META-APPLIED ETHICS AND THE SEARCH FOR METHODOLOGICAL FOUNDATIONS

BY
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CHAPTER 1

THE NATURE OF APPLIED ETHICS

I. APPLIED ETHICS AND THE PROBLEM OF IMPLICIT METHODOLOGIES: INTRODUCTION

Over the last two decades, we have witnessed the emergence of a seemingly new branch of philosophy known as "applied ethics". To most, this new term, "applied ethics", is generally recognized as the area of philosophy that deals with practical moral issues that arise in biomedical, business and environmental contexts. Unlike the general discipline of philosophical ethics, which typically centers on metaethics and moral theory, applied ethics solely concentrates on analyzing, and in some cases, solving, the concrete moral perplexities we face today.

For many, this practical approach to ethics is refreshing. We can finally stop merely thinking about ethics and instead really do ethics. I happen to be one of those who finds the emergence of applied ethics a welcome change from the abstract, often tired, discourse that comprises "ordinary" philosophical ethics. Instead of the seemingly far-removed thought experiments that act as a testing ground for moral theories, we are finally employing real cases in our discussions of normative ethics. All sorts of concrete ethical issues are being tackled head-on within this discipline, including euthanasia, genetic screening, medical resource allocation, corporate moral responsibility, affirmative action programs, animal testing and natural resource depletion.

However, as appealing as this practical approach to normative ethics sounds, I embrace it with some reluctance. This is because although we are clear about *what* we are analyzing and trying to "resolve" in applied ethics, it remains suspiciously unclear as to *how* we are actually doing applied ethics. This is especially curious given that moral philosophers are now being called on, more than ever, to participate in activities where philosophers must defend their moral conclusions (presumably in a convincing manner) amongst not only other philosophers, but also those from other disciplines. These activities range from sitting on hospital committees to forming public policies (on various levels), as well as testifying in court as "moral experts".

For some time now I have been puzzled by this apparent lack of methodological discussion within applied ethics, especially in bioethics. It seems to me that amongst the plethora of articles, journals, seminars and even media contributions dedicated to conquering issues in biomedical ethics today, there is a vagueness about how moral conclusions are in fact derived. This is not to say that applied ethicists are guilty of neglecting to cite reasons for the positions for which they argue within their respective media, as surely they do (e.g., appealing to slippery slopes, injustice, moral obligations, etc.). However, it is to say that the whole reasoning process being employed in applied ethics is rarely, if ever, made explicit. Even through my own experiences in applied ethics settings (as limited as they may be) I have learned that when it comes to methodology, much remains either vague or implicit. A perfect example comes from the instruction sheet of a take-home exam given to students enrolled in a medical ethics course with which I was recently involved. The instructions read as follows: "Using an ethical process familiar to you, please discuss the ethical issues...You must come

to a definite recommendation and provide an ethical basis for it." In many respects, I felt sorry for these students, given that "ethical processes", although touched upon in the beginning of the course, were never really explicitly discussed nor given adequate explanation. With all due respect to those teaching this branch of applied ethics, I suggest that this aspect of biomedical ethics really needs to come to the forefront in order for this new discipline to have a true philosophical and critical edge. Thus to summarize, the problem with applied ethics today is that it remains unclear as to the precise relationship between the body of knowledge found within philosophical ethics as a whole and the resolution of concrete ethical dilemmas.

Consequently, the project I set out for myself centres on answering the following three questions: *(1) What exactly are we applying in applied ethics? (2) How is ethics actually being applied, if it is being applied at all? (3) Which approach proves most "successful" in applied ethics?*

To no one's surprise, including my own, there is no one universally accepted set of answers to these questions - different philosophers simply have different approaches to applied ethics. However, what might come as somewhat of a surprise to some is that philosophers also seem to differ with respect to the goal or purpose of applied ethics. The fact is, the relatively ambitious goal of providing concrete solutions to moral problems or advocating public policies, as suggested above, is not a goal shared by all philosophers. What follows from this is that the answers to all three of the questions I have posed (especially the third question) are going to be inevitably contingent upon the particular goal the philosopher has in mind. In other words, what is being applied, how it is being applied, and whether one method of application proves to be a "better" method than another, will be relative to the

assumed goal. Given this, one would expect that the first order of business here would be to make a case for one particular goal of applied ethics. However, for reasons of clarity, brevity, and quite frankly, fear of succumbing to an inextricable metaethical and epistemological debate, I have chosen not to defend any one particular goal of applied ethics in this paper. Rather, my approach will be to answer the above questions in a hypothetical manner, each according to a specific goal (to be outlined in the proceeding section).

The remainder of this opening chapter will be dedicated to answering the first question: *What* is being applied in applied ethics? This question will be approached on a more general level than the other two questions, with the main intent of unpacking the term "ethics" in applied ethics. The second, third, and fourth chapters will be more specific in nature, concentrating on elucidating, illustrating, contrasting and ultimately evaluating (relative to the assumed goal) the three most widely discussed methodologies of applied ethics: (1) Ethical engineering: a top-down, monistic theory-based approach, (2) Principlism: a middle-down, pluralistic principle-based approach and (3) Casuistry: a bottom-up, case-driven approach.

