

TOWARDS AUTHENTIC CONVERSATIONS. AUTHENTICITY IN THE PATIENT-PROFESSIONAL RELATIONSHIP

VILHJÁLMUR ÁRNASON

Department of Philosophy, University of Iceland, IS 101 Reykjavík, Iceland

ABSTRACT. The purpose of this paper is to evaluate the significance of the existential notion of authenticity for medical ethics. This is done by analyzing authenticity and examining its implications for the patient-professional relationship and for ethical decision-making in medical situations. It is argued that while authenticity implies important demand for individual responsibility, which has therapeutic significance, it perpetuates ideas which are antithetical both to authentic interaction between patients and professionals and to fruitful deliberation of moral dilemmas. In order to counteract these consequences, an alternative idea of authenticity is introduced. According to this idea, authenticity is not regarded primarily as individual sovereignty, but as an ability to participate in a dialogue in which the subjectivity of both partners is respected. Such practice, based on mutual trust and responsibility, would enhance common decision-making and overcome the alienation between patients and professionals.

Key words: Authenticity, conversations, medical decision-making, patient-professional relationship, respect for persons

1. INTRODUCTION

"Patient autonomy" is a popular slogan these days. In medical ethics this idea has usually been explicated in terms of liberal theories of individual freedom. But there are other theories of freedom that are worth considering in this context. The most radical doctrine of individual freedom in the history of philosophy can be found in existentialist writings. In this paper I examine whether the existential notion of authenticity has any significance for our understanding of the patient-professional relationship and medical decision-making. In the first part I briefly describe the main characteristics of authenticity, especially as it appears in the existential philosophy of Jean-Paul Sartre. In the second part I evaluate three models of patient-professional interaction in light of the notion of authenticity. In the third part I consider the implications of existential authenticity for moral decision-making in health care. I argue that the existentialist version of authenticity is far too demanding, monological and individualistic to be suitable in the context of health care. The demand for radical individual

self-governance must be rejected in favor of a dialogical interaction between persons who engage in "authentic conversations."

2. THE EXISTENTIALIST NOTION OF AUTHENTICITY

In his book, *Existentialism*, John MacQuarrie writes:

Existence is authentic to the extent that the existent has taken possession of himself and, shall we say, has moulded himself in his own image. Inauthentic existence, on the other hand, is moulded by external influences, whether these be circumstances, moral codes, political or ecclesiastical authorities, or whatever.¹

According to MacQuarrie's words, authenticity really is personal freedom in the sense of radical self-governance.² This freedom of the existential subject consists in a dynamic process of creating oneself. We do not become free by escaping all "natural effects" and by subjecting the passions to the rule of reason. Rather than excluding or repressing part of ourselves, we can fully be ourselves only by assuming the totality of our being. The existential subject takes hold of him- or herself and becomes *authentic* by assuming responsibility for his or her entire life. It is essential to the existential conception of human existence that the individual accepts the responsibility placed upon him/her as a free human being.

In existentialism the individual's *choice* is of pivotal significance for all ethical considerations. This choice is not characterized in terms of intellectual deliberation between objectively presented possibilities, but rather as the way in which the individual realizes possible modes of existence. Existentialism regards it as a unique characteristic of human existence that one never passively undergoes one's condition; one lives in an active way and projects one's life on the basis of the concrete situation. In the course of this activity, one gives meaning to one's world, which has no significance independently of this process. Rather than being imposed upon human agents, all standards of behavior and models of life arise, therefore, within the structure of interpretations created by human activity. Historically speaking, the center of emphasis is thus transferred from the universality of which the individual is only an instance to the individuality through which everything takes on meaning and significance.

