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Addressing Controversies in Bioethics by Adapting Lonergan's Functional Specialties: Reflections on a Series of Collaborative Experiments

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Bioethics is an area of reflection and practice in which stances on questions of anthropology are key. How health care providers and researchers understand the human person shapes their work and informs their values and decisions. Concepts of the human person are continually called into question by emerging biomedical and technical interventions on human life. In this paper we will focus on Lonergan's transcendental method, which he elaborated as the 'anthropological component' of investigations in theology and other fields.[1] Our focus will be on one of the other fields. Specifically we provide an account of how Lonergan's functional specialties were adapted to bioethics and used to organize several international research colloquia that, each time, brought together from around the world a group of about 70 bioethicists and people with related expertise to address and come to consensus on a controversial topic in bioethics. We will begin this paper by presenting highlights of discussions, in 2006, of a working group of scholars familiar with the work of Lonergan on how to adapt his functional specialties to bioethics. After that, we will reflect on what we have learned through applying this method in subsequent colloquia in bioethics.

History

Those who work in Catholic bioethics or fields relating to bioethics seldom have opportunities to come together to reflect on the foundations of bioethics. Moreover Catholic bioethicists around the world tend generally to work in isolation from one another, although the issues that they try to address are increasingly more complex and global in scope. In addition, there are diverse approaches and stances among bioethicists, reinforcing alienation and the breakdown of communications. The International Association of Catholic Bioethicists (IACB), which is sponsored by various national associations of the Order of Malta, was founded in 2005 to promote regular opportunities for Catholic and other bioethicists to encounter one another and to discuss overlooked, emerging or controversial bioethical questions and foundational issues in bioethics. Since 2005, William F. Sullivan has served as the director of the IACB.

By identifying and consolidating points of agreement in these discussions and articulating questions for further inquiry and collaborative research, the IACB seeks to enhance the capacity of Catholic bioethicists to engage in public policy discussions for the common good and to help advance the thinking of Catholic bioethicists in those areas of bioethics where Church teaching has not yet been developed or where there are divergent positions on how to understand and apply such teaching. IACB colloquia have been held in Toronto, Melbourne, London, Paris, Cologne, Philadelphia, Madrid and Rome. The discussions that take place during the IACB international colloquia are summarized in consensus statements that have

[1] Lonergan B. *Method in theology*. London: Darton, Longman & Todd Ltd., 1971; rpt. Toronto: University of Toronto Press, 1990, p. 25.

been published in print and also electronically at the IACB website[2]. The colloquia have addressed topics such as care of the frail elderly[3], medically assisted nutrition and hydration[4], health care systems that have appropriated business models of administration and management[5], stem cell research and regenerative medicine[6], care of people with Alzheimer disease and related progressive cognitive impairments[7], use of sedatives in the care of persons who are seriously ill or dying[8], and care of people with intellectual and developmental disabilities and their families.[9] [10]

In 2006, the IACB brought together some scholars familiar with Lonergan's work, most of whom also have expertise in bioethics, to discuss the application to bioethics of Lonergan's elaboration of functional specialties in theological investigations. These scholars were Patrick Byrne, John Heng, Christine Jamieson, Renata Leong, Mark Miller, Daniel H. Monsour, Michael Stebbins, and William F. Sullivan. What follows are highlights from these discussions.

Method in bioethics

Bioethics today is an evolving field. There is no universally accepted definition of bioethics. Some consider bioethics to be a sub-discipline of moral philosophy or practical ethics; others think of bioethics as an umbrella term incorporating many disciplines such as medicine, law, philosophy and theology, each with a different method. Not everyone affirms that bioethics has its own distinctive method although, as bioethics becomes professionalized, there is a tendency to accept this view. Even so, there is need for an adequate account of method in bioethics.

The most common way of defining bioethics today is not in terms of methods used but of topics addressed.[11] Generally bioethics is thought to be the field that considers ethical issues in health care and biomedical research. As the capabilities of technology and the range of what is considered to be a part of medicine continues to expand, the scope of bioethics likewise is extended to include, for example, sexual ethics, social ethics and environmental ethics. As this happens, the range of activities included in bioethics grows. Clinical ethics

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[2] http://www.iacb.eu

[3] *National Catholic Bioethics Quarterly* 2004; 4(1): 151-58.