II. THE GOAL(S) OF APPLIED ETHICS

When philosophers step into the applied ethics arena, exactly what do they hope to achieve? To what end is their so-called "moral expertise" directed? Like the issue of methodology, this issue is also an implicit part of applied ethics. While it is difficult to find any direct attempts to respond to these questions in the applied ethics literature, one can infer (from that same literature) that applied ethicists have either the first or both of the following two objectives in mind:

(1) To provide conceptual and moral analysis and clarification in hope of reaching a greater degree of consensus amongst legitimate decision-makers in a given case.

(2) To provide morally correct action-guides for real cases backed by "moral justification".

For the purposes of this paper, any approach to applied ethics that adheres to *both* objectives will be referred to as Prescriptive Applied Ethics (Prescriptive AE), while on the other hand, any approach to applied ethics that adheres to the first objective and *only* the first objective, will be referred to as Facilitative Applied Ethics (Facilitative AE).

III. WHAT IS BEING APPLIED IN "APPLIED" ETHICS?

A. PRESCRIPTIVE APPLIED ETHICS:

As alluded to before, this new discipline "applied ethics", be it Prescriptive AE or Facilitative AE, simply appears to involve applying ethics to real cases. However, what is meant by this rather general term "ethics"? What precisely are we applying to these real-life cases? Does "ethics" refer exclusively to the normative branch of ethics and the received moral rules, principles and theories that are typically contained within it, or does the "ethics" in "applied ethics" involve more than this? Much of the literature points to Prescriptive AE being, for the most part, the application of normative principles and theories commonly found in the normative branch of ethics, e.g., principles of justice, utilitarianism, contractarianism, Kantianism, etc.. For example, the term "bioethics" (the most widely discussed form of applied ethics) is defined in the *Encyclopedia of Bioethics* by K. Danner Clouser as follows:

> Medical ethics is a special kind of ethics insofar as it relates to a particular realm of facts and concerns and not because it embodies or appeals to some special moral principles or methodology...It consists of the same moral principles and rules we would appeal to, then argue for, in ordinary circumstances. It is just that in medical ethics these familiar moral rules are being applied to situations peculiar to the medical world. [1]

Similarly, Ronald Green points out, in an article specifically dedicated to bioethics methodology, that:

> Writers like Beauchamp, Childress, Walters, Pellegrino, Gorovitz and others repeatedly describe bioethics as a form of "applied ethics", or "applied normative ethics". This means that it involves (but is not confined to) the application of general ethical theories to the specific problems raised by medicine and biological research.[2]

It should certainly come as no surprise that this is central to doing Prescriptive AE given that our concern here is effectively with normative questions, i.e., what one *ought* or *ought not* to do. However, as Green correctly implies, Prescriptive AE is not restricted only to the application of normative ethical theory. A more realistic and complete account, I would suggest, involves the application of both *metaethics* and *general analytic skills*, in addition to the rules, principles and theories common to the normative branch of ethics.

1. Applying Metaethics: The role of metaethics is especially important in Prescriptive AE. To recall, Prescriptive AE assumes that philosophers ought to advocate particular solutions to particular moral problems so long as they can "morally justify" those conclusions. As a result, philosophers doing Prescriptive AE must presumably have some account of what constitutes moral justification in ethical discourse. Such an account will likely involve justification at two levels: (1) At the *normative level*, where there is an initial appeal to one or more normative rules, principles and theories and (2) At the *metaethical or epistemological level*, where there is a (usually implicit) appeal to a theory of the nature of moral justification, or if you will, a moral epistemology. It is at this second level where the philosopher's metaethical assumptions are inevitably brought to bear on the moral problem at the case-level. This is because it is one's theory of the nature of moral

justification/reasoning that ultimately provides the justification for the principles and theories used at the normative level.

Theories of the nature of moral justification are most often *foundational* approaches to morality, where moral values and principles are justified in virtue of more fundamental metaphysical and/or theological beliefs, e.g., intuitionism, descriptivism, divine command theory, etc.. Formally defined, "moral foundationalism" holds that "one's moral belief *p* is justified just in case *p* is either (a) foundational (i.e., noninferentially justified or self-justifying) or (b) based on the appropriate kind of inference from foundational beliefs."[3] While moral foundationalism has been traditionally favoured by philosophers, many more contemporary philosophers have found favour with *coherence* theories of justification. The idea behind coherence accounts is that justification is determined in virtue of how moral judgments "fit" with other considered moral (and nonmoral) judgments. Moreover, "moral coherentism" holds that "one's moral belief *p* is justified insofar as *p* is part of a coherent system of beliefs, both moral and nonmoral, and *p*'s coherence at least partially explains why one holds *p*."[4] Whether one is definitively a moral foundationalist or a moral coherentist, the fact remains that one (or perhaps more than one) theory of the nature of moral justification is always being applied in Prescriptive AE.

