargaining partners" thus transforming "the essence of the doctor-patient relationship from status to contract" (Miller, 1980, p.2100). In other words, there was a strong opposition to accommodate the legal requirements of informed consent to treatment.

Moreover, there was a deeply held belief shared by the medical profession, that the doctor-patient contacts foster the most ethical relationships and that there is no need to initiate any change. However, the conceptual foundation of the new medical ethics where the moral issue of health care conceived as a human right essential to 'life, liberty, and the pursuit of happiness' provided new problems for physicians to consider (Veatch, 1972, p.5). Within the context of increasing pressure to recognize ethics and human values as necessary elements in the practice of medicine, and to respect what is essential to patients' humanity, such

as self determination, dignity, freedom and individuality, the need for a new model of the doctor-patient relationship was evident. Traditionally, medical students have been taught medicine as an applied science including the rhetoric of the scientific tradition that the scientist must be 'pure' (Veatch, 1972, p.5). In other words, there must be no considerations of value⁴. In the case of the doctor that would mean considering only what can be done from the scientific point of view completely disregarding the question of what should be done. However, such a rigid distinction between science and values is difficult to sustain conceptually and is no more appropriate for the doctor-patient relationship than is the concept of paternalism. In his timely article, Robert Veatch suggested that the 'contractual model' of doctor-patient relationship, where the doctor recognizes both the patients' right to exercise freedom of control over their own bodies and the role of their personal values, is "the real framework for medical ethics in a revolutionary age" (Veatch, 1972, p.7).

However, the step from theory to practice was far from accomplished as the furore over Reibl v. Hughes suggests in the following comments:

Although it may be asserted that individual self-determination is the basis for the doctrine, it has been argued its function has been to expand the liability of your profession.... "Informed consent" is a means of making awards for bad results...By

plucking language from court decisions and academic writings in the United States, the Supreme Court has imported these uncertainties into this country (CMPA, pp.39-46,1981).

The struggle of patients to maintain an autonomy based on their own values in the decision-making process was thus perceived as a desire for financial reward in cases of malpractice⁵.

In September 1987, that is, seven years after the Supreme Court of Canada decision of Reibl v. Hughes, the Biomedical Ethics Committee of The Royal College of Physicians and Surgeons of Canada prepared a two page release entitled Informed Consent - Ethical Considerations for Physicians and Surgeons. This document outlines the informed consent to treatment in the following way:

Competent patients (those who can make rational decisions about their medical care) have the right to make such decisions. The physician is morally obliged to protect this right by providing patients with all reasonable data about diagnostic and therapeutic procedures, and possible alternatives and risks, and by allowing patients to make their decisions without coercion (p.9).

In other words, the physician has the responsibility to determine whether or not the patient is competent⁶. If the patient is competent, that is, capable of making a rational decision about medical care, the physician must make sure that all appropriate and additionally requested data are provided to the patient. Only then can the patient make

informed decisions about his/her medical care. The reality, however, is different:

Patients, in being deprived of basic information about their conditions and alternative treatment options, are in no position to raise the questions they may want to ask but cannot clearly formulate. When they then appear confused, stupid, embarrassed, and tongue-tied, doctors (and often patients too) view such behaviour as evidence of incapacity. Thus, incapacity, all too readily assumed and, in turn, fostered by physicians, becomes a self-fulfilling prophecy (Katz, 1984, p.x).

The doctor-patient dialogue as a basis for a patient's rational decision-making process is virtually nonexistent, or at best, based on the presumption that patients are unwilling or unable to grasp the 'esoteric medical knowledge' relevant to their treatment. As Lorne Rozovsky (1993) suggests, many doctors and other health care professionals claim that the health care system is not structured to accommodate the legal requirements for consent to treatment. Many doctors and health care professionals also dismiss the notion of patients' rights to all information as unrealistic when patients are given explanations about their treatment. Moreover, when the information requested includes copies of all materials on patients' files, access to such information may present a problem⁷ regardless of the patients' right to see and have copies of everything in their medical records (The Medical Post, April 5, 1994, p.34).

In its Code of Ethics for Nursing (1991), the Canadian Nursing Association recognizes the competent patient's consent as an essential part of health care by stating the following:

Based upon respect for clients and regard for their right to control their own care, nursing care reflects respect for the right of choice held by clients (CNA, 1991, p.3).

The patient's right to self-determination is clearly recognized and respected by the Canadian Nursing Association. Moreover, the Code of Ethics provides an even more inclusive understanding of informed consent defined as a process:

Consent, properly understood, is the process by which a client becomes an active participant in care. All clients should be aided in becoming active participants in their care to the maximum extent that circumstances permit. Professional ethics may require of the nurse actions that exceed the legal requirements of consent. For example, although a child may be legally incompetent to consent, nurses should nevertheless attempt to inform and involve the child (CNA, 1991, pp.3-4).

In other words, it is the moral obligation of a nurse to nurture the patients' self-determination by both encouraging them to participate in the process of care and by exceeding the legal requirements of care when necessary. The standards under of the Code of Ethics illustrate the nurses' responsibility not only to inform the patients about the nursing care that is available to them but also to "assess the understanding"⁸ of patients concerning their care and to

respond to patients' requests for information and explanation [concerning their care] "when in possession of such knowledge necessary to respond accurately" (CNA, 1991, p.4). However, when the questions of patients require "information beyond that known to the nurse", the patients "must be informed of that fact" and referred to a more appropriate health care practitioner for response (CNA, 1991, p.4). Therefore, the CNA Code does not require the nurse to provide any information concerning medical procedures performed by physicians. In reality, the "delegation" of the consent process to Registered Nurses has become a standard practice in our health care facilities (Rozovsky, 1993, p.21, The ONA News, July-August 1993, p.14). However, with the new strict definition of informed consent as accepted in Ontario, the ONA advises its members not to obtain consents to any proposed treatments on behalf of other health care professionals.

The issue of patient comprehension was raised as the primary difficulty in obtaining informed consent to treatment (CMPA, 1981, p.46, Katz, 1984, p.x, Miller, 1980, p.2102). The argument advanced by the medical establishment was based on the perception of informed consent cases as involving complicated and highly technical questions which could be resolved only by medical judgement. Moreover, the

paternalistic attitude embedded in doctor-patient relationships was emphasized in the following comment:

However empirical research seems to show the inadequacies of doctor-patient communication and patient comprehension to be such as to make the giving of truly informed consent rather impractical (CMPA, August 1981, p.46).

In other words, total responsibility for medical decisions is best left in the hands of doctors, since patients are perceived to be incapable both of comprehending the doctors' explanations and of retaining the information for their own decision-making processes. Formal medical education is usually based on the deliberate selection and systematic structuring of learning experiences within the traditional norms of each discipline. Professional medical colleges such as Johns Hopkins have well established curricula covering the aspects of medical training mainly from the hard scientific perspective of anatomy, physiology and biochemistry. For the first two years of studies, medical students at Johns Hopkins seldom see any patients (Rachlis, 1994, p.180). The *raison d'etre* of these educational processes is predicated on the notion that any disease can be discovered, its cause scientifically determined, treatment formulated and predictions about its outcome made in isolation from the particular sick person in question (Cassell, 1991, p.ix). However, in the practice of humane holistic medicine (which includes the practice of informed

consent), doctors and other caregivers must know more about the person⁹ than just the scientific explanation of the particular disease as it affects the person. In other words, we must put the disease and the person back together as a whole entity. However, the belief that scientific and technical knowledge constituting medicine's esoteric knowledge are beyond the comprehension of patients is still predominant among doctors despite the view that technical scientific knowledge and medical information are different as expressed in the following extract:

Such contentions overlook the fact that the esoteric knowledge physicians need to acquire for purpose of diagnosis and treatment is quite different from the knowledge physicians need to communicate to their patients for purposes of decision making (Katz, 1984, p.x).

At first glance, such a suggestion may seem difficult to put in practice. However, closer examination reveals that the extent of how we "know each other through shared ideas, beliefs, culture and language is remarkable" (Cassell, 1991, p.x). With appropriate changes in the formal education of health care professionals we can begin what Cassell calls the "job of the twenty first century" and discover the person behind the disease (Cassell, 1991, p.x). However, it is not going to be an easy task. The dominant scientific model of medicine and other health care professions results in the well-established belief that no knowledge is real

unless it is scientific, that is, objective and measurable. Cassell rightly points out that such an approach values science as opposed to experiential knowledge and reflects the dichotomy between the art and science of medicine (Cassell, 1991, p.x). By concentrating exclusively on scientific and technical knowledge in the practice of medicine, doctors overlook the fact that the knowledge of how to communicate with patients is entirely different in its nature from the medicine's 'esoteric' knowledge .

Aristotle, one of the greatest philosophers of antiquity, defines experiential knowledge as practical wisdom reflected in the excellence of practical thinking of the good and experienced person (EN, VI, 5, 1140a 25-28). Moreover, he considers experiential or practical knowledge to be an indispensable element in the development of human character and the moral structure of civilized society (EN, X, 9, 1181b 5-15). For example, in the case of doctors, Aristotle believes that this kind of knowledge is different from the one acquired by the study of medical text books since it is knowledge of individuals, and such knowledge continuously enriches doctors' ability to practice both the art (knowledge of individuals) and science (knowledge of universals) of medicine (Metaphysics, I, 1, 981a 15-20; EN, X, 9, 1181b 2). Experiential knowledge, however, poses one serious problem for the scientific model of medicine, for it

is closely tied to our emotions, passions and desires. By contrast, the scientific perspective in medicine denies the fact that "only another person can empathetically experience the experience of a person", or put in other words, that the good a medical technology can do for patients is qualitatively different from the human contact between patients and health care professionals (Cassell, 1991, p.xi). Experiential knowledge is an integral part of proper medical care since it creates the basis for inter-relatedness between the patient and the health care professional. In other words, if the relationship between the patient and the doctor is really a caring relationship, then the doctor, in Aristotelian terms, must recognize and consider the special needs¹⁰ of a particular patient with a particular disease in particular circumstances. And it is this type of experiential knowledge, which Aristotle defines as phronesis, that will provide a qualitatively different doctor-patient relationship, as I shall discuss in the following chapter.

Nel Noddings, a contemporary feminist philosopher, defines the two parties of the relation as "one-caring" and the "one cared-for" (Noddings, 1984, p.4). Noddings interprets the relation ontologically, that is, as a basic fact of human existence or being and where both parties contribute to the relationship. Therefore, the caring

relationship may be defined as 'reciprocal'; however, the reciprocity as Noddings explains, "is different from that of contract theorists such as Plato or John Rawls" (Noddings, 1984, p.4). The focus of her attention is on how to meet the 'other' in a moral way:

Ethical caring, the relation in which we do meet the other morally, will be described as arising out of natural caring—that relation in which we respond as one-caring out of love or natural inclination. The relation of natural caring will be identified as the human condition that we, consciously or unconsciously, perceive as "good". It is that condition toward which we long and strive, and it is our longing for caring—to be in that special relation—that provides the motivation for us to be moral. We want to be moral in order to remain in the caring relation and to enhance the ideal of ourselves as one-caring (Noddings, 1984, p.5).

Noddings believes that ethical caring naturally arises out of our natural desire and inclination to care. Such a condition is always perceived as good and, therefore, it is desired by all human beings. The reality of ourselves as one-caring is the ethical ideal which we consciously or unconsciously desire. Consequently, in Noddings' sense, ethical caring does not depend upon rule or principle but on the development of an ideal self. The ideal self is the one which is developed from our earliest memories of being cared-for and caring. And it is this ideal self that is important in how to meet the other morally (Noddings, 1984, pp.94-95). I will analyse Noddings' view of ethical caring

as it relates to doctor-patient relationship in the third chapter of my thesis.

1.3 Conclusion

The concept of informed consent to treatment is consistent with the change of direction from a paternalistic relationship between doctor and patient to a more open relationship based on shared responsibility¹¹. The process of informed consent is patients' right balanced by doctors' duty to provide relevant medical information to their patients as established by the Supreme Court of Canada decision in Reibl vs. Hughes. Thus the process of informed consent is considered an essential prerequisite in medical care.

However, there are differences in the interpretation of such a process in various professional documents published by the health care professionals themselves. There are some practical consequences arising from the interpretation of informed consent such as the issue of patients' autonomy and comprehension of information as this relates to communication with doctors and other health care professionals. Moreover, the scientific and technical knowledge acquired by both theoretical studies and clinical practice in medicine does not equip doctors with the ability

to participate in a more meaningful dialogue with their patients. Communication between doctors and patients requires a different kind of knowledge¹², namely, practical/experiential knowledge or moral discernment as defined by the Aristotelian concept of phronesis. Experiential knowledge arising from the doctor-patient relationship will also be instrumental in the establishment of the concept of 'caring.' The concept of 'caring' is an inherent aspect of the doctor-patient relationship and a foundation for an informed dialogue which respects the rights and needs of both parties.

In the following chapter I shall argue that Aristotle himself assigns a major importance to the doctor-patient relationship and the question of experience (Metaphysics, I, 1, 981a,5-10). I shall define and examine the Aristotelian notion of phronesis. My analysis will begin with complete definitions of phronesis followed by the distinction of phronesis from scientific and technical knowledge. I shall argue that phronesis or practical/experiential knowledge must be included as an essential element in the doctor-patient relationship. Consequently, the kind of knowledge which comprises scientific, technical, and practical issues will provide a more inclusive form of understanding in which to situate the dialogue involved in the doctor-patient

relationship as this is reflected in the process of informed consent.

Endnotes

¹The trial judge of the Ontario Court of Appeal approached the question of proper disclosure of the attendant risks by defining the scope of such duty. First, it is a particular case of the duty which is required of professional persons in fiduciary positions called upon specifically or by implication to give information or advice to clients who intend and are entitled to rely on such statements to determine their course of action. The duty of disclosure does not require warning the patient of the dangers incident to or possible in any surgical procedure, such as the dangers of anaesthesia or the risk of infections, which people of ordinary knowledge are presumed to appreciate. However, such a duty relates to the specific risks within the doctor's knowledge which are particular to the contemplated treatment. The scope of such duty is defined by the evaluation of a variety of inter-related factors such as: the presence of emergency, the patient's emotional and intellectual make-up, his/her ability to appreciate and cope with the relevant facts, the gravity of known risks both in terms of their likelihood and the severity of their realization. The trial judge then concluded that the difficulty of the independent evaluation of these factors by a lay tribunal has caused the law of this jurisdiction to leave the definition of the scope of this duty in any particular case a matter essentially of medical judgement, one to be determined by the court on the basis of expert medical evidence (114 D.L.R., (3d), 1980, p.7).

²Ibid., 7.