From the ethical perspective, this meaning-giving activity is best described in terms of the relationship between freedom and values. One of the most common examples of inauthenticity, or "bad faith" (*mauvaise foi*) as Sartre calls it, is to see our situation as endowed with ethical meaning independently of our choice. To use Sartre's terminology we tend to see meanings and values as a part of our "facticity" rather than as belonging

to our "transcendence." Sartre calls this instance of bad faith with respect to the status of values "the spirit of seriousness." He describes this attitude as one of escape, an attempt to conceal freedom through false but reassuring conceptions of values. This we do in order to avoid the experience of anguish, which Sartre defines as the "reflective apprehension of freedom by itself;"³ it is my awareness of the fact that I cannot avoid giving significance to my situation and that I alone am responsible for it. We must attach meaning to our situation without having any "excuse behind us, nor justification before us."⁴ Unfortunately, in Sartre's view, most of us do not have the courage to live out and endure this truth and hence "most of the time we flee anguish in bad faith."⁵

It is an obvious consequence of this existentialist conception of values that they can not be regarded as fixed qualities or properties upon which I may base my actions and moral choices. On the contrary, it is I who set up values through my choices, that is, in the course of my actions. The existentialist would, therefore, replace traditional formulations of the relationship between value and action of the form, "I do X because *it* is valuable," with the formulation, "By doing X *I maintain* that X is valuable." Whereas in the first case, I imply in the spirit of seriousness that my action is dictated by a value which exists independently of my act, in the second case I act on the assumption that values arise in and through my actions. To use one of Sartre's examples,⁶ I cannot say, without denying my freedom and thus lapsing into bad faith, that I went to the war in spite of my disapproval of it, because it is precisely by going to the war that I demonstrate my approval of it and thus decide its value. In choosing ways of life, we color the world with values. In the last analysis, therefore, values are ways of existing, freely chosen modes of being in the world. In determining our own lives and shaping our own selves, we create values.

Not only are there no values inscribed in things and acts, there is absolutely no objective basis for social norms and moral codes. This is not to say that the existentialists neglect the phenomena of cultural intersubjective norms, but rather that they regard them as the alienation of values. Insofar as individuals direct their lives in accordance with values which they uncritically receive from without, as it were, they are living inauthentically: denying their freedom and individuality. The authentic life, on the other hand, is presented as the full acknowledgment of the radical freedom of human existence, free of all submission to some axiological authority or foundation. Accordingly, it is characteristic of existentialist ethics to restrict its conception of *authentic* ethical life to the creative morality of the autonomous individual. The traditional morality of obligation, sanctioned by theoretical principles, divine commandments, social

conventions, or rigid conceptions of human nature, is *inauthentic* since it requires submission to an authority which is independent of the individual's own choice.

It is essential to the existentialist view of authenticity that the ethical subject be the author of his/her own actions. If our actions are to be called fully moral, they must be freely undertaken and we must assume full responsibility for them. This conception of morality rejects altogether the notion of externally imposed obligations and substitutes for it the ideal of self-imposed obligation. Submission to rational laws and external authority is replaced by personal integrity and resoluteness. Each individual and each situation is unique and the agent's response to an ethical situation can, therefore, never be validated in advance by reference to impersonal and objectively valid rules. In a most suggestive passage in *Being and Time*, Martin Heidegger writes:

The situation cannot be calculated in advance or presented like something present-at-hand which is waiting for someone to grasp it. It merely gets disclosed in a free resolving which has not been determined beforehand but is open to the possibility of such determination.⁷

Persons are on the existentialist view continually in the making, and values are disclosed only in the course of their actions; this makes it difficult to abstract ethical considerations from the concrete situation in which they find themselves each time. Ethical life is thus inevitably "contextualized" and the emphasis upon the moral *content* is radically reduced. Instead, the emphasis is placed upon the character and the *style* of an individual mode of existence.⁸ The message of existentialism is that people should show the courage to exercise their freedom and to commit themselves through a passionate and resolute decision. And, as John McQuarrie remarks: "not so much the content of the decision as simply its character as a personal act, fully and intensely appropriated by the agent is what matters."⁹

3. AUTHENTICITY AND MODELS OF INTERACTION IN HEALTH CARE

In order to evaluate the implications of the existential notion of authenticity on the professional-patient relationship, I will now briefly consider three models of interaction that have been discussed in the bioethical literature. I call them the *paternalism model*, the *patient-autonomy model* and the *co-operation model*.¹⁰

3.1. *The Paternalistic Model*

The model of interaction between patients and health-care professionals implied in the Hippocratic tradition has been properly described as benevolent *paternalism*. This model has been dominant in the history of nursing and medical practice until quite recently. The ruling idea behind this practice is quite simple. The patient seeks help from professionals because they have expert medical knowledge which the patient lacks. It is the duty of the professional to make use of this knowledge in such a way that it secures the best interests of the patient which are to be evaluated in terms of his/her medical condition. Patients should not be worried with information about their condition because, in addition to lacking medical knowledge, they are sick people who need comfort. Therefore, the professional will not involve the patient in a complicated decision-making process, but makes the decisions him- or herself based on professional knowledge and experience.