Perhaps an example can help clarify how justification - both at the normative level and at the epistemological level - operates in Prescriptive AE. Imagine a debate between two people over the legalization of physician-assisted suicide. On the one hand, we have *'A'* in favor of legalization and, on the other, we have *'B'* who denounces it. Suppose after stating each of their respective positions on the matter, *A* presses *B* for the reasoning behind his

moral stance and *B* initially responds by claiming: "Giving someone a lethal injection, no matter what motivation lies behind it, amounts to killing an innocent human being and killing an innocent human being is always wrong!" At this point, *A* now goes one step further and asks *B* about the justification that lies behind this belief about the wrongness of killing innocent human beings. At first, *B* seems frustrated by this line of questioning, as he had never thought of this belief as one that needed to be justified; it seemed to be something that was obviously or self-evidently true. However, after further reflection, *B* comes to the realization that the justification for this belief is grounded upon a more basic belief, namely in the belief that God commands us to refrain from such actions. Accordingly, we can infer the following about *B*'s moral reasoning process: (1) To justify his moral judgment at the normative level, *B* is applying a rule prohibiting the killing of innocent human beings and (2) In order to justify the rule prohibiting the killing of innocent human beings, *B* is applying a foundational approach to moral justification such that God's commands are the fundamental theological beliefs.

As a final note about the role of metaethics in Prescriptive AE, I want to point out that despite its emphasis on justifying the moral prescriptions it advocates, justification at the epistemological level is something that is almost never made explicit. In the same article (mentioned above) on bioethics methodology, Ronald Green draws attention to the fact that many moral philosophers (who appear to be doing Prescriptive AE) ,e.g., Rawls, Gewirth, Gert, Taylor, and others, have little difficulty skirting metaethical/epistemological issues.

Specifically, Green asks:

> How, for example, when principles are in conflict, is it possible to make progress in normative discussion unless one has at hand some procedure for establishing priorities among principles, and how is that procedure defended apart from a more basic understanding of the moral reasoning process?[5]

Speculating why this might be, is in itself a large question that I shall make no attempt at answering here. Nonetheless, it seems to be reasonable to expect that those doing Prescriptive AE recognize that metaethical assumptions are inevitably brought to bear on moral judgments at the case-level and consequently, such assumptions must be made explicit (to some degree) in a similar way that justification is at the normative level.

2. Applying General Analytic Skills: In addition to applying theories of the nature moral justification and of course various normative theories, the "ethics" in Prescriptive AE also involves the appeal to *general analytic skills* common to all philosophers. These general analytic skills to which reference is being made are comprised of mainly *two* elements: (1) *Conceptual analysis and clarification* and (2) *Producing and evaluating argumentation.*

If there is one necessary component to the applied ethics discipline as a whole (including both Prescriptive and Facilitative AE) it would certainly be that of conceptual analysis and clarification. Within biomedical circles, this entails the critical examination and elucidation of complex concepts such as 'euthanasia', 'autonomy', 'informed consent', 'justice', 'competence' , 'personhood', 'voluntariness', 'death', 'dying', 'disclosure', etc.. Conceptual analysis may involve making distinctions and sub-distinctions, pointing out ambiguous terms, and moreover, producing more complete definitions. For example, within the euthanasia debate, before we even try to reconcile the various principles and theoretical

considerations that are cited in support of or in opposition to this practice, we must come to grips with the rather complicated notion of 'mercy killing' and the various concepts that surround its discussion. More specifically, we must ask ourselves what the conceptual difference is, if any, between "killing" and "letting die" and acts of "commission" as opposed to "omission". Similarly, it may be argued that normative questions surrounding the issue of abortion will remain unanswered so long as we avoid the complex, yet certainly analyzable conceptual issues that lie underneath, e.g., making more explicit the criteria for "personhood". In these two examples, it is easy to see the important role conceptual analysis and clarification can play within applied ethics, as the normative issues surrounding a case (i.e., pertaining to what one *ought* to do) seem dependent upon the clarification of conceptual issues. What this initial process of analysis and clarification hopes to achieve is that in some instances the moral conflicts that we face at the outset, can be explained away. In other words, as a result of a more complete understanding of the concepts involved, legitimate decisionmakers can make a decision free from conflict and distress. However, even if conceptual analysis and clarification cannot itself totally eliminate the conflict, (whether that conflict resides within oneself or with another) we can at least expect that this process will, in the end, pinpoint a more accurate source for the moral disagreement.

Another element that is presumed to be necessary within applied ethics (both Prescriptive and Facilitative) is the production and analysis of argumentation. Here, the philosopher is interested not only in constructing moral arguments but also in evaluating the arguments and justification processes used by other decisionmakers. The philosopher has at his/her disposal the sharp ability to pick out errors and unwarranted leaps of logic in moral

persuasion, to cite counter-examples and point out disanalogous reasoning. In a paper dedicated to the role of philosophers in the public policy process, Richard Momeyer maintains that this element involves "constructing elegant, tightly reasoned arguments; uncovering hidden assumptions; showing the unexpected consequences of consistently applying a principle or rule; showing where important questions have been begged; revealing fallacies in reasoning, and on and on..."[6]

B. FACILITATIVE APPLIED ETHICS

The three elements that are applied in Prescriptive Applied Ethics - normative precepts, metaethics and general analytic skills - are the same elements that get applied in Facilitative Applied Ethics. However with Facilitative AE, the *role* of normative precepts and metaethics tend to differ substantially. As for the role of general analytic skills, what has been said in regard to Prescriptive AE also holds true for Facilitative AE.