[4] *National Catholic Bioethics Quarterly* 2004; 4(4): 773-82.

[5] *National Catholic Bioethics Quarterly* 2005; 5(4): 767-81.

[6] *National Catholic Bioethics Quarterly* 2008; 8(2): 322-39.

[7] *National Catholic Bioethics Quarterly* 2010; 10(3): 549-67.

[8] *National Catholic Bioethics Quarterly* 2012; 12(3): 489-501.

[9] In press, *Journal of Religion and Society*; *National Catholic Bioethics Quarterly*.

[10] The first attempt to apply Lonergan's functional specialties to bioethics was on the topic of human genetics. This took place at the Loyola Retreat Centre in Guelph, Ontario, Canada in June 2002. A description of the method used and the resulting papers were subsequently published. See Heng, J and Sullivan, WF, Expanding horizons for moral discernment, in *Ethics and the new genetics: an integrated approach,* H. Daniel Monsour, ed. Toronto: University of Toronto Press, 2007, pp. 165-77.

[11] Addressing bioethical topics are what Lonergan's refers to as a "field specialization", which he distinguishes from subject and functional specializations. See *Method in theology*, *op. cit*, p. 125,

consultations, research ethics reviews, and contributions to public policy are just a few examples of activities that constitute what doing bioethics entails today.

There have been three significant trends shaping bioethicists' reflection on their method. First, there is a controversy about whether there is anything normative in bioethics. Some bioethicists, such as Edmund Pellegrino, attempt to ground what he calls 'medical morality' on norms inherent in the healing relationship.[12] In Western societies, however, it is increasingly taken for granted that personal judgments of value are immune from public scrutiny, and that diverse perspectives are equally valid, even if they are sometimes contradictory or dialectically opposed. The role of bioethics, therefore, is often reduced to identifying and clarifying values, as well as negotiating resolutions to conflicting values, without also critically reflecting on foundational norms. Second, and perhaps as a corollary of what we have just highlighted, bioethics in Western societies tends to be separated as a field of inquiry and investigation from theological ethics and moral theology. It is sometimes asserted that they even have distinct methods. Third, there are different views on whether the method in bioethical reflection should be 'top down' or 'bottom up', that is, proceeding from principles to particular cases or the reverse. Much of recent Western bioethical reflection, at least by health care professionals, consists of applying the four fundamental principles elaborated by Tom Beauchamp and James Childress, namely, respect for autonomy, non-maleficence, beneficence, and justice.[13] The basis for these principles, and their relation to one another, is seldom critically examined.

Are Lonergan's Functional Specialties Relevant to Method in Bioethics?

Although Lonergan illustrated the operation of the eight functional specialties only in theology, he held that their basis and applications are much more general. That is, they are based on the related and recurrent cognitive and deliberative activities that human beings perform, which is at work in all fields of inquiry and investigation.[14] Individuals who advert adequately to the activities in which they are engaged in knowing and deciding can affirm the occurrence, relations and normative significance of these activities, namely, of experiencing, understanding, judging, and deciding.

This has bearing for the methodological question in bioethics regarding whether there is anything normative that bioethics studies. In bioethics, as in other fields of human inquiry and investigation, Lonergan would argue, the ultimate norm is not a set of concepts, principles or rules. On the side of the inquiring subject, it is the set of activities of knowing and deciding, which if performed well and persistently, result cumulatively in better bioethical judgments and decisions over time. These activities are animated by the desire of the human person for transcendence (e.g., unconditioned truth, being, goodness, and love),

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[12] Pellegrino ED. Toward a reconstruction of medical morality. *American Journal of Bioethics* 2006; 6(2): 65-71.

[13] Beauchamp TL, Childress JF. *Principles of biomedical ethics*, 5th ed. New York City, NY: Oxford University Press; 2001.

[14] In *Method in theology*, *op. cit.*, pp. 133-134, Lonergan provides the grounds for his eight functional specialties and how he derived them from the operations of the transcendental method that is common to all areas of investigation.

which is ultimately fulfilled in this life by religious experience or being in love unrestrictedly. On the side of the object of investigation in bioethics, the norm is the scale of values that characterize authentic human flourishing, which decisions by bioethicists should take into account and aspire to instantiate. For Lonergan, the totality of kinds of values and the relations among them, are specified in the following set: vital, social, cultural, and personal and religious values.