This may sound convincing and even realistic but it is not unproblematic. It is true that professionals have expert knowledge of a patient's medical condition, but that premise is not sufficient to support all the conclusions just described. *Firstly*, it is not correct to say that professional knowledge of the patient's medical condition is identical to knowledge of the patient's best interests. These interests cannot be fully identified without knowledge of the patient's preferences, values and wishes. The patient is an individual with a unique history and particular life projects, and cannot be treated as a person unless his or her own point of view is taken into account. Usually there are various treatment options, and, as a rule, no single decision should be deemed correct without consulting the patient. *Secondly*, it is misleading to maintain that informing patients causes them to worry. The view has long prevailed in medicine that truth should be used by doctors as a therapeutic device to be given in appropriate amounts, or not at all, if they believe it will harm the patient. But recent studies have indicated that even from this perspective truth is the best policy in the professional patient relationship:

The damage associated with the disclosure of sad news or risks are rarer than physicians believe; and the *benefits* which result from being informed are more substantial, even measurably so. Pain is tolerated more easily, recovery from surgery is quicker, and cooperation with therapy is greatly improved. The attitude that "what you don't know won't hurt you" is proving unrealistic; it is what patients do not know but vaguely suspect that causes them corrosive worry.¹¹

This brief description of paternalism model suffices to show that it is in stark opposition to the existential notion of authenticity. In fact, it

condemns the patient to inauthentic existence by making him or her unable to exercise personal freedom. The patient is thus reduced to a thinglike, passive state of being which, according to the existential philosophy of human subjectivity, is utterly degrading and dehumanizing. In order to fulfill the requirements for existential authenticity two obligations must be met. The professional has the negative duty not to subject the actions of the patient to controlling influence. This, of course, implies the positive duty to inform the patient in order to foster autonomous decision making. But more interestingly the patient also has a positive obligation to responsibly participate in the decision making so as to be a free agent and not an inauthentic patient.

The existentialist critique of the paternalist model differs from the more common liberal criticism in that not only does it criticize the authoritarian practice of the professionals but seems to *demand* that patients exercise their autonomy. Respect for autonomy implies only the minimal requirement of not controlling the life of another person, as long as she is competent and/or does not harm the interests of others. This demand is essential in health care because it protects the person from illegitimate interference. The requirement for authenticity oversteps this liberal line by insisting that the person exercise her autonomy in a particular way. It is not sufficient that the professional refrains from violating the patient's autonomy; it involves the much stronger claim that the patient must make decisions which are genuinely *his own*. Such a demand is rarely, if ever, appropriate in health care.

Existentialism, therefore, does not accept the so-called "fiduciary paternalism," or paternalism based on trust, where the patient chooses simply to yield to the "priestly physician" or to see the nurse as a "surrogate mother."¹² This means that the demand for authenticity requires that patients exercise their "first order" autonomy and not only their "second order" autonomy.¹³ Second order autonomy, on the existential view, would be an inauthentic and blameworthy escape from freedom in bad faith. Paradoxically, this strong existentialist requirement for patient responsibility may result in paternalism of another kind, because it threatens the patient's autonomy to choose the way in which he or she fulfills the role as a patient.