³The Supreme court of Canada set a precedent in two major decisions, *Reibl v. Hughes*, [1980] 2S.C.R. 880, 14 C.C.L.T. 1 and *Hopp v. Lepp*, [1980] 2 S.C.R. 192, 13 C.C.L.T. 66. The required disclosure does not include all known risks and benefits, but rather the basic requirement is what the objective reasonable person in the patient's particular position would agree to or not agree to if informed about the material and special risks inherent in the proposed surgery (*Rozovsky & Rozovsky*, 1990, pp.7-12).

⁴The Hippocratic Oath does not say that the values of

patients shall be taken into account. It clearly defines the values and judgement of doctors as the primary decision-makers via the well established ancient command of "primum non nocere - above all, do no harm" (Oath of Hippocrates, 5th century B.C.). However, the considerations of benefit and harm, which are dependent on individual preferences, can only be carried out by patients with the assistance of their doctors.

⁵As compared to the US court cases it may have been understandable, however, it did not occur in Canadian consent cases. See Rozovsky (1993).

⁶The law in Canada presumes that all patients are legally competent to consent to treatment. However, this assumption is not absolute and can be removed by compulsory treatment legislation or a court order. The question of mental capacity is linked to the competence by the same assumption that the patient is mentally capable of giving consent unless proved otherwise. The assessment of mental capacity is left in the hands of health care professionals using certain criteria such as: presence or absence of consciousness, severe pain compromising the ability of a patient to think clearly, influence of drugs and alcohol, presence or absence of lucidity, coherency dementia traumatic injury and stroke.

⁷The problem is inherent in the administrative/institutional policies and procedures which protect information concerning possible litigation (e.g. copies of accident/incident reports not being kept in patients' files but separately under the Occupational Health and Safety Committee files which are not available for legal discoveries). In such cases, where there are disagreements between patients and doctors, such files are not available to the patients' legal counsellors.

⁸There is a concern arising given the contract model of informed consent to treatment, namely, that we require voluntary, informed consent by both parties to the contract and that this model need not place the burden on one party making the other party informed. The nature of fiduciary contract is actually different from the standard contract model because it reflects the health care professionals' duty to act in a way that benefits patients. For example, in a standard contract model such as the sale of an automobile, it is not my responsibility to teach the purchaser how to drive. However, in a fiduciary contract it is my duty as a doctor to explain the risks and benefits of the proposed treatment and make sure that the patient

understands. In this way doctors end up with a duty to explain to the patients what is proposed in a way of treatment, and, if the explanations are understood then patients are aware of risks involved and will make informed choice. In this fashion, patients take the responsibility for their decisions and if a risk occurs, there is not a legal recourse for negligence since the informed consent took place.

⁹Such a knowing will include both the health care professional's knowledge of her field combined with understanding of the particular patient in question, her specific situation, concerns and values.

¹⁰See endnote #4

¹¹It is the patient's duty to disclose truthfully all problems and difficulties regarding the medical complaint. The patient is not entitled to a complete scientific lecture on the nature, risks, benefits and reasonable alternatives unless she asks. However, it is not clear just how much she is entitled to, but whatever it is, the patient is entitled to have questions answered and to be informed in a way she could understand. In other words, it is also her responsibility to understand the choices presented regarding the proposed treatment and also be aware that one alternative that must always be considered is to do nothing.

¹²By different type of knowledge I don't mean that the patient has to bring herself up to the level of a scientific study of medicine. Rather, I am in agreement with Jay Katz's notion that there is a widely held professional belief that "medicine's esoteric knowledge cannot be understood by patients", and that to acquire such knowledge would demand "prolonged study and clinical experience which patients do not possess" (Katz, 1984, p.x). Katz than continues to explain that such contentions overlook the fact that the esoteric knowledge doctors need to acquire for purposes of diagnosis and treatment is quite different from the knowledge they need to communicate with their patients. Moreover, Katz explains the difference between the medical knowledge and medical judgement in doctor-patient relationships. He sees the difference as a balance between medical knowledge (the way doctors elucidate the risk and alternatives to a proposed procedure in the light of their professional experience) and the medical judgement (the way doctors establish the limits of appropriate disclosure to patients). The distinction is crucial for understanding the law of informed consent (Katz, 1984, p.74).

2. PHRONESIS IN ARISTOTLE AND THE PROCESS OF INFORMED CONSENT TO TREATMENT

In this chapter I shall analyse the concept of phronesis (practical knowledge or moral discernment) as a fundamental and distinctive feature of Aristotle's ethical theory. I shall, first, argue that the doctor-patient relationship in Aristotle's philosophy is a significant paradigm for understanding other ethical relationships. Indeed, Aristotle frequently employs medical examples to illustrate concrete situations in his ethical theory. I shall then go on to consider the concept of phronesis and discuss its definitions from both historical and philosophical perspectives. Finally, I shall contrast the concept of phronesis with those of episteme and techne, and show that phronesis is an indispensable element in both the development of human character and the ethical practice of medicine, as reflected in the process of informed consent to treatment.

The Nicomachean Ethics (EN) is part of what Aristotle calls the philosophy of human nature (EN X, 9, 1181b 15). The philosophy of human nature examines those things which constitute people in their being human, reflecting on the

principles and causes of human beings being human. Aristotle explains what he means at EN IX,7 (1168a 5), where he points out that our being is the actualization of our specifically human potential. This, in turn, is accomplished by living and doing. For Aristotle praxis or doing is the manner of being a person. Indeed, person as praxis is the concern of his ethical thinking considered as philosophia (Schuchman, 1980, p.124). For Aristotle, Ethics is ontological in nature and was understood as such by Aristotle himself¹. To put it differently, ethics is ontological in nature because it presupposes a theory of human nature which accounts for how man's distinctively rational and social character is revealed in praxis. What does Aristotle mean by man's being understood as praxis? There is no better starting point available to us than the famous first sentence of the Ethics:

Every art and every inquiry, and similarly every action and pursuit, is thought to aim at some good; and for this reason the good has rightly been declared to be that at which all things aim (Ethics I, 1094a, 1-3).

In other words, Aristotle suggests that all specific accomplishments of men are things which men "do" and it is this "doing" what he refers to as praxis which encompasses the totality of human performance. In this view, Aristotle sees man (or in the contemporary milieu both men and women) as maker (techne), knower (methodos) and actor (praxis te kai

prohairesis) and these three aspects are the way, therefore, in which the man accomplishes his own being human. Consequently, praxis or "doing" as a way of man's self-actualization is Aristotle's explanation for man's being (Schuchman, 1980, p.30-31).

In the first book of the Metaphysics, Aristotle's discussion centres on the acquisition of science and art through memory and experience (Metaphysics I, 980b, 27). Using the paradigmatic relationship between doctor and patient to show how it is that we gain knowledge, Aristotle argues:

Now art arises when from many notions gained by experience one universal judgement about a class of objects is produced. For to have a judgement that when Callias was ill of this disease this did him good, and similarly in the case of Socrates and in many individual cases, is a matter of experience; but to judge that it has done good to all persons of a certain constitution, marked off in one class, when they were ill of this disease, e.g. to phlegmatic or bilious people when burning with fever—this is a matter of art (Metaphysics I, 981a, 5-12).

It is our experience gained from observing and understanding the same phenomena experienced by different individuals which eventually enables us to form one universal judgement about a class of objects. However, as illustrated in the above case, the capacity to judge that a certain treatment will alleviate disease in a group of individuals, having more or less the same symptoms, is a matter of art. Or, as Alasdair MacIntyre puts it, "...it is techne which enables

us to discern unity in multiplicity..." (MacIntyre, 1990, p.61). MacIntyre interprets techne in the same sense as H.H. Joachim, namely, as art or craft, or "experience illumined and controlled by intelligence"² (Joachim, 1951, p.202). Aristotle then goes on to compare action and experience to art and once again uses the doctor-patient example to explain the importance of experience:

With a view to action experience seems in no respect inferior to art, and men of experience succeed even better than those who have theory without experience. (The reason is that experience is knowledge of individuals, art of universals, and actions and productions are all concerned with the individual; for the physician does not cure man, except in an incidental way, but Callias or Socrates or some other called by some such individual name, who happens to be a man. If, then, a man has the theory without the experience, and recognizes the universal but does not know the individual included in this, he will often fail to cure; for it is the individual that is to be cured.) (Metaphysics, I, 1, 981a, 13-24).

In this passage Aristotle clearly considers experience as an indispensable part of our actions, and again uses the paradigmatic relationship between doctor and patient to show that without practical knowledge about the particular patient the doctor may not be successful in the proposed treatment. But how does the doctor acquire such knowledge and understanding of the particular patient? It is by acquiring practical knowledge or phronesis which, after all, is concerned with both universals and particulars (EN, VI, 5, 1141b 15 -20).

To understand Aristotle's thinking about man and his notion of phronesis we must be extremely careful not to obscure its meaning in terms of the new concepts arising from later interpretations (Schuchman, 1980, p.20). One such concept is clearly recognized by G.E. Moore in Principia Ethica where he presents the notion of the "principle of prudence" (pp.102-104). The latin term prudentia was used by Medieval scholars to translate the Aristotelian notion of phronesis and even if such a concept proved to be historically effective, as Paul Schuchman points out, it:

...still constitutes only one possible interpretation which might be given to the main ideas of former thinkers. This is especially true in the case at hand, where the translation of phronesis by prudentia is not only interpretation, but also a tradition in itself (Schuchman, 1980, p.20).

In other words, there are new ways to interpret traditionally established concepts. One possible way is the reversal of the historical process with the aim to re-discover the beginning of a tradition and question its originative character. In the case of phronesis such examination will require us to establish the origins of the term phronesis.

The term phronesis has its origins in the Homeric writings where phren or phrenes depicts the central portion of human body, including the diaphragm, the lungs and the parts about the breasts, as the centre of perception

(Schuchman, 1980, p.21). However, the Homeric depiction of the organ is not only anatomical in nature, but it also denotes its function. From the noun phren arises the verb phroneo which denotes an activity or condition described as "to be minded, either of reflection or purpose" and its active infinitive phronein. Moreover, as Schuchman continues, quoting the French philosopher Pierre Aubenque:

... the verb phronein expresses not merely an intellectual function, but an emotional state and a tendency to action, an interior disposition much more complex and nuanced than the simple activity of thinking or knowing (Schuchman, 1980, p.22).

This capacity of phronesis encompasses both the intellectual and the affective components of the whole person. Moreover, it does not designate only a function and possession of an intellectual faculty; it also refers to a normal exercise of this faculty or function.

The Socratic understanding of virtues as forms of phronesis was criticized by Aristotle who only granted that all virtues implied practical wisdom (EN, VI, 1144b, 20). Socrates was concerned with the kind of knowledge which directed action and, consequently, this was the practical knowledge of good and evil. Plato, who was critical of reducing phronesis to a mere technique, believed that goodness itself is something distinct and separate from the many individual things which are good. Such a separation is embedded in the Platonic idea of two distinct worlds, the

everyday physical world (space and time) and the world of Forms (not existing in space and time) as described in the analogy of the cave (Republic, VII, 514a-521b). As a result, phronesis for Plato can be interpreted as consisting of the contemplation of the Form of the good, which guides our actions by proposing to us this Good-in-itself as the ultimate norm and ideal for all our actions. The Platonic conception of phronesis as "philosophical wisdom" (obtainable only by philosophers), and as the most rigorous exercise of all "sciences" aimed at the end to provide absolute norms for our actions, was abandoned by Aristotle in his Ethics. Aristotle realized that the kind of theoretical knowledge of the Form of Good, separated from the instances of the good, cannot provide us with the correct determination of the human good. Consequently, Aristotle himself went much further than Plato, as Schuchman observes:

...he sought to develop a doctrine of phronesis which was closer to that of Socrates and Democritus, and which did not demand a "philosophical" knowledge of the good in itself or of man's being in its general form or eidos, but a "particular" knowledge, taking into account the wealth and diversity of human desires, situations, decisions and actions. From this particular knowledge of man's being, the phronimos could choose those determinate ends and actions which fulfil man's well-being or good (Schuchman, 1980, p.23).

In other words, the Aristotelian concept of phronesis is ontological³ in nature with its emphasis on the person who possesses phronesis (the phronimos) as the measure of good action.

Aristotle's concept of phronesis as practical knowledge, moral discernment, or living well touches upon the deepest concern of man himself. It is the first genuine attempt to think in its own terms the essence of that particular concern which man has for his own being. In Ethics, Book VI, Chapter 5, Aristotle argues that in order to understand the concept of phronesis we need to look at the persons whom we credit with it, those whom we call phronimoi (men of practical wisdom) (EN, VI, 5, 1140a 25). What do we find when we observe these men? Aristotle answers as follows:

Now it is thought to be the mark of a man of practical wisdom to be able to deliberate well about what is good and expedient for himself, not in some particular respect, e.g. about what sort of things conduce to health or to strength, but about what sorts of things conduce to good life in general (EN, VI, 5, 1140a 25-28)

In other words, phronesis or practical wisdom is the excellence of practical thinking of the good and experienced man, and the capacity to think well about the sorts of things that constitute living well in general⁴. However, living well as the highest good for man does not mean the search for one supreme value such as wealth, honour, or

knowledge. Rather, practical wisdom involves the ability to deliberate well and such deliberation is a process in which the right logos (rational principle) is employed by the phronimos (the man of practical reason) in the articulation of what it means to live well. Phronesis as the ability to deliberate well cannot be reduced to episteme or theoretical scientific knowledge in its abstract universality and necessity; nor can it be reduced to techne or productive knowledge, since action and making are different kinds of things. Good action for Aristotle is an end in itself, whereas making has an end other than itself (EN, VI, 5, 1140a 30-35, 1140b). Thus, phronesis as deliberation is a process in which the right logos is employed by the phronimos.

What is meant by the "right logos"? Aristotle clearly distinguishes the life of man in terms of growth, nutrition, movement, and sense perception from that activity of man involving logos or, as Aristotle puts it, "an active life of the element that has a rational principle" (EN I, 7, 1098a 3-4). The original meaning of logos is 'reason' or 'speech' or 'account', and thus logos consists of the true judgement pronounced in the inner speech of thinking by which "we are able to disclose and behold things in how and what they are, could be, and should be" (Schuchman, 1980, p.130). The excellence of thinking allows us to disclose in

the right logos that which is good for ourselves and other people in general. Moreover, Aristotle credits this capacity to those who are able to manage household or state affairs because they can perceive what is good for themselves and what is good for men in general (EN VI, 5, 1140b 10-11).