Making thematic the above cognitive activities in which all bioethicists engage when they are knowing and deciding addresses the question of whether there is a distinct method in bioethics from that in theological ethics or moral theology. Lonergan's response would be that the basic structure of knowing and deciding is the same for both. Bioethics that is based on the activities of knowing and deciding draws on a foundation that is common and accessible to all knowers and deciders. Such a foundation purports to be trans-historical, trans-cultural, trans-religious and does not even presuppose adherence to any religion. Dialogue and collaboration is therefore possible among bioethicists of good will from diverse backgrounds. Nonetheless for bioethics that is based on the transcendental method and the functional specialties, theology is a significant partner since it has bearing particularly on the discernment of what is good and loving.

Lonergan identified ends for each of the four sets of activities in the basic structure of human knowing and deciding and proposed that, when investigators seek to attain each of these distinct ends, a separate functional specialty arises. Put another way, all the activities in the structure of human knowing and deciding are present in every functional specialty but the activities in the structure cluster into four distinct groups, with each such group having its own proper, if partial, end. The structure is duplicated for areas of investigation that have two phases: reflecting on past achievement and appropriating it for future applications. Thus Lonergan derived eight functional specialties which, in theology, are research, interpretation, history, dialectic, foundations, doctrines, systematics, and communications.

The distinction between the first four functional specialties and the last four could be expressed in a slightly different manner: There are functional specialties that work on what is required to understand and to judge critically what *others* have accomplished in answering particular questions; there are also functional specialties that address those questions in *one's own name* or that of *one's group*.

Is bioethics an area of inquiry and investigation that, like theology, has two phases? The answer to this question also pertains to discussions within bioethics of two divergent methodological approaches: 'top down' principlism and 'bottom up' particularism. Lonergan holds that judgments regarding what is good are always concrete, but principles generalized from good past judgments and informed by foundations also guide future judgments about the good to be enjoyed or achieved in particular cases. Thus bioethical inquiry has two phases, and the functional specialties describe the sorts of collaborations in inquiry and investigations that are necessary to reflect on examples or cases, principles, and the appropriation and application of them to emerging questions and contexts.

The functional specialties in bioethics

Although all eight functional specialties are relevant to bioethics as a whole, there are different types of investigations for various activities in bioethics, and not every activity has the need for investigations that involve all eight functional specialties.

Furthermore, the eight functional specialties that Lonergan named for theology might be adapted to what is particular to bioethics as follows: research (assembling the data on the state of scientific and ethical knowledge on particular issues and types of cases), interpretation (analyzing, synthesizing and understanding this information), history (studying the development of bioethical problems and solutions), dialectic (probing the philosophical roots of controversies), foundations (affirming morally acceptable bases for moral stances), positions/policies (formulating moral stances and drawing out their implications for an ethical framework to guide practices and policy making), systematics/planning (judging the best ways to apply this ethical framework in relation to particular issues), and communications (using means to reach various audiences and translating words into action).

Dialectic and foundations are the two central functional specialties in bioethics. Research, interpretation, and history are skills that critical scholars in many fields are likely to have developed in their training and investigations, but dialectic can only be done well by individuals and groups that have philosophical and theological training and expertise, and have affirmed and appropriated for themselves the foundational values and positions that they apply when reflecting on various questions and disputes in bioethics.

There is obviously a practical aspect to bioethics. Hence ‘positions’ would need to include not only general principles but also a concrete ethical and policy framework; ‘systematics’ would need to include practical planning for changes in practices or new practices altogether that are derived from this framework; ‘communications’ could be broadened to include various ways of implementing plans in health care systems and in public health programs.

Although dialectic and foundations are central to bioethics, expertise in the functional specialties of history, positions/policies and systematics/planning are the functional specialties most urgently needed in contemporary bioethics. To do dialectic well, philosophers, theologians and bioethicists require an adequate understanding of the historical development of positions and counter-positions, and this is often an element in their work for which there are presently few resources and a lack of expertise. In tackling bioethical issues, both the ability to reflect on and articulate foundational values and positions as well as the capacity to draw out implications for practice and policy making are crucial. Although some philosophers and theologians engaged in bioethics also have training, experience and expertise in health care, health care administration or health policy making, most do not. Effective inter-disciplinary teamwork is crucial to bridge the gap between theory and practice, but such collaborations are in reality often difficult to organize and facilitate.