1. Applying Normative Ethics: Unlike Prescriptive AE, Facilitative AE does not appeal to normative rules, principles and theories for the purpose of "moral justification". Instead, it is likely that most philosophers doing Facilitative AE call upon these precepts to identify "relevant moral considerations" or to construct an initial "moral backdrop" for the case at hand. Generally what is involved here is that philosophers are relied upon to flag morally relevant rules, principles, theories that warrant consideration, e.g., 'patient autonomy', 'sanctity of life', 'justified paternalism', 'justice', 'utilitarianism', etc., which in turn serve to facilitate moral discourse among the appropriate decision-makers. Within Facilitative AE, no one of these moral precepts is necessarily weighted more heavily than another; they are initially presented to decision-makers with the exclusive intent of providing

them with a multiplicity of moral perspectives. Presumably, philosophers are, more than any other concerned body, well-suited for this task as their training is for the most part, geared towards understanding and critically evaluating not some but *all* of these moral dimensions.

By not attempting to justify, or advocate in any way , one particular moral precept (or group of moral precepts), there is a sense of "moral neutrality" or "moral objectivity" with respect to the role of normative ethics in Facilitative AE. While this may be the case, one must keep in mind that this does not in any way imply that philosophers doing Facilitative AE are without moral commitments altogether. All that this confirms is that for one reason or another (to be discussed below) the Facilitative applied ethicist has reservations about revealing those commitments within this context.

2. The Role of Metaethics: With Facilitative AE, metaethical assumptions come into play only insofar as philosophers must justify their relatively limited role in applied ethics. In other words, the only reason for an appeal to metaethical assumptions at all would be if (those doing Facilitative AE) are prompted to justify the claim that providing concrete moral resolutions for specific cases is an inappropriate task for applied ethicists. Reasons for thinking that this is an inappropriate task will likely vary, nonetheless, in most cases I suspect that these reasons are linked to personally unresolved metaethical issues such as the "problem of the criterion" or "the controversial nature of the relationship between metaethical and normative claims" or "the epistemological status of moral language". Philosophers who choose to do Facilitative AE are obviously of the opinion that despite the inability to come to grips with these foundational questions, they, as philosophers, can still make a significant contribution to the applied ethics discipline in the form of "moral facilitator".

Finally, what needs to be pointed out, irrespective of one's conception of the goal of applied ethics, is that in order for an applied ethicist to be effective, one must also be capable of comprehending the relevant facts surrounding the case at hand. As an example, consider the *empirical* issues involved in making an ethical decision in the field of biomedicine. Before any course of moral action can be advocated, various social and medical information must be acquired. For example, we need to consider important questions such as: What is the primary source for moral "discomfort"? What is the rate of success of the treatment? What are the optional methods of treatment, if any? Can we reasonably predict the medical consequences of certain treatments or methods of care? Unless we have the appropriate background to deal with these questions, no level of "moral expertise" and philosophical training will be of help to one trying to do medical ethics. What can be inferred from this is that applied ethics not only requires the application of normative precepts, analytic skills and metaethics, but also the application of background knowledge particular to the applied field, e.g., biomedicine, environmental science, business, etc. Thus it seems fair to say that applied ethics is not a discipline solely for philosophers. One philosopher who has been adamant about this point is Arthur Caplan, who clearly denounces a "strictly philosophical" approach to the field of bioethics:

> It is not at all obvious why those schooled in moral theory would be adept at applying their skills to moral issues in the biomedical sciences. After all, expertise in moral theory hardly qualifies one for service in the *empirically* arcane lands of biomedicine. If technical skills plus a mastery of empirical fact and scientific theory is not the stuff of which sound moral judgment is made, it is also true that a knowledge of ethics *simpliciter* is not going to be sufficient for the analysis of theory policy issues and moral choices in the biomedical sciences.[7]

As it turns out, it appears many share this belief as formal ethics committees have standardly

been made up of various experts, including physicians, lawyers, psychologists, etc., not just "moral experts".

Thus far, I have attempted to provide a summary of what is *generally* applied in applied ethics. To recap, we have seen that both Facilitative AE and Prescriptive AE involve an appeal to essentially *three* things: (1) Normative rules, principles and theories (2) Metaethics and (3) General analytic skills. In the following three chapters, the three most widely discussed approaches to applied ethics will be illustrated, compared and contrasted precisely in these terms. In other words, for each respective methodology, I propose to reveal its normative content, its metaethical assumptions (or lack thereof), and the extent of its use of general analytic skills.

-----CHAPTER 2----------

ETHICAL ENGINEERING: THE STANDARD, PRE-REFLECTIVE MODEL OF APPLIED ETHICS

I. INTRODUCTION

Upon surveying the various applied ethics methodologies used today, it seems appropriate to start with the model most philosophers seem to have been employing during the inception of applied ethics. Generally, the philosophers doing applied ethics in the early to middle seventies, advocated a "top-down" approach which involved a straightforward application of traditional ethical theory to concrete problems. By "ethical theory" I am simply referring to one general moral principle or more than one explicitly related set of principles. The presumption was that particular moral judgments could be *deduced* from ethical theory, and as a result, the critical question in applied ethics was: Which particular ethical theory is to be applied? Once the "correct" moral theory had been identified, the only thing left to do was to determine, with reference to the relevant facts surrounding the case, whether the moral action contemplated was covered by that principle or explicitly related set of principles.

Admittedly, there is little evidence to support the idea that this approach to applied ethics was the only approach adopted by philosophers in the early to middle seventies. However, if we look back to the some of the first philosophical publications in the field, especially the anthologies written for pedagogical purposes, it is apparent that the ethical engineering model is most definitely the methodology being used. For example, one of the first bioethics anthologies to be published was *Moral Problems in Medicine* (1976) by

Samuel Gorovitz et. al. Essentially, the way the book is laid out is such that there are two preliminary chapters dedicated to explaining the two major ethical theories - utilitarianism and Kantianism - and once these are explained, the traditional moral problems in medicine such as physician-patient relationships, death and dying and allocation of medical resources are then discussed in light of these two theories. Unlike some of the anthologies in biomedical ethics today, methodology, as a topic in itself, is simply not addressed in these early texts. In Gorovitz's *Moral Problems* for instance, the only explicit references to methodology, are two paragraphs found in the introduction which state:

> The moral philosopher [interested in in the general area of medical ethics] wants to to make morally correct decisions and perform morally correct actions. Ideally, such principles or principle will be comprehensive (applicable to all case that arise), decisive (yielding an answer in all cases), and justified (defensible against other proposed principles). Further, we want the principles or principle to be specific enough to give us actual guidance in real cases. "[8]

Granted, this in no way reflects a complete nor exclusive methodological account of early applied ethics, but certainly this gives one a good sense of what was generally being advocated by philosophers at this time.

In order to depict a more complete account of this applied ethics methodology, I have decided to borrow Arthur Caplan's "engineering model" of applied ethics (thus the chapter title, "Ethical Engineering"). According to Caplan, the following was, and still is, the "standard view"[9] of applied ethics:

> (1) there is a body of knowledge concerning ethics that persons can be more or less knowledgeable about; (2) this knowledge becomes "applied" in medical settings by: (a) deducing conclusions from theories in light of relevant empirical facts and descriptions of circumstances and (b) analyzing properly the process of the deduction (i.e., watching for logical fallacies, ambiguities in the meaning of key terms, improper classifications of entities, misdescriptions, etc.); and (3) the process of applying ethical knowledge to moral problems must be carried out in an impartial, disinterested, value-free manner. [10]

What clearly distinguishes the engineering model from other, more contemporary models of applied ethics is the notion of "deducing conclusions from theories" that we find in (2a). Notice however, deduction is a legitimate process here only because of the underlying assumption that *all* moral judgments are justified in a systematic way such that they are, in effect, traceable to *one* overarching moral theory. Therefore, it is said that ethical engineers hold a *monistic* view on the nature of moral judgments, or in other words, a "one-theory-fits-all picture of moral analysis".[11] But as suggested earlier, the crucial question that remains is: Which moral theory "fits all"? As can be expected, there is no consensus amongst philosophers in regard to this question. Presumably some philosophers will pronounce utilitarianism as the all-encompassing moral theory as where others will defend Kantianism and yet others might even argue for a contractarian theory of ethics. At any rate, the whole debate surrounding the one "correct" moral theory is something that is effectively up for grabs here with the engineering model.

Given this, we can see that ethical engineering is not specific in regard to its normative content; there is no one theory or principle that comes attached to this model. Consequently, this makes the engineering model very difficult to assess (in the terms outlined in Chapter One) unless of course we can fill in the normative content with one theory or another. Thus in the following section, I propose to illustrate and critically evaluate the engineering model by incorporating the most prevalent normative moral theory in the twentieth century: utilitarianism.

I. THE UTILITARIAN ENGINEERING MODEL

In order to keep things as simple as possible here, I have decided to approach the Utilitarian Engineering Model (UEM) from the point of view of *Classical Utilitarianism* commonly attributed to John Stuart Mill. Mill's Classical Utilitarianism can be summarized as follows:

> First, actions are to be judged right and wrong solely in virtue of their consequences. Nothing else matters. Right actions are simply those that have the best consequences.
>
> Second, in assessing consequences, the only thing that matters is the amount of happiness or unhappiness that is caused. Everything else is irrelevant. Thus right actions are those that produce the greatest balance of happiness over unhappiness.
>
> Third, in calculating the happiness or unhappiness that will be caused, no one's happiness is to be counted as more important than anyone else's. Each person's welfare is equally important.[12]

Accordingly, the *normative content* of the utilitarian engineering model (UEM) is made up of the principle of utility and only the principle of utility, which, in short, equates to the directive that states: "One always ought to do that which maximizes happiness and minimizes unhappiness for all those affected". Given this, the most central aspect of the UEM will involve deducing particular moral judgments from the principle of utility in light of relevant case circumstances. An example can best illustrate how the UEM will work as an applied ethics methodology.

Consider Mr. G, a cranky, stubborn, independent-minded, seventy-four year old father and grandfather, just diagnosed with prostatic cancer which is deemed incurable and inoperable. Once given the diagnosis, his physician of seven years, Dr. H, reassures him that although his condition will in fact worsen over the next few years, good palliative treatment is available. When Dr. H asked Mr. G if he had any questions at this point and time, Mr. G

responded by saying, "No, I don't have any questions but I will tell you something, doc'. Nobody, but nobody is to be told about this under any circumstances, including my wife . Do you understand?!" Initially, Dr.H tells Mr. G that this might not be in his best interest and suggests that the three of them ought to sit down and discuss his condition together. Unfortunately, this line of reasoning does not prove convincing for Mr. G, and as a result, Dr. H dutifully but unwillingly respects Mr. G's wishes. About three months later, Dr. H receives a phone call from Mrs. G reporting that her husband's condition has worsened substantially and although Mr. G denies any discomfort, he clearly appears to be in severe pain, especially when urinating. For the first time since the diagnosis, Mrs. G pleads with Dr.H to tell her what is "going on" and insists that she feels helpless just standing by and watching her husband suffer and is also concerned that he has put off several appointments since the disgnosis. Knowing that on one hand, disclosing the nature of Mr. G's condition to Mrs. G breaches doctor-patient confidentiality, while on the other hand, not telling Mrs. G is in all likelihood not in the best interest of his patient, Dr. H is seemingly faced with a moral dilemma: Does he or does he not tell Mrs. G about the prostate cancer?

Well, according to the UEM, the first step towards resolving this dilemma is to gather all of the relevant facts of the case. Specifically from the information given above, I think we can infer two relevant pieces of information: Firstly, considering Mr. G's intractable disposition, there is good reason to think that his condition might worsen sooner than he admits to himself and others that he needs medical attention. Secondly, if Mrs. G was informed of his condition, there is hope that she, or perhaps his children, could persuade Mr. G to seek treatment immediately. Other relevant information which cannot necessarily be

directly inferred from the information given must also be taken into account. This may involve finding answers to questions such as: What risks does Mr. G expose himself to if he delays medical treatment? Is one of those risks a significantly hastened death? Does Mr. G have a wish to die? Is Mr. G a competent individual?

The next step according to the UEM is to clarify and analyze any and all relevant concepts, moral or non-moral. In the case given, one could argue that concepts such as 'paternalism', 'doctor-patient confidentiality', 'autonomy', and 'competence' are all relevant and in need of further clarification and analysis. For example, among other things, the ethical engineer might want to draw attention to the distinction between violations of rights to privacy and violations of confidentiality or perhaps might also want to provide the decisionmakers with some of the various interpretations of *paternalism*, (e.g., Feinberg's distinction between strong and weak paternalism).

Once the ethical engineer has attempted to clarify these relevant concepts as much as possible, he/she is now in a position to apply the principle of utility to the case at hand. Quite simply, this amounts to answering the following question: Will telling Mrs. G about the prostate cancer maximize or minimize the happiness for everyone affected? As can be expected, the answer to this question is not absolute in nature, but nonetheless we can presumably form some conclusions based on *probable* outcomes. In this case, it seems fair to say that, all things being equal, telling Mrs. G about the prostate cancer will result in more happiness than unhappiness for Mrs. G, Mr. and Mrs. G's children and grandchildren and for Dr. H. It also may be argued that ultimately it will result in more happiness for Mr. G himself despite the fact that he might be caused much initial unhappiness. Taking all of these

probabilities into consideration, it may be argued that the amount of happiness resulting from telling Mrs. G outweighs the unhappiness, and thus according to the UEM, Dr. H. *ought* to disclose this otherwise confidential medical information to Mrs. G. [One may notice that in terms of normative justification, the UEM operates in the same way as the more commonly known normative theory *act-utilitarianism*; both approach the question of what one ought to do from the perspective of how this *particular* action affects the balance of happiness over unhappiness, not how the *generalized* action, i.e., moral rule, affects the balance of happiness over unhappiness. In both cases we see that moral rules are completely by-passed, as the principle of utility is simply applied *directly* to the case and a particular moral judgment is deduced from that principle.]

Now that we have seen how justification works at the normative level in the UEM, I now want to consider how the principle of utility is itself justified, and thus make explicit some of the *metaethical* assumptions brought to bear on the Utilitarian Engineering Model. Keeping in mind that for the purposes of this paper the UEM is to be understood according to a Millean point of view, these assumptions will be drawn out by examining Mill's theory of value and his theory of the nature of moral justification.

According to Mill, what is good in and of itself, good as an end, and what has intrinsic value is happiness and only happiness. This view is considered to be a *hedonist* theory of the good or theory of value. Mill's defense of this theory of value is found in the fourth chapter of *Utilitarianism* entitled "Of What Sort of Proof is the Principle of Utility is Susceptible" and it is here where we get some insight regarding his theory of the nature of moral justification. Quite simply, the argument given in support of his hedonist doctrine is that as a matter of

fact, human nature is such that we do desire happiness and because we do desire it, and ultimately desire it alone, it follows that it is the only thing *desirable*. In his own words, Mill argues that:

> If the opinion which I have now stated is psychologically true - if human nature is so constituted as to desire nothing which is not either a part of happiness or a means of happiness - we can have no other proof, and we require no other, that these are the only things desirable. If so, happiness is the sole end of human action, and the promotion of it the test by which to judge of all human conduct; from whence it necessarily follows that it must be the criterion of morality, since a part is included in the whole.[13]

Arguing on this basis is clearly a foundational approach to moral justification whereby the very fact that we do desire happiness, is the fundamental psychological/naturalistic foundation on which morality is grounded. Generally speaking, to hold this view is to be an *ethical naturalist* - one who maintains that moral terms such as 'good' can be defined in non-moral, empirical terms. Thus to summarize, we may conclude that with respect to metaethical content, the (Classical) UEM employs both a *hedonist* theory of value and a *foundational* theory of the nature of moral justification, namely, ethical naturalism.

Now that the metaethical, normative and analytical aspects of the UEM have been made explicit, I now want to consider how this methodology might be assessed and critically evaluated in light of each of the two goals of applied ethics that have been outlined thus far: Prescriptive Applied Ethics and Facilitative Applied Ethics.

What should be noted about the proceeding evaluation, and all subsequent evaluative discourse relative to Prescriptive AE, is that this author does not share in the belief that a *true* account of morality is something that we can acquire "knowledge of", and as a result, evaluating a methodology's ability to yield "morally correct" action-guides will not simply be

a matter of holding up these various methodologies to the "moral truth" to see how each measures up. Keeping in stride with this line of reasoning and my earlier insistence on refraining from lengthy debates converging at the meta-level, evaluating these methodologies will also not involve attempts critically to assess ethical naturalism as a plausible theory of the nature of moral justification nor hedonism as the correct theory of value. Instead, this author is of the opinion that the best that can be offered in terms of evaluating these models of applied ethics (on prescriptive grounds) is to examine how they fare against criticism by those who professionally reflect upon these matters, i.e., philosophers. Short of the criteria of truth, traditionally, the criteria used by philosophers to evaluate the "correctness" of normative theories have involved features such as clarity, simplicity, explanatory power, determinateness, practicability, coherence, completeness, fecundity, etc.. Of these various criteria, it seems that there are three particularly relevant considerations for applied ethics. They are: (1) *Determinateness:* an applied ethics methodology must produce clear, unambiguous, and determinate resolutions to concrete ethical problems (2) *Completeness:* an applied ethics methodology must to a certain degree account for a wide array of moral values. The more moral values it can account for, the more complete or comprehensive it is (3) *Discursiveness:* an applied ethics methodology must produce moral resolutions that can be backed by *reason,* i.e., moral resolutions that are neither arbitrary nor purely intuitive in nature.

II. PRESCRIPTIVE APPLIED ETHICS AND THE UEM

To recall, Prescriptive Applied Ethics is defined as a goal of applied ethics such that it is the philosopher's job to: (a) provide conceptual and moral analysis and clarification in

hope of reaching a greater degree of consensus amongst legitimate decision-makers and (b) provide morally correct action-guides for real cases backed by moral justification. It is the objective we find in '(b)' that clearly distinguishes Prescriptive AE from Facilitative AE and thus it is also here where we must engage our evaluative discussion of the UEM. Can the UEM provide morally correct and morally justified action-guides for real ethical problems and dilemmas? Historically, it has been the contention of many philosophers that the most serious problem facing utilitarianism is that the principle of utility, taken alone, without supplementation, is not *sufficient* for a normative ethical theory; it is not a *complete* moral theory. Consequently, it may argued that the biggest difficulty (not necessarily the only difficulty) with the utilitarian engineering model of applied ethics is that it is unable to account for the variety of moral values brought forth by the specific cases it faces.

The most standard type of objection directed at utilitarianism is one which is based upon the claim that there are instances where maximizing happiness for all those affected leads not to what is morally correct but rather to what is obviously morally incorrect. Several such "counter-examples" have been offered by philosophers over the years but one of the most notorious examples is H.J. Mcloskey's "race riot" example. Mcloskey's example is set out as follows:

> Suppose a utilitarian were visiting an area in which there was a racial strife, and that during that visit, a Negro rapes a white woman, and that race riots occur as a result of the crime, white mobs, with the connivance of the police, bashing and killing Negroes, etc. Suppose too that our utilitarian is in the area of the crime when it was committed such that his testimony would bring about the conviction of a particular Negro. If he knows that a quick arrest will stop the riots and lynchings, surely as a utilitarian, he must conclude that he has a duty to bear false witness in order to bring about the punishment of an innocent person.[14]

Of course what this particular example intends to illustrate is that the principle of utility is unacceptable to the extent it does not account for justice, or more concisely, the moral ideal that we ought to punish only according to desert. Moreover, this example, and many others like it, tend to suggest that utilitarianism by its very nature is far too narrow in scope, as it focusses only on consequences and the fulfillment of happiness while ignoring other components of morality such as the sanctity of life principle, individual moral rights, commandments of the Decalogue and, of course, justice. Presumably those who take this line against utilitarianism view these components to be *necessary* for morality or somehow *independent* of consequences. It has also been argued that there is something severely misguided about the idea that morality is contingent upon what just so happens to make us happy. After all, if as a matter of fact, the fulfillment of everyone's happiness (for some reason) did not include the moral imperative that we ought to respect human life, morality might then seem like a very peculiar enterprise. In sum, utilitarianism is said to fail because our conception of morality is much more complex and pluralistic in nature than utilitarianism is willing to concede, and accordingly, it is said to be an incomplete or incomprehensive theory.

Admittedly, there are several responses that utilitarians have historically made against this charge, including the response that notions of justice, sanctity of life and human rights can all be subsumed under the principle of utility itself, i.e., when we really think about it, the only reason we embrace these notions in the first place is because they maximize happiness not because they have some sort of independent, pre-eminent status.[15] Nonetheless, even though the charge of incompleteness is not itself a knock-down argument against the theory, it was,

and probably always will be, what most casts doubt on its ability to yield morally *correct* action-guides.

III. FACILITATIVE AE AND THE UEM

Related to the above criticism is the charge that as a result of its incompleteness, the UEM is also not conducive to yielding a great degree of consensus among decision-makers. Really, the argument is quite simple. If in fact utilitarianism cannot account for other moral values distinct from maximizing happiness, like the sanctity of life principle or justice, there is also reason to think that the UEM will not be an effective facilitative device in applied ethics. After all, how, for example, can we expect the various decisionmakers on a hospital policy committee to reach a greater degree of consensus via a theory that is, generally speaking, unreflective of a wide range of moral values? This weakness attributed to utilitarianism becomes even more evident when it is juxtaposed with other normative theories the facilitator may draw upon that supposedly can better handle a variety of moral perspectives. For example, Tom Beauchamp and James Childress' "principlism" methodology is grounded in what they call a "common morality theory of ethics" and they think that this type of normative theory is obviously a better tool for yielding consensus in applied ethics than, say, utilitarianism. In a chapter dedicated to surveying the various types of ethical theory used in biomedical ethics, they write:

> We cannot reasonably expect that a contested moral theory [like utilitarianism] will be better for practical decisionmaking and policy development than the morality that serves as our common denominator. Far more social consensus exists about principles and rules drawn from the common morality (for example, our four principles) than about theories. [16]

The other difficulty that the UEM faces a facilitative model is that many instances,

identifying all of the relevant moral agents whose happiness/unhappiness ought to be considered, i.e., who makes up "all those affected" in our utility calculation, will be met with little or no consensus at all. The types of cases that will most obviously reflect this difficulty will be cases involving reproductive, maternal or genetic issues where decisionmakers might need to consider the interests of "potential persons" (fetuses) or defective neonates whose status in the moral community is, quite frankly, very ambiguous. However, one can also imagine this to be a problem for the more simple, common, cases in biomedical ethics too. Consider a clinical clerk in her sixth week at the hospital whom is given an opportunity to do her first lumbar puncture on a woman suspected to have meningitis. Considering the pain that can be inflicted on the patient if this procedure is not executed properly, the question arises: Should the patient be informed that this is the clerk's first lumbar puncture? At first, this might seem like a very easy case to settle for decisionmakers incorporating the UEM. After all, it would seem that the only person's welfare we need to consider is the patient's. However, I suspect that if physicians made up a segment of the decisionmakers in this case, they might insist that the welfare of prospective physicians, like our clerk in this case, ought to enter into the utility calculation just the same. They might argue that if they always disclosed the fact that this was an intern's first procedure, no matter what procedure that might be, patients might never give consent and proper clinical experience might never be gained. So we see that to whom we extend the utilitarian calculation to include is not always going to be clear with the UEM, and as a result, cause much disagreement, thereby severely impeding its ability to be a successful facilitative device in applied ethics.

CHAPTER 3

IS THERE LIFE AFTER DEATH FOR CASUISTRY?

I. WHAT IS CASUISTRY?

Another methodology that has been advanced, especially in the last ten years, is a case-driven method that takes a fundamentally different approach to applied ethics. This methodology has often been referred to as a "bottom-up" approach (which contrasts with the "top down" theory-driven approach). It is referred to as bottom-up simply because it starts at the case level itself; it is the facts and circumstances that surround the particular case that fuel the moral reasoning process. The leading advocates for a case-driven methodology are Albert Jonsen and Stephen Toulmin. It was their collaborative effort, *The Abuse of Casuistry*, published in 1988, that really brought to the fore the bottom-up approach to applied ethics. Here, they defend a secularized version of the Roman Catholic priesthood practice of casuistry which was prominent in the sixteenth and seventeenth centuries. Although most of the book concentrates on an historical approach, uncovering the reasons why "casuistry" was and still is considered a pejorative term and "what misconceptions have led philosophers to deny 'case ethics' any respectable intellectual pedigree"[17], the remainder of the book is dedicated to defending the idea that "the casuists' art has a legitimate and central part to play in practical ethics."[18]

But what exactly is casuistry? Turning to a standard dictionary definition to answer this question is misleading, as Jonsen and Toulmin point out in the opening chapter of their

book. The Oxford English Dictionary defines casuistry as: "the part of ethics which resolves cases of conscience, applying the general rules of religion and morality to particular instances in which circumstances alter cases or in which there appears to be a conflict of duties."[19] It is easy to see why Jonsen and Toulmin criticize the accuracy of this definition, as on the face of it, this definition looks blatantly "top-down". They argue that a more adequate definition of casuistry involves the following:

> the interpretation of moral issