

without proposing a better way of treating the sick and dying. He hesitates to move toward suggestions, however, without a comprehensive re-envisioning of medical practice. He discusses insights from Heidegger about beings “at hand” and “not at hand,” observing that our illnesses and diminishments help us to properly value and mourn what we used to have “at hand.” The medical enterprise, focused on trying to restore the functioning of individual organs, inevitably falls short because it cannot adequately address “the loss of embodied capacities, potencies, histories, projects, and purposes” (295). Medicine still finds itself unable to grasp the significance of formal or final causes in its approach to the needs of critically ill patients; however, individual health care providers can look both to themselves to recapture the initial experiences of suffering that drew them to become health care providers, and to living nonscientific traditions for a more holistic view of the human being: “Whether the doctor is capable of intervening with technology or not, it is the response of suffering-there-with-the-other that soothes . . . the suffering of the other” (305).

Bishop’s *The Anticipatory Corpse* provides a rich set of philosophical, theological, and medical insights into end-of-life care,

which continues to cry out for more humane ways of addressing the needs of patients and their families. Issues of medical futility and the acceptability of brain-death criteria continue to appear in the headlines, as families refuse to let loved ones be removed from ventilator support while their hearts are still beating. Ethicists as well as family members and patients could very profitably read the individual chapters in *The Anticipatory Corpse* as well as many of the articles and books cited in almost eighty pages of notes and bibliography. Sensitive and experienced ethicists like Dr. Bishop are needed to help us not lose sight of our profession, as the renowned Dr. Pellegrino envisioned it, so that we may be prepared to decide on the right and good healing action for the anguishing and vulnerable person who is depending on us.¹²

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¹ Edmund Pellegrino, “A Philosophical Basis for the Patient–Physician Interaction,” in *Hippocrates Is Not Dead: An Anthology of Hippocratic Readings*, ed. Patrick Guinan (Bloomington, IN: AuthorHouse, 2011), 25–36.

***Dignity Therapy:
Final Words for Final Days***

by **Harvey Max Chochinov**

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While there may be far-reaching agreement that patients suffering from terminal illness are entitled to care that maintains, rather than diminishes, their sense of dignity, it is an altogether more difficult task to provide concrete measures by which that goal is actually achieved. In this book, psychiatrist and palliative care expert Harvey Max Chochinov confronts that challenge by developing both an empirical model of

dignity and a corresponding therapeutic intervention (called dignity therapy) designed to enhance a patient’s sense of value and worth during end-of-life care. There is much of value in Chochinov’s thoughtful and careful work, but when cast in the light of ethicist Jeffrey Bishop’s recent critique of the palliative care industry, some potentially problematic aspects of the initiative can also be discerned.

Chochinov begins the book by describing the empirical basis for the development of the dignity therapy initiative. Based on the results of in-depth interviews conducted with patients battling end-stage cancer, Chochinov's research team developed their "model of dignity in the terminally ill." Described in detail in the opening chapter of his work, this three-component model delineates the specific internal and external factors that contribute to a terminally ill patient's lived experience of dignity.

The first component of the model ("illness-related concerns") focuses on the patient's physical and psychological symptoms as well as their cognitive and self-care functional capacities. The second component ("social component inventory") refers to the extrinsic, environmental factors that impinge on the patient's well-being. Specifically, this component focuses on such factors as degree of social support, the "tenor of care" that is offered to the patient, and the patient's ability to maintain some sense of privacy despite undergoing a panoply of medical assessments and interventions. The third component ("dignity-conserving repertoire") refers to the patient's own behaviors, values, and belief systems that play an ameliorative role in confronting a terminal illness. Some of the beneficial psychosocial attributes highlighted by the author as serving a "dignity-conserving" function include a sense of hopefulness, resiliency, acceptance, role preservation, and spirituality.