The virtue of temperance is closely related to practical wisdom, since it maintains and preserves phronesis. The man who is destroyed by pleasure or pain does not understand that the originating causes of things that are done consist in the end at which they are aimed; he fails to understand that in every case he should choose to act for the sake and because of these ends (EN, 5, 1140b 18-19). Again, Aristotle draws our attention to the relationship of phronesis and the recognition of ends as good. In other words, phronesis is itself an arete (excellence, virtue) and no scale of excellence can exist within it. However, as Aristotle points out, it is not simply a trained ability (or skill) since such a capacity can be forgotten but phronesis cannot be forgotten (EN, 5, 1140b 20-30). To forget phronesis is equal to forgetting what it means to think and it is precisely this type of thinking which is closely linked to our ethos or character (Schuchman, 1980, p.77). In Aristotle, one's ethos is the character produced by moral as opposed to intellectual

habits. An intellectual virtue is born and nurtured by teaching which requires experience and time; moral virtue, on the other hand, grows as a result of habituation and is therefore called ethike, a name derived from the word ethos (habit) (EN, II, 1, 1103a 15-20).

Aristotle compares various aretai (virtues) of thinking, beginning with scientific knowledge as the judgement of things that are universal and necessary, concluded and demonstrated from first principles. However, these first principles cannot be an object of scientific knowledge, art or phronesis because that which can be scientifically known can be demonstrated and art, as well as phronesis, deals with things that are variable. Nor are the first principles the objects of sophia (philosophic wisdom) since, as Aristotle points out, "it is the mark of the philosopher to have demonstration about some things" (EN, VI, 6, 1141a 3). Aristotle concludes that the state of mind which never deceives us is the nous or intuitive reason. Alasdair MacIntyre rightly points out that:

The principles which nous grasps are those from which we argue in setting out those sound deductive arguments which have the status of demonstrations. Demonstration is thus dependent on dialectic for the acquisition of the premises which provide it with a starting point. And this ... is equally true of theoretical inquiry and of practical reasoning...since the first principles of theoretical inquiry into the nature of practical reasoning and of the practical reasoning which issues in action are one and the same (MacIntyre, 1988, pp. 91-92).

In other words, phronesis belongs to those capacities by which we reach the truth and are never deceived. However, Aristotle does not mean that we never make mistakes in our deliberations. He clearly points out later in Chapter 8 that "... error in deliberation may be either about the universal or about the particular;..." (EN, VI, 8, 1142a 20). How can this be possible? Failing to recognize "the characteristics of a particular which are relevant to the actions that we should be about to perform" is due to "lack of experience of the relevant set of particulars or from inadequate episteme, so that we do not understand the universal, the concept of the form which this particular exemplifies" (MacIntyre, 1988, p.92). Here, again, we can see that phronesis is related essentially to our own being human which consists in that process of striving to be human found in those activities that aim at fulfilling our own ontological being. Aristotle then continues in Chapter 7 as follows:

Therefore wisdom must plainly be the most finished of the forms of knowledge. It follows that the wise man must not only know what follows from the first principles, but must also possess truth about the first principles. Therefore wisdom must be intuitive reason combined with scientific knowledge—scientific knowledge of the highest objects which has received as it were its proper completion (EN, VI, 7, 1141a 16-19).

The reasoning of the phronimos consists in the ability to pass from the sphere of universals to the sphere of

particulars which can be grasped by perception alone. Hence, from the conception of conduct you cannot predict what is to be done here and now "as you can prove that the angles of the triangle are equal to two right angles" (Joachim, 1951, p.210).

Therefore, practical wisdom or phronesis is concerned with things that are human and about which we can deliberate well, by aiming, in accordance with calculation, at the best for man attainable by action. Aristotle again points out that practical wisdom is not only concerned with universals but must also recognize particulars because practice is concerned with particulars. This is why some men who may not know but have experience are more practical than others who know. Aristotle regards experience as a kind of particular knowledge e.g. knowing that chicken meat is light and good for man. This contrasts with such abstract knowledge as that light meats are good for man, which may be asserted without knowing which are light meats (EN, VI, 7, 1141b 15-20). What is Aristotle's aim in making these distinctions? I believe that he means to emphasize that the object of phronesis is the practical well-being of man, understood in the widest sense of being in the world with others (the notion of community). Aristotle is asserting that the main concern of man is his being human and not his being this or that particular kind of man.

Within the framework of Aristotle's ethical thinking the concept of moral knowledge is not to be construed as episteme. The universality of episteme reflects the absolute good in itself conceived of as an abstract universal. Aristotle is clearly critical of this Platonic conception when he questions the ability of the Platonists to speak about all goods (I, 5, 1096b 10). If nothing other than the Idea of good is good in itself then the Platonic form is empty. "The good, therefore, is not some common element answering to one Idea" (EN, I, 5, 1096b 25). Knowledge of the universal and of the essential structure of goodness itself will not help the doctor to heal his patients. The doctor does not need to study health in the abstract but in particular and concrete ways; for example, the health of man or of a particular man because "it is individuals that he is healing" (EN, I, 6 1097a 10). However, I take it that Aristotle means that the doctor not only needs both scientific and technical knowledge to understand the health of man in general, but also needs practical knowledge to understand the health of a particular patient. The universality of objective scientific knowledge or episteme, defined by insight and deduction dealing with the essential, unchanging and universal, is not the universality of man's knowledge of the good. In rejecting the Platonic form as an empty generality, Aristotle is

thought by some commentators to be separating Ethics from Metaphysics (Schuchman, 1980, p.153). I believe this to be an erroneous interpretation. As H.H. Joachim puts it:

Aristotle's general position as to mind's knowledge of the primary, indemonstrable, universal truths is substantially the same as that of Plato;...He agrees with Plato that (a) there are no ready-formed innate ideas in the soul: i.e. we are not born with an explicit conscious recognition of universals, primary truths; but that (b) we are born with a mind so constituted that it can explicitly and consciously grasp such truths (Joachim, 1951, p.198).

For Plato, our knowledge of universal truth was a matter of recalling the perfect knowledge of the forms which the soul possessed before birth. Aristotle, on the other hand, is trying to show that the conditions for grasping universals are an inherent or latent power of the human soul. For Aristotle all action directly or indirectly exhibits some emotion and the excellence of one's character will be achieved by the appropriate emotion exhibited to the right degree (between excess and defect) which has to be determined by reason (EN, VI, 1, 1138b 25). Aristotelian ethics gives us a special insight into the meaning of the good life for man, and because man is by nature a political animal the good life takes place within the context of society. Consequently, Aristotle suggests the question of what is a good life must be answered by political science (EN, I, 2, 1094a 24-11) and concludes that the highest of

all goods achievable is eudaimonia (happiness) (EN, I, 4, 1095a 15-20). It is Aristotle's intention to show in the Nicomachean Ethics how our reflective understanding can enable us to achieve happiness by living an ethical life within society (Lear, 1988, p.154). According to Aristotle, a genuine pursuit of happiness is not the satisfaction of desires for pleasure, honour or money (EN, I, 4, 1095b 15-30) but a life of virtuous activity (EN, I, 8, 1098b 30). The organization of our desires is a motivating force to live such a happy virtuous life, a life in which virtues are states of the character:

We must, however, not only describe virtue as a state of character, but also say what sort of state it is. We may remark, then, that every virtue or excellence both brings into good condition the thing of which is the excellence and makes the work of that thing be done well; e.g. the excellence of the eye makes both the eye and its work good; for it is by the excellence of the eye that we see well. Similarly the excellence of the horse makes a horse both good in itself and good at running and at carrying its rider and at awaiting the attack of the enemy. Therefore, if this is true in every case, the virtue of man also will be the state of character which makes a man good and which makes him do his own work well (EN, II, 6, 1106a 14-24).

In other words, the virtues are states of character of people who habitually perform good actions and who are already well brought up since for Aristotle excellence arises out of habit and not from lectures (Lear, 1988, p.166).

If phronesis is not universal in the sense that episteme is, is it comparable to techne? Paul Schuchman argues that productive knowledge or techne is similar to phronesis, since it could be "understood as a genuine mastery of the thing to be made, and in this regard it is especially similar to phronesis which Aristotle characterizes as the capacity to think well for the sake of living well" (Schuchman, 1980, p.154). However, this seems inconsistent with Aristotle's statement that "making and acting are different" (EN, VI, 4,1140a). Techne is distinguished from phronesis because production is different from action, and the distinction is one between movement and activity (Joachim, 1951, p.205). Techne can be learned and can also be forgotten. Moral knowledge, on the other hand is not learned in this way nor could it be forgotten because we do not stand over moral knowledge as something that we could acquire or not like a craftsman's blue print. We do not have moral knowledge fully in advance as applicable to specific situations and Schuchman is correct in stating the following:

What is right cannot be wholly determined independently of the situation that requires right action from me, whereas the form of what a craftsman desires to make is already fully determined independently of any particular instance of what is made (Schuchman, 1988, p.155).

In other words, the phronimos must be different from the craftsman since the object of phronesis is acting or living

in a certain determinate fashion while the object of techne is to produce things of certain character⁵ with a view to a result beyond the producing. What is most important is the product and the craftsman's state of mind, will or purpose in the making are important only to that extent that they affect the character of the product. Thus the products of techne are relatively free and independent of the personality of the maker having their goodness or badness in themselves (Joachim, 1951, pp.12, 13). In this regard the difference between phronesis and techne is the relationship of means and end.

Phronesis is concerned with right living in general and both the right means and the right end cannot be learned before we face particular situations, whereas in techne we learn first "and then find means for putting it into action" (Schuchman, 1980, p.155). Phronesis, therefore, cannot be interpreted to be an extension of skill-like technical knowledge because it cannot be taught. Moreover, as Schuchman himself puts it:

Phronesis does not first exist as a complete body of propositions, but must be brought progressively to relative adequacy by continuous insight into the moral requirements and possibilities of our concrete and situated existence. By embracing both means and ends, moral knowledge once again shows its essential otherness from techne (Schuchman, 1980, p.155).

Thus the self-deliberation of the 'continuous insight into the moral requirements and possibilities' is teleological because its concern is the ultimate dominant end of human well-being. Moreover, practical knowledge cannot be separated from the experience of particular situations as is possible in the case of techne. As Joachim puts it:

...the works of techne have their value in themselves. But the success of the phronimos is the acting well itself. His 'works' are what they are in his living them: the telos (end) of his praxis (action) is eupraxia (good action) itself (EN, 6, 1100b, 9-10).

The end as the good of one's action is itself a certain kind of life, namely, the life of morally good conduct. Since the means have intrinsic value as not only means but also ends in themselves, they are thus constituent portions of the end (Joachim, p.218, 1951).

In closing Book VI, Aristotle states that it is impossible to "be good in the strict sense without practical wisdom, nor practically wise without moral virtue" (1144b, 30-32). In other words, the best state of man's ethos is called its excellence or arete. Phronesis cannot exist without arete ethike (moral virtue) and no arete ethike is possible without phronesis (Schuchman, 1980, p.159). As Aristotle points out, "it is evident that it is impossible to be practically wise without being good" (EN, 1144a, 36). Phronesis as practical wisdom goes beyond mere techne or skill because it enables the individual to practise moral

virtue. It is practical to the extent that it enables the virtuous individual to make judgements about particular situations where the precise nature of the good may be ambiguous. These judgements will not be merely crafty or self-serving but will display an understanding of the more general characteristics of what it means to be a good person in the context of human society. This ability to relate the particular to the universal in making judgements about the good lies at the heart of what some have called "Aristotle's obscure concept of 'practical wisdom'" (Callan, 1993, p.164). What is obscure is not so much Aristotle's concept but the conceptual gulf that separates it from the understanding of modern men and women. The kind of wisdom about which he writes is foreign to the world that we now inhabit. What does then phronesis mean for us now, living in the contemporary modern world? It means practical knowledge that is not only scientific or technical in nature, but rather views individuals in the context of their particular circumstances and not simply as abstractions that represent a general rule or formula. It may be that in coming to understanding the concept of phronesis, however, we can learn to put it into practice.

The question of informed consent to treatment and its relation to phronesis has not been addressed in either the medical or biomedical ethics literature. By and large

doctors are educated and trained to take both episteme and techne into account but not phronesis. For example, the Biomedical Ethics Committee of The Royal College of Physicians and Surgeons of Canada proposes the following in their statement on advanced training in biomedical ethics:

Physicians who pursue advanced training in biomedical ethics will develop the skills necessary to identify, analyse critically, and to resolve moral problems that arise in medical practice (RCPSC, p.1, 1990).

In other words, medical ethics as an essential part of medical practice is just another skill necessary to be developed in order to apply correctly the principles, formulate the rules and prepare the guidelines for clinical practice. Moreover, such an approach stresses the obligation of the medical profession:

...to recognize and to deal with cases of value conflict is important in the care of individual patients, in the micro and macro allocation of health care resources, and in the formation of health care policy (RCPSC, p.1, 1990).

The need for advanced training in biomedical ethics is not as much concerned with recognizing, understanding and respecting the patients' rights such as informed consent as it is with controlling the expenditures and setting the policies. The obligation of doctors will centre on the recognition of value conflicts when there is a danger that the clinical decisions may turn away from "acceptable ethical norms" (RCPSC, p.1, 1990). What can this approach

to the moral/ethical education of doctors tell us about the relationship with their patients?

Doctors' education is grounded in science. The theory and practice of science is shaped by personal, professional, social and cultural values. Rigorous attention to ethics and human values is significant if medicine as an applied science is aimed at pursuit of the human good. The doctor asking what is wrong with the patient and what can be done from the scientific point of view must also ask what should be done. This is a question of values, and needs to include a concern that the patient be in a position to make an informed consent and to participate in the medical decision-making process. However, the current practices of training in biomedical ethics only encourage doctors to elicit patients' compliance with medical advice and the use of behavioural technologies to increase it. There are attitudes and traits of character usually recognized as compatible with being a doctor which will strengthen both the level of personal integrity and the relationship with their patients. These include loyalty to patients' well-being, truthfulness in recognizing limitations in knowledge, and recognition of patients' rights to accept or refuse any doctor or medical care recommended (CMA, 1990). In this sense, a valuable new synthesis between the scientific, technical and practical

knowledge is needed to accomplish the transition toward empathetic and compassionate patient-centred care.

Endnotes

¹'Ontological' may be a problematic term. Does Aristotle presuppose a finished essence upon which ethics is based, or only presupposed assumption? To clarify Aristotle's assumption, he does not presuppose a fully worked out essence. His theory of being is derived partly through his understanding of what ethics means in practice. Acting ethically means acting well toward others; after all, friendship and citizenship is an indispensable part of human flourishing. However, Aristotle is aware of the difficulty of 'selling' the virtuous life to a non-virtuous person. It is only the person who is already acquainted with the ethical point of view who will recognize that acting ethically is part of human flourishing (Barnes, 1988, p.170).

²Perhaps there may be concern that this point is vague. However, it may be vague because we do not know yet what he means. I am following Aristotle's own method and what he means by intelligence will become clear later.

³The particular knowledge which takes into account the wealth and diversity of human desires, situations, decisions and actions is based upon the intelligent moral experience of the phronimos, that is, his or her own reflective determination of the ideal of life (Joachim, 1951, p.89).

⁴Although this seems to be directed at a universal and therefore in some tension with what I said so far, I take it that Aristotle's notion of good life in general expresses his belief that a man can attain the good life only within society. Therefore, the question of what is a good life cannot be answered in abstraction from the society and, moreover, society provides much of the context and opportunity to live a good life. In this sense, the things conducive to a good life may be considered as universal, such as the context of 'society' which is universal for all human beings (Barnes, 1988, p.154).

⁵I believe that the apparent similarity can be explained in terms of telos, as the completed stage of an activity by which making things (e.g. paintings, shoes or other objects) and doing things (teaching, healing, managing) both represent the completion or fulfilment of

something, namely the final point toward the achievement of which a process is directed.

3. A CONTEMPORARY ETHIC OF CARING

3.1 Introduction

In this chapter I will examine the central ethical problem raised by the concept of informed consent, namely, the need to capture the human dimension in health care ethics. The dominant view of ethics as the philosophical study of morality in the Western tradition has tended to emphasize a somewhat abstract, rational and hierarchical structure of moral reasoning. The process of moral reasoning tends to concentrate "on the establishment of principles and that which can be logically derived from them" while overlooking and consequently devaluing local, specific, practical knowledge and judgements about particular moral situations (Noddings, 1984, p.1). This tendency towards a quasi-scientific discourse has given contemporary ethics a mathematical appearance and reinforced the myth that the expert must stand outside the situation, essentially uninvolved and detached, in order to pronounce expert judgement. Moreover, this tendency towards a rationalistic notion of moral reasoning has led to a certain disregard for

both human involvement and basic human emotions on the understandable grounds that these are obstacles to necessary critical evaluation. Consequently, it has become impossible to regard the raw human dimension as central to or indeed of any importance for moral decision-making.

But is this necessarily all there is to say on the matter? Is it simply impossible to include the "human" dimension, that is, how a human being feels or acts in terms of supposed basic emotions and drives, because even if we know what such a dimension might be, we would still not readily agree on all its components or even its basic nature; or again were we somehow to agree, might we not yet be ready or indeed able to utilize the probably Hobbesian universe thus disclosed for treatment, if the reality of raw emotion is too brutish for any polite analysis. It is a major part of the thesis of the present study that the so-called "human" dimension is essential to the development of any worthy ethics in the field of health studies and that "raw" emotion in some recognizable configuration has to be taken into account in the development of a health care ethic. What I mean by "human" in this case will become apparent as we proceed.

Because I am proposing to include the human dimension in the ethics of informed consent, I will present the problem exclusively from the perspective of patients,

doctors, and institutions and shall examine how these different perspectives relate and which ethical systems might help to solve the problem. There are two major ethical theories which frequently play a major role in the process of informed consent; the deontological ethics of Kantianism and the teleological ethics of utilitarianism. The former holds that the rational principles governing our behaviour are of utmost importance while the latter locates rightness and wrongness in the consequences of our acts. John Stuart Mill developed the first detailed and systematic ethical theory defined as utilitarianism based on the philosophy of Jeremy Bentham. The central concept of this theory is the "greatest happiness principle" which, as Mill explains, "holds that actions are right in proportion as they tend to promote happiness; wrong as they tend to produce the reverse of happiness (Mill, 1957, p.10). In this sense, the utility of an action is determined by its ability to promote or produce happiness and thus the right action among alternatives is the one which has the greatest utility (promotes the greatest happiness). The utilitarian position in ethics embraces two major forms: act-utilitarianism and rule-utilitarianism. Both theories provide objective criteria for assessing the moral quality of acts, although in different ways. The former enables us to examine the effects of specific individual acts in a particular case by

looking for alternatives which would maximize happiness and minimize suffering, while the latter judges the moral worth of an act according to the good or bad consequences that follow from a general moral rule of conduct such as 'never lie' etc.

The right to self-determination, embedded in the principle of individual autonomy and inherent in the concept of informed consent, is derived from the Kantian notion of persons as rational, moral agents whose rights to determine their destinies should always be respected. Thus, at first glance, the consent requirement designed to protect patients from harm and recognize them as moral beings, capable of making choices for themselves, would seem to be firmly grounded in Kantian ethics. However, from the perspective of doctors, "there is a danger of exaggerating these rights at the expense of both the duties of patients to co-operate with physicians, and the rights of physicians and other health care professionals, which may conflict with those of patients" (RCPS, 1987, p.9). Moreover, the disclosure of material and of special risks is interpreted differently by individual doctors. Hence, the question of what duty is and which duty is to be performed in which circumstance is a complex one, since it depends very much upon the particular situation or circumstances in question, and conflicts between doctors as well as patients and doctors may easily

arise. Therefore, the authorization to treatment given by the patients may be based on inadequate information interpreted differently by different doctors (Rozovsky, 1993, p.19).

For the last decade, the courts in Canada had questioned the validity of current practices of obtaining consent to treatment. Consent is considered to protect the health care institutions and staff from litigation. However, the problem arises with the notion that informed consent should not be an end, but a means of optimal medical care for all patients. From the perspective of institutions, the informed consent form is perceived as an end to any medical care, providing satisfactory protection in case of litigation for both doctors and institutions. There are situations in which patients cannot agree with doctors on what should be done. If doctors are obliged to respect the Hippocratic injunction to "benefit and do no harm to the patient" then they must calculate their actions according to utilitarian calculations of benefit and harm. These calculations, in turn, place the doctors back in the paternalistic model of the parent and child relationship where the child must accept the decision of the parent. While maximizing overall utility, the doctors ignore the moral autonomy of patients in favour of the concern for their "own good" and could easily justify their acts on the

basis of either Kantian or utilitarian ethics or both. As I indicated earlier, the ethical view of utilitarianism is based on the consequences of actions and is therefore teleological (derived from the Greek word telos which means "end"). In this sense, the doctors may focus on their actions and its results thus allowing for the familiar distinction between a person's character and the rightness or wrongness of his or her acts in a given situation. Consequently, the utilitarian approach allows us to acknowledge what seems to be well recognized fact of moral experience, namely, that even sincere and well-intentioned persons may sometimes do the wrong thing. Considerations of agents' intentions, feelings, or convictions are seen as barely relevant, or at best secondary in deciding what is the right thing to do. In the case of informed consent, a utilitarian ethic may sometimes¹ require that we lie (or in other words use the therapeutic privilege) to patients who are considered to be emotionally disturbed and who will suffer harm if they were to participate fully in the disclosure process. Therefore, a utilitarian ethic may justify in some cases the doctrine of therapeutic privilege as a valid concept in the doctor-patient relationship. But in fact such a privilege can and should by no means be upheld in every case. The central objection to utilitarian ethics as a workable foundation for the concept of informed

consent, however, is its inability to provide any sound basis for understanding an agent's motivation for moral behaviour. As I stated earlier, considerations of agents' intentions, feelings, or convictions are seen as barely relevant to the question of what is the right thing to do. Consequently, utilitarian ethics allows us to make the familiar distinction between the character of agents and the rightness or wrongness of their acts in a given situation, but fails to explain how the two elements in this distinction are to be related².

Again, by contrast, to take up the third form of ethical theory which we have discussed in relation to Aristotle above, virtue ethics may well be capable of remedying a certain deficiency in the other theories, for instance, of bridging the gap between duty and consequences, or between the agency, and the moral value of particular acts; and we have argued that in Aristotle's theory there is much to be recommended. Nevertheless, there are significant philosophical problems with any theory of virtue ethics, and significant human problems with Aristotle's theory; for in the latter case Aristotle presupposes in his Ethics that understanding or experience has already been lifted up into self-understanding, however minimal; he presupposes, that is, that his learners already practice the virtuous life and have some understanding of the need for the wisdom which

Aristotle is talking about. However, in medical care one can afford no such luxurious presuppositions, given the necessarily egalitarian distribution of treatment (one cannot institute a self-awareness clause prior to treatment) and in the philosophical case, given what we have just said about medical care, virtue ethics seems to include intrinsically the problem of moral sanctity; that is to say that at the heart of virtue ethics and in its hidden presuppositions, as it were, the implicit imperative toward heroic moral artistry seems to be included, if well hidden. However, medical care cannot in any sense be predicated upon the imperative to heroic moral artistry either because of its implied immediacies or because it is simply bad manners or irrelevant to ask a suffering person to bear his or her infirmity in an integrated moral fashion. Consequently, while virtue ethics has much to recommend it and while this theory well may be able to include both agency and the evaluation of moral acts or again duty and consequences, there is still need of a further dimension especially in health care which is capable of being appealed to by a wide number of, if not all, human beings, regardless of their cultural, intellectual, or religious persuasions or prejudices.

In this context the thesis of the present chapter can now emerge, and it is this: the fundamental, but hitherto

absent dimension for health care ethics can be found partly in an ethics of caring. Ironically, the one philosophical analysis missing from the health care field, an analysis which is capable of dealing with the immediacy of human need and resource, is that of care itself. In this chapter, then, I shall present one important version of this notion and then in the following chapter go on to criticise and to suggest some further developments necessary to it.

3.2 The Human Dimension in an Ethic of Caring

From the perspective of an ethic of caring developed by Professor Nel Noddings, the fundamentally human dimension, significantly overlooked in other ethical theories, becomes necessary for the subsequent moral reasoning which is implicitly based on it. To support Noddings' concept of ethics based on natural caring as a feminine approach rooted in receptivity, relatedness and responsiveness, I will at the end of this chapter present a nursing concept of caring practice guided by the same principles and reflected in the work of Patricia Benner and Judith Wrubel, The Primacy of Caring.

Nel Noddings advocates an ethic of caring as a specifically feminine and novel approach to ethics and moral education. The formation of principles as well as the

concepts of fairness, justification and justice "have been discussed largely in the language of the father"; in other words, ethical systems have acquired a masculine rather than a feminine spirit (Noddings, 1984, p.1). Ethical views, she argues, have been so traditionally focused on "principles and propositions" and "terms such as justification, fairness and justice" that "human caring and the memory of caring and being cared for... have not received attention except as outcomes of ethical behaviour" (Noddings, 1984, p.1). Noddings proposes an ethical theory that does not build on the traditional moral principles. When we establish a moral principle, we may also present an exception such as is the case in the forbidding of killing; in any case, the exception to a principle may show that it was not well formed. In this particular climate it is easy to attack others who do not share our beliefs. We live in a world full of violence and many deeds, as Noddings observes, "are so often done in the name of the principle" (Noddings, 1984, p. 1-2).

An ethic of caring, by contrast, should be expressed in a feminine view and should allow hidden aspects, largely missing in the existing rationalistic paradigms of ethics and moral education, to emerge:

It is feminine in the deep classical sense—rooted in receptivity, relatedness, and responsiveness. It does not imply either that logic is to be discarded or that logic is alien to

women. It represents an alternative to present views, one that begins with the moral attitude or longing for goodness and not with moral reasoning (Noddings, 1984, p.2)

For Noddings, ethics does not begin at the intellectual level with an analysis of the concept of goodness but rather at the emotional level with the desire to be a good person³. It is important at this point to emphasize that Noddings talks about a 'feminine' as opposed to a 'feminist' view of moral education, a view that is derived from our affective response. In other words, emotions, feelings and the desire to be good form the real foundation of our ethical behaviour⁴. Indeed, when women are presented with a hypothetical moral dilemma they ask for more information, not because they cannot think in abstract terms, organize principles hierarchically or establish logical conclusions but in order to construct a picture resembling a real moral situation. For Noddings, abstract thinking is perceived "as peripheral to, or even alien to, many problems of moral action" (Noddings, 1984, p.2). Moreover, abstract thinking with its propositional logic resembling geometry will depersonalize our caring approach since moral decisions are made in real situations (Noddings, 1984, p.3). Although Noddings does not deny women's ability to think abstractly or derive conclusions logically using the language of justice just as well as men can, she insists that this

language is not their first choice. Rather, women enter the moral realm "through a linguistic back door" giving reasons for their acts or making decisions based on feelings, needs, impressions and a sense of personal ideals as opposed to universal principles (Noddings, 1984, p.2).

Noddings defines many different uses of 'care' such as inclination toward something (e.g. the study of philosophy) or someone (e.g. my spouse) when we can experience an affective mental state of anxiety, fear, or solicitude toward something or someone. To 'care' may also mean to be responsible for the protection, welfare and maintenance of something or someone. For example, I may have an inclination toward philosophy and willingly spend a lot of time with it, and if I have a regard for my spouse, his ideas, desires and needs will greatly matter to me. A human caring may include all of the different definitions of 'care'; however, the essential elements of human caring are centred in the relation between "one-caring" and one "cared-for" (Noddings, 1984, p.4). When we care, we have a regard for people, for what they think, feel and need, and all of this will matter to us (Noddings, 1984, p.9). A central problem of any rationalist approach to ethics is its failure to acknowledge this fact. As a result, such approaches lose sight of the basic fact that we share "with each other the feelings, the conflicts, the hopes and ideas that influence

our eventual choices". By focusing solely on the justification for actions in terms of moral principles ethics has tended to miss "what motivates and touches us" in the ethical sphere (Noddings, 1984, p.8). Moreover, while both logic and reasoning in terms of logos are important, they have a secondary role to play to eros. Consequently, Noddings defines eros as an attitude "rooted in receptivity, relatedness and responsiveness" that enables us to begin any ethical discourse with the "moral attitude or longing for goodness and not with moral reasoning" (Noddings, 1984, p.2).

The notion of receptivity, relatedness and responsiveness is fundamental in any human caring relationship. Noddings talks about a 'feminine' view of moral education, a view that is derived from our affective response as an embodiment of our feelings, emotions and needs. In other words, for Noddings, ethical deliberation begins at the emotional level with our desire to be good rather than at the intellectual level with our analysis of the concept of goodness. An ethic of caring is primarily concerned with concrete, particular situations in which people find themselves rather than with abstract ethical principles that are then applied to such situations. An ethical understanding of oneself and others emerges from the subjective experience of those involved in caring

relationships, like those between mother and child, teacher and student or doctor and patient. Caring, then, is not simply being concerned with goodness toward humankind in general or being concerned with people who have no concrete connections with us. There is a fundamental difference between the kind of care a mother has for her child and the kind of 'care' a well-fed Canadian adult has for a starving African child s/he has never met. Real caring requires actual encounters with specific individuals—it cannot be accomplished through good intentions alone. Noddings does not reject the idea of indirect caring for an African child but she asks what motivates people to care in this way. She suggests that the question can only be answered by those claiming to care. If their interest lies only in what she refers to as "equity", or in the desire to be given credit for caring by donating money, for example, then such an action only represent an acceptable substitute for genuine caring (Noddings, 1984, pp.11-13).