The importance of communities of bioethicists

Bioethics develops continually because it depends on the ongoing struggle of bioethicists to be authentic knowers and deciders, which is never a finished project in history. The activities of knowing and deciding might be performed well or poorly in bioethics, depending on the ability of individuals to transcend various biases and other impediments to authentic knowing and deciding. Likewise, cooperation among specialists proficient in various functional specialties on inquiries or investigations in bioethics can be done well or badly/poorly. Effective collaborations require some degree of experimenting to get the process right, persistence, and openness to self-transformation, learning and conversion on the part of participants.

To support these ends, it is necessary to foster and promote communities of bioethicists, such as the IACB, that are devoted to developing authentic habits of thinking and feeling among bioethicists and have the practical resources to organize regular and effective collaborations.

The structure of IACB colloquia

The academic program of a typical IACB colloquium is structured according to Lonergan's elaboration of functional specialties. The group of bioethicists familiar with the work of Lonergan on functional specialties, who met in Toronto in 2006, formulated these recommendations of general organizational principles for the IACB colloquia. They are offered here as an example of how we sought to apply Lonergan's work to bioethics:

(a) Focus on a specific current controversy while situating it within a broader moral context, for example, research using human embryonic stem cells in regenerative medicine considered in relation to human development. Avoid tackling too many controversies at once.

(b) As part of research, prepare a focused bibliography with the most important papers available electronically.

(c) Select team leaders who will be the main writers of a background paper for each day that will (i) synthesize research, interpretation and history relevant to the topic; (ii) identify opposed positions by the most influential thinkers; (iii) unpack underlying conflicting values; (iv) consider foundations that apply to the issue. Also select team leaders who will be the main writers of a foreground paper for each day that will (i) propose positions and concrete policies on the topic, including conditions and exceptions in implementing these policies; (ii) relate these positions and policies to other positions; (iii) consider how best to communicate and implement these positions and policies in society at large. Team leaders should be individuals who understand the goals and process of the colloquium and are engaged in the functional specialties of dialectic and foundations. Some of the experts whose research the main writers draw on could participate as co-panelists to answer questions with the main writers at the colloquium.

(d) Plan sufficient pre-meeting time to allow the main writers of the papers to assemble a team of researchers who can communicate with one another, and for participants to read and think about the papers. Avoid reading these papers at the colloquium; presentations should just highlight the most important discoveries and allow time afterwards for questions to clarify, but not to evaluate, points.

(e) Allot at least half the time for the first two days of the colloquium to small group discussions to evaluate points made in the papers, to relate the foreground papers to the background papers, and to allow participants with opposed positions to engage with one another.

(f) Select a small number of participants for each discussion group who have expertise and experience in the most relevant aspects of the issue being discussed. Facilitators and reporters should be carefully chosen and informed of their roles.

(g) Schedule plenary sessions at the end of each day to present and discuss any changes to the foreground papers that emerge from the small groups.

(h) At the colloquium, prepare a draft statement, based on the foreground papers, that will synthesize and incorporate the most important insights that emerge from the colloquium discussions. This document should be circulated to the group for live group editing. The revised draft document should then be sent to each participant after the meeting on the understanding that only proposals for minor revisions will be considered. When the participants are sent the final version, they are invited to be co-signatories. Issues that remain unresolved should be elaborated in the footnotes as possible topics for future colloquia.

(i) Communicate the results. Aim to submit the colloquium statement, with a short introduction, to a scholarly bioethics journal. In addition, aim to prepare a summary for the popular media. If possible, translate the statement and media releases into some of the world's major languages. The papers prepared for the colloquium should also be published through a readily accessible electronic medium.

(j) Participants invited to the colloquium should be willing to collaborate constructively with others. Special care should be taken to involve participants from developing nations and non-Catholic participants. Care should also be taken to avoid a situation where proponents of the extremes of a range of positions are pitted against each other.