3.2. *The Autonomy Model*

In light of the criticism of the paternalism model of patient-professional interaction, it is not surprising that it has been increasingly rejected in recent decades. The most radical theoretical alternative to this state of affairs is

a model of interaction based primarily on patients' *autonomy*. On this model, the patient is assumed to have a *right* to control what is done to his or her body. Since it is the patient's own life and limbs that are at stake in medical situations, the patient – and not the doctor or the nurse – should have the final authority to decide what is done. Their role should primarily be to provide the medical information upon which the patient can base his or her choices. It has even been suggested that professionals should present the patient with options in a “neutral” way, so as not to impose values or preferences upon the patient and thus diminish his or her autonomy. Instead of being the patient's father figure or a surrogate mother (as the paternalism model suggests), professionals are to take on a much more distanced technical role in relation to the patient. Robert Veatch has called this the “engineering model” in medicine and Sheri Smith talks about the “nurse-technician.”¹⁴ The role of the patient becomes in effect one of a consumer whose wishes are to guide the health care services.

The exclusive aim of this model is to maximize patient autonomy. In light of the existential doctrine of authenticity it might appear to be an optimal state of affairs. This may be true if we look only at the role of the patient. The patient is certainly given full elbow room to exercise freedom. But the problem is that the medical situation is one of *interaction*, a relationship which involves more than one individual. While the paternalism model violates patient autonomy and precludes authenticity, the patient autonomy model threatens the integrity and authenticity of the professional. The existentialist notion of authenticity is of no help here; in fact it perpetuates the problem. By laying all emphasis upon the resoluteness of the individual decision it offers no mediations between two or more individuals in the process of reaching a common decision. But in the context of health care this is the most important task. The demand for radical self-control is alien to the patient-professional interaction.

It is the right of the patient to control – in the last analysis – what is done to his body. But this right must be understood primarily as a *negative* right. By this I mean that (s)he has the right to control what is *not* done to his or her body, in other words the right to refuse treatment (which implies the right to consent to a proposed treatment). In order to enable the patient to do this (s)he must be informed of the medical options, their prognosis, the side-effects and so on. However, the right of the patient to control treatment usually cannot be understood as a positive right except in the general sense that in medical need (s)he is entitled to the goods of health care. The patient does not have the right to determine entirely what kind of services (s)he receives. The legitimacy of his/her wishes is limited by the objectives of health care and the obligations of health care professionals.

In other words, the rights of the patient must have *a sensible connection to the duties of the professionals*. It is not the professional's duty to obey patient's wishes, whatever they may be. Doctors and nurses must also protect their professional integrity and abide by their role-specific obligations.

Existentialists, like Sartre, are highly critical of professional role morality (some of Sartre's examples of bad faith are about the rigidity of role playing). They argue that if professionals are too bound by their roles and codes of conduct they do not exercise their autonomy, but rather passively succumb to external influences:

An Existentialist will see role morality as conforming to an expected type and being guided by rules, and so as sub-personal "*mauvaise foi*". [. . .] To accept a role is to evade the responsibility of seeing that one is free not so to act, and of freely deciding what one wants to be. It is to evade freedom by sheltering behind one's social function.¹⁵

This is a legitimate concern and exemplifies the most fruitful aspect of the existential notion of authenticity: the responsibility of the individual for his or her own actions and decisions. But the critique of role morality can easily be overstated. In real life individuals can rarely disregard their roles without evading responsibility. Properly regarded, roles and ethical codes do not force health care professionals into rigorous routines which take no account of individual situations. The demand for professional responsibility appeals to the freedom of the professional *conscientiously* to do his or her job, not as a rigid role-player, but as an authentic person. If we are to apply the existentialist view consistently, it must take into account the authenticity of both partners. This means that while certain restrictions may be placed upon the autonomy of the patient as well as on the professional, this may enhance responsible authenticity overall, because both partners would sincerely participate in the process of decision-making. My thesis is that this can only be properly accomplished in authentic *communication* or conversations between patient and professional.

