

Week 2

Methods of Bioethics:

The Four Principles Approach, Casuistry, Communitarianism

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Objectives:

At the end of this session, participants should be able to:

1. Identify the major analytic frameworks and approaches to case resolution in bioethics including casuistry, principlism, and communitarianism
2. Analyze cases in terms of the principles and analytic frameworks of bioethics
3. Apply each approach to problematic cases

The lecture will help you to reach these objectives by:

- Reviewing the approaches that traditional "applied philosophy" has taken to ethical problem solving. This will consist of a review of the theories of deontology & utilitarianism
- Explaining how the approach bioethics takes to problem solving differs from traditional approaches. This is illustrated by bioethics' "founding myth" of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research
- Providing an exposition and demonstrating the application of the methods known as principlism and casuistry
- Providing an exposition and demonstrating the application of the method known as communitarianism
- Providing a summary of the points on which there is something of a consensus among the methods

Readings:

Edmund D. Pellegrino, "The Metamorphosis of Medical Ethics: A 30-Year Retrospective," *Journal of the American Medical Association*, 269(9): 1158-1162, 1993.

Mark G. Kuczewski, "Casuistry," *Encyclopedia of Applied Ethics*, Academic Press, 1997.

Mark G. Kuczewski, "Communitarianism and Bioethics," *Encyclopedia of Bioethics* (3rd edition), MacMillan Reference USA, 2003, pp. 477-483.

Susan B. Rubin, "Beyond the Authoritative Voice: Casting a Wide Net in Ethics Consultation," in R. Charon & M. Montello (eds.) *Stories Matter: The Role of Narrative in Medical Ethics*, New York: Routledge, 2002, pp. 109-118.

Suggested Further Readings:

Ezekiel J. Emanuel, *The Ends of Human Life: Medical Ethics in a Liberal Polity*, Cambridge, MA: Harvard University Press, 1991.

Mark G. Kuczewski, *Fragmentation and Consensus: Communitarian and Casuist Bioethics*, Washington, DC: Georgetown University Press, 1997.

Daniel Callahan, "Communitarian Bioethics: A Pious Hope?" *The Responsive Community*, 6(4): 26-33, 1996.

(I) Traditional applied philosophy

Traditional applied ethics, that is, ethics developed from the 16th Century forward, has generally taken "**top-down**" **approaches** that are modeled on the kind of reasoning used in **geometry**. In geometry, you first lay down some, preferably rather few, definitions and axioms which are considered self-evident (i.e., capable of no further proof) and then try to grind out answers to more specific problems from this foundation. As a result, these traditional philosophical theories are referred to as **foundationalist**. They believe one must create a foundation from the most general and abstract truths and then reason deductively to work out the particulars. What philosophers sometimes call the "**locus of certitude**" (the place of greatest certainty) is in the most general levels of abstraction. Such thinking generally separates values from facts and builds ethics upon a foundational value statement, taking that statement as the point of departure. The **two main theories** of this kind that arose from the period known as the Enlightenment are deontology and utilitarianism.

(1) **Utilitarianism** (Its most famous exponents are John Stuart Mill & Jeremy Bentham) They claim that what is moral is what leads to happiness or pleasure; The **principle of utility** is sometimes summarized as "**the greatest good for the greatest number.**" This is sometimes misleadingly called "hedonism" because of the identification of the good

with “pleasure.” Of course, a utilitarian takes the fun out of hedonism by pointing out that moderate living is usually more conducive to pleasure than a life of debauchery.

(2) **Deontology** (Its best known representatives are Immanuel Kant & John Rawls) “Deon” is the Greek word for “**duty**.” Deontologists take it as self-evident that what is right is doing one's duties, fulfilling one's obligations. Of course, deontologists must give us some formula to help determine what one's duties are. Perhaps the oldest version of this approach might be Golden Rule ethics, i.e. “Do unto others as you would have others do unto you.” Immanuel Kant developed the **Categorical Imperative** to serve as such a formula. In one version, the Categorical Imperative commands us to "Act only on that maxim whereby you can at the same time will that it should become a universal law or a universal law of nature." (In this formulation, deontology is a kind of "what if everybody did that?" ethics). Another well known formulation compels us to "Act as to treat humanity, whether in your own person or in that of any other, never solely as a means but always also as an end."

The main problem that has been historically noted about these is that they are so **general** and **abstract** that they are difficult to know how one should apply them to cases. When such is attempted, it is usually possible to support the intuitively correct response with either theory or to argue on both sides of the issue with the same theory. As a result, there is a desire to move to a lower level of more specificity.

For instance, consider the case of **Karen Ann Quinlan**. She was a young woman in what would today be termed a permanent vegetative state (PVS). Her family did not want the ventilator that supported her respiration to be continued. Can utilitarianism and deontology tell us what should be done in such a situation? Utilitarianism counsels us to do what would maximize happiness. I think most people would probably think the total amount of happiness in the USA will increase if people are not forced to remain alive on ventilators indefinitely. Although this line of reasoning is intuitively plausible, some argued at the time that allowing the removal of the ventilator would eventually impact negatively on the general happiness because it would cheapen life and this would manifest itself in a variety of undesirable consequences. Both arguments are good utilitarian arguments and the theory of utilitarianism does not itself tell us how to choose between them. Such a choice is ultimately based upon our experience and intuition. Traditional theories do not wish us to have to use our intuitions at such key points in a policy discussion.

The case is similar if we try to apply Kant's Categorical Imperative to Karen Ann Quinlan's situation. Counseling her caregivers to avoid treating her solely as a means to an end only has obvious consequences if some peculiar circumstance is involved such as that they are keeping her alive for money. Since she is then being used as a means to their end (of money), would make their actions wrong. But, since nothing like this seemed to be happening, this formulation is unhelpful. A similar analysis would follow if we applied other formulations of the categorical imperative.

In sum, the main point is that these ethical theories do not live up to their aspiration of providing definitive guidance. Rather, their application seems to demand the very intuition and experience that theories usually hold in contempt. Remember, traditional ethical theories find the locus of certitude in the foundational principles and see no certitude in experience and judgment.

(II) Bioethics' Founding Myth

In last week's readings, we saw ethicist Al Jonsen discuss how bioethics was born of controversies that led to the empanelling of the **National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research**. Jonsen's story has become more or less "accepted wisdom" among bioethicists about the discipline's origin. One of the important themes of this tale is that the commission was remarkably successful by proceeding in an issue-by-issue, case-by-case manner. He claims that the commission was expected to struggle for agreement since there was no single ethical theory upon which the commissioners could rely. But this never proved to be an obstacle to the work of the group which managed to issue authoritative guidelines regarding human experimentation and was able to publish a report of the concepts or principles that guided its inquiry (The Belmont Report). In effect, bioethics was born sans theory and has proven that they are not required for progress. Nevertheless, virtually all bioethicists agree that there is some sort of method behind progress and have conducted a fruitful debate regarding what that method might be. The leading candidates generally include the four principles approach (principlism), casuistry, and communitarianism.

We can easily see how the "founding myth" of bioethics embodies assumptions that are quite different from those of traditional ethical theories. The procedures of the National Commission and the methods developed by those philosophers who were a part of the commission's deliberations, are based on the claim that we can begin with the "**common morality**" and discern moral guidelines to illuminate difficult situations. This kind of thinking is **antifoundationalist** in that it does not assume a single self-evident starting point. It is **pragmatic** in that it gathers facts and seeks to bring debate to closure in recommendations. It is **coherentist** because the one major checkpoint for any particular recommendation is whether it coheres with other recommendations. In philosophical terms, the kind of thinking that dominates contemporary bioethics does not accept a hard and fast fact-value distinction or the famous Enlightenment dictum, "No 'ought' from an 'is'." That is, gathering the facts moves one close to the answers. Values are inextricably linked with facts and can be developed from reflection on the facts gathered.

(III) Bioethics' Best-Known Methods: The Four Principles Approach and Casuistry

The Four Principles Approach (a/k/a Principlism)

In the founding myth, we heard about the National Commission for the Protection of Human Subjects Of Biomedical and Behavioral Research, and the preface to the guidelines for human subject research it issued on April 18, 1979 known as The Belmont Report: Ethical Principles for the Protection of Human Subjects of Research. Several of the philosophers associated with the commission's work articulated their thoughts on bioethical method at around the same time. Tom Beauchamp and James Childress published the first edition of their landmark text Principles of Biomedical Ethics in the same year as the Belmont Report (1979). The Belmont Report talked about three "principles" or concepts that are considered integral to the investigator-subject relationship: respect for persons, beneficence, and justice. Beauchamp and Childress built upon these concepts in developing their "four principles approach," also known as principlism.

The Four Principles:

Respect for Autonomy--respect people's decisions/values

Beneficence--help people

Nonmaleficence--don't harm people

Justice--treat like cases alike; distribute benefits and burdens fairly

The Characteristics of the Four Principles:

The four principles are **role-specific duties**. They are the duties that physicians (perhaps generalizable to health-care professionals) owe to patients. They are **prima facie duties** which means that they are duties that are considered always to be in effect. They are sometimes called **mid-level principles** because they occupy a level of generality and abstraction below universal, foundationalist principles such as the categorical imperative or the principle of utility but above concrete particular judgments. For principlists such as Beauchamp and Childress, the **locus of certitude** is in these **mid-level principles**. It is difficult for anyone to doubt that a physician has a duty to help her patients, not harm them, etc. These are claimed to be more certain than concrete judgments about particular matters and the highly abstract principles of traditional ethical theories. (Note: the principlists do not deny that there is value to the principles of ethical theorists. They simply claim that such principles are too general to guide particular decisions in the doctor-patient encounter. Beauchamp and Childress claim that their four principles are compatible with either deontology or utilitarianism.)

According to the framework of the four principles approach, there is **no intrinsic priority** to any of the principles; they are all of equal weight. The working hypothesis of Beauchamp and Childress is that problems in medical ethics take the form of a dilemma in which two of the principles come into conflict. For instance, in a classic case such as that of Karen Ann Quinlan, the problem is that her health-care providers feel the pull of their obligation to respect her autonomy and to try and make her well (beneficence). Since both obligations are always in effect, having to choose one over the other creates a moral dilemma. In choosing one means that these caregivers will not honor the other.

But, since a choice must be made, Beauchamp & Childress must provide moral guidance for that choice. They provide ways to justify the choice of one principle over the other. These “justificatory conditions” are how we “**balance**” **conflicting principles**.

In the third edition of the *Principles of Biomedical Ethics*, Beauchamp and Childress provided the following list of conditions that justified “infringing on a prima facie norm,” i.e., choosing one principle over the other. (The pithy summations in parentheses in #'s 2 – 5 are supplied by the lecturer.)

“Justificatory Conditions” for infringing on a prima facie norm

- (3rd edition of *PBE*--see also Pellegrino, p. 1160)
- (2) The moral objective must be realistic. (Be Realistic)
 - (3) No morally preferable alternative action is possible that would fulfill both of the conflicting duties. (Seek win-win solutions)
 - (4) Choose a solution that minimizes the infringement of duties. (When win-win can't happen, choose the “next best thing”)
 - (5) Seek to minimize the effects of that infringement. (Clean up after yourself)

In the fourth edition of *Principles of Biomedical Ethics* (p.34), Beauchamp and Childress add a new number one condition. (The parenthetical remark is a quotation from Beauchamp & Childress).

- (1) Better Reasons can be offered to act on the overriding norm than on the infringed norm (for example, typically if persons have a right, their interests deserve a special place when balancing those interests against the interests of persons who have no comparable right).

Let us consider how these conditions apply to a case such as that posed by Karen Ann Quinlan. The caregivers face the dilemma between respecting what they are told Karen Ann Quinlan would want (Her parents claimed they knew, based upon previous conversations with her, that she would not wish to be sustained by the ventilator.) and their duty to help her medically. This sets up a conflict of respect for autonomy and beneficence. Which should her caregivers honor? (We can ask this in the converse: Which duty should they infringe upon?) According to the original set of justificatory conditions from the third edition of *PBE* (#'s 2 –5), it would seem best to respect Karen Ann Quinlan's autonomy and infringe upon the principle of beneficence. Because Karen Ann Quinlan is in a permanent vegetative state, there is virtually no hope of making her better through medical intervention. There is a very limited sense in which medical interventions can be said to be “helping” this patient. As a result, the principle of respect for autonomy is weightier in this case than the principle of beneficence.

Beauchamp and Childress added the new number one justificatory condition to account for the fact that, at least in the U.S.A., not all four principles are considered equally weighty. Usually, respect for autonomy is intrinsically a weightier principle than the other three prima facie duties. For instance, even if Karen Ann Quinlan had a reasonable chance of recovery, if we definitely knew that she would not want treatment, we would

probably still believe that morality (and legality) require us to respect her autonomy. However, we should note that there is at least some room for balancing autonomy at the bedside. Often when a clinical situation requires pits the patient's wish to refuse treatment against caregiver beliefs that the patient should give recovery a chance, a negotiated settlement in which the patient agrees to accept treatment for a limited time is reached. This kind of solution is a version of justificatory condition #3 in which both principles are respected. The patient's autonomy is respected because she agrees to the trial period, the caregiver's duty to beneficence is honored in the trial period and information is gathered regarding how realistic the hopes for recovery are (justificatory condition #2).

The **four principles approach** is clearly **useful** in that the principles have supplied a handy **terminology** for medical ethics and a practical checklist of considerations. The question that arises from the four principles approach is about whether the locus of certitude is really in these four principles. In other words, are the four principles the most fundamental kind of knowledge in biomedical ethics? In looking at the way in which we parsed the Quinlan case, it is plausible to claim that we knew all along what was right in the case, i.e., allowing the withdrawal of the ventilator. We then tried to find an interpretation of the case in terms of the four principle approach that would justify this outcome. The idea that certain clear, paradigm cases are the ultimate source of ethical knowledge is the thesis of the method known as casuistry.

(Please note that Principles of Biomedical Ethics is now in its 5th edition. The references in this lecture are to editions 3 & 4. It seems that as Beauchamp & Childress create additional editions, they are becoming less explicit with their own position & increasingly eclectic in their approach. Hence, it takes greater exegesis in the fifth edition to illustrate these same points.)

Casuistry (a/k/a Case-Based Reasoning)

Prominent among the members of the National Commission was Albert Jonsen, who we have already seen, has been very successful in developing the founding myth of bioethics. Philosopher Stephen Toulmin was a consultant to the commission and aided in the development of this legend, especially in their book, *The Abuse of Casuistry* (1988). It is their claim that the commissioners found agreement as long as they focused on cases or instances of the issues and only ran into problems when they turned to the explanation of their areas of agreement. It was in this explanatory phase that the commissioners split along disciplinary and ideological lines. For them, the **locus of certitude** is in the **cases**.

The key to the method is the use of **paradigm** and **analogy**. Casuists argue that when we are faced with a troubling case, we need to retreat to similar but much clearer cases on which virtually any reasonable person would agree. These clear cases are paradigms. For a casuist, "**the circumstances make the case.**" Reflecting on the paradigms makes possible the identification of the features or circumstances of the case that make the solution clear. The presence of these circumstances in the problematic case allows the application of the solution in the paradigm case by analogy. If such circumstances are not

present in the problem case, then the solution cannot be transferred from the paradigm case. Casuist Carson Strong places these insights into a systematic series of steps.

Carson Strong's casuistry:

1. identify the middle-level principles and role-specific duties pertinent to the given situation.
2. identify the alternative courses of action that could be taken.
3. identify the morally relevant ways in which cases of the type in question can differ from one another.
4. for each option under consideration, identify a case in which that option would be justifiable, i.e., identify a paradigm case.
5. Compare the problem case to the paradigm cases.

For instance, Al Jonsen applied a similar version of this method to a case of physician-assisted suicide and asked whether it was right or wrong. In the end, he concluded that a paradigm of morally acceptable physician-assisted suicide would be an instance in which the patient was in permanently unrelievable pain and a physician who knew this patient and her wishes well aided the patient in dying. Note that this paradigm case does not settle the public policy question concerning the legalization of assisted suicide (Jonsen himself is opposed to legalization of the practice). But, such a paradigm is an instance of a case where most persons would say the physician did nothing morally blameworthy. Conversely, we see in Jonsen's reasoning a paradigm in which assisted suicide is clearly wrong; the circumstances of such a case include not exhausting other possibilities for pain relief, not investigating whether the patient is thinking clearly and expressing a stable desire, etc. The question concerning whether a particular instance of assisted death is moral depends on which paradigm it resembles. Let us see how this works with a more common issue such as truth telling.

Case Analysis & Application of Casuistic Method

Josh Kramer II, a 55 year-old patient with a long history of nodular goiter, presented with a recent growth of thyroid mass and hoarseness. He was told that he had a cancerous growth and that he will need to have the tumor removed and start an aggressive round of chemotherapy. Mr. Kramer agreed to the proposed treatment. However, Kramer's wife and children told the oncologist that Josh Kramer the Ist died of the same exact illness and that complete truthfulness would devastate Mr. Kramer. Thus, when the tumor could not be completely removed, Mr. Kramer was merely told that his recovery would be lengthy and that much preventive treatment would be needed to keep the cancer from recurring. Because of great skill in deception and a tightly orchestrated effort to conceal the truth, Josh Kramer II died without ever being told of his terminal illness.

Such a case clearly raises the question whether it is alright to withhold the truth from a patient. If we approach this as principlists, it would seem to be a conflict between

respecting the patient's autonomy (which would seem to entail that he receive all the information pertinent to the management of his medical care) and a desire not to harm the patient by telling him information that would prove injurious (nonmaleficence). We need to decide which principle carries more weight in the case of Josh Kramer II. The casuist would suggest creating a paradigm in which it is clear that it would be alright to withhold information and a paradigm in which we should clearly tell the truth to him. Then we can see which paradigm Mr. Kramer's case more clearly resembles.

Finding paradigms requires some **creativity**. To find a case in which it is definitely morally acceptable can take some doing. If we definitely knew a patient would jump out a window upon hearing the news of his diagnosis, we would probably find it acceptable to withhold the truth. But, this is a difficult paradigm to employ since it is hard to place a great deal of faith in our predictions about patients jumping out of windows. Another paradigm that suggests itself might be one in which we knew that the patient would not want to be told bad news. To complete this paradigm, we would have to ask ourselves how we could be sure that the patient would not want to know. A truly paradigmatic instance would be one in which the patient actually told the caregiver he would not want to know. So, the paradigm in which nonmaleficence is the paramount principle is a case where the patient "waives" his right to the truth.

This paradigm suggests its opposing paradigm in which respecting the patient's autonomy trumps the duty of nonmaleficence. Namely, in a case where the patient definitely wishes to know about his condition, we should tell him the truth even if it has an immediate negative impact such as leading to an episode of depression.

Deciding which paradigm Mr. Kramer's case resembles more closely will require some skill in communication. One could not simply say to Mr. Kramer, "I have some bad news. Do you want me to tell it to you or withhold the truth?" This would be to tell him the bad news whether he wanted it or not. One might have to start in some other fashion, e.g., "Mr. Kramer, there are likely to be many reasons for optimism and some setbacks in terms of the prognostic information we gather during the course of your treatment. Your family believes that it would be better for you to focus on getting well and not on this changing information. They think you would prefer that we tell them the details of each diagnostic test and they will share information with you as you request it. Are they correct or do you feel you'd wish to know all the information as we go along?" It is important to note that the philosophical **methods** in bioethics point us in a **direction** to proceed. They do not tell us concrete things such as how to talk to patients. That is a matter of **clinical skill** and **judgment**.

In sum, **casuistry** is a method that can be very **useful** in clinical ethics consultation. When dealing with a difficult case, it helps to step back, consider the options, and set up hypothetical paradigms in which each of the alternatives is justified. The consultant then has a method of operation: to investigate the case at hand to determine which paradigm the case most closely resembles.

Casuietry is also a highly **interpretive** endeavor. When we first began working with the four principles approach, we assumed that we knew what each of the principles meant. But we only knew their meaning in the most superficial way. In each of these cases, casuistry seems to be based upon the idea that we only know what a principle like beneficence or nonmaleficence will mean in the case by examining its particulars. That is, is withholding the truth from a patient an act of nonmaleficence or not? We saw that the answer to this depends on the circumstances of the case. In the case of Josh Kramer II, if he wishes to know this information about his condition, it is probably more harmful to withhold it from him than to tell it to him. Thus, respecting his autonomy is more likely to work hand-in-hand with the other principles than to be in conflict with them.

Problems/Criticisms of Casuistry

Casuistry is **based** on the moral dimension of **routine practice** and **everyday life**. It assumes that we have a developed moral sense that can identify the right action in most situations and can draw upon these intuitions in dealing with problematic cases. However, this strength also leads to a **conservative bias** because it assumes that most practices embody a moral dimension that should be respected. In the case of a nation such as the U.S.A., such a bias is likely to be in favor of solutions that favor autonomy since that value is so deeply engrained in our traditions.

Similarly, the practice of casuistry is always **dependent upon** the composition of the case. One must describe the case at hand. Which paradigm it most closely resembles may depend on which facts one chooses to include in the **case description**.

Neither of these criticisms can be eliminated once and for all. They are problems of which one must be aware and try to take into account in each situation. Any solution one reaches using casuistic methods is always probable, not certain. This is, of necessity, the case because casuistry is an **inductive method**. When one reasons inductively, it is always possible that one has drawn a wrong conclusion from the facts provided. This means that the casuist must always be willing to listen to new and different data and perspectives.

(IV) Communitarianism

Casuistry raised a number of questions concerning the relationship of the community to our moral reasoning. Casuistry assumes that much of our routine practices and everyday institutions embody an implicit morality. But, it also raised the fear that it may reify a particular bias, in our case, it may come to enshrine autonomy as the supreme value. A movement called communitarianism, which thematizes these questions, has received much attention in recent years.

Several possible meanings of communitarianism

1. The rights (of an individual) are coupled with responsibility (the community)
2. The good of the community can outweigh the rights or good of an individual, e.g., presumed consent to organ donation
3. Considerations of the welfare of the community should be balanced against the rights of the individual
4. Deliberation is a communal, not individual activity. Solutions to important questions require coming to a "shared common understanding" through the development of communal deliberative mechanisms.

Each of these meanings is embraced by some communitarians. Implicit within each is that the locus of certitude is in the needs and deliberative processes of the community. Daniel Callahan, founder of the Hastings Center, places an emphasis on the idea of communitarianism as an antidote to our individualistic bias in medical ethics. Callahan claims that the way we typically approach any question is to look at the impact of the decision on the particular decision maker, not the impact on the community. Thus, if we have a new technology such as the cloning of human beings, we will typically look at a case in which the use of this technology would seem unobjectionable. Then we would ask by what right anyone could deny this technology to this person. The result is that there is no weighing of the interests of the community in the decision-making process.

Callahan raises an important cautionary note. In our discussion of Beauchamp and Childress's four principle approach, we noted that respect for autonomy seemed to be a weightier principle than the others. How we can articulate the interests of the community and develop mechanisms to represent these interests is a major problem. In debates about medical insurance, the interests of insurers and other powerful groups are generally well represented. Yet the community has an interest in the health care of each of its members. But, this interest has traditionally failed to hold sway in the making of public policy. Communitarians typically differ among themselves in terms of concrete proposals to ensure that communal deliberations take place that can correct for these individualistic biases.

Case Analysis & Application of Communitarian Methods

In the book, *Everyday Ethics: Resolving Dilemmas in Nursing Home Life* (Rosalie A. Kane, Arthur L. Caplan, editors, New York: Springer Publishing Company, 1990, pp.71-78) a case involving a chair in a nursing home is described. In particular, a new resident sits in a particular chair in a common area and is then told that she is in the chair of another resident. The new resident resists moving since the chairs "belong to everyone." However, the resident who claims that it is her chair seems menacing and the staff at the nursing home suggest that the new resident find somewhere else to sit. What does communitarianism contribute to the discussion of such a case?

A communitarian might lean on several insights:

1. Each of the residents in question should consider not only her rights, but also the good of the community.

2. The residents would do well to have an agreed upon procedure for resolving conflicts among the residents. If such a process is well done, each resident will feel obliged to live by the results of such a mechanism.
3. In deciding which resident is right, we might wish to ask what kind of community a nursing home is most like, e.g., a hotel, a neighborhood, a family? The more intimate the community, the more reasonable it is to expect the person to subjugate her rights to the good of the group.

As with most methods, communitarianism offers us no single answer to all problems. It thematizes certain important considerations and suggests a direction of inquiry. But skillful completion of that inquiry will require a great deal of judgment and skill by the ethicist.

(V) Conclusion

In conclusion, it is easy to think about philosophical methods and be somewhat misled by the different names and types of approaches. But several features and assumptions are shared by each method. In particular, I wish to draw your attention to several points of commonality.

What all the methods have in common (the consensus on method):

- **There is no such thing as "applied ethics" in the traditional sense.** Ethics does not first work out a theory and then apply it to experience. Bioethics proceeds by looking at the cases and ordinary practice and reflecting upon the implicit assumptions.
- **Methods are useful.** Methods help us to make our reflection upon experience more systematic and each method makes thematic certain factors that could easily be overlooked in everyday thinking about moral problems.
- **All methods in medical ethics presuppose a kind of narrative construction.** We must construct the case at hand in order to know what paradigm it resembles. And, how we tell the story of the case will help us to interpret the meaning of the principles in the case. In many ways, becoming a good ethicist means becoming a skillful narrator of cases. (It is for this reason that I included the reading of Susan Rubin's chapter on narrative in clinical case consultation.)
- **Medical ethicists seek "reflective equilibrium" balancing perceptions of particular cases and more general levels of reflection.** Although ethicists generally work with the case in front of them, they seek consistency in their ways of handling cases, and as we saw with communitarianism, aim for their solutions to fit into the larger picture of the life of the institution and the community.
- **The usefulness of method is largely character-dependent.** As we saw in the case Josh Kramer II, the identification of paradigms, as well as their actual implementation in the clinic, requires a good deal of skill. It is this

skill that one hopes to develop in studying bioethics as well as doing clinically related activities. These skills are sometimes referred to by a variety of names including clinical judgment, practical wisdom, or the Greek word for practical wisdom, “phronesis.”