Noddings is well aware of the different meanings of 'care' (e.g. caring for animals, objects or activities such as one's work, or human caring as above) but argues that the key elements of caring, rooted in receptivity, relatedness and responsiveness, are located in the particular relationship between the "one-caring" and the "one cared-for". That is to say, caring as such emerges primarily in a

particular, situated relationship. To care means for us to be open to the needs of others, to receive and relate to their feelings and emotions, and to respond to their actual needs. For a relationship to be of this kind, our caring must be received by the person we care for. Only then will "the freedom, creativity, and spontaneous disclosure of the cared-for" be nurtured by the "one-caring", thereby making the relationship complete (Noddings, 1984, p.74). To care means for us to be in a particular relationship with others which enhances our ideal of ourselves as caring. This means that we "want to be moral in order to remain in the caring relation", continuously fostering our ideal of ourselves as "one-caring" (Noddings, 1984, p.5). Moreover, our caring actions are not routinely fixed by some rule but are guided by affection and regard for the other person (Noddings, 1984, pp.13, 24). As for laws and principles, Noddings by no means diminishes the role of rational objective thinking in the ethics of care. However, she points out that "we must at the right time turn away from the abstract...to the concrete" in order to allow "subjective thinking and reflection" to flourish, and give us the "time and space for seeing and feeling" (Noddings, 1984, p.26).

In other words, Noddings insists that ethics is about particular relations, "generated by some rule that describes the affect-or subjective experience-of the members", taking

place in concrete and practical situations between two parties where the first member is the "one-caring" and the second is the "cared-for" (Noddings, 1984, p.4). Noddings builds her theory upon the most instinctive and immediate caring relationship, that of mother and child. In a deep classical sense, this relationship reflects the basic structure of human existence in so far as the human encounters founded upon receptivity, reciprocity and response may be signified primarily by the instinctive mother and child relationship. After all, as Noddings puts it:

To receive and to be received, to care and be cared-for: these are the basic realities of human being and its basic aims (Noddings, 1984, p.173).

In genuine encounters of caring and being cared for both parties contribute to such a relationship in distinctive ways. Relations are not just abstract, unordered pairings, Noddings argues, but concrete particular events in which the relationship constitutes a set of ordered pairs, namely, "one-caring" and one "cared-for" (Noddings, 1984, p.4). In such relationships we encounter the other morally, as someone to be cared for, with the intention that our caring will somehow be completed in the other. Ethical caring as an openness to the needs of others is not, at least in the initial stages, dependent on rules or principles, but rather upon the natural development of a more mature self, and

ultimately an ideal self, "developed in congruence with one's best remembrance of caring and being cared for" (Noddings, 1984, p.94).

Why, then, does Noddings insist that ethics is generated by some rule, if it does not arise immediately out of principles? It is the beginning of the intimate and concrete connection in the particular relationship that defines the affective or subjective experience between two parties, which Noddings considers as being "generated by some rule". In this sense we may explain her concept of rule as arising out of a natural inclination reflected in our commitment to both the cared-for and our continual receptivity (Noddings, 1984, p.175). In the case of mother-child relation, the "rule" expresses the normal form of the relationship embedded in the relationship itself, not in any directive for or effect of a particular mode of caring. This allows the apparently 'raw' or emotional content of basic human behaviour to be given a new significance. By preferring the emotional rather than the developed or intellectual level of analysis in ethics, the particular relationship between the two parties is to be based upon "... feelings, needs, impressions, and a sense of personal ideal rather than [to] universal principles and their application" (Noddings, 1984, p.3). Ethical caring, insists Noddings, is a way of being in the world—it is both

ontological in nature because it arises out of natural caring where we care "out of love and natural inclination" and central to human experience (Noddings, 1984, pp.4-5). People receive the relation of natural caring consciously or subconsciously as a human condition that is good. It is precisely this condition towards which we strive or should strive, Noddings argues, in our relationships with other people. To care means for us to be in that particular special relation with others, which in turn enhances our ideal of ourselves as caring. When we are in a caring relationship we "want to be moral in order to remain in the caring relation" and continuously to foster our ideal of ourselves as "one-caring" (Noddings, 1984, p.5). Noddings claims that there is something uniquely universal about the caring attitude, since we all experience caring in both being cared for or caring for someone situations (Noddings, 1984, p.5). By contrast at a later stage, Noddings emphasizes, in thinking in abstract terms, we have already moved away from the 'person' to the 'problem' (Noddings, 1984, p.36).

Caring, then, is not simply being concerned with goodness toward humankind in general or being concerned with people who have no concrete connections with us. Although Noddings realises that we will care about our family and friends more than anyone else, she urges us to advance

beyond our present circles of intimate connections by means of 'chains' developed by our 'personal' or 'formal' relations. The 'personal' interpretation will include individuals who are linked to persons for whom we already care such as a friend of a friend etc. The 'formal' interpretation, on the other hand, will include future individuals who are formally linked to those we already care for such as in the case of future residents in a special care home or future patients in a doctor's office. As Noddings puts it:

Chains of caring are established, some linking unknown individuals to those already anchored in the inner circles and some forming whole new circles of potential caring. I am "prepared to care" through recognition of these chains (Noddings, 1984, p.47).

Noddings claims that right now there exist (or will exist) individuals in the world to whom we will eventually be related. Therefore, she suggests that we build caring through the strength of anticipated hypothetical relationships.

However, Noddings is well aware of the conceptual difficulties this model raises with regard to complete strangers, that is, the individuals who lie outside both our personal and formal networks. Their demands are much harder to meet because we do not know where they fit and what personal needs they will pass onto us. Noddings confesses that the caring person "dreads the proximate stranger, for

she cannot easily reject the claim he has on her. She would prefer that the stray cat not appear at the back door—or the stray teenager at the front"; what is implied here is the fear of a request which cannot be met without hardship on the part of the caring person (Noddings, 1984, p.47). How then does one meet the demand of a perfect stranger? Noddings' answer here is similar to the concept of the categorical imperative: "I must"; however, in her case the "I must" "suggests itself as bounding upon the one in whom it occurs" (Noddings, 1984, p.48). Clearly, the "bounding upon" indicates the reciprocity of our dependence in caring relationships. We are aware that the one cared-for is dependent on us; however, we, as caring, are also dependent on the one cared for. It is the moral goodness we want for perfection of our ethical self that makes us partly dependent on the others, and each choice we make in our caring relationship will either maintain, enhance or diminish us as ones-caring (Noddings, 1984, p.175). Moreover, Noddings believes that "this peculiar dependence holds beyond caring relationships into antagonistic and adversarial relations" in which the "unscrupulous" party can deprive us of our lives, fortunes and the ethical ideal we strive for (Noddings, 1984, p.48). To what extent we can be forced to betray our guiding principles, deny our love and sacrifice our ethical selves depends on the strength of

the ethical ideal for which we are striving (Noddings, 1984, p.48).

What is the "ethical ideal" that we are, or ought to be, striving for? Noddings presents the ethical ideal of ourselves as a personal/social construct, a picture of ourselves, which arises out of natural caring and must be realistic and attainable. When we are in genuine caring relationships and situations we naturally shift our energies towards those whom we care for. However, we need to be received, understood and accepted by those whom we care for if the picture is to be complete. Although there are situations in which we both fail to receive the others and we are ourselves not received, nevertheless, a picture of goodness begins to form:

I see that when I am as I need the other to be toward me, I am the way I want to be—that is, I am closest to goodness when I accept and affirm the internal "I must". Now it is certainly true that the "I must" can be rejected and, of course, it can grow quieter under the stress of living. I can talk myself out of the "I must", detach myself from feeling and try to think my way to an ethical life. But this is just what I must not do if I value my ethical self (Noddings, 1984, p.49).

There is a sense of obligation introduced by Noddings here, however, the 'goodness' to which she refers is clearly arising out of the state of natural caring and the ethical self is an ongoing process or "an active relation between my actual self and a vision of my ideal self as one-caring and cared-for", and as such, "caring for others does not arise

out of the ethical self, but the ethical self arises out of caring for others" (Noddings, 1984, pp.49-50). Moreover, Noddings does not deny the fact that we are "free to affirm or reject the impulse to care" when we are involved in many situations and faced with many decisions, however, our decision to turn away from both our feelings and understanding of the situation in question will separate us "not only from others but from our ideal selves" (Noddings, 1984, p.51). In other words, Noddings believes that we have the freedom to cut ourselves from the 'chains' that link us "to loved others" but once we establish this process we are moving away, leaving behind all who cared for us and perhaps even ourselves, into a world of "strangers and loneliness" (Noddings, 1984, p.51). For Noddings this is not a natural human existence since we are not naturally alone but as she puts it:

I am naturally in a relation from which I derive nourishment and guidance. When I am alone, either because I have detached myself or because circumstances have wrenched me free, I seek first and most naturally to reestablish my relatedness. My very individuality is defined in a set of relations. This is my basic reality (Noddings, 1984, p.51).

In other words, although it depends upon the particular person in the particular situation how to respond to the demand of a perfect stranger, we continuously strive to nurture our ethical ideal self as one-caring and cared-for

which connects us naturally to others and again reconnects us through others to ourselves.

Noddings claims that caring relationships are not about universals but about particulars, and that is what makes each individual different. Along with the principles and rules as a primary guide to ethical action, she also rejects the notion of universalizability. The traditional approach in moral philosophy demands that moral principles be universalizable. If one is obliged to perform action X under certain conditions, then the other person under sufficiently similar conditions is obliged to do X. Noddings claims that the conditions of the principle of universalizability appear to depend on a concept of "sameness":

In order to accept the principle, we should have to establish that human predicaments exhibit sufficient sameness, and this we cannot do without abstracting away from concrete situations those qualities that seem to reveal sameness. In doing this, we often lose the very qualities or factors that gave rise to the moral question in the situation (Noddings, 1984, p.85).

As Noddings sees it, the concept of sameness cannot satisfy the particular moral condition which makes the situation different. However, she accepts that we can receive guidance from an effort to discover universalizable principles since we can arrive at the doctrine of "prima facie duty", as described by William David Ross. "Prima facie duties" are regarded as morally self-evident, tend to be absolute duties

and are regarded as absolute duties if no other "prima facie" duty conflicts with them. Yet such a doctrine, as Ross himself acknowledged, does not provide real guidance for "moral conduct in concrete situations" but it only "guides us in abstract thinking; it tells us, theoretically, what to do, "all other things being equal" (Noddings, 1984, p.85). Unfortunately, all other things are seldom, if ever, equal and Noddings again insists upon the differences in each particular moral situation. It is possible that the morally correct action for A will be to do X and for B not to do X. As it is, she believes that we connect "right" and "wrong" in accordance with our ethical ideal, thus implicitly placing our ethical ideal above the principle as a guide to moral action (Noddings, 1984, pp.84-85). As Noddings insists, there is no danger of relativism since the ethical ideal is founded not upon a universalizable principle but rather upon a universal, but always concrete and particular relationship: a desire to maintain the caring relation which is equally accessible to both men and women alike.

How could such a theory be accessible to both men and women? Surely Noddings theory is exclusively feminine, if not feminist? Conscious of this and other forthcoming criticism, Noddings is well aware that her view may be considered "affectivist" and "feminine". Although the ethic

of caring builds upon the foundation of affective reaction, she rejects the former accusation as too hastily applied and implicitly, but falsely assuming that if we recognize the affective base of morality then we diminish the role of reasoning in ethical conduct. She explains:

I do not respond out of blind sentiment, but I put my best thinking at the service of the ethical affect. If I exclude cognition, I fall into vapid and pathetic sentimentality; If I exclude affect—or recognize it only as an accompaniment of sorts—I risk falling into self-serving or unfeeling rationalization (Noddings, 1984, p.171).

In other words, laws and principles are naturally and in the course of further development incorporated in the ethics of care. Consequently, Noddings by no means diminishes the role of thinking and reasoning in ethical conduct. However, as for the latter label of her ethic being exclusively "feminine", Noddings is willing to accept this on one condition, that is, "only if we understand that all of humanity can participate in the feminine as I am describing it" (Noddings, 1984, p.172).

From what we discussed so far, it is clear that in her ethics of care Noddings identifies relationships between people as more fundamental to reality than the laws and principles which purportedly guide them. Like Aristotle, Noddings believes that virtue can be taught and claims that "an ethic of caring can be communicated just as effectively as an ethic of rules and principles can" and, moreover,

because "our initial experiences of care come easily, almost unconsciously, we act from a natural caring that impels us to help others because we want" to continue our caring relation (Tong, 1993, p.111). As Noddings puts it :

The relation of natural caring will be identified as the human condition that we, consciously or unconsciously, perceive as "good". It is that condition toward which we long and strive, and it is our longing for caring—to be in that special relation—that provides the motivation for us to be moral. We want to be moral in order to remain in the caring relation and to enhance the ideal of ourselves as one-caring (Noddings, 1984, p.5).

Unlike Kant, Noddings believes that we respond to the needs of others not because we must do so, but because we choose to do so. In this sense, an ethic of caring "strives to maintain the caring attitude and is thus dependent upon, and not superior to, natural caring" (Noddings, 1984, p.80). In other words, an ethical caring arises out of natural caring, which in turn arises out of the particularity and immediacy of the basic human mother and child relationship. What about the obvious objection that not every child or every mother experiences this pure idyllic relationship. Surely if a child experiences a 'bad' relationship at this level, this will make it impossible for the child to be open to this paradigm; and even more seriously, if such a relationship is always particular and it is out of such particular relations that ethics must develop, then if the paradigmatic relationship is absent or perverted, then the child should

never be able to develop into a properly ethical caring person.

Another example which grows out of the mother-child relationship is the relationship between teacher and student. Noddings, herself an educator, draws on her rich professional experience as a mathematics teacher to illustrate that her ethic of caring can be universally applicable to our practice as professionals. In the following example she shows how the ethic of caring applies to the practice of teaching.