Experiences of IACB colloquia

What have we learned from the application of Lonergan's functional specialties in organizing IACB colloquia? We have learned, first of all, how important it is to have adequate research assembled before each colloquium, and this requires not only access to library resources and the assistance of skilled librarians but also gathering and assembling information from people closest to the bioethical issues being studied and discussed—for example, biomedical

researchers, clinicians, patients and their family members. For example, the 2013 Rome colloquium on 'Ethical practices and policies in the health care of people with intellectual and developmental disabilities and their families', involved a young adult with intellectual and developmental disabilities and several participants with family members with such disabilities presenting and actively participating in the discussions. Their first-hand perspectives on issues of significance to them greatly shaped the consensus statement that emerged from those discussions. Participants at that colloquium concluded that, notwithstanding their fundamental differences, all of the models of health care for people with intellectual and developmental disabilities that have been proposed so far by ethicists and policy makers share a common presupposition. As is true of virtually all of health care ethics, these models seek to guide health care providers in what they should *do for or to* their patients. Virtually absent is a consideration of how they should *be with* their patients, that is, how to be attentive to them as individuals with needs but also as people who, with their families and other regular caregivers, can be partners in care who have something to offer in and through their experiences of disability. This led participants to develop an ethical framework for health care of people with intellectual and developmental disabilities based on this new perspective.

The functional specialties of research and history in bioethics, we have found, includes the work of assembling, understanding and reflecting on typical cases from which the questions and issues that are being investigated arise. This work is indispensable to a nuanced understanding of relevant factors that investigators in other functional specialties need to take into account. For example, in the Toronto colloquium on controversies surrounding the withholding or withdrawing of medically-assisted nutrition and hydration for people in a state of post-coma unresponsiveness (that is, diagnosed as being in a 'persistent vegetative state'), bioethicists who were working on articulating an ethical framework to guide practices and policies learned from colleagues who presented and discussed various concrete case scenarios. This discussion of concrete cases brought to light the merits and difficulties of an analysis based on the ordinary/extraordinary and proportionate/disproportionate means distinction in Catholic moral reflection on this issue and helped the bioethicists to formulate the nuanced guidelines that emerged from that colloquium.

Similarly, at the 2009 Cologne colloquium on care of people with progressive cognitive impairments, participating bioethicists were assisted by the work of clinicians who discussed cases highlighting the unique features and circumstances of people living with different kinds of progressive cognitive impairments such as Alzheimer disease, vascular dementia, fronto-temporal lobe dementia, Lewy Body disease, and Parkinson's disease. This led to a careful examination of the ethical issues relevant to these different situations. An illustration of the impact of these discussions was the formulation of a recommendation in the consensus statement about the importance of training physicians and other health care providers to recognize and diagnose cognitive changes, to differentiate between emergent conditions, to provide the appropriate treatments and supports for different conditions, and to prevent older persons with a treatable condition, such as delirium, from being inaccurately diagnosed with a dementia, with potentially severe consequences including institutionalization and prolonged mental anguish.

In every colloquium, emphasis has been placed on the two key functional specialties of dialectic and foundations. With respect to dialectic, an effort was made by participants in each colloquium to distinguish complementary and dialectically opposed stances among various bioethical positions on the ethical controversies being discussed. As far as possible, dialectically opposed positions were traced to differences in ethical theory or approach and to differences in underlying assumptions regarding how we know and relevant features of reality, including what we understand about the human person.

To take an example, the 2013 Philadelphia colloquium discussed the use of sedatives in the care of persons who are seriously ill or dying. A holistic approach to addressing 'existential suffering' was contrasted dialectically with a solely biomedical approach. It was pointed out that the biomedical approach is rooted in ethical theories derived from utilitarianism, which holds that avoidance of the greatest distress and burdens for those involved is justified by any means, including intentional killing. It was noted that this view involves a limited understanding of the role of intention in moral agency and of the human person, whose value, according to this ethical theory, is conditioned only by his or her capacities for agreeable or pleasurable experiences.

