Part 3. Classic Texts in Bioethics

The Abuse of Casuistry and Clinical Ethics

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Introduction

Every author who writes an academic book hopes that it will have some influence. I have authored or co-authored ten such books, but I really don't know whether they have had influence or, if so, how much. Some have sold well; others dropped into oblivion. Those who bought them may not have read them, or having read them, rejected their message. I see these books sometimes quoted or cited, but have never gone to the citation index to learn more. Thus, my ambition to influence my field with written words may or may not have been fruitful.

Nevertheless, I asked the editors if my submission to the Classic Works feature of this special issue of Theoretical & Applied Ethics whether I could write on several of my own books. They graciously agreed. Naturally I would be pleased if some other contributor noticed one or another of my books but, should no one do so, these works of mine will have some honor, even if from their own authors. The two works I intend to discuss are both co-authored; The Abuse of Casuistry, with the late Stephen Toulmin (Jonsen & Toulmin, 1988), and Clinical Ethics, with Mark Siegler and William Winslade (Jonsen, Siegler & Winslade, 2010). These are two very different books but both aim at a central focus of bioethics, namely the ethical questions posed by clinical cases.

History

Dan Callahan wrote the signal statement of what was then the new field of bioethics. His 1973 article, "Bioethics as a Discipline," advised the practitioners of this "not yet full discipline," to develop "methodological strategies and procedures for decision-making" (Callahan, 1973). These methods should manifest the traditional modes of philosophical analysis, namely, logic, consistency, careful use of terms and rational justification of claims." At the same time, "the discipline of bioethics should be so designed, and its practitioners so trained that it will directly (at whatever cost to disciplinary elegance) serve those physicians and biologists whose positions demand that they make the practical decisions."

This advice contained two conflicting recommendations. The philosophical methods then in fashion were not suited to practical decision-making. Callahan wisely recognized this in the parenthetical "at whatever cost to disciplinary elegance." G. E. Moore opened a new era of moral philosophy with his Principia Ethica. In the first pages, he wrote that "judgments about (what is good conduct) form the substance of what is commonly supposed to be a study different from Ethics and one much less respectable, the study of Casuistry"(1903, p. 4). For decades after Moore wrote, the more respectable study of ethics had been almost exclusively absorbed with his major question, "what is good?" rather than the less respectable question, "what is it good or right to do?" At the time Callahan wrote, moral philosophy had been submerged almost completely into linguistic analysis, and even when that analysis wandered close to practical decisions, it probed the meaning of the words rather than the cogency of the choice to the case. Bioethics, in its beginnings, was in need of casuistry, that is, a reasonable approach to the actual cases faced by "physicians and biologists."

Stephen Toulmin, an eminent philosopher whose own philosophical career had begun in the era of linguistic analysis, realized this problem. While serving as philosophical advisor to the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, he and I, who was a commissioner, discussed this problem. I had some familiarity with the traditional casuistry of Roman Catholic and Anglican moral theology. We wondered whether that approach to moral problems which prevailed from the 16th to the 19th century, might shed any light on the problems posed to the Commission: under what conditions might human beings be engaged as subjects of biomedical and behavioral research? At the time the Commission began its work, there were some general answers to that question. The Nuremberg Code and the Helsinki Declaration of the World Medical Association had spelled out basic principles, for example, research subjects should not be coerced, research should be socially valuable, animals should be used before humans. However, how those general answers would be applied to particular forms of research and to particular classes
of subjects remained unexplored. Was it morally permissible, for example, to perform even socially valuable research on children or on persons mentally deficient? These were the casuistic questions about what is the right thing to do.

Casuistry

Toulmin and I obtained a National Endowment for the Humanities grant to support research on the history of the casuistic reasoning of 16th Century European moral theology. We asked whether classical casuistry had a methodology. Did it have a form of reasoning and logical structure that allowed the casuists to move from broad principles into the tangled circumstances of actual cases and emerge with reasonable answers. Our study resulted in The Abuse of Casuistry: A History of Moral Reasoning.