As a mathematics teacher, one is aware that this subject inspires a great fear in many students. Noddings insists that such subjects as mathematics must be laid out in such a way as to embrace the entire range of human experience which means to explain its history and applications, and as well as its potential personal and professional use as this relates to the individual students' lives. As a teacher, one may deeply care about both the subject and one's student's learning the discipline. However, the child does not want to learn and has difficulties with a topic for the first, second or nth time. What does the caring teacher do? She acknowledges that the interests of the cared-for student are not directed to mathematics. A caring teacher respects these findings and continues to care for the child as a child, showing that the

care, respect and nurture remain in her relationship with the child. Moreover, she does not give up but continues to try to introduce mathematics in the best possible way as if she were saying: "Here is something I find delightful, and I would like to share it with you" (Noddings, 1984, p.192). After all, the effort of teaching is not to sort the students out into those who have learned quickly and who may be labelled "successes" and those who have not learned and are declared "failures"; "the effort, if learning really is our goal, is a mutual one" to which both the "teacher and student contribute significantly to what is achieved" (Noddings, 1984, p.192). However, at a certain point when the caring teacher realizes that the child does not care about the subject, nevertheless, she continues to care for the child and recognizes the child's strengths in other subjects, which in turn allows the child both to remain in relation and grow intellectually (Noddings, 1984, p.192). In this way, it is possible to suggest that Noddings consciously accepts that relations are more fundamental and more understandable than the success in individual subjects.

3.3 The Primacy of Caring

Is Noddings' concept of ethics, based on natural caring as a feminine approach rooted in receptivity, relatedness

and responsiveness, applicable to clinical nursing practice? From the perspective of Patrica Benner and Judith Wrubel, as set forth in their book The Primacy of Caring, an ethic of care is central to any clinical nursing practice:

Nursing is ... a caring practice whose science is guided by the moral art and ethics of care and responsibility...caring as a moral art is primary for any health care practice (P.Benner, J. Wrubel, 1989, p.xi).

Caring, insist the authors, is central to the human experience of being a nurse, because it is the most basic and natural form of existence in the world and in the nursing practice. Like Noddings, Benner and Wrubel understand the concept of caring in terms of our immediate connectedness to the world, since in care our thoughts, feelings and actions are united in a natural, conscious or unconscious way, which in a fundamental sense involves our knowing and being in the world. Why is caring primary? Caring establishes the basis for meaningful existence in the world and creates the possibility of developing further caring relationships with others; it helps the health care professional to recognize which interventions help the patient and "it sets up the possibility of giving help and receiving help" (P.Benner and J. Wrubel, 1989, pp.1-4). Moreover, the caring relationship enables the one cared for to receive the care offered and feel cared for in return within the caring context, which includes the emotions and

feelings of both the patient and the nurse. Consequently, because every caring situation is different we cannot generalize and isolate effective actions and apply the same criteria successfully to another situation:

We must consider the caring context because the nature of the caring relationship is central to most nursing interventions. The flexibility and diversity of expert practice depend on the nurse's involvement in the situation (P. Benner, J. Wrubel, 1989, pp.4-5).

In other words, the authors argue that scientific knowledge combined with expert nursing techniques are not enough for expert nursing practice. The enabling caring condition is the connection and concern of the nurse in the particular caring context with the particular patient, and this forms a necessary precondition for the intelligent implementation of both scientific knowledge and technique.

If clinical nursing practice is to be guided by an ethics of care, it must be able to distinguish the nursing perspective from purely scientific and biomedical methodologies on the grounds that these are too restricted to provide an adequate account of what actually occurs in everyday nursing experience. Nursing theories, on the whole, have been generally formulated in the tradition of classical seventeenth century science and have embodied an atomistic and mechanistic view of the person. Benner and Wrubel offer a different view of nursing practice, one which is based "upon the notion of good inherent in the practice and the

knowledge embedded in the expert practice of nursing" (P. Benner, J. Wrubel, 1989, p.xi). In other words, the authors present a coherent theoretical perspective which considers caring as the primary and essential component of day-to-day nursing practice. The theoretical perspective of nursing practice as interpretive theory concerned with helping people to cope with illness is based on the phenomenology of Martin Heidegger and Maurice Merleau-Ponty. The phenomenological interpretation of nursing practice accounts for the lived experiences both of being healthy and of being ill:

Being healthy and being ill are understood as distinct ways of being in the world. These phenomenologists consider the person's way of being in the world as prior to reflective thought; and that way of being sets up the conditions under which treatments will be sought or help will be appropriated (P. Benner and J. Wrubel, 1989, p.7).

There is more to nursing practice than appropriate nursing procedures performed according to a set of accepted standards, or the scientific functional knowledge of human bodies as machines and a feeling of compassion for the patient. We need both to understand human nature and grasp the meaning of illness for the patient. Only then can we form professional judgements inspired by human wisdom as Benner and Wrubel put it:

In this book, human wisdom is taken to be more than rational calculation. Although problem solving and goal attainment are important functions, the understanding of what it is to be

human also includes issues of significance. Therefore, human studies can be reduced neither to mathematical accounts nor to causal statements about the relationships between isolated elements (P.Benner, J.Wrubel, 1989, p.8).

In our modern world, still influenced by Newtonian mechanics, the self is viewed as separate from and in opposition to others. Based on this view, our concerns for others are perceived as distinct and separate from ourselves, or as competing with our own self-interests. The successful coping with professional caregiving is still recognized as the ability to separate oneself, as a professional, from the one cared for. In this sense, caring is devalued since it is considered suspect to individual desires and needs where the Cartesian self should ideally engage only in self-care in order to preserve its autonomy (P. Benner, J. Wrubel, 1989, p.368).

There is, however, another view of the self in the phenomenological tradition according to which the person is viewed as related to others and defined by these relationships. In this view, concern for others does not necessarily compete with self-interest, but rather allows for mutual understanding and realisation of "a world where one can care and expect to be cared for (P. Benner, J. Wrubel, 1989, p.367). It is by inclusion of this concept of 'self' that Benner and Wrubel propose a new theoretical foundation of nursing ethics, one which does not consider

the autonomy of an individual as the pinnacle of achievement in professional nursing practice. As they put it:

Instead, we hold that caring and interdependence are the ultimate goals of adult development. To care and feel cared for promotes personal and societal health. Caring is the most basic human way of being in the world (P. Benner, J. Wrubel, 1989, p.368).

In this sense, Benner and Wrubel present a more inclusive theoretical foundation of nursing practice based on the phenomenological and feminist efforts of making the primary aim of the nursing profession that it became a caring practice. They hold the view that there is something which can meaningfully be termed "human nature", that this links fundamentally all human beings regardless of intellectual, cultural, moral, or social distinctions, that this is pre-cognitive to the degree that it is grounded in instinctive, but intelligible human behaviour capable of being developed into wider forms of human caring, and that this human nature is not a "thing" in the sense of a blueprint or series of rules, or even consequences, but rather an activity or relational process which implicitly embraces later more developed, social structures, but which remains a fundamental guide for the deepest and most vulnerable of human situations, namely, those of health care. In this, Benner and Wrubel are clearly in agreement with Noddings' theory, though they in fact had no knowledge of her work. This may well serve then as an independent confirmation of

the immediate practical necessity for developing an understanding of care, which is able to link all peoples of whatever religious, intellectual, cultural backgrounds (or the lack of these) in an immediate, shared, and coherent pre-rationalistic framework, a framework notwithstanding which is not opposed to rationalism, but rather may be said to establish the possibility of a human rationalism. In other words, a developed theory of justice and rights should not form the basis for our caring, but rather our caring should serve to ground a developed theory of justice and rights.

How practical, in sum, is this approach? It depends on what is meant by 'practical'. If by 'practical' we understand the application of moral principles in different situations, then this approach certainly disrupts the traditional ways we look at ethics, namely, as a blueprint of rules and principles to be applied in various ethical situations. In other words, in the well-established moral context of 'practical' ethics, any notion of caring for others arises out of established principles and a detached view of an ethical self which is developed by learning and understanding moral principles in order to act in accordance with our best knowledge. An ethic of care, on the other hand, is 'practical' because it turns the moral focus in the opposite direction: that is, it claims that an

ethical self arises primarily out of caring for others. In other words, it would be unfair to test an ethic of caring by the same standards we apply to other traditional or contemporary approaches, for we should be subjecting caring to principles, techniques, or other "cognitive" practices rather than allowing the latter to be illuminated by the former. At the same time, if such an ethic is to be 'practical' in a wider sense, some sort of a reasonable test would seem necessary, if we are not to leave the fundamental structure of care at a relatively undeveloped, and consequently uninformative stage. In the following chapter, therefore, I shall take up the problem of this reversal of perspective required in the care-paradigm, and argue that the respective shortcomings of Noddings' view and of Aristotle's theory of character find an implicit remedy in each other's strengths. An ethical theory which incorporates these strengths from both philosophies, I shall suggest, can serve as the springboard from which the deeper structure of care can provide a more comprehensive outlook upon health care, and one which at the same time remains practical.

Endnotes

¹However, this is not always true because a rule-utilitarian ethic may have certain rights in place which protect autonomy of an individual. John Stuart Mill held this view which is compatible with the anti-paternalistic stance.

²There is a strong Aristotelian 'flavour' in Mills utilitarian theory, and one may suggest that the two elements in this distinction may be related because acts will flow from the character to a great extent.

³In contrast, Aristotle may not entirely agree with Noddings' analysis, namely, he would emphasize the role of logos as an important part of the deliberation of a person of practical wisdom.

⁴This aspect of Noddings' theory is similar (to a degree) to Mill's and Hume's views as far as this accounts for motivation (i.e. moral psychology).

4. PHRONESIS AND CARING: ARISTOTLE AND NODDINGS ON INFORMED CONSENT

4.1 Introduction

In this thesis I have argued for an ethical approach to informed consent to treatment based on the concepts of phronesis (practical knowledge or moral discernment) and caring, as articulated by Aristotle and Noddings. Both philosophers assert, albeit in different ways, that morality or ethics is rooted in the character of the person and that some form of habitual caring is central to a relationship such as that between doctor and patient. For Aristotle, ethical theory arises out of practical knowledge or moral discernment, while for Noddings it stems from relationships based on caring. Put differently, the experience of displaying practical knowledge or of caring for another is of primary concern for Aristotle and Noddings, and they believe that any ethical theory must recognize this fact. To this extent, ethics for both of them is practical because it views our everyday experience in such relationships as doctor/patient, teacher/student, parent/child as an

indispensable part of our ethical understanding (Noddings, 1984, p.5; Metaphysics, I, 1, 981a, 13-24; EN, VI, 11, 1143b, 10-15).

In the context of informed consent to treatment, an ethical theory based on phronesis and caring provides a framework for understanding the relationship between doctor and patient by focusing on the following characteristics: the practical knowledge of the doctor, the caring relationship between him/her and the patient, and the often ignored concerns of the patient herself. The emphasis of this kind of ethical theory is upon the practical situation in which a doctor and patient face the issue of informed consent together, and on the ethical issues arising from this experience. Moreover, this ethic considers each practical situation in which a doctor encounters a patient in a caring relationship on its own merits; that is to say, by means of an appreciation of the specific aspects of the practical knowledge and caring needed for dealing with an individual patient. The reason for this is that a doctor's practical knowledge may need to adjust to the particularities of an individual patient in order to provide care and enable him/her to act in an ethical way. I shall show how this is borne out by reconsidering the case of Reibl vs Hughes below¹.

In the rest of this chapter, then, I explain how Aristotle and Noddings' ethical theories provide an understanding of informed consent to treatment that stresses the reciprocal nature of the doctor-patient relationship. I shall elucidate the distinctively ethical characteristics that each approach requires, and underline the commonalities and differences between them by concentrating on one particular case, namely that of Reibl vs Hughes which first brought attention to the importance of informed consent to treatment in Canada. Reconsideration of this case in light of Aristotle and Noddings' theories enables me to show how a doctor making use of phronesis and paying attention to caring would have afforded Reibl, the patient, the relevant knowledge required for informed consent. By considering the case in this light, I suggest that ethical theory needs to pay attention to the rich details of daily practice in order to provide an inclusive understanding of the problem of informed consent. In this context, Aristotle's theory of phronesis, suitably adopted and updated, needs Noddings' theory of basic ethical care in order to provide a much needed comprehensive approach to the patient-doctor relationship in which both emotion and reason can contribute to a genuinely human and non-partisan morality.

4.2 Reibl vs Hughes Reconsidered in Light of Aristotle

In the first chapter of this thesis I analysed the landmark 1980 decision of the Supreme Court of Canada in the case of Reibl vs Hughes, showing how it was the duty of a doctor to provide relevant medical information to his/her patient in order to secure informed consent. The concept of 'relevant medical information' was interpreted by the court as a clear legal obligation to provide information related to the patient's condition. This includes information about the nature and gravity of the proposed treatment, the material risks attendant upon both the procedure and any alternative courses of action, and the likely consequences of a patient's refusal to undergo the treatment. At the same time, the court recognised that the nature of medical practice does not allow the doctor to present a discursive lecture on the particular ailment, nor does it call for complete disclosure of every possible risk involved in the medical treatment in question. Details of extremely remote risks may simply serve to frighten the patient rather than inform her. However, the doctor is required to answer fully and honestly all additional questions asked by the patient. The court declared that the legal obligation to disclose information was part of a doctor's duty of care to his/her patient.

Liability in the case of Reibl vs Hughes was based on both a breach of the doctor's responsibility to disclose the necessary information and on a causal link between his neglect of this requirement and the resulting injury. The method used by the court to establish the causality requirement was that of an 'objective reasonable person' standard. That is to say, in determining whether or not Dr. Hughes disclosed sufficient information to Reibl, the court considered what a reasonable patient in similar circumstances would need to know in order to make an informed decision. In this way, the court showed that such a patient would have refused consent because s/he had not been given sufficient information. The Supreme Court ruled in favour of Reibl, having established that Hughes had been negligent in the manner in which he had disclosed the information required for informed consent, namely the breach of the duty of disclosure, by telling Reibl only about the risk of a stroke as one which may happen in the future if he does not have the surgery (D.L.R. (3d), 1980, p.34). The record of evidence clearly justified "the trial Judge's findings that Reibl was told no more or understood no more than that he would be better off to have the operation than not to have it" (D.L.R. (ed), 1980, p.3).

The court also established that the objective standard is based on:

...what the average prudent person, the reasonable person in the patient's particular position, would agree to or not agree to, if all material and special risks of going ahead with the surgery or foregoing it were made known to him (D.L.R. (3d), 1980, p.16).