The major handicap of the paternalism model is that it blocks communication between patient and professionals. The paternalistic, not to say authoritarian practice of medicine is, as Jay Katz has aptly said, a history of silence.¹⁶ There are instructive illustrations of this in the Hippocratic corpus. For example, Hippocrates admonished physicians to perform their duties:

calmly and adroitly, concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and sincerity, turning his attention away from what is being done to him; sometimes reprove sharply and emphatically, and sometimes comfort with solicitude and attention, revealing nothing of the patient's future or present condition.¹⁷

Such a mute or monological practice treats neither the patient nor the professional as a person. Physicians become estranged from their patients, which increases the feelings of abandonment already evoked by illness. This estrangement is not overcome by following the autonomy model which provides limited options for authentic communication between patient and professionals. On the model of autonomy, the relationship remains monological rather than inter-personal and dialogical; only now it is the professional who is on the receiving end. In sum, the patient autonomy model suffers from the same basic flaw as the paternalism model; neither model is as such designed for nor conducive to *conversations* between patients and professionals. Instead, each in its own way inhibits thoughtful and considerate interaction *between two persons*. Neither model, therefore, can foster *mutual authenticity*.

3.3. *The Cooperation Model*

The third and the last model of patient-professional relationship that I will consider in relation to authenticity is the *cooperation* model of interaction. To preclude misunderstanding I want to make clear that I do not have in mind a so called contractual model which sees the relationship of a patient and a professional in terms of a semi-legal *contract*.¹⁸ Though a contract model may be appropriate in some other professional/client relationships (such as between a lawyer and a client), it is not well suited for the patient-professional relationship because the contract presupposes a more equal relation between the partners than is possible in most health care situations. The patient is inevitably the weaker partner in at least two senses: In addition to being sick he or she lacks medical knowledge to evaluate his or her own condition. This makes the patient unusually dependent upon health care professionals, because he is often full of "personal anxieties and fears that illness and its treatment engenders."¹⁹ The contractual model not only overestimates the independence and psychological autonomy of the patient, but also reinforces the alienation amongst people that pervades professional relationships as well as society at large. Interaction mediated by a contract still maintains distance and indifference which is alien to a good patient-professional relationship. It invites exchange of viewpoints and values but does not engage the partners in a dialogue.

The cooperation model of patient-professional interaction is the only model that explicitly takes communication as its starting point. It is based on the conviction that the objectives of health care can best be realized in conversations between patients and professionals. This is both because a conversation, as Gadamer observes, "opens up the treatment and accom-

panies healing,"²⁰ and because it is an optimal way to treat both the patient and the professional as persons. It is in the daily conversations that take place (or do not take place) that this moral demand is acted out (or neglected). This is because the vulnerability of the human being is not only physical but also, and even primarily, psychological. This psychological vulnerability is inextricably linked to the linguistic nature of man which makes him radically dependent on interpersonal relationships and understanding.²¹

This vulnerability of the patient requires thoughtfulness and consideration that go far beyond medical attention to life and limb. The tension between the respect for autonomy and the concern for welfare is at the heart of the patient-professional dialogue. As Onora O'Neill has remarked: "We experience it every time we try to work out how to share others' ends without taking them over."²² This tension characterizes many ethical problems in the area of health care, where the professional must find a fitting balance between non-interfering distance and caring presence. Kant discussed the former under the heading of respect and the latter under the heading of love: "The principle of *mutual love* [*Wechselliebe*] directs men constantly to *come nearer* to one another; that of *respect* [*Achtung*], which they owe one another, to keep themselves at a *distance* from one another."²³

The professional-patient interaction requires distance because it safeguards the "space" that is necessary for each person to be herself, and it requires presence because the aim of the interaction is the patient's health and welfare. From Kant's perspective the paternalistic model disrespects the patient by imposing on him/her a suffocating, benevolent presence, while the distance of the autonomy model is so great that it endangers the patient's welfare. There is no theoretical solution to the tension between the requirements for presence and distance in the patient-professional relationship, but it is constantly dealt with in good medical practice. The vehicle of that *praxis* is authentic conversation.

Communication in health care has two main objectives, to *inform* the patient (and professional) and to provide the patient with *emotional support*. These objectives roughly correspond to Kant's ideas of respect and mutual love. The former implies respecting the patient's autonomy which he or she can only exercise by accepting or rejecting the options for treatment proposed by the professional. A necessary precondition for this is that the patient be truthfully and sufficiently informed. Though the notion of "informed consent" requires just that, the dialogical nature of informing patients is all too rarely taken into account.²⁴ Informed consent requires conversations because the equalities and inequalities of the partners in the

dialogue complement one another: "Physicians know more about disease. Patients know more about their needs."²⁵ Both partners have to convey their knowledge and let the dialogue be a mid-wife of a shared decision which respects the integrity of both the patient and the professional.²⁶ The guiding idea of the cooperation model of patient-professional interaction is that decisions are taken in a spirit of *mutual trust and responsibility* created in a truthful dialogue.

