CASUISTRY IN MEDICAL ETHICS: REHABILITATED, OR REPEAT OFFENDER?

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ABSTRACT. For a number of reasons, casuistry has come into vogue in medical ethics. Despite the frequency with which it is avowed, the application of casuistry to issues in medical ethics has been given virtually no systematic defense in the ethics literature. That may be for good reason, since a close examination reveals that casuistry delivers much less than its advocates suppose, and that it shares some of the same weaknesses as the principle-based methods it would hope to supplant.

Key words: casuistry, ethical method, medical ethics

1. INTRODUCTION

In recent years, and especially since the publication of The Abuse of Casuistry, by Albert R. Jonsen and Stephen Toulmin[1], many persons working in medical ethics have advocated the revival of the medieval art of casuistry as a method of moral thinking especially suited to addressing ethical problems in medicine. Given the frequency with which writers in medical ethics declare themselves casuists, there are surprisingly few published attempts at any sustained, in-depth defense of the application of casuistical methods to specific problems in medical ethics. I will argue that there is a very good reason for that shortage: the appeal of casuistry is a superficial one, that promises much more than it delivers.

Before beginning my critical assessment, it will be useful to get some understanding of why casuistry attracts such eager adherents from medical ethics. Understood vaguely as a method of moral reasoning rooted in judgments about cases rather than in commitments to abstract principles, casuistry’s appeal has two sources – reactions against principle-based approaches to ethical problems; and the practical and pedagogical centrality of the “case” in medical ethics.

There are roughly four sorts of criticisms directed against the application of general ethical principles to the problems encountered in medical ethics. All of these objections are drawn from the surge of anti-foundationalism [2] arising in moral philosophy over the last decade, and all of them have been applied to the practice of medical ethics in prominent articles familiar to medical ethics scholars [3,4].

The first criticism is that without benefit of a single, defensible, overarching moral principle (and fat chance of that!), appeals to principles will, in genuinely hard cases, always lead to moral conflict among competing principles; a conflict which is irresolvable in terms of the principles themselves. One is driven to an inarticulate and intuitive "balancing" of competing moral considerations, the outcome of which cannot be justified by appeal to any common or higher moral principle. This balancing approach might be exemplified by some discussions of informed consent, in which the issue is conceived as a conflict between the patient's right to autonomy and the physician's duty to protect the patient's welfare. In any case in which this conflict is present, one has no formula or algorithm for assaying the weights which are in the moral balance. In the end, there is just the sheer "judgment" that the scales point one way rather than another.

Second, even when we operate within the scope of a single moral principle, all we have to work with is a truism, as Edmund Pincoffis noted [5], which is too abstract to generate any unequivocal conclusion about any specific circumstance. Its application requires interpretation, a process which must employ means other than an appeal to the principle itself. What does the grand Kantian injunction to "respect persons as ends in themselves" tell me about whether I am obligated to provide information to patients about even the remotest risk of death from a procedure I'm about to perform? Nothing in the principle tells me what "respect" requires in this specific context. Even a "lower-level" medical ethical principle like "Competent, informed adult patients have the right to refuse life-saving treatment" is indeterminate in its application, because there are degrees of "competence" and "informedness", and some implicit judgment must always be made whether this patient is competent and informed enough to refuse treatment. The gap between principle and application is unbridgeable except by some non-principled mode of thinking.

Third, the idea that our commonly accepted ethical principles are the wholly sufficient grounds of moral justification ignores the likelihood that they are based in "local" history and custom, and subject to distortions. Ethical argument rooted in abstract principles overlooks the social and historical context in which ethical problems, and the taken-for-granted ethical principles applied to them, arise [6].
Finally, unlike scientific theories, ethical theories which systematize intuited considered judgments [7] don’t tell us anything we don’t already know, and therefore have no real explanatory or justificatory power [8]. There is no abstract principle which is more secure or well-founded than the considered judgments which embody it. “It would be wrong to leap over the table now and strangle you” carries for most of us much more moral conviction than “Do Not Kill.”

3. THE PRACTICAL AND PEDAGOGICAL CENTRALITY OF THE CASE

If these are potent objections against reliance on principles (and I think at least some of them are), then what room is left for moral reasoning? If appeals to moral principles have been debunked, can moral skepticism or relativism be far behind? At least some of the philosophical critics of foundationalism have moved in those directions [9]. But skepticism and relativism are easier in moral philosophy than in real life, because in real life one has to actually make decisions which are justifiable to oneself and which survive scrutiny by others. One needs to be able to provide persuasive reasons for a course of action. If the core content of those reasons is not moral principles, then perhaps it should instead be our settled convictions about actual cases. At the very least, it would seem, basing our reasoning in cases rather than principles would appear to be a first step in avoiding these apparent liabilities of principle-based moral argument.

Such a strategy will be attractive to persons in medical ethics, for whom the case is the central focus of professional attention. Cases are at the heart of teaching in medical ethics. Aside from a few anthologies, there’s scarcely a textbook around that doesn’t include a good supply of cases for students to gnaw on. The problems that are brought to the ethicist to solve are predominantly individual cases. And controversies and resolutions of controversy often turn around cases. A long line of cases served as successive focal points for arguments about the permissibility of withdrawing artificial food and fluids, which culminated most recently in the case of Nancy Cruzan [10].

Thus, a case-based method of reasoning seems just what the doctor ordered for medical ethics.

4. CASUISTRY TO THE RESCUE?

At least for its modern exponents, casuistry fills that prescription. Although it makes use of moral rules, or maxims, these are more devices for organizing
paradigmatic cases, rather than independent and higher grounds of moral justification. Those grounds lie first and last in the paradigmatic cases which the maxims distill, and which embody our core moral beliefs.

When setting out to characterize "casuistry," it is important to be precise about what we mean, since the term is used very loosely at times by those in medical ethics. "Casuistry" cannot usefully refer merely to the give-and-take of reasoned moral argument, and the resulting evolutionary improvement in moral understanding; neither can it refer to the use of paradigm cases as a testing ground for the refinement of moral principles or theories. These may indeed be features of casuistry, but they are not characteristics which distinguish it from most other approaches to ethical reasoning.

Jonsen and Toulmin provide a more precise definition. Casuistry is "the interpretation of moral issues, using procedures of reasoning based on paradigms and analogies, leading to the formulation of expert opinion about the existence and stringency of particular moral obligations, framed in terms of rules or maxims that are general but not universal or invariable, since they hold good with certainty only in the typical conditions of the agent and the circumstances of action" ([11], p. 297).

In their book ([11], Ch. 16), and a later article by Jonsen alone [9], Jonsen and Toulmin further describe the characteristic steps in a casuistical analysis. The first task is to describe the problematic case in full detail, together with the moral reasons, or "maxims", that people would apply to the situation. This Jonsen calls the Morphology ([9], p. 298 ff.).

An adequate description of the case, and most especially the relevant maxims that would be applied to it, will make it possible for us next to place it into a Taxonomy identifying the "type" or types of case to which the problematic case belongs, and the paradigmatic examples of right and wrong conduct within the type ([9], p. 301 ff.).

One is now in the position to make the critical analogical judgment (rather than a deductive inference) which assesses which of the paradigmatic cases most closely resembles the case under debate. This holistic judgment requires an appreciation of Kinetics: the "way in which one case imparts a kind of moral movement to other cases ..." ([9], p. 303). One knows what that "movement" is by virtue of "practical wisdom." "Prudent judgment must discern the relevance of a maxim in the light of the matter under consideration" ([9], p. 304).

The feature of casuistry that stands out as distinctive in Jonsen and Toulmin's characterization is its reliance on argument by analogy with paradigm cases. It is this feature that draws the important contrast with principle-based approaches, whose idealized mode of reasoning is a deductive inference from a well-refined principle to the case at hand.

Carson Strong illustrates a version of this method with an example of a
Jehovah’s Witness refusing a life-saving blood transfusion (although he doesn’t use the Jonsen/Toulmin vocabulary) [12].

The problematic case is a pregnant, near-term Jehovah’s Witness woman who developed abruptio placenta (premature separation of the placenta from the uterus), requiring a C-section to protect both mother and infant. She agreed to the C-section, but with no blood transfusion. Following surgery, which delivered a healthy child, she developed further complications, requiring blood transfusion to save her life. She continued to refuse blood, with the support of her husband, who said that if his wife died, he and other family could care for their seven children, despite their financial insecurity.

According to Strong, the maxims involved in this case are the principle of autonomy which respects refusals of treatment by competent adults, in potential conflict with a principle of beneficence which imposes a duty to protect the interests of the children in having their mother survive. Together with the description of the case, we would now have the Jonsen/Toulmin “morphology.”

Corresponding to the alternative courses of action available (which in this case would be either to respect the woman’s refusal, or not) we can identify paradigm cases which exemplify the circumstances in which the patient’s right to autonomy is overcome by the obligation to protect her or her children’s welfare, and the reverse. As one of his paradigmatic cases, Strong describes a Jehovah’s Witness father refusing blood, who will leave no means of support, either financial or emotional, for his children after his death. In this case, Strong contends, the principle of beneficence rules, and a court order forcing treatment would be justified. The contrasting paradigmatic case would be one in which the Jehovah Witness father is financially secure, with family members nearby. His surviving children will be easily and well supported if he should die. In this case, autonomy outweighs beneficence, and a court order would be unjustified.

We now have the problematic case placed within the Jonsen/Toulmin “taxonomy”, and are ready to compare the actual case with the paradigmatic ones. The question will be which of the paradigm cases most closely matches the circumstances of the case being decided. This assessment of the “kinetics” of the cases is the judgment of “practical wisdom” that Jonsen refers to.

Strong’s own judgment is that even though there are differences in “mitigating” factors, there is a “serious question” whether the family in the actual case could provide economic and emotional support for the deceased parent’s children, just as there was in the first paradigmatic case. Therefore, Strong concludes, that paradigm case argues (by analogy) for the decision to seek a court order in the case at issue.
5. THE ARGUMENT FOR CASUISTRY

What can be said on behalf of this approach to moral reasoning? Part of Jonsen and Toulmin’s case is just to argue against the alternative, principle-based view, and so they echo many of the complaints against principle-driven ethics described earlier.

But they also have a positive argument which relies on a contrast they make (borrowed from Aristotle) between “theoretical” and “practical” knowledge. In reasoning theoretically, we are more certain of the truth of our axioms than of the conclusions reached by use of them ([1], p. 25). In practical reasoning, it is the reverse. We are more certain that “Chicken is good to eat” than we are of any theoretical explanation or principle offered to support it.1

Their argument then is that ethical reasoning must also be practical rather than theoretical, since in ethics too we are much more certain about our judgments of particular cases than we are about any theoretical or general principle. If so, ethical thinking must be like other paradigmatic instances of “practical judgment.” This conclusion is supported by other features common to ethical thinking and other forms of practical reasoning: the arguments are concrete (about a specific case), temporal (in a specific historical context), and presumptive (their conclusions aren’t necessarily or timelessly valid).

But merely to claim that ethical thinking is “practical” in these broad respects is not yet an argument on behalf of casuistry as the specific form that ethical thinking should take. (Note, for example, that utilitarian approaches can have all of the listed features of practical reasoning.) To make this additional argument, Jonsen and Toulmin place a lot of weight on the analogy between one form of practical judgment — medical diagnosis — and casuistry. Both rely on a holistic “pattern recognition” and arguments by analogy between “classical” or “paradigmatic” cases and a specific troubling case. If medical diagnosis exemplifies practical reasoning, and if ethical thinking is a kind of practical reasoning, then ethical thinking must look like medical diagnosis.

Presumably, Jonsen and Toulmin did not intend to make the argument quite this explicitly, since the inference is logically fallacious. Even in the form of an analogy, however, it still has significant problems as a positive argument on behalf of casuistry. Let’s suppose that clinical diagnosis is a kind of pattern recognition, where one reason by analogy from previous cases to make a diagnosis in the present one.2 To begin, one important difference between ethical and diagnostic thinking is that the diagnostic judgment, unlike the ethical judgment, is not primarily a judgment about what to do. It’s one thing to make the diagnostic judgment that your patient has benign prostatic hypertrophy, based on a holistic impression of the reported symptoms, their history, the feel of the surface of the prostate on rectal exam, and so on. But it’s a separate
decision what to do about it: leave things alone, perform surgery (but what sort?), treat symptomatically with drugs? This decision about action is not so easily thought to be a kind of pattern recognition where the decision is made by analogy with known cases. The decision about treatment (especially if one follows the decision analysts) is more a matter of toting up advantages and disadvantages of the alternatives, based on generalizations and probabilities, and basing one's final judgment on the weight of the evidence. Thus, if Jonsen and Toulmin had only taken the therapeutic judgment as their paradigm of practical reasoning, rather than the diagnostic one, the analogous model of ethical reasoning which would have emerged would look more like a Russian balancing of competing ethical considerations than it would argument by analogy to paradigmatic cases.

Another significant problem arises from the claim that what diagnostic thinking and ethical thinking have in common is "pattern recognition." "Pattern recognition" is itself ambiguous as a description of a kind of judgment.

In one sense, pattern recognition is a holistic act of perception, where one either gets it, or doesn't. An experienced painter might hold up a chip of paint, compare it with a standardized color chart, and say "Look, this is violet, not purple." But in another sense, pattern recognition is more like the recognition of consistency in reasoning. "Artificial insemination by donor (AID) is like adultery" is at its core more like an analytic judgment than a holistic perception, because it follows, and is sensitive to, an enumeration of the reasons which are thought to support the condemnation of adultery together with the evidence that each of these applies to the case of AID. Thus, to say that ethical thinking must be like diagnostic thinking because each of them involves "pattern recognition" begs the crucial question of which sort of pattern recognition is (or should be) in use in ethics.

An important aspect of this distinction is that it is only the first sense of "pattern recognition" that supports thinking of ethical judgment as ultimately a matter of "discernment" by the expert, which Jonsen and Toulmin take to be an essential element of casuistry. If distinguishing right from wrong is like distinguishing violet from purple, there is no more gainsaying the judgment of the ethical expert than there is the judgment of the color expert. Indeed, since these judgments are acts of holistic and unanalyzable perception, we have to cede epistemic authority to someone in order to bring closure to disagreements, since by definition there would be no ways by which disagreements could be further understood and negotiated. As others have noted [13], there is a corresponding strain of moral authoritarianism in Jonsen and Toulmin's revival of casuistry, which is wholly consistent with casuistry's tradition.
Jonsen and Toulmin’s revival of casuistry as the antidote to an absolutist, principle-bound rationalism is an ironical reinterpretation of traditional casuistry, at least as that tradition is understood by other commentators.4

J.P. Sommerville, for example, points out that the worse excesses of casuistry, pilloried by Pascal, were the result not of any belief in the flexibility of principle of the kind that Jonsen and Toulmin advocate, but quite the reverse[14].

Take, for example, the doctrine of mental reservation, one of the most well-known of casuistry’s excesses. According to the doctrine of mental reservation, the English Catholic priest John Ward neither lied nor did anything wrong, when he answered his Protestant captors’ direct questions by saying that he was not a priest, and that he had not been across the sea. When he said he was not a priest, what he meant to himself was that he was not a priest of Apollo; and when he said he had not been across the sea, what he meant was that he had not crossed the Indian sea.

According to Sommerville, the casuists were driven to this doctrine not by a disdain for principle, but because of dogmatic allegiance to principle. Since Augustine, the official doctrine of the Church had been that lying (a false statement intended to deceive) was always wrong. Its wrongfulness could be mitigated by other factors, such as avoiding harm, but these could only make it less of a sin.

The duty not to lie was an absolute duty, because it was based on the 9th Commandment not to bear false witness. So for captured priests, the ethical problem as understood by the casuist was not a matter of how to weigh the demands of competing principles according to the circumstances; it was to find a way to claim that no lying took place.

Their first solution was to endorse equivocation, so long as the statement was true in the sense in which the speaker intended it. Alternatively, “what counted ... was whether your statement did in fact have a true meaning and whether you meant it in the sense in which it was true” ([14], p. 168). As a consequence, “dexterity at punning became a virtue” ([14], p. 171). But even this did not solve the problem for captured priests, because the core conflict between the absolute duty not to lie and the less stringent duty to prevent injustice and harm would once again arise whenever the questioner was clever enough to back the captive into an unequivocal corner. Unless, of course, one could make any statement whatsoever true by use of a "mental reservation."

It is pertinent to note that there may be other, longer-lived products of casuistry which are also rooted in the necessity to steer around absolute prohibitions. Joseph Boyle has recently argued that the Doctrine of Double Effect, also developed by the casuists (and used uncritically in medical ethics),
is a doctrine that does no justifiable moral work outside absolutist moral systems [15].

This historical association between casuistry and absolutist moral systems may be more than coincidental. If ethical thinking is primarily casuistical, and casuistry in turn is a type of pattern recognition, then there needs to be a stable, fixed, and fairly specific set of moral maxims which, with their associated paradigms, provide the “pattern” to be recognized. Otherwise, pattern recognition would not be the only or the primary task of ethical thinking, for we would also have the task of agreeing upon the standard pattern to be used.

7. PROBLEMS AND LIMITS OF MODERN CASUISTRY

Even if the epistemological arguments on behalf of casuistry are not convincing, it might still be the case that in practice the casuistical model works as a satisfying framework for organizing our approaches to moral problems. But in fact there are serious limitations and objections to its application, that leave casuistry at no advantage over the principle-based approaches it would hope to supplant. Indeed, what we find is that casuistry suffers from virtually the same problems as a principle-based approach, and then some.

First, the appeal to paradigm cases assumes that the proper ones have been selected for comparison, and in any contentious ethical question, where there are competing ethical considerations or “maxims”, there will also be alternative sets of paradigm cases to which analogies can be drawn. Return, for example, to the case of the Jehovah’s Witness woman discussed by Strong. Confronted with Strong’s set of paradigmatic cases, she might well have asked in response whether he would have been prepared to remove a kidney from her without her consent, had one of her children needed a kidney transplant in order to get off dialysis. If the answer is “no” (which is the answer the courts have given), or even if it’s “unsure”, then isn’t forced organ donation a paradigm case of a competing type that supports a decision not to transfuse her against her will, even for the sake of her children’s health?

But now our casuistical reasoning is complicated by the need to decide from the very outset which of the two paradigmatic types is more compelling, and that judgment looks suspiciously just like a Russian balancing between prima facie duties. Which maxim takes priority: Parents have a duty not to harm their children? or Persons should not be forced to sacrifice themselves for others? Casuistry is not the superior alternative to a balancing approach. On the contrary, it too requires a balancing of moral weights between principles, or some alternative way of choosing between competing lines of paradigmatic cases before the analogical, casuistical argument can even begin.
Second, it is not obvious how casuistry is any more articulate than a rule-based approach in explaining the connection between rules, principles, or maxims on the one hand, and specific moral judgments on the other. Assume that the casuistical maxim is "Medical information should be kept confidential." According to the casuist, the meaning of that maxim is contained in a set of paradigmatic cases exemplifying when sharing information is a breach of confidentiality (e.g., when you tell the patient's husband that she has a lover), and when it's not (e.g., when you provide copies of records to the patient's insurance company with his written permission). So long as the case before us is exactly similar to one of the paradigmatic cases taken to exemplify the maxim, the application of the maxim to it is no problem. But what if the case before us is the decision by the patient's physician to ask a specialist to look over the patient's chart to provide help in diagnosing what may or may not be gall bladder trouble, but without getting the patient's explicit permission? Is that a breach of confidentiality or not? However one decides, there are no fully articulate grounds for the decision. On the one hand, the patient didn't give permission; on the other hand, it was done for the patient's benefit; on the one hand, for all we know the patient may have a deep distrust of strange consulting physicians; on the other hand, gall bladder disease is not a very stigmatizing ailment. This is precisely the spot where Jonsen and Toulmin resort to the inarticulable mysteries of "discernment." Once outside the well-worn grounds of the paradigmatic cases, casuistry doesn't have the resources to explain why or to what extent the distinctive features of the non-paradigmatic case are determinative. This is not a problem unique to casuistry, of course; but casuistry doesn't seem to make any distinctive progress in solving it.

Third, in its reliance on settled convictions about paradigm cases, casuistry runs the danger of uncritical conventionalism and conservatism. It provides no way by which the settled paradigms themselves might be challenged. For this reason, even though the casuist applies his art within a specific time and place, making no presumptions about "timeless" principles, casuistry is no more historically self-conscious than more "theoretical" approaches.

Finally, in its reliance on the paradigm case and argument by analogy, casuistry provides no avenue for other, indispensable types of moral argument, especially appeals to consequences. This is a liability that casuistry does not share with other approaches.

8. AN EXAMPLE:
JONSEN'S CASUISTICAL ANALYSIS OF THE "CASE OF DEBBIE"

All of these liabilities can be illustrated by Jonsen's defense of casuistry, in
which he applies the casuistical method to the well-known case of "Debbie" [11].

"It's Over, Debbie" is a anonymously written short piece describing the actions of a gynecology resident called in the middle of the night to the room of a 20-year old woman dying of ovarian cancer. She had not eaten or slept for days, was vomiting, and suffering from pain and air hunger. Her only words to the resident were "Let's get this over with." The resident asked the nurse to draw 20mg of morphine, told the patient it would help her rest, and administered it, expecting that it would sufficiently depress her respiratory drive that she would quickly die. She did [16].

The first step in the casuistical analysis of this case is to describe its "morphology": the circumstances of the case (the facts), and the maxims, or the pithy rules that seem to apply to the situation. In this case, the most obvious maxims which would be brought to bear are that 1) It is wrong to kill; 2) A physician should relieve pain and suffering; and 3) A physician should respect the patient's wishes regarding treatment, even when death may result.

The next step is to fit the case within a moral "taxonomy": identifying the "type" of case, and the paradigmatic examples of obviously right and wrong conduct within the type.

I argued earlier that this critical judgment is not itself amenable to casuistical reasoning. In his analysis, Jansen stipulates that in Debbie's case, the type involved is cases of killing. In defending this judgment, he asserts that "the alternative proposal that the relevant taxonomy is care for the patient might be briefly entertained but would probably be dismissed by most commentators as question-begging" ([11], p. 301).

Jansen doesn't explain why placing the case in the taxonomy of care for the patient is any more question-begging than placing it in the taxonomy of killing, when the question seems precisely to be which of these competing moral imperatives should govern our moral judgment about this case. The lack of an explanation is not surprising, because the casuistical argument by analogy cannot adequately handle this sort of question.

Argument by analogy is directed to answering the question, "Is Debbie's case more like paradigmatic cases of killing, or paradigmatic cases of caring, or paradigmatic cases of respecting refusals of life-saving treatment?" When faced with a genuine moral problem, the answer to this question is going to be "A little bit of each." We can't categorically classify the case as only one or the other "type." So we are pushed onto a different kind of question, which is not a question of classification, but of moral weight: in the circumstances, which of these maxims is the more important to follow? The question, and its answer, are the staples of Rossian balancing of conflicting obligations. The answer, admittedly, is a judgment that may be relative to the circumstances of the case. It
is not a judgment, however, that can be adequately based on analogies with paradigm cases, unless we already have at hand a paradigmatic case just like the present one, and which exemplifies an already well-accepted balancing of the competing considerations. But in that instance, we wouldn't be having a moral controversy about the case before us!

Another limitation of casuistry, which may be unique to it, is its inability to account for one of the major kinds of reasoning applied to the issue of voluntary active euthanasia: appeals to the consequences of any policy permitting active euthanasia.

In his discussion of the case, Jonsen asserts that an "approach that the casuist might take is to explore the implications of a physician accepting voluntary euthanasia requests even in appropriate circumstances ... this approach is a form of the so-called "slippery slope" response" ([11], p. 305).

The argument is a familiar one: if we permit physicians to provide active euthanasia to patients at their request, we will be launched on a slippery slope that leads to the horrors of the Nazi "euthanasia" program. This is not an analogical argument; assessment of it turns on an evaluation of the strength of the factual evidence that this would indeed be the consequence of permitting active euthanasia. No doubt a casuist, like any other moral thinker, should take account of potential consequences of policies or patterns of choices. But this critical evaluation lies outside the bounds of case-focused casuistical thinking. Naturally, the Nazi program should be taken as a paradigmatic case of an evil euthanasia policy. But a slippery slope argument does not usually assert that voluntary euthanasia requests even in appropriate circumstances are morally just like a Nazi program, but rather that they may lead to an evil program. This argument relies on the decidedly non-casuistical (and false) principle that whatever practices may lead to an evil are themselves evil.

Another characteristic problem surfaces even if we allow by stipulation that the case of Debbie is properly classified as a killing, rather than as some other type of act. According to the method of casuistry, our job would be to see how this case fits into the taxonomy of paradigmatic cases involving killing: unprovoked wanton killing, killing for personal gain, killing in a jealous rage, killing in self-defense, killing to protect others, etc., all of which offer elaborations of what we mean by the maxim "Thou shalt not kill."

Jonsen's assessment is that "The fact that exceptions to the prohibition against killing remain very close to the protection of self and others suggests that killing to relieve pain [or with consent] might be an inadequate candidate" for being classified as a justifiable killing ([11], p. 302).

Here we confront one of the other fundamental problems with casuistry - its uncritical conventionality. The method assumes that everything that might be relevant to justifying a killing has already been incorporated into the settled,
conventional paradigms. The reliance on analogies with those conventional paradigms cannot answer what is perhaps the critical moral question raised by voluntary euthanasia: is consent a morally valid exception to the prohibition against killing? The standard paradigms beg this question, because they never have taken it up (or else they answer it dogmatically).

There is an historical reason for this. The idea that my life may be at my own disposal, rather than God’s, is of only recent vintage. If the wrongness of killing is thought to consist in the usurpation of God’s prerogative, then my consent to my own death is of course beside the point. If it hadn’t been for the role of Middle Eastern theology in European moral development, the paradigms of justified killing might have been quite different.

As a method of moral analysis, casuistry can neither recognize this historical contingency, nor accept the moral relevance of any theological or other critique of it, which would be critiques of a non-casuistical sort. In this respect, the casuistical evaluation of voluntary euthanasia is no more historically aware than principle-based approaches would be.

Finally, to complete our illustrations of casuistry’s limitations, we should take a look at Jonsen’s resolution of the case, which assesses its “kinetics”:

In Debbie’s case, the degree of her lucidity, the extent of her pain and its intractability, the scope of the resident’s familiarity with her case, are all crucial features ... susceptible of greater and less and the only way of judging “how great and how less” comes from the wisdom of experience.[11], p. 304.

Debbie’s case is resolved casuistically with ease ... the casuist can note that defects in the voluntary nature of the request ... are sufficiently serious that no exception to the dominance of the maxim against killing is justified. The resident was wrong to administer the morphine in a lethal dose’[11, pp. 305–306).

There are two aspects of this reasoning that are significant for the evaluation of casuistry. First, the judgment that her request was not sufficiently voluntary is not based on any casuistical argument by analogy to any paradigm of justified killing, even though Jonsen has said that this is the pertinent classification. For by his admission, there are no accepted paradigm cases of ethically justifiable voluntary euthanasia.

At best, Jonsen is making his casuistical assessment relative to paradigms of acceptable refusals of life-prolonging treatment. But if these cases are the pertinent analogues, then Jonsen’s conclusion about Debbie’s case will not come as easily as he claims. When the question is whether to accept a patient’s refusal of a life-prolonging treatment, the level of evidence for her competency that’s demanded is usually taken to be relative to the price that will be paid if an incompetent refusal is in fact mistakenly honored[17]. If in the circumstances, the harm to the patient of withholding the treatment is small, the standard of evidence will be low. Thus, in Debbie’s case, the question would be whether we should have honored her demand not to be placed on a respirator, if she had
made it under the same problematic conditions as her apparent request for active euthanasia. I am confident the answer is “Yes;” at the very least, it is not an easy “No.” But then, an argument by analogy would appear to support a judgment about the case opposite to the one favored by Jonsen.

We have here an illustration of yet another of the liabilities of casuistry mentioned earlier. The moral judgment that we reach by way of casuistical analogy will depend mightily on which type of paradigm case we take to be the right analogue. That choice, in turn, cannot itself be one that is based on analogies to paradigm cases.

A final limitation revealed by Jonsen’s conclusion is that in making the judgment that Debbie’s request was not sufficiently voluntary, the casuist is really in no better shape than adherents of a principle-based approach, who also must judge whether a principle supporting voluntary euthanasia for the competent informed adult applied in this case or not. The casuist, relying as he does on the deliverance of “practical wisdom” rather than on any further reasoning, analogical or otherwise, is no more articulate than anyone else in explaining the connection between the maxim or principle and its application to any non-paradigmatic case at hand.

9. WHAT CAN BE SALVAGED?

Casuistry is being promoted as an antidote to the serious inadequacies that plague the dominant principle-based approach in medical ethics. A principle-based approach seems unable to avoid the necessity of relying on intuitive judgments in balancing competing ethical principles; it cannot adequately support the interpretations and judgments that must be made in applying principles to cases; it may be naive about its own historical contingency; and it gives principles an epistemological pride of place over concrete judgments of cases that they don’t deserve.

Except perhaps for the last of these, however, we’ve just seen how casuistry suffers from the very same, or closely-related difficulties. It has, in addition, its own special problems, most importantly an inherent moral conservatism that seems inadequate for handling the sorts of unprecedented ethical issues that are arising in health care.

Casuistry, therefore, is by no means an alternate model of moral reasoning preferable or superior to principle-based approaches in medical ethics. And yet casuistry’s starting premise—that our understanding of our moral principles is rooted in paradigmatic cases—is nevertheless appealing to me. Casuistical analysis, in the most general sense of drawing comparisons with paradigmatic cases, may still be a useful element of moral problem-solving. What more modest purposes might it serve? I think there are several.
To begin with, determining whether the problem case fits closely with a paradigmatically right or wrong action is an essential first step in understanding the nature of the moral issue it presents. It may be that when fully and properly described, the case is not morally problematic at all, because the right action is patently clear, and no further analysis or argument is called for.

For example, would it make a difference to our ambivalence about the case of Debbie if it turned out that she and the resident were deep and bitter enemies, such that there was reason to suspect that the resident’s motives were in part malevolent? If it would, is this because the case would now much more closely resemble some paradigmatic cases of wrongful killing? I think this would be a relevant similarity, even if by itself it was not a decisive one. For one thing, we would now have reason to reinterpret what Debbie meant when she told the resident, “Let’s get this over with”.

So paradigm cases can alert us to some of the ways in which the story about the present case needs to be filled out before we can make an adequately informed judgment about the nature of the moral problem which faces us.

Paradigm cases can also serve another purpose, as suggested by another well-known case of physician-assisted dying — the story of “Diane”, told by Timothy Quill [18]. Unlike Debbie’s resident, Dr. Quill had a long and deep relationship with his patient, characterized by careful exploration of all of the options short of a lethal overdose of barbituates. It is because this case much more closely resembles paradigmatic cases of compassionate caring and respect for individual dignity that it raises more sharply than the case of Debbie a challenge to the traditional paradigms of justifiable killing. Using the case of Debbie as the occasion for asking whether voluntary active euthanasia is morally permissible feels like a philosophical abstraction rather than a genuine ethical quandary. And so, paradigm cases may also serve as a source of moral sentiment, and it is by association with conflicting sets of them that new cases present problems to be solved, even if the paradigms don’t themselves provide the solutions.

NOTES

1 Parenthetically, this is a badly ambiguous example for Jonsen and Toulmin to use, even if we should excuse the Greeks for it. Clearly, whether their claim is true or not depends on whether we understand the example to mean “Chicken tastes good when eaten”, or “Chicken is a healthy food to eat.” Only the first is more secure than any theoretical explanation or justification for it; but presumably Jonsen and Toulmin don’t want to assimilate ethical judgments to matters of taste.

2 Although one should note that this model of diagnostic thinking is itself a matter of contention. Attempts to computer-model diagnosis, for example, assume that the process is implicitly Bayesian.

3 Of course, there is another reason we cede epistemic authority to experts: we haven’t the time to become experts ourselves, and the experts’ past performance has shown their
judgments to be reliable ones. We trust the uneasy diagnostician because time and time again, he had turned out to be right. But this is not an explanation useful for Jonsen and Toulmin. Outside the mantle of religious authority, there is no comparable method of confirmation available for judging the trustworthiness of the ethical expert. (I'm grateful to Ed Erde for reminding me of this alternative.)

4 Even as it is in places understood by Jonsen and Toulmin, since in Ch. 10 of The Abuse of Casuistry, they recount the history of the doctrine of mental reservation discussed below. Of course, they do not draw the same conclusions as I do about the affinities between casuistry and moral absolutism.

REFERENCES