There is a striking similarity here between the phronimos in Aristotle's sense and the average prudent person in the patient's particular position referred to by the Supreme Court. Indeed, the important passage above can be understood in the following way: by emphasizing what the average prudent person would decide in the patient's particular position if s/he knew all of the risks involved in undergoing surgery, the court makes use of criteria that closely resemble the Aristotelian concept of the man of practical wisdom or phronimos (EN, II, 6, 1105b 19 - 1107a 27). Like the phronimos, whose rules "are based upon his own intelligent moral experience—i.e. his own reflective determination of the ideal of life" so the moral rules of the 'objective reasonable person' are based upon the "particular position" in which s/he finds herself (Joachim, 1951, p.89; D.L.R. (3d), 1980, p.16). In each case, the moral agent makes judgements that are grounded in his/her own experience (the 'particular'), arriving eventually at rules (the 'universal') that adapt to the different circumstances in which s/he finds herself. It is not simply the case that these rules are flexible but, more importantly, that because they originate from particular

moral experience their ongoing validity is grounded in the changing experience of the agent. This also holds true of the moral rules which s/he applies to others—they must be appreciative of the different situations in which others find themselves and of their very different experience. In both cases, the validity of moral rules stems from their ability to include the variations in concrete experience, not the demands of an abstract moral principle. Put differently, the delicate balance of good action allows for the passions and feelings of experience to be determined not by a rule but by the rule "which varies with the different situations in which he [the phronimos] acts" (Joachim, 1951, p.89); that is, not a universal moral principle, but a particular rule in a particular context with universal application.

What, then, would a doctor who was practising phronesis do when faced with the particular case of Reibl? As I showed in Chapter II, the Aristotelian concept of phronesis as practical knowledge or moral discernment is the kind of wisdom or excellence that the good and experienced man makes use of in situations calling for balanced judgement (from this point on I will replace Aristotelian 'man' with the word 'person'). Practical wisdom involves the ability to deliberate well, a process in which the right logos (rational principal) is employed by the phronimos (the

person of practical reason) in the articulation of what is good both for ourselves and other people (EN, II, 1107a). The ability to deliberate well, however, cannot be reduced to episteme or theoretical scientific knowledge which deals with abstract universals, since moral discernment is first acquired from particular situations and only related at a later stage to more general circumstances. Similarly, it cannot be reduced to techne or productive knowledge, since action and making are different kinds of things. Good action for Aristotle is an end in itself, whereas making has an end other than itself (EN, VI, 5, 1140a 30-35, 1140b). Phronesis as practical wisdom, therefore, goes beyond mere techne or skill, enabling the person to practise moral virtue by making judgements about particular situations where the precise nature of the good may be ambiguous. These judgements are based on an understanding of how to relate the particular to the universal by situating individuals in the context of their particular circumstances rather than as abstractions representing a general formula or rule.

A doctor practising phronesis would start by considering a number of important facts or "special considerations affecting this particular patient" (D.L.R. (3d), 1980, p.3). For example, s/he should be aware that Reibl is Hungarian in origin and that since English is his second language his understanding of the situation may be

limited. Coming from what was then an Eastern Block country, he is also likely to trust the authority of a doctor implicitly. Moreover, as a Ford Motor Company worker of 44 years of age, he is entitled to pension benefits if he continues at his job for about another year and a half (114 D.L.R. (3d), 1980, p.4). The relevance of these facts to the doctor's treatment of Reibl's medical condition is as follows: s/he would recognize that one of the considerations weighing upon him was the fact that he was only a year and a half away from earning a life-time retirement pension. Moreover, because of his paralysis Reibl was "not eligible for certain extended disability benefits available under the collective agreement between the Ford Motor Company of Canada Limited and its hourly employees of 10 years standing" (D.L.R. (3d), 1980, p.6). In other words, Reibl would have no other financial support if he were to become permanently paralysed.

Any doctor, including one who practises phronesis, might well be puzzled by the fact that Reibl had persistent headaches but no apparent neurological defects. Indeed, the problem in this case is to discern the medical diagnosis/prognosis of these migraine headaches. The results of the arteriogram test indicated that Reibl had a blockage in the left carotid artery located in his neck. As a qualified neurosurgeon who had performed 60 or 70 surgeries

Hughes was aware that only 4 or 5 of them were done on patients who did not show any detectable neurological disfunction or abnormality. Reibl, who also had no obvious signs of brain damage, was kept unaware of the fact that one of Hughes' five patients on whom he had operated had suffered a stroke (D.L.R. (3d), 1980, p.24). The doctor would then recognise that the following risks were involved; namely, a twenty percent possibility of a stroke materializing during or after surgery. By way of contrast, Reibl has only a ten percent chance of suffering a stroke in each year that he lives with his current condition. This suggests that the risks involved in undergoing surgery outweigh those in foregoing it.

A doctor in this context might also ask a number of questions that situate the patient and his illness in the broader context of his social, family, and work life. The purpose of these questions is to find out if he is the only wage earner in his family, and whether or not this is a cause of financial worries and stress². Questions concerning the patient's health would focus on his past medical history (e.g. previous head injuries) and try to establish any links between his present medical condition and past illness. The doctor would then try to explain to Reibl, in terms that he understands, what might be causing the problem (e.g. a blockage in the artery is not the cause of his headaches or

high blood pressure but it might pose a danger of a stroke in the future). Having analysed the possible causes, the doctor might indicate the different ways of dealing with the problem. These include undergoing surgery immediately, or postponing it for one and a half years in the hope that Reibl will be able to earn his life-time retirement pension. Postponing the surgery would have the added benefit that Reibl might recover sufficiently that he would not need it at all after a year and a half³. In each case, the doctor would explain the risks and benefits involved so that Reibl can make an informed decision. These involve pointing out that surgery may not solve Reibl's problems. The doctor might also give special consideration to the fact that since English is Reibl's second language, s/he may need to involve his family doctor, Dr. Szabo, during the consultation so that any discussion of medical findings can be translated into Hungarian⁴.

The significance of asking both personal and medical questions is that they enable a doctor with phronesis to understand Reibl's concrete life situation in ways that might otherwise escape him/her. The possible relationship between his medical condition and the ongoing stress caused by financial worries may well become clearer. Moreover, the significance of Reibl's impending retirement with full pension may be crucial to the decision of whether or not

surgery is an appropriate course of action. If the risks involved would mean that he could no longer work and hence could not collect his pension then the wiser option appears to be that of postponing surgery for at least a year and a half. Unless the doctor asks both kinds of questions s/he may reach a different conclusion and advocate immediate surgery. This, in fact, is what happened and Reibl suffered a massive stroke which paralysed the right side of his body and rendered him impotent. As a result, he could not work or collect his pension, becoming totally dependent upon his family, the state and the medical profession. After ten years of litigation he was awarded a global settlement of \$225,000 when the Supreme Court restored the original judgement (D.L.R. (3d), 1980, p.4 and 35).

A doctor practising phronesis might well have avoided the kinds of mistakes that were made in treating Reibl. While the judgement of this thesis has the benefit of hindsight, it is not hard to see that the thoroughness with which such a prudential doctor would have assessed Reibl's condition stands in stark contrast to the rush to surgery which characterised the actions of his actual doctors, actions which had dire consequences for Reibl's life. Phronesis or prudential discrimination would seem to make a practical difference in the approach to medical care ethics.

4.3 Reibl vs Hughes Reconsidered in Light of Noddings' Ethic of Caring

In the third chapter of this thesis I analysed the concept of an ethic of caring developed by Nel Noddings. As emblematic of the fundamentally human dimension, caring has been largely overlooked by rationalist ethical theories, which have focused on "principles", "propositions" and "terms such as justification, fairness and justice" (Noddings, 1984, p.1). If such theories considered caring at all, it was only as an outcome of ethical behaviour directly related to the rules and principles guiding the agent. Noddings argues that human caring, which includes the memory of caring and being cared for, is the proper primary basis of moral action.

Noddings' ethic of caring identifies relationships between people as more important than any laws and principles designed to regulate human behaviour. An ethic of caring arises out of relationships of natural caring, such as those between parent and child, that impel us to care for others because we want to continue in that caring relation. Noddings identifies natural caring as "the human condition that we, consciously or unconsciously, perceive as "good" ...toward which we long and strive...that provides the motivation for us to be moral" (Noddings, 1984, p.5). In other words, our notions of goodness and morality are

dependent upon the kinds of caring relationships which are part of the human condition, particularly those between parent and child, but also between teacher and student, and doctor and patient.

However, one may well object that if goodness is only determined by a relationship between the one-caring and the cared-for, then such a determinate "goodness" can surely not apply in relationships beyond itself. Noddings might reply that there is something properly 'universal' about the 'caring attitude' that underpins her ethics. Our memories of caring are not memories belonging exclusively to us alone; they are the kind of memories to which practically all human beings have access. Moreover, she insists that "the impulse to act in behalf of the present other is itself innate. It lies latent in each of us, awaiting gradual development in a succession of caring relations" (Noddings, 1984, p. 83). Noddings' use of the term 'impulse' clearly indicates her earlier rejection of the Kantian notion of 'duty'. However, we are not ordered by the impulse to care because we have a choice to accept or reject what we feel. Our choice will reflect either our strong desire to be moral, which derives from our fundamentally natural desire to be related, or we will reject the feeling due to some internal state of imbalance and thus diminish the vision of our ethical ideal. After all, Noddings insists that the ethical self is an

ongoing process in which we reflect on the active relation between our actual selves and a vision of our ideal selves as one-caring and cared-for (Noddings, 1983, p.49). Morality, Noddings believes, is not about responding to others' needs while neglecting or denying one's own interests. Rather, she insists, morality is to affirm one's own interests while responding to the needs of others. To put it differently, when we act morally, we do so not because we should (as in the Kantian sense) but because we choose to do so. Consequently, for Noddings ethical caring is dependent upon and not superior to natural caring (Noddings, 1984, p.80).

Another objection to Noddings' ethic of care is the problem of justification. How do we bridge the enormous gap between caring relationships and the right/wrong distinction? For Noddings, ethical caring does not depend upon rules or principles but upon the development of our ideal self. What does she mean by the ethical ideal self emerging apparently out of the supposedly natural situation? Implicit in the caring relationship is the wish to be received as oneself. Minimal experience reveals that the wish to be received is a reciprocal dynamic involving certain standards of behaviour and response from oneself. Consequently, the wish to be better than one apparently has just been (e.g. visiting your elderly neighbour instead of

mowing her lawn)⁵ is an implicit part of an emerging caring relation. Such an ethical ideal, or ethical understanding of oneself, emerges from our experiences of past and present caring relationships. When we are guided by the ethical ideal, the traditional approaches to justification are mistaken because they turn us inward to search for the principle or rule by which we should direct our ethical conduct. Once we are involved in the abstract discussion of moral judgements, we lose sight of the motivation and logic which reside not so much outside the person as in the human context within which the person is necessarily situated. Noddings insists that moral judgements are not derived from facts or principles but from the caring attitude. To put it differently, she believes that moral statements arise from the attitude built upon natural caring (Noddings, 1984, p.95). Consequently, she claims there is no justification as such for adopting the "moral" viewpoint and, moreover, she believes that the moral viewpoint is a priori, in the sense that this is prior to any notion of justification (Noddings, 1984, p.95). When we are in a caring relationship we do not seek justification for our actions but rather the reciprocity, fulfilment and completion of both parties in such a relationship. Noddings is well aware of the doubt expressed by her male colleagues who may question her ethic of caring as a nice affectionate project which has nothing

to do with 'really' doing ethics; after all, ethics is defined as the study of justified action. To this criticism Noddings replies that if we want to understand what 'caring' is, we should look at what its practitioners actually do, not what theorists say they should do. Only then will we have the necessary evidence from particular caring relationships to provide a plausible basis for ethical theory.

What, then, might a doctor practising caring do in the case of Reibl? She would begin by understanding that the concrete relationship between herself and Reibl is and must be a caring one. As such, it provides the most suitable basis for arriving at truly informed consent to his proposed medical treatment. This would involve an open dialogue in which she would try to understand Reibl's ways of life, his needs and desires, as well as his fears about the proposed surgery on his artery. While it may be difficult for a caring doctor to accomplish all of this, doing so will enable her to become fully aware of Reibl's experience. Such a relationship requires time, sympathy, compassion and understanding on the part of the doctor. A doctor practising caring would first realize that Reibl's poor English might hinder his understanding of both the medical diagnosis and proposed surgery. To ensure that he fully comprehends any information regarding his condition, a doctor practising

caring would secure the cooperation of Dr. Szabo, who was fluent in both Hungarian and English. Although there were several meetings between Reibl and Dr. Hughes over a period of four to five days, Szabo was present only at one of those meetings. His presence was required to support Hughes' professional opinion that the surgery was necessary in order to avoid the possibility of a future stroke. Unfortunately, Szabo himself did not fully understand the proposed surgery and its risks, only that Reibl 'was in good hands'. Only after Reibl insisted that Szabo explain more about the surgery to him in Hungarian did he admit that he did not understand the proposed surgery (4).

Hughes' relationship with both Reibl and Szabo was based on the superiority of his professional role as a specialist and neurosurgeon. To put this differently, Hughes professed to know better than either his patient or his colleague since he believed that they were incapable of judging the value of the proposed surgery. In contrast, a doctor practising caring would share his own views with Reibl⁶, encouraging him to ask questions based upon his own values and provide honest answers to his concerns. Such a doctor would be open to Reibl's feelings and emotions, and would respond to his actual needs in appropriate ways. For instance, it was Hughes' responsibility to take into account the values of his patient when considering the risks of the

surgery. When he was asked, for example, what medical intervention would best promote Reibl's well-being, his answer was unequivocally in favour of the proposed surgery. This judgement reflects the values of his own specialty rather than any appreciation of Reibl's own values. A doctor practising caring, however, would include a more extensive consultation with Reibl and his wife in order to determine what were his fears and concerns. Such consultation would touch not only upon Reibl's medical condition, but on his social, financial, occupational, religious convictions as well as upon those other aspects of life that made up his total well-being. This kind of consultation is an example of putting the well-being of the patient first and is consistent with the Code of Ethics which states explicitly: "Consider first the well-being of the patient" (CMA, 1990). This means that doctors should take into account the distinctive values of their patients, by considering them first before their own professional values. Such a doctor would act in this manner because his/her ethical understanding emerges from the subjective experience of the caring relationship between him/her and the patient. In such a relationship, the doctor would not diminish the role of rational objective thinking but rather would balance it with the concrete caring experience, perceived as good and as providing a sufficient motivation to be moral.

At the same time, the doctor's caring must be received by Reibl who will feel encouraged to disclose freely his hopes and fears concerning the proposed surgery and its effect on his future life. For example, Reibl would not be afraid to admit that he would rather choose to live "a short life and live like a normal person" than to "live the rest of it like a cripple" (D.L.R. (3d), 1980, p.19). In this process both Reibl and the doctor would share with each other their feelings concerning the proposed surgery, particularly any conflicts between their individual values regarding Reibl's treatment and its prognosis. They would also discuss the hopes that Reibl has about his future well-being, including his ability to pursue a normal life, and his hobby of painting and drawing (D.L.R. (3d), 1980, p.24). Such a doctor would openly discuss with Reibl and his wife, and with Szabo present if necessary, the results of the arteriogram test that indicated two blockages, one in his artery and the other in the back of his head. The first blockage was operable whereas the second, according to Hughes' professional opinion, was not. Unfortunately, it was the second blockage which caused Reibl's paralysis after surgery was performed on the first one (D.L.R. (3d), 1980, pp. 22, 24). Considering that the test results pointed to two blockages, a doctor practising caring would, at this point, have turned away from his abstract objective

knowledge of surgery to Reibl's concrete situation and allowed his/her appreciation of this particular case to take precedence; this would give him/her time and space to see and feel Reibl's particular situation. Taking into account all of Reibl's concerns, a doctor practising caring would not recommend that he undergo the proposed surgery⁷. In this fashion, the relationship between Reibl and Hughes would have been based in a direct practical fashion on the relatedness, receptivity and reciprocity of caring.

4.4 A Comparison between Aristotle and Noddings: The Need for Prudence and Caring as Basic Compatible Key Elements in the Ethic of Caring and the Concept of Informed Consent

Aristotle and Noddings' ethical theories have quite different presuppositions. Aristotle starts his ethical discussion with habits, presupposing that men are already habituated at a fairly developed level to act ethically, and to discover in their individual actions the embodiment of their principles. Moreover, they come to see their ethical actions as embedded in their emotions by virtue of reason, which uncovers and scrutinizes them. For Aristotle, every action aims at an end which is the good in its various guises. We are end-directed beings. What, then, constitutes our distinctive good, our distinctive happiness? Aristotle

answers this question as follows: the activity of the rational soul in accordance with virtue, namely the best and most complete virtue. One's final end is always implicitly involved in what one does, and acting virtuously is not a means to an end of living a happy life. Rather, acting virtuously constitutes a happy life (EN, I, 7, 1097b22-1098a20).

Aristotle's Ethics is not intended to set out precise rules on how to act but rather to develop a self-understanding of the desire to live an ethical life and the social/political context in which this is situated. It is the activity of the rational soul in accordance with logos which enables the virtuous man to reason and think consciously of the demands of a particular situation, thereby enabling him to act ethically. In this sense, an ethical virtue, "as it were, flows through mind" (Lear, 1988, p.172), that is, we come to reflective understanding of the reason why it is good to live an ethical life, which, in turn, motivates us to live it. Aristotle, unlike Plato, does not see the relationship between emotion and reason as an antagonistic one in which reason either controls the emotions or yields to them. For Aristotle, emotions can themselves be the embodiment of reason and as such be more or less rational, that is, sensitive to the particular situation, responsive to cognitive modification, and

rationally appropriate. Emotions are not blind forces and Aristotle believes that we can live a rational emotional life and know what to do here and now. Consequently, it is in terms of the interplay between reason and emotion that Aristotle describes the practical moral knowledge of the phronimos.

By way of contrast, Noddings begins her ethic of care with instincts and emotions originating in the natural caring of the mother. For Noddings, emotions are fundamental in our ethical actions since they enable us to understand morality in the context of what it means to be human. She believes that there is something definite to being human, namely the unity of affection, reason and action before they get split-up by, and into universal rules and principles. In this sense, Noddings discovers principles in basic human activity, not outside the emotional structure but within it. She starts with the relationship of 'caring' on the basis of which she articulates the structures of moral/ethical action. In such a relationship our initial experiences of being cared for or caring for someone come easily, almost unconsciously. To put it differently, Noddings believes that all (with the exception of the most deprived or depraved) human beings "feel the pain and joy of others" and remember the experiences of caring or being cared-for (Noddings, 1984, p.104)⁸. Our actions originate from a natural caring,

and because we want to be moral, we remain in the caring relation which enhances our ethical ideal. Hence, we engage in the sort of reflection that makes us see not only that we act morally but also why we do so. In other words, caring gives way naturally to at least minimal self-reflection. Noddings insists that both men and women have access to their memories of being cared for and caring, and not only can but must learn how to care if they are ever to become moral.

Is Aristotle's wider understanding of human nature compatible with Noddings' uncritical acceptance of natural caring? I suggest that Aristotle and Noddings are compatible largely in their practical approach to the problem of informed consent in the context of a changed doctor-patient relationship and in their rejection of definitive universal ethical principles. Both philosophers reject the notion that from a priori principles we can deduce practical solutions to ethical problems in the same fashion as scientific theories provide principles from which solutions can be deduced. Aristotle and Noddings also provide reasons why we should consider ethics as practical, and not simply theoretical, and they present a persuasive argument showing how ethical theory may be shaped by the demands of practice. In the context of informed consent to treatment, an ethical approach based on a synthesis of both phronesis and caring

may provide a more inclusive framework for understanding the relationship between doctor and patient. While Aristotle puts emphasis on logos and its complex relationship to both the intellect and emotions within the context of phronesis, Noddings, on the other hand, defines eros as a primary attitude that enables us to begin any ethical discourse with a desire and longing for goodness and not with moral reasoning. In this sense, a synthesis of their ethical deliberations will include the affective response of individuals as an embodiment of their emotions combined with the reflective reasoning of the person of practical wisdom about all particular facts in each ethical case. It cannot be anticipated that all people are able or willing to participate in such ethical deliberation based on the new deep structure of caring and phronesis. The new account of the doctor/patient relationship emerging from this proposed synthesis of Aristotle and Noddings is, in fact, critical of the popular view of informed consent to treatment as a means principally of securing the patient's acquiescence in the doctor's clinical judgement of what is best for the patient. In this sense, the synthesis of Aristotle and Noddings' ethical theories may begin to formulate an answer to current criticisms of consent to treatment based on the premise that doctors cannot obtain valid consent to treatment because they cannot guess which treatment option

will serve a particular patient's best interests. Moreover, it may well support the idea that these guesses could be made more accurately if patients were paired with health care professionals who share their "deep" value systems⁹.

The proposed synthesis of such ethical deliberation will reflect the paradigm shift that medical ethics is undergoing at the present time. The orthodox, static world view of universal moral principles is changing to a process-oriented, practical view of medical ethics, and the theories of Aristotle and Noddings may contribute directly to this more relational kind of approach. It questions, for example, such major concepts in medical ethics as person and relationship (Terlep, 1996), viewing individuals not only as persons in relational situations but also as members of a community which thrives on the virtuous actions of its members. Concrete relational situations such as those between doctors and patients enable us to become aware of, and receptive to, the other person by recognizing the 'other' in ourselves. Moreover, this experience allows greater empathy in doctor-patient relationships, and lessens the emphasis on the professional authority of the doctor as 'one who knows best'. In ways that are similar to Aristotle and Noddings, process-oriented approaches to medical ethics herald a more inclusive, caring, and practical understanding of such problems as informed consent.

Moreover, the synthesis which I have proposed with regard to ethical deliberation between practical wisdom and caring is also reflected in the work of Benner and Wrubel (1986). For example, nursing practices encompass the particular as well as general knowledge, and include contextual and relational knowledge in addition to rule-governed abstract principles. Like Aristotle and Noddings, their approach is well grounded in the lived practical experience connected with illness and the relationships between caregivers and those for whom they care. In an ethic of care, relevant human concerns and their impact on the decision-making process in caring relationships receive the kind of recognition which they deserve.

In his article Abandoning Informed Consent, Robert M. Veatch eloquently argues that consent to treatment is merely a transitional concept in modern medical ethics. It has emerged as a central stratagem in contemporary medical ethics to balance the medical paternalism reflected in the decision-making authority of doctors. Such an authority has been found inappropriate for modern medical practice because it is in conflict with the principle of individual autonomy which became of paramount value in Western medical ethics. However, consent to treatment is still to some extent viewed by health care professionals as a mere formality to satisfy legal requirements. By and large, the legal/medical

foundation of consent to treatment does not work, since consent is not obtained in all cases and court decisions in these cases reflect the failure of the legal system to confront the reality of health care practices in Canada today (Rozovsky, 1993, p.19; Veatch, 1995, p.5). Consequently, there are serious questions that must be addressed concerning consent to treatment, especially in light of changing medical technology.

While the response from those interested in this concept such as philosophers, lawyers and doctors has addressed both its positive and negative aspects, the practice of informed consent suggests that the external perceptions of doctors may not match the internal reality of patients. To put it differently, Veatch argues that we should seriously consider whether or not consent ought to remain central to modern medical ethics and claims that:

Clinicians cannot obtain valid consent to treatment because they cannot guess which treatment option will serve a particular patient's best interests. These guesses could be made more accurately if patients were paired with providers who share their deep values (Veatch, 1995, p.5).

Veatch questions the traditional authoritarian understanding of the clinical decision-making process in which the doctor, on the basis of his or her medical knowledge, determines what is believed to be in the best interest of the patient and proposes the course of treatment in accordance with this belief. Normally, there is good reason to suppose that a

doctor as an expert in one component of well-being cannot know whether the proposed medical intervention will also contribute to the patient's sense of accomplishment and deep personal preoccupations. In other words, the doctor must be able to estimate correctly the proper relationship between the patient's medical good and the rest of the components of the more comprehensive good to serve the patient's overall well-being (Veatch, 1995, p.9). Veatch argues that the most we can anticipate from a doctor is an adherence to a "professional standard" of recommended treatment which will indicate what the majority of similarly situated doctors would have chosen. In other words, the consensus of the medical profession cannot provide an adequate basis for deciding what the treatment of choice is for a particular patient. If the doctor cannot figure out what is the best treatment for the patient, then it is impossible to obtain valid consent to treatment; and if consent is no longer a concept adequate to assume that a patient's values and beliefs will be reflected in the decision-making result, then, we might well ask, what are the alternatives?

Veatch believes that an alternative approach which may solve problems with the consent model is to be centred on a more comprehensive doctor-patient relationship in which "deep" value systems of both are also capable of being shared. Such a system would promote value pairings based on

the most fundamental world-views of the patient and the doctor which, in turn, can provide some assurance that the technically competent doctor could guess more accurately what would serve the best interest of the patient. In this way, Veatch argues that the consent to treatment will be "replaced with a more radical, robust notion of active patient participation in the choice among plausible alternatives—either by getting much greater information to the patient or by actively selecting the professional on the basis of convergence of "deep" value systems" (Veatch, 1995, p.12).

Regardless of what the doctors treating patients say, patients' perceptions of their relationship with doctors are a significant measure of doctors' credibility. What, then, are the options for pairing the individuals on the basis of their deeply shared values? One possibility may be the consideration of caring as one deeply shared value between the doctor and the patient. I believe that there may be good reason to suggest the possibility of a doctor-patient relationship based on the combined ethical theories of Aristotle and Noddings precisely because of their practical and inclusive nature. In this sense, the practical aspect of explicit value sharing should organize the health care delivery in a way which will recognize that values are a necessary and essential part of health care decision-making

and cannot be dismissed or handled adequately by merely obtaining the consent of the patient to a standardized guess of the doctor.

However, Veatch's alternative solution has, in my view, one major flaw, since yet again it leaves executive decision-making process in the hands of an essentially rationalist and technologically expert plutocracy (namely, doctors), which has no need to change its own cognitive health-care paradigm, and effectively presses a sub-class of empathetics into service which possesses no real capacity to make proper autonomous decisions or to change the system. What this thesis has attempted to show is that there is a need for a new paradigm which can unite the best of our habitual approaches with a thorough new orientation to health care based upon a non-partisan view of what it means to be human. In a time when there is increasing need that all members of the human race be treated with fairness and equity as human subjects and agents (and not as subordinates or objects) there is clearly a need for a new more comprehensive paradigm in health care. Furthermore, it seems particularly appropriate in the light of over two and a half thousand years of rationalist, paternalistic paradigms that a new approach to health care be situated in a feminist paradigm, and particularly one which is plainly relevant and fair to all human beings, men and women. I suggest,

therefore, that it will never be enough to insert a class of empathetics into the medical system. Rather the system itself needs to be turned on its head so that all medical professionals are compelled to rethink what health care means from the heart and finger up to the crown of the head.

Endnotes

¹All information used in this chapter regarding the court proceedings Reibl vs Hughes is obtained from the Dominion Law Reports, Supreme Court of Canada, Laskin, C.J.C., Martland, Dickson, Beets, Estey, McIntyre and Chouinard, J.J. October 7, 1980.

²As a matter of fact, after signing a consent form for the proposed operation, Reibl postponed his operation for a few days in order to enable him to see his lawyer about arranging a mortgage on his house.

³The breach of duty of disclosure revealed that Reibl understood that he would be better off to have the operation than not to have it. This was not an adequate nor a sufficient disclosure of the risk attendant upon the operation itself, a risk well appreciated by Dr. Hughes in view of his own experience that of the 60 or 70 such operations that he had previously performed, 8 to 10 resulted in death of the patients. Although the mortality rate was falling by 1970, the morbidity (sickness or disease) rate, according to Dr. Hughes, was still about 10%. Moreover, the court findings stated that there was no emergency that made surgery imperative in this case, no noticeable neurological deficit. Dr Hughes himself placed the risk of a stroke as one off in the future (4-5 years) and any immediate risk would be from the surgery, not from foregoing it.

⁴Reibl talked with Dr. Szabo on several occasions regarding his concerns about the surgery after a hospital roommate's wife had told him that she refused surgery for the same problem. On one occasion, Szabo told him: "Look, I don't know much about it. If I knew that I would be a specialist myself. You are in good hands with Dr. Hughes and do whatever he tells you" (p. 19, plaintiff's evidence). And from the plaintiff's cross-examination again in the words of Reibl: "I asked him in bold language in mine and in English and with Dr. Szabo I understand enough English. I said, If you don't know how to pronounce it in Hungarian try to explain it to me in English. His answer was: "You are in good hands and if I would know the answer for it I would be a specialist myself". Moreover, the court pointed out that Dr. Hughes must have been aware of Reibl's difficulty with

the English language and that he should have made certain that he was understood. This he failed to do.

⁵By visiting our elderly neighbour we are placing ourselves into the concrete, particular relationship between one-caring and the cared-for. We are approaching the situation as being open to her need for human contact—responding, relating, and showing reciprocity in our action as a caring neighbour.

⁶The doctor might share the views regarding the proposed surgery taking into account the objective reasonable person standard combined with prudential discretion since the purpose of the discussion is to explain the surgery and not to intimidate the patient.

⁷In this particular case with the virtue of hindsight the doctor practising caring might not recommend the surgery, however, what is important is the fact that all concerns expressed by the patient are taken into account regardless of the decision (not to operate) in this case.

⁸Noddings is aware of J.P. Sartre's separation of joy into two different categories. Joy as a 'feeling' represents a balanced state when one is being able to be moved by it whereas joy as an 'emotion' represents a degradation of consciousness when one moves from a reflective to non-reflective state of consciousness (Noddings, 1984, pp.132-133).

⁹Robert M. Veatch, "Abandoning Informed Consent", Hastings Center Report, 25.no.2. (1995): 5-12.

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