The other main objective of communication in health care, to provide the patient with emotional support, cannot always be clearly separated from the objective of informing the patient. As Cicily Saunders, director of St. Christopher's Hospice in London, writes:

Every patient needs an explanation of his illness that will be understandable and convincing to him if he is to cooperate in his treatment or be relieved of the burden of fears. This is true whether it is a question of giving a diagnosis in a hopeful situation or of confirming a poor diagnosis. [...] Once the possibility of talking frankly with a patient has been admitted, it does not mean that it will always take place, but the whole atmosphere is changed. We are then free to wait quietly for clues from each patient, seeing them as individuals from whom we can expect intelligence, courage, and individual decisions.²⁷

The question is not *whether* the patient should be informed or not, but rather *when* and *how* that is done. Both the timing and the way in which the patient is "told the truth," for example, are matters of concern for the patient's welfare. This underscores the fact that dialogue is not a strategic device which is employed in order to let the patient cooperate, but an inter-personal mode of being. This mode of being I call *authentic conversation*.

In order to account for the phenomenon of authentic conversations the existentialist notion of authenticity is far from sufficient. Existentialism has not been conducive to this idea of communication. All too often its ideas are monologically constructed, because of its emphasis on the exclusive, solitary individual. Moreover, existentialist authenticity rests upon a false dilemma: Either I am the master of the situation or I succumb to external influences. In genuine human interaction these are not the alternatives. The demand for individual sovereignty destroys conversations which are aimed at mutual understanding. The "magic" of a good, authentic conversation is precisely that we do not control it as individuals but are caught up in it and give in to its own movement, which is governed by the subject matter. The phenomenon of conversation shows us the primacy of the subject matter over the individual subject. At the same time, the individual is most truly himself – most authentic according to my account²⁸ – when he forgets himself and opens up to the other in dialogue. This dialogical openness is a necessary condition for authentic interaction between patients and professionals. If that is sacrificed for the sake of individual self-mastery, the

conversation is most likely to become a tool for manipulation and strategic action.

This idea of communication between patient and professional in cooperative search for a choice which respects the authenticity of both partners will not be easily realized. Individual, institutional, educational and ideological factors preclude the implementation of this ideal in everyday practice. As Jay Katz has argued, the current communicative practice of physicians must change radically:

The new conception of [. . .] mutual trust [. . .] relies not only on physicians' *technical* competence but also on their willingness to share the burden of decision making with patients and on their *verbal* competence to do so. It is a trust that requires physicians to trust themselves in order to trust their patients, for to trust patients, physicians first must learn to trust themselves to face up to and acknowledge the tragic limitations of their own professional knowledge; their inability to impart all their insights to all patients; and their own personal incapacities [. . .] to devote themselves fully to their patients' needs.²⁹

Willingness and competence to converse are minimal prerequisites of the cooperation model, while humble acceptance of professional limitations and respect for the patient as an intellectual and emotional being contribute to an authentic dialogue. This, admittedly, takes time, and the quantitative accomplishment of the busy physician would clearly be diminished, and hence the income that increases in proportion to the number of patients "seen" each day. But in spite of these practical obstacles it is important to have a sound guiding idea according to which people can evaluate and improve their practices.

4. IMPLICATIONS FOR MORAL DECISION-MAKING

Authenticity is not to be seen as the sovereign will of the patient, but rather in terms of a *shared decision-making* between patient and professional. I have already tried to show how existentialism precludes such a dialogue by the monological formulation of its key ideas. But there is another serious obstacle to shared decision-making in existential philosophy. This is the pervasive, decisionistic attitude towards morality. In my description of the existential notion of authenticity in the beginning of this paper I emphasized the view that the authentic person rejects the objectivity of values and insists on radical choice. This is aptly illustrated by a famous example in Sartre's essay on existentialism and humanism. A young man is torn between remaining with his ailing mother and going off to join the Resistance. Sartre points out that no ethics can resolve this dilemma and that there is no rational way to adjudicate between these two claims. His

advice to the student simply is: "You are free, so choose." Taking this example into the context of health care, the implication may be that the professional is to do the same to the patient who is confronted with a hard choice between different options for medical treatment: There is no objective, rational way to resolve your dilemma, so choose.