As another example, in the 2009 Cologne colloquium, participants examined and discussed different positions bioethicists have taken on the care of people with progressive cognitive impairments based on their various philosophical starting points on the question, "is there still a person in someone with such impairments?" An influential view, advocated by thinkers such as Michael Tooley and Derek Parfit, holds that radical changes in a human being, such as those caused by progressive cognitive impairments, destroy or diminish his or her personhood. The participants in this colloquium rejected this position. Other bioethicists hold that the person living with progressive cognitive impairments, even when severely affected by these impairments, is still a member of the human species or human "natural kind". They base their position on Aristotelian-Thomistic metaphysics and on contemporary analytic philosophy. Still others propose a broader conception of how personhood is manifest than through rationality and self-direction. They argue that personhood could include the capacity that all human beings have of conveying meaning through their bodily senses and movements, emotions, and relationships. Such thinkers appeal to notions such as "forms of life" and "embodiment", based on the later work of Ludwig Wittgenstein, or "incarnate meaning", based on the work of Bernard Lonergan, or the capacity for communication through "empathy", based on the work of Edith Stein. Some bioethicists also emphasize that love entails an unwavering commitment to another person, whether or not there are detectable signs of a familiar personality.

For the IACB colloquia, the work of foundations has involved affirming and articulating clearly certain values and principles that are drawn from both theological and philosophical deliberations that are relevant to the bioethical issues being discussed. For example, in the 2013 Rome colloquium on care and support of persons with intellectual and developmental disabilities, respect for the intrinsic dignity of such persons was defended on the grounds that:

"Every human being, as such, has intrinsic dignity and worth equal to other human beings. This philosophical principle is the basis of the *Universal Declaration of Human Rights*, which affirms that 'recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.'"[15]

Equally, the participants in the colloquium proposed theological formulations that ground a respect for the intrinsic dignity of all human beings:

"For Christians, every human being is made in the image and likeness of God. Each is known and immeasurably loved by God. Each has a role in the building up of God's kingdom in history and a meaning in life. Each is invited to participate in everlasting happiness with God. As the Second Vatican Council's Pastoral Constitution of the Church in the World, *Gaudium et spes*, puts it: 'The root reason for human dignity lies in man's call to communion with God.'" [16]

"Christians affirm that the capacity in humans to love and be loved is based on their creation in the image and likeness of God, who is love (*caritas*). Through God's gift, human beings are invited to participate in loving communion with God and with other human beings. Christian love or *caritas* does not depend [entirely] on the reciprocity of the one being loved but stems from a personal encounter with the self-giving love of Jesus Christ and a regard of all human beings, from the perspective of Christ, as God's beloved children and my brothers and sisters who desire to be loved as much as I do."[17]

These theological formulations contain insights that deepen and go beyond the philosophical ones. The claims that each human being both is uniquely loved by God and individually given a meaning and purpose for existence and is also inherently relational and belongs in the communion of the human family -- complement and build upon the human rights ethical framework, which tends to gloss over differences among human beings and views the subjects of rights as individuals apart from their communities. The focus on rights and duties in bioethics is further amplified to include the Christian concept of love (*caritas*), which supplies the motivation and shapes the attitudes of the one providing health care. This expands on the notion of justice to include other equally significant ethical notions such as the fundamental connectedness and mutual interdependency of human beings.

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[15] Sullivan WF, Heng J. People with intellectual and developmental disabilities and their families: an ethical framework and recommendations for health care practices and policies. Consensus statement of the 6th International Colloquium of the International Association of Catholic Bioethicists (IACB). In press, *Journal of Religion and Society* 2015, Supplement 12; quoting *Universal declaration of human rights*. New York: United Nations, 1948, preamble.

[16] Ibid., quoting *Pastoral constitution of the Church in the world (Gaudium et spes)*. Vatican Council II (Dec. 7, 1965), no. 19.

[17] Ibid., quoting Benedict XVI, *Deus caritas est* (2005), no. 18.

Often in the IACB colloquia, the work of Lonergan has provided a heuristic for the articulation of the philosophical and theological foundations. We have been fortunate to have, among those who helped to plan and participate in these colloquia, many persons who have studied the works of Bernard Lonergan.

For example, in the 2007 London colloquium on stem cell research and regenerative medicine, there was a shift of thinking among participants about how to articulate a philosophical position to support the moral status of embryonic humans that emerged from considering Lonergan's notions of the 'statistical world view', 'historical consciousness' and 'emergent probability'. Participants concluded that a range of characteristics and trajectories of early development can be identified as *typical* for human beings without requiring that every individual possess all those characteristics or follow the same trajectories at any given moment in his or her developmental story.

At the same colloquium, Lonergan's distinction between descriptive and explanatory understanding was also found to be clarifying. According to Lonergan, descriptions relate sense data to the knower who experiences them; explanations deal with things "not as related to our senses, not as represented in our imaginations, but as understood in their relations to one another."[18] Descriptions and explanations are complementary formulations of insights. In medicine, reliance on descriptive understanding is necessary in planning patient care to meet patient's individual needs. The exclusive focus on descriptive understanding, however, can also lead health care providers to overlook important relations among data. This oversight can undermine a holistic approach to care by neglecting the psychological, social, and spiritual dimensions of persons, and by failing to take into account the unity of their development and subsequent life transitions.

As an illustration, in their presentation at the 2007 London colloquium mentioned above, Patrick Byrne and Michael Stebbins showed how the then dominant descriptions by some scientists of human morula or blastula simply as a "clump of cells" indicates a seriously truncated understanding of developing human life. This descriptive understanding needs to be complemented, they argued, by an explanatory one. The latter takes into account how various stages of human development relate to one another in an intelligible and directed pattern. By insisting on both descriptive and explanatory understandings of developing human life, one can appreciate and affirm the unity-identity-whole of embryonic humans that is not possible solely on a descriptive understanding of a being at one point in time.

Conclusion

Through its colloquia, the IACB serves to bring Catholic bioethicists and others together to work out solutions to complex and controversial bioethical issues. In so doing, we recognize the importance of enabling bioethicists and other knowledgeable and experienced persons to listen to one another, discern and affirm foundational values on a given set of questions, and draw out implications for positions, policies and plans. We have found the works of Lonergan very helpful in providing not only foundational categories and notions, but also a

[18] Lonergan BJF. *Insight: a study of human understanding*. San Francisco: Harper and Row, 1978; reprinted Toronto: University of Toronto Press, p. 528.

practical method based on functional specialties that promotes an effective division of labor for collaboration among participants in these colloquia and that clarifies the goals for what needs to be done. Lonergan's method of functional specialties allows bioethicists to focus on their contributions from within their own functional specialty or specialties, and to allow colleagues knowledgeable and skilled in other functional specialties to add their contributions to the whole collaborative investigation. Above all, Lonergan emphasizes religious experience as the ultimate fulfillment of what human beings intend in knowing and deciding, which heightens their capacity to apprehend values and affirm their relations to one another in an authentic scale of values. Based on this understanding, we have included in every IACB colloquium a spiritual program for participants with time for individual and communal prayer.

We shall end with a quotation on the relevance of Lonergan's method to collaborative research in bioethics taken from William F. Sullivan's book, *Eye of the Heart: Knowing the Human Good in the Euthanasia Debate*. The afterword to this book provides an account of the first attempt in 2002 to apply concretely Lonergan's method to addressing a bioethical topic through the auspices of the then newly founded Canadian Catholic Bioethics Institute (CCBI).

"The CCBI's first think tank brought together about forty people with different areas of expertise in an attempt to make an original, integrated, and fruitful contribution to a very difficult set of questions, and to do so within a short period of time. Yet it was organized by only a few people who understood something of Lonergan's vision. Many of the academics who were part of this process, and who had little if any knowledge of Lonergan's work, were understandably baffled by the whole process; it was something they had never seen happen before. Neverthless, many of them were energized by the opportunity to discuss these issues with colleagues in other disciplines. One seasoned professor commented in his evaluation of the think tank that this collaborative work was the best experience he had had of what the 'university' (*universitas*) was really meant to be – something he had never previously experienced in all of his academic life."[19]

Our hope is that such collaborations in bioethics based on Lonergan's vision, which have proved to be remarkably effective and fruitful, can be extended to discuss other issues in the future and also be taken up by other groups of bioethicists.

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[19] Sullivan, WF. *Eye of the heart: knowing the human good in the euthanasia debate*. Toronto: University of Toronto Press, 2005, p. 302.