It was not enough to proclaim that bioethicists should concentrate on cases rather than theory. We attempted to reveal the mode of reasoning that made possible a substantial casuistry. We found the roots of casuistic reasoning in an Aristotelian approach that acknowledged the irreducible singularity of cases about which practical decisions must be made and stressed the centrality of the circumstances that constituted cases. We also traced casuistry back to the discipline of rhetoric that had flourished in European education from classical times through the Renaissance. That discipline provided an elaborate exposition about how to formulate a persuasive argument that would move persons to act in particular ways in particular situations. Unlike the pejorative use of "rhetorical," which implies distortion and deception, classic rhetoric aimed to present reasonable arguments in support of the right course of action. Most notably, we recognized that casuistry, unlike philosophy, aimed to provide practical, reasonable approaches to the moral problems posed by penitents to confessors in the Catholic practice of confession. This intent assured that the cases must be evaluated in very particular terms and that fair and practical advice be given. In these features, casuistry was a precursor of bioethics as Callahan had envisioned it, "designed to... serve those physicians and biologists whose positions demand that they make the practical decisions."

In a widely noted article, "How Medicine Saved the Life of Ethics," Toulmin summed up the thesis of our study this way: "by reintroducing into ethical debate the vexed topics raised by particular cases, they (bioethicists) have obliged philosophers to address once again the Aristotelian problems of practical reasoning which had been on the sidelines for so long. In this sense, we may indeed say that, during the last 20 years, medicine has 'saved the life' of ethics" (Toulmin, 1982). The literature of the early decades of bioethics was produced almost exclusively by scholars trained in philosophy and theology. Principles of Bioethics, by philosopher Tom Beauchamp and theologian James Childress, became the standard textbook (2009). This book exposed with elegance those "modes of philosophical analysis, namely, logic, consistency, careful use of terms and rational justification of claims" that Callahan had recommended. Beyond this, it developed four principles that could function as the essence of bioethical reasoning: respect for autonomy, beneficence, non-maleficence and justice. In these early years, bioethics had caught the attention of those physicians and biologists that Callahan had envisioned as among its future practitioners. They were truly practitioners, who had to bring their knowledge to resolution of actual clinical and laboratory problems. The dense thicket of circumstances that make up real cases still remained beyond the reach of analyses such as Beauchamp and Childress proposed. A passage from the Nicomachean Ethics posed a warning to those bioethicists who wished to go beyond theory and principles: "Matters of practical conduct have nothing invariable about them. . . moral issues arising in particular cases are not a scientific matter. Rather as in medicine or navigation, they require human beings to consider what is appropriate to specific circumstances" (Aristotle, Book II, ii, 3-1, 1104a).

Clinical Ethics

With this warning in mind, three nascent bioethicists, Mark Siegler, a physician, William Winslade, a lawyer, philosopher and psychoanalyst, and I, a theologian and philosopher, set out to write a book that would emulate classical casuistry. We produced Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine. We wished to provide physicians with an approach to moral problems that both matched the thinking they habitually brought to medical decisions, and focused on the very particular circumstances of clinical cases. Rather than begin our analysis with the four principles posed by Beauchamp and Childress, we began, as the casuists would, with the circumstances that make up a case. We proposed that every clinical case was constituted by four invariant features: medical indications, patient preferences, quality of life and contextual features. Every problematic clinical case could be viewed in the light of these four features and the principles "considered (in light of) what is appropriate to specific circumstance. Clinical Ethics was divided into four chapters, each devoted to one of the features, but we insisted that each case must be view in the light of all four. Richly described clinical cases illustrated the chapters; several of them were traced through each chapter. Recommendations were offered for the management of each case, but with the caution that every real case has variable features and takes place in distinct circumstances.
Discussion

Bioethics came into fashion during the decades of intense debate about the morality of racial segregation, gender discrimination, and the war in Southeast Asia. Environmental concerns followed soon thereafter. Moral philosophers participated in these debates. The journal *Philosophy & Public Affairs* was founded to give voice to their contributions. In this way, the urgent problems of public life forced themselves into the realm of academic ethics. Bioethics took hold in a particularly strong way, since medical schools throughout the country inaugurated courses and appointed professors. These professors, often philosophers but sometimes physicians, sought ways to present their topic in ways that would suit the needs of students of medicine. The philosophers had to become sensitive to the realities of clinical medicine; the physicians had to appreciate ethical theory. Both had to merge into a bioethics much like that Dan Callahan described in 1970. At the same time, bioethical writing flowed out of departments of philosophy, religious studies, sociology, and other related academic disciplines. These products reflected the more abstract, rigorously argued style of their origins. So bioethics has remained today both practical and theoretical, sometimes mixed, sometimes distinct.

I believe that the influence of *The Abuse of Casuistry* and of *Clinical Ethics* arises from their attempt to lean in both directions. The first book stands in the field of philosophy and religious studies and leans toward the practical world of medical decision making. *Clinical Ethics* stands in the world of clinical medicine and leans toward moral philosophy. Both books are a warning that ethics in medicine must bear the marks of proper moral philosophical reflection and of the circumstantial realities of clinical thinking. Neither should erase the other; both should invigorate each other. Whether or not contemporary bioethicists quote these books or consider themselves principalists or casuists, I believe they recognize that, in their work, they must lean in both directions. They must devise for themselves a methodology that allows them to do so without falling over.

After 24 years in print, *The Abuse of Casuistry* still maintains small but steady sales. *Clinical Ethics* is now in its seventh edition. It has been translated into seven languages. It is used widely as a textbook for medical students and as a reference for ethics committees. I assume that these two books have had some influence in bioethics. *The Abuse of Casuistry* and *Clinical Ethics* should be viewed as products of the same lineage, the casuistic tradition. The first book attempts to revive that long lost tradition and make it relevant to ethical reasoning about cases. The second applied the tradition, in a general way, to the practical task of clinical bioethics. Since these books have appeared, bioethicists have argued about the merits and the methods of the casuistic approach. A vigorous debate about casuistry versus principles was waged in bioethical literature during the 1990s.

Successive editions of Beauchamp and Childress have reviewed that debate. Still, all who work in the field of bioethics recognize that bioethics is immersed in the practical, whether it comments on health policy, scientific discovery or clinical care. We believe that *The Abuse of Casuistry* and *Clinical Ethics* both have influenced "the discipline of bioethics . . . so designed, and its practitioners so trained that it will directly (at whatever cost to disciplinary elegance) serve those physicians and biologist whose positions demand that they make the practical decisions."

Notes

1. See, for example, the special issue of the *Kennedy Institute of Ethics Journal*, Theories and Methods in Bioethics: Principism and its Critics (1995).

References

Aristotle. *Nicomachean Ethics.*
Hans Jonas and Death

Daniel Callahan, The Hastings Center

Background
One of the first research projects of the newly formed The Hastings Center in the early 1970s was on "Death and Dying." It was organized in response to the rise of complaints about end-of-life-care, notably poor pain relief, insensitive doctors, and indifference to patient wishes. It followed on an earlier project on the definition of death. The project members of both groups were an interested and talented group, all of whom would go on to make an enduring mark on bioethics, among them Leon R. Kass, Paul Ramsey, Alex Capron, Eric Cassell, and Hans Jonas. What was most distinctive about this group in comparison with others working on end of life care in that era was its interest in death and its place in human life, not simply how the dying should be cared for.

Hans Jonas stood out among this very talented group. Trained in philosophy in Germany, a student of Martin Heidegger and a friend of Hanna Arendt, he was also Jewish and fled his native country, eventually joining the Faculty of the New School for Social Research in New York City. With the exception of me, he was the only philosopher in the group and one not trained as an analytic philosopher as I had been. Many American philosophers did not hold him in high esteem, his European training and interests out of fashion. But to our research group, many of them unimpressed with the reigning analytical mode, he was the very model of what a philosopher should be. His interests ranged among religion, biology, medicine, and continental philosophy. And in his person and history he was the nearest thing to a truly wise person most of us had ever met.

Jonas made his mark on me by his interest in the meaning and place of death in human life, spelled out richly in an article published in the Hastings Center Report in 1992, "The Burden and Blessing of Mortality" (Jonas, 1991). The word "mortal" was his point of departure. He wrote that the word merges two meanings: "that the creature so called can die, is exposed to the constant possibility of death; and that, eventually, it must die, is destined for the ultimate necessity of death. In the continued possibility I place the burden, in the ultimate necessity I place the blessing of mortality."

Blessing? In what way could death be a blessing? He was not, moreover, referring to a miserable individual's death, one marked by pain and suffering. It was death itself as a feature of our lives that was for him the blessing. Yet acutely aware of the fact that human beings resist death, wanting to live rather than to die, and that resistance is part of what it means to be human, he had to deal with the tension that an inevitable death poses for that part of our nature. "Being," he wrote, "has become a task rather than a given state, a possibility ever to be realized anew in opposition to its ever-present contrary, not being, which inevitably engulf it in the end….life has in it the sting of death that perpetually lies in wait, ever again to be staved off, and precisely the challenge of the no stirs and powers the yes."

Jonas makes the case of the necessity of death and its blessing in the language of evolution: "for what else is natural selection with its survival premium, this main engine of evolution, than the use of death for the promotion of novelty, for the savoring of diversity, and for the singling out of higher forms of life with the blossoming forth of subjectivity." And here is the blessing: "The ever-renewed beginning, which can only be had at the price of ever-repeated ending, is mankind's safeguard against lapsing into boredom and routine, its chance of retaining the spontaneity of life….dying of the old makes place for the young." He adds an important two-fold caveat to avoid the appearance that any and all deaths are a blessing. On the one hand, he contends, "it is a duty of civilization to combat premature death," and on the other, that death is only a blessing "after a completed life, in the fullness of time." The difference in Jonas's way of looking at death was profound for me, and in three ways, affecting my view of aging, of death in our individual lives, and of the place of death in devising health care systems.

Aging and Death
In the mid-1980s I became interested in the problem of health care for the elderly and particularly the likely fate of the Medicare program. Even then the projections showed that program to become insolvent in the future, a victim of longer lives for the elderly combined with more expensive high-technology treatments to keep them alive. Without some theory of limits, there would be no economically viable way of paying for their care. But for most people the idea of any limits, any rationing of care for the elderly was anathema, at once cruel and ageist.

But, I concluded, limits would be legitimate if death of the elderly is an evolutionary benefit for the young and for the species. As for the individual, death is
not normally treated as a tragic event for those who have lived long and full lives, "in the fullness of time." There is rarely weeping at the funeral of someone who has died after age 80, unlike the death of a child or a young adult.

Death in our individual lives. Now it might well be said that, even if we make an exception for the very old, every death is still an evil for everyone else. It cuts off the possibility of the further enjoyment of the benefits of living a life, removes us permanently from the joys and satisfaction of our lives with others, and offers no obvious benefits of any kind. Jonas does not say why there is a duty to combat premature death, and in fact does not say a great deal about why life is worth living. That omission may show that he did not fully appreciate the value of life and perhaps that is where an evolutionary perspective has a major shortcoming. It tells us why some species survive and others do not, and why death makes possible change. But there are experiences and possibilities in the content of the lives of the human species not found in any other one. We might, Jonas suggests, become flat and bored if we lived indefinitely, much less to the point of immortality. Perhaps so, perhaps not: who knows? But in a curious way, his omission of an examination of the meaning of evolution for human life shows me that such an analysis would force us to move in a direction left unexplored by Jonas.

Death and health care. The provision of health care pushes us in that direction. What do we want good health for? One reason is to avoid pain and suffering. Another is that good health is a necessity for a person to fulfill his or her individual potential, that of living a human life open to all the possibilities of life. That is not to say that sick and disabled persons are necessarily precluded from such a life, but health care can help them manage and often overcome those impediments.

The difficulty with modern health care is that medical progress and technological innovation have bought us great benefits, but increasingly at an unaffordable price. Medical progress as pursued in modern medicine is essentially an open-ended venture, one that in principle knows no scientific boundaries. As progress makes possible the constant raising of the standard of good health, it no less makes it impossible to find a final resting place; only more and more suffices, but not infinite ways of paying for it.

At the heart of the drive for ever more health and longer lives is an unwinnable struggle against death, taken to be the great enemy of life. Jonas's way of thinking about death offers an alternative path for medicine and health care. It should aim to help us live out an accepted finite life span, aiming to have a high quality of life during that span. This is obviously important in thinking about health care for the old, but if we have been tutored to think that death itself is the enemy, then it will be difficult to draw a line with the aged. Death itself must be seen differently in order to have a health system with affordable aims. The route of public health and prevention offers an alternative path, reducing recourse to expensive high-technology medicine in favor of greatly improved care at lower levels.

References