Though convincing at first sight, Sartre's example is deceptive for at least two reasons: Firstly, Sartre is clearly wrong to use this example to substantiate his theory of the subjectivity or non-reality of values. If values were a matter of individual decision, the young man would not find himself in this dilemma. He is in this dilemma because he is faced with two powerful *moral claims* based on real human values.³⁰

Secondly, Sartre is right that no moral theory can resolve this dilemma, but he is wrong in concluding that nothing can help the young man to reach a decision. Sartre's treatment of this matter is a striking case of abandonment. Placing all emphasis on individual liberation, he neglects the deliberation that often serves as the mid-wife for authentic choice. Authentic conversations provide the forum for such deliberation. But this accounts only for the *way* in which people are to interact in such situations. The content of the deliberation, *what* they are to think about, can also be laid out in general terms. It consists of three major factors:

- 1) A sense for *the situation*. This is where everything starts and to this we are bound to return. The "facts of the matter" must be made clear and evaluated and the nuances of the situation need to be taken into account. This requires respect for the particular persons, context sensitivity and existential commitment. In medical context this interpretation of the facts and assessment of consequences often calls for professional expertise. But the most difficult task is to see in a complex situation what is the right or fitting thing to do.
- 2) The situation must be evaluated in light of general *ethical principles and values*. The situation is morally complex because more than one important principle or value is at stake. In a medical context for example: Should life be prolonged or autonomy respected? Should the welfare of the patient take primacy over his will? Such questions cannot be answered independently of the facts of the situation. It is the task of moral theory to clarify this dimension and to enlighten the conversations, but it cannot be expected to solve any particular dilemma.
- 3) The situation is evaluated and inhabited by concrete persons who have particular life conditions as well as certain *roles* and *professional responsibilities*. The roles of the partners in the dialogue grant them an identity, the elucidation of which is needed for an assess-

ment of relevant rights and duties. It is impossible to reach a sensible moral decision about our *actual* duties in a concrete situation without knowing who we are and how we relate to other people.

Of these three factors existentialism has only emphasized parts of the first. The authentic person must respond to the situation and take responsibility for it. This is an important demand which has often been neglected both in theory and practice. In medical context this assumption of responsibility can be of major therapeutic significance because it enables the patient to harness his or her own healing powers rather than to passively undergo treatment. This is the most important aspect of the existential demand for authenticity, and in this sense it can be seen as a precondition for authentic conversations and cooperative decision-making between patients and professionals.

But if the situation is abstracted from the other two factors, it becomes empty and out of touch with the reality of the case. It is precisely this abstraction that has led to the value-decisionism of existentialism. One of the main reasons for this one-sided emphasis on the situation is that many existentialists have been fighting another, equally dangerous tendency which is to abstract the general values and role-specific duties from the situation. Then the principles and/or professional roles acquire a life of their own, some superhuman objectivity which violates moral experience. At worst this abstraction results in orthodox *legalism* without any context-sensitivity. Ignoring the importance of choice and evaluation this legalism fanatically tells us what to do. However, the opposition between decisionism and legalism is a false dichotomy. The tension between particular choice and general principles is always mediated in praxis. I see no better way to practice this mediation than deliberation of the matter in authentic conversation between those affected by the decision.

5. CONCLUSION

The upshot of my analysis is that the existentialist notion of authenticity is too monological, individualistic and overly demanding to be fruitfully applied in the area of medical ethics. It demands that the acting persons acquire self-governance in the sense that their actions are their own and not moulded by external circumstance. I propose that we see authenticity in health care not as the sovereign will of the patient, but rather in terms of *a conversation* between patient and professional aiming at a shared decision. It is not so much a question of being in control of a situation or being controlled by it as it is to delve into the subject matter and

deliberate about it in a thoughtful dialogue. Only in this way is it possible to be authentic in the sense of respecting subjectivity of both self and other. In practicing authentic conversations, we come to realize that hell is *not* other people, as Sartre once claimed, but the alienation invoked by distorted communication.

Acknowledgements – The author wants to thank the Alexander von Humboldt foundation whose grant enabled this research.

REFERENCES

1. MacQuarrie J. *Existentialism*. London: Penguin Books, 1972: 206.
2. It is debatable how well this characterization applies to many who have been labelled existentialists, but it is clearly true of Sartre's type of existentialism which is the one I have in mind in this paper.
3. Sartre J-P. *Being and Nothingness*, Trans. Barnes HE. New York: Philosophical Library, 1956: 39.
4. Sartre J-P. "Existentialism", Trans. Frechtman B, *Existentialism and Human Emotions*. New York: Wisdom Library, 1957: 23.
5. Sartre, *Being and Nothingness*: 556.
6. Sartre J-P. *Being and Nothingness*.
7. Heidegger M. *Being and Time*, Trans. MacQuarrie J, Robinson E. New York: Harper and Row, 1962: 355.
8. This implies a kind of an "aesthetics of existence," cf. Sartre's perspective on human life as a work of art (see Sartre J-P. *Existentialism*).
9. MacQuarrie J. *Existentialism*: 187.
10. These models are ideal types, theoretical constructs that accentuate typical features, but need not be found as such in medical practice.
11. Bok S. *Lying: Moral Choices in Public and Private Life*. New York: Pantheon Books, 1978: 234.
12. Veatch RM. Models for ethical medicine in a revolutionary age, Smith S. Three models of the nurse-patient relationship. In: Mappes TA, Zembath JS, eds. *Biomedical Ethics*. New York: McGraw-Hill Book Company, 1981: 56–59, 120–126.
13. Childress JF. The place of autonomy in bioethics, *Hastings Center Report* 1990;20: 12–17.
14. Veatch RM. Models for Ethical Medicine.
15. Emmet D. *Rules, Roles and Relations*. New York: St. Martin's Press, 1966: 152.
16. Katz J. *The Silent World of Doctor and Patient*. New York: The Free Press, 1984.
17. Macklin R. *Mortal Choices*. Boston: Houghton Mifflin Co., 1987: 9.
18. Both Robert Veatch and Sheri Smith support such a model (see Veatch RM. Models for Ethical Medicine).
19. Katz J. *The Silent World*: 226.
20. Gadamer H-G. *Über die Verborgenheit der Gesundheit*. Frankfurt am Main: Suhrkamp Verlag, 1993: 161.
21. Habermas J. *Moral Consciousness and Communicative Action*, Trans. Lenhardt C, Nicholsen SW. Cambridge, Mass.: The MIT Press, 1990: 199.
22. O'Neill O. Between consenting adults, *Philosophy and Public Affairs* 1985;14: 252–277:265.
23. Kant I. *Die Metaphysik der Sitten*. Stuttgart: Reclam, 1990: 337.

24. Faden RR, Beauchamp TL. *A History and Theory of Informed Consent*. New York: Oxford University Press, 1986.
25. Katz J. *The Silent World*: 102.
26. Socrates used the analogy of the mid-wife for his method of helping others to give birth to ideas. Authentic conversation has a different maieutic function, aiming at informed *decisions*.
27. Saunders CM. Telling patients. In: Reiser SJ, Dyck AJ, Curran WJ, eds. *Ethics in Medicine*. Cambridge, Mass.: The MIT Press, 1977: 238.
28. This is clearly different from the existential notion of authenticity which gives primacy to the self-conscious subject over an authentic participation which requires that we "lose ourselves" in the dialogue and give in to its own movement. I have discussed this point elsewhere by comparing Sartre's and Gadamer's notions of play (see: Árnason V. Morality and humanity, *The Journal of Value Inquiry* 1988;22:3–22).
29. Katz J. *The Silent World*: 102–103.
30. Taylor C. Responsibility for self. In: Rorty AO, ed. *The Identities of Persons*. Berkeley: University of California Press, 1976: 290.