A dignity-conserving practice of particular importance to Chochinov's work is "generativity," that is, giving something of the self for the benefit of future generations. Generativity is typically given concrete expression in acts like raising children, teaching young people, or otherwise sowing the seeds of one's time and talents for another's harvest. Chochinov believes that dignity therapy provides terminally ill patients with an opportunity to fulfill this psychosocial task by creating a "generativity document" for their loved ones. The creation of this document allows even the most difficult days of pain and isolation to be imbued with meaning and purpose.

The bulk of Chochinov's work is devoted to providing a meticulously detailed step-by-step instruction manual for health care workers interested in using dignity therapy as a way of assuaging patients' feelings of isolation or meaninglessness. A brief summary of the dignity therapy process is as follows: After obtaining the patient's informed consent, the therapist engages the patient in an audio-recorded, semi-structured interview that lasts about an hour. The first part of the interview elicits biographical information, whereas the second part focuses on specific bits of wisdom, guidance, or other information the patient would like to share with loved ones. The interview protocol consists of questions such as "Tell me a little about your life history, particularly the parts that you either remember most or think are the most important." "What are your hopes and dreams for your loved ones?" And "What have you learned about life that you would want to pass along to others?" (95–96).

Chochinov emphasizes that the interview itself is a significant part of the therapeutic initiative. If done correctly, the patient feels attended to and gratified to be able to contribute words of enduring significance. As the interview unfolds, the therapist's attention is fixed not on the patient's clinical history but rather on the stories told and the wisdom proffered. Chochinov provides numerous examples of the heartfelt insights and reminiscences typically elicited by the interview questions.

The recording is first transcribed verbatim and then is carefully, but substantially, edited. To emphasize the importance of this editing process, the longest chapter of the book, comprising well over a quarter of the text, consists of two fully transcribed interviews done with actors posing as simulated patients during a publicly presented dignity therapy workshop. These verbatim interview transcripts are followed by edited versions in which Chochinov assiduously annotates the reasons for each change. By walking the reader through this process, the author highlights the pragmatic as well as ethical complexities of editing generativity documents.

The substantially transformed narrative is then read to the patient, who is given the opportunity to clarify, modify, and amend the document. Once the patient approves of the document, it is presented to the person or persons chosen by the patient. The goal of the dignity therapy process is to manufacture a clear, coherent, and easily read “generativity narrative” that captures the person’s true essence.

Chochinov summarizes research that shows that this brief intervention carries significant benefits for both the patient and his or her loved ones. Specifically, a sense of generativity is gained by fulfilling a unique task for the benefit of future generations. For many patients, participating in dignity therapy can serve as a buffer against feelings of anguish, uselessness, or despair. The recipient of the generativity document benefits in turn by receiving a “permanent record” of a loved one’s thoughts, wisdom, and reminiscences.

Although the intervention is primarily employed with patients suffering from end-stage cancer, Chochinov believes that it may prove beneficial to anyone who is still in full possession of cognitive faculties but is facing life-limiting circumstances.

There is certainly much of value in Chochinov’s work. His empirical model of dignity allows researchers and health care workers to break down the otherwise nebulous concept of dignity into observable and assessable components that can be targeted for fruitful interventions. Further, there is little doubt that many patients and families who participate in dignity therapy find it an uplifting and meaningful project. Finally, one of the unquestionable merits of this work is the sincerity, sensitivity, and authenticity with which the author grapples with the possible difficulties that might arise in each step of the therapeutic process. Clearly, for palliative care agencies and workers who are considering the possibility of utilizing dignity therapy with their patients, this is an essential text.

Nevertheless, a recently published critique of the palliative care industry (which predates Chochinov’s work) raises some important questions concerning current

psychotherapeutic trends in end-of-life care. In *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying*, ethicist Jeffrey Bishop provides a trenchant critique of the emergent “biopsychosociospiritual model” of palliative care. Bishop argues that the medical industry has inexorably extended its reach of expertise and sovereignty into the psychological and spiritual domains of both the dying and the bereaved in an increasingly intrusive effort to provide what he terms “totalizing care.”¹

Bishop argues that “palliative care cloaks the dying in assessments and interventions created by expert discourses in biology, psychology, sociology, and spirituality.”² According to Bishop, these discourses shape and modify the psycho-spiritual processes to which they have extended their influence such that the palliative care industry has begun to scientifically operationalize, assess, minutely manage, and ultimately control the *ars moriendi*. The usurpation and appropriation of the dying and grieving processes by the medical community renders patients and families unwitting actors playing out pre-established roles in socially constructed scripts authored by palliative care experts. Thus, “a good death is one that is managed in all its facets by those whose expertise defines a good death.”³

Bishop’s critique of the palliative care industry’s “management” of the dying and bereavement process is a valid issue to be raised when weighing the advantages and disadvantages of dignity therapy. Although Chochinov stresses the importance of patient autonomy, his description of the dignity therapy process nevertheless entails the scrupulous management of what he refers to as the “generativity agenda” (129). The process itself is usually initiated, not by the patient herself, but rather by a health care worker. Chochinov is disinclined to entrust family members to undertake the biographical interview, because he fears they may lack the “skill set” and “objectivity” required to produce an adequate final product (178). The generated product is a written transcript rather than an audio or video recording, because the former can be more easily modified and is

not disadvantaged by “the distraction of how someone looks or sounds” (66). Chochinov also cautions that the therapist “must be careful to monitor for, and if necessary manage, the so-called ‘ugly stories’—that is, content that might prove harmful to a generativity document recipient” (128). Finally, a central task of the editing process is to select, from any portion of the interview, a suitably poignant and resonant ending to the document.

If the dignity therapy process unfolds as it should, a patient’s irrelevant musings, circuitous thinking, colloquialisms, halting words, platitudes, harsh judgments, and utterances of grief and anguish are painstakingly rendered into a streamlined, coherent, uplifting, and smoothly varnished “pristine narrative” (172). The seminal question that Bishop’s work poses regarding such end-of-life psychotherapeutic initiatives is this: At what point does “managed care” become “over-managed care?”

Chochinov begins his work with a prefatory meditation on the biblical account of the death of Jacob. In so doing he reminds the reader that it has long been a part of the human drama for a family to gather when one

of its members is dying and receive the grace of last words. It is unfortunate that Chochinov does not, at the conclusion of his work, refer back to that framing story. Doing so would be an instructive way to cast in clear relief how the understanding and experience of death and dying have changed over the centuries. One might well begin by noting that no intermediary is present at Jacob’s passing to translate his difficult prophetic statements into a palatable and more easily digested narrative. Rather, his progeny are left with the burden, or perhaps the opportunity, to construct, however inartfully, their very own narrative of their loved one’s unfathomable and ineffably mysterious life.

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¹ Jeffrey P. Bishop, *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying* (Notre Dame: University of Notre Dame Press, 2011), 277. See review on page 177 of this issue.

² *Ibid.*, 276.

³ *Ibid.*, 277.

*Epistemic Authority:
A Theory of Trust, Authority, and Autonomy in Belief*

by Linda Trinkaus Zagzebski

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292 pages, bibliography and index, ISBN 978-0-19-993647-2

At first blush, the notion of authority would seem to clash with our modern concepts of egalitarianism and autonomy. I am just as capable of forming religious and ethical beliefs as the next person and, even if I have to rely on others in practice, the ability to know for myself would at least seem like an ideal to strive for.¹ Linda Zagzebski, the author of this book and the earlier *Virtues of the Mind* (1996), questions those claims because anarchy, a lack of authority, can be just as worrying for freedom as can the abuse of authority. Over the course of the eleven chapters of *Epistemic Authority*, she attempts

to show us how the values of intellectual flourishing and rugged self-reliance conflict.

Beginning with the rational need to resolve dissonance, Zagzebski invites us to extend the trust we have in our own epistemic efforts to those of our neighbor: “If I have a general trust in myself and I accept the principle that I should treat like cases alike, I am rationally committed to having a general trust in them also” (55). This key premise is contentious. In another review of this book, Anne Baril raises several counterexamples to the claim, including the lack of carryover—from being forced to trust ourselves to saying that self-trust is