A perspective from Bioethics. A dialogue with Dr. Bioethicist Mariela Mautone

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MM: For a long time, in Uruguay psychoanalysts have developed closed activities. They have an autonomous community, with their own internal rules, that have been transmitting in their training. On the other hand, in the psychoanalytic relationship, something happens that doesn´t take place in the other relationships, even in the field of psychology or psychiatry, that has to do with the way the speech of the patient impacts on the other person, and with the common space made by the analyst's and the patient's speech. I see this common space as untransferable to another person. They create together as an own space built between both of them; which the patient leaves when the treatment is over. However, there is, for example, the issue of supervision. There is a third party that gets into the relationship and it is ignored by the patient. It may have to be treated. Today, in the field of human rights, it cannot be ignored a third party that gets into a relationship.

N: Even when the anonymous nature of the patient is kept for this instance?

MM: Even so. It is a very close and endogamic population the one which has access to psychoanalysis in Uruguay. You are endogamic, but patients also come to take part of the endogamic issue. There is confidential data that can be disguised: what's my name, where I live; but there is sensitive data too, which cannot be changed without distorting the speech. They have to do with my values, my sexual orientation, how I deal with aggressiveness, my relationships at work, and these are very hard to disguise without losing validity.

N: Are those aspects as well taken as patient's data? Can the patient's speech itself be taken as a personal data?

MM: It is sensitive information and it is the one that should be protected the most. Nowadays and concerning the concept of what human rights are, this cannot be otherway. In Medicine, when we undertake procedures, we cannot give any information if the patient does not know.

N: It is interesting the reference to the medical field you have done. I see there a complex situation that puts psychoanalysis in other place, because the medical procedure is executed by

one or another doctor. But in psychoanalysis, as you have said, there is something that arises between two. However, do you also consider it as patient's data?

MM: Definitely, it is patient's data. You are going to have to discuss so much among you as psychoanalysts. You are in the middle of a conflict of interest. You have to publish. You need to publish but you do not show it to patients. Why do you have such reserve in showing? Because you think it is going to create discomfort… And it does!

N: Definitely, psychoanalysis' development is based on diffusion and discussion of clinical material. I do not see a mean intention in not showing; I see it as a way of avoiding to expose the patient in a situation that places him in an uncomfortable position. The place of the patient in the analysis is a very complex issue. Some authors propose that, in mental health, the right of autonomy does not work due to the transferential aspects. The patient is never autonomous; and posing to a patient that one wants to write or present his material may cause the emergence of a bunch of questions that put the patient in a compromising situation. Why does the patient say yes? And what happens if the patient says "no"? How does he feel going on with the treatment? Actually, there are authors who say that when this issue is posed to the patient, the analysis is over.

MM: I do not see it in this way. Talking about adults' psychoanalysis, by definition, the person who has access to analysis is capable of deciding and has the right to decide. After that, it comes the issue of saying whether I want to share this with colleagues during the analytical process. I see this is difficult. Another issue is also the destiny of the analyst's notes. What shall we do with the notes when the analysis is over? What sense it has that the analyst saves them?

N: APU's ethic's code claims that the passed away analyst's notes must be destroyed. However, would you compare the analyst's notes with a clinical file? Analyst's notes also include the impressions of the analyst, not necessarily the patient's speech.

MM: Sure, but those are impressions that have to do with the patient's person. The patient has the right to ask what is it going to be done with his notes. Why are you going to keep it? If, maybe, you are going to dictate a lesson, you have to tell the patient that you will inspire on his speech to do it.

N: That you will inspire on the patient's speech? Even so?

MM: Of course, you are going to use the material for others. You have to find the way of taking into account the patient's right, without it affects the relationship. The analyst can legitimately

feel the right of publishing; because it is his/her job. Any professional has the right to grow and build a career, and this has to do with the contact among peers and not locking up.

N: It may seem natural to us because we have been trained in this way, and it seems natural working with clinical material; or inspiring, as you said, on clinical material. Showing the own work, the dialogue with colleagues, receiving inputs and questions are a part of it. The issue is that psychoanalysis is a different field from all other because there is the voluntary aspect of the patient and there is what it comes out of the process, which is unknown by the patient and by the analyst. It is what gets discovered during the analysis. There are authors who say that when the patient is given the work to read because of the informed consent, and so he or she can make corrections, the patient becomes almost a co-author. Others, instead, claim that, as a consequence, the work does not reflect the perception of the analyst. It is something else, because the analyst is going to propose aspects that would be welcomed by the patient in order to have his/her approval; and so the things get distorted. And what happens with the difficulties, with the interrupted treatments? Then, do we miss all of what is important to discuss and dialogue about?

MM: No, you do not have to miss all of it. The issue is that you have not found a solution. The principles of bioethics take you to be very honest and respect the people's right. You start an analysis with someone, do you care or don't you care what is going to be done with your material? How do you feel about it?

N: And how would you see going to a modality of explaining that the psychoanalytic institution works in this way with anonymous and disguised material as a part of our job and the development of the profession? I mean, psychoanalysts nucleated by the IPA work in this way, preserving the patient's anonymity. Would it be a way of making viable these aspects through the institution that comprises all of us?

MM: I think so, it is fine. However, psychoanalysis has also to notice that it is under the same rules of every XXI individual; but not making the patient believe that it is a reality made by two. Or that during the psychoanalytic work it is going to be a closed community; and that whatever is done with the material, it could be done, for instance, after the process is finished. A good thing could be: 'look, Sir, you come here, there will be many difficulties. I may need to supervise because things will also happen to me'.

N: What happens is that when the patient seeks analysis, he is looking for a person to whom the patient attributes knowledge that is going to help him; and a psychoanalyst works with it.

When you start an analysis, the analyst is located for the patient in a certain place, and when the analysis is over, the analyst has nothing to do with what you thought he/she was. And this is part of the analytic work itself. I mean that the analytic process itself, if everything goes well, is going to be taking the patient to see the analyst closer to the real person he/she is. And this is also hard, because it is not simply telling the patient: 'you think I know, but I do not know that much'. It may be said, perhaps; 'look, we, analysts, discuss our work in certain environments'. I do not know… I think there is certain cultural acceptance in this way; but apart from this, there is a perception that the patient has…

MM: I am not convinced at all by this. You will look for an analyst and there is a certain connection that has to go through a more affective than rational aspect, I guess; however, indeed the analyst remains located in a place that has nothing to do with any other place that no one has in our lives. This happens to the patient. But if we want the work to be developed in the frame of bioethics, bioethics is going to ask for the recognition of certain aspects, and neither an informed consent nor a signed paper, but the minimal acknowledgement of the two people about the commitment they have. The patient will try to be as honest as possible; he will try to go to the sessions… The patient will try… Of course, then other things happen. And the analyst will try to join the patient through this process and he may need supervision. It is true that you cannot be absolutely autonomist and sometimes paternalism is needed. For the orthodox autonomist, it could not be done more than giving the patient the options.

N: And would you be identified as 'paternalist' even when you are using your medical knowledge to propose something or not to the patient?

MM: Yes. Even so we are accused of paternalists.

N: But there are situations in which the patient can choose things that are not good for their integrity. Where is then, the patient's right to live?

MM: Yes, I arrive to a point and I think that there are situations in which the patient has no elements to decide or he is not in conditions of doing it. I understand that the flexibility of the thought is the only thing that saves it. It is not about absolute codes. However, the person who decides to psychoanalyze itself is autonomous; the patient knows where he is getting in.

N: And can't we consider that the patient also knows that our way of working as psychoanalysts includes the discussion of the clinical material with colleagues?

MM: No, it is not enough. Because the patient is blind and he wants to believe that the place is exclusively his. If you get into dialogue with bioethics, you will be questioned on these aspects, including the research's ethics. One thing I had in mind, which you mentioned, is what happens when the analyst knows about extremely dangerous behavior, and there is no choice than informing. There are situations when you do not know how to do to avoid breaking the rules, although life is the priority in human rules. There are situations that are no-solution dilemmas, but if you know that someone is going to commit a crime, you have to report him. If you are called to go to court, it will be something to see within the treatment. Nevertheless, if a child's custody is at stake, you will have to declare if the call arrives. There are minimum aspects that have to be clear. For instance, going back to the notes. Today, I would ask you what you are going to do with the notes.

N: Well… when you receive a patient, you are thinking about the encounter and not about what you are going to do with the notes, because you actually do not know. You do not know what is going to happen. However, I believe that analyst's notes are very personal, and each one works with it in his/her way. Sometimes you write, sometimes not. Sometimes you write a dialogue, or patient's data, or words, or a dream, or sometimes they are your impressions. And sometimes the patient asks what we do with the thing we write.

MM: It could also be said that the notes are mine; they are things I write, which I sometimes re-read and they are things that help me to help you.

N: And how would you see then that conciliates the field of bioethics and the analysts' interests in moving forward with the development of the discipline, while looking after the patient's rights? We have a great contradiction which is as inevitable; we want this confidentiality frame to be respected, but we need to discuss clinical material.

MM: In the XXI century, medicine is a two parts task and the own interest of professional development does not infringe any right. The way I see the things is not based on a code; it is in the framework of thought and review of things.

N: How is the link between bioethics and law? Does it depend on the region? For example, in some countries, clinical material can be used within the medical team inside the hospital without consent. However, it is not the same everywhere. Do patient's rights change with the law in every country? How is this?

MM: Yes, here there was an ethical code of the Medical Union that was the 'mother' document, let's say; which was after modified because great progress has been made on patients' rights.

In 2014, the medical ethical code was voted and it remains a law for the whole country. The scope should be analyzed, but everything related to the course of a treatment for people's wellbeing is practically framed by the law.

N: At APU we have an ethical code. But when you say it is by law…

MM: It is compulsory. If it appears on the code, I have no freedom to think what I would do.

N: It should be seen to what extent this code includes institutionalized psychoanalysts and see to what extent it could affect the use of the material.

MM: Recently, the mental health law was made public. It is interesting because there are problems abroad that will after arrive here. For instance, the matter of forced hospitalization and everything it implies about the person's vulnerability when the patient is no longer responsible for his/her acts; and indeed the community's vulnerability. I remember that there was an impressive discussion in Spain concerning the situation of a 15 years old girl who had denied eating and then, respecting her own autonomy, she was left without intervention until the last consequences. I thought that the girl was sick or that she could be treated; that it was not her autonomy which was behind her decision. We argued a lot about it and we could not reach an agreement.

N: So, again, what is the extent of the patient's autonomy and under which circumstances?

MM: There is nothing rigid in this field. We could be rigid; within a team, a way of treating it may arise. I do not respect autonomy when someone can self-harm so, so, much. The person may not be completely conscious of the situation and their consequences for life.

N: According to what you say, there are situations in the field of health, and I guess mental health as well, when autonomy is compromised. I mean, in what measure and under which circumstances am I autonomous? And I believe that this is a crucial point concerning the use of clinical material and the matter of consent in our discipline. And besides, even the patient's consent does not guarantee the patient's protection.

MM: This is a very subjective field. I consider the informed consent as the aberration of bioethics.

N: How is that…?

MM: The use that has been given to it here in medicine is, in first place, for protection of the institutions; then, to protect doctors, to a lesser extent though. However, the law also says that

the person's right to ignore has to be respected. It is different conception. Informed consent was philosophically born because there is a deep mistrust in doctors' work. It was born in the USA because they understand that there is an abusive use of medical practices, so they pose that the doctor has to say and the patient has to decide. It is something strange that slips into the profession; it may happen to you and it is very hard to work afterwards. There are things you will have to go through; not as a matter of written informed consent documents, but as a matter of agreements, of more human aspects, of personal relationships. There are bioethical positions, more than one. I do not know how much you talk about these issues.

N: Well… We are trying to do it in a deeper way.

MM: Yes, perhaps you still lack of a process of internal thought that you should have. Things have changed; it is not Freud's activity… You nourish and give feedback to yourselves in an endogamic way. And you listen very little the others' voice. You create explanations and counter-explanations of why you do this or the other, but you are actually not including a person that has something to do from another point of view and who nowadays has to be listened. There are many ways of promoting patient's trust towards the analyst, but not with the rigidness of the informed consent. I think that the analyst's values are perceived in the session. If you analyze what do I break if I make a minimal human and verbal contract… I may need eventually to supervise, write, publish…

N: I imagine what you say. I receive a child patient's parents who sometimes have no idea of how I work. I ask them: 'do you know how this works?', and I explain them: 'I will pot some toys over the table, we are going to dialogue and play together, etc. But until when do I have to explain? That I will write a paper? I do not know. I do not have it in mind when I receive a patient. I think that posing would have nothing to do with the meeting.

MM: However, how is that the confidentiality issue comes up? Why do you question yourselves about it?

N: Because a patient can recognize himself in a way of working, in a dream and can feel uncomfortable about it. And despite of being careful and disguising the material, it is not completely controllable, and we need to transmit clinical material and our experience.

M: Sure. I believe there are two ways. One is to think in terms of how what you do impacts on the other, but not from the point of view of an isolated union between analyst and patient.

N: It is OK, but there is a certain dimension that necessarily has to be this way to make things work…

M Yes, but you have to think how to give the best framework to both parties. You could enrich taking into account how the patient would feel; thinking about what someone could have said from the patient's position.

N: We have all been patients, and some of us perhaps still are.

MM: That's it. But now you are affected by this. There is a look of the conflict. You will always have the analyst's view on this issue and it is fine; and the counterweight is not going to come from your peers, but from the outside. A layperson has always to take part of an Ethics' Committee; he/she has to be the one who alerts. The layperson always shows you what you cannot see, and this happens in every profession. I have been with anthropologists, philosophers and writers laypersons; they are people with a special sensitiveness. The layperson member is necessary, no matter who he or she is.

N: It is the other view… It is very interesting what you say. I think that the patient is part of the situation and he/she is not a layperson.

MM: It is the other view, which is so necessary, indeed. And asking myself what would happen to me. Being able to think what I would do or what I would wish for my children in this situation. This is a breaking point and the other view has to be there; the look of the supposedly or potentially affected. And recognizing that you do not work in health care just because you want to contribute to the patient's wellbeing, but also because of the passion for knowledge. That is why I believe that you will find in yourselves, talking among yourselves, or some people more willing to look themselves at work, or a group more willing to think, and remembering that there is another person who could be yourselves in another situation and in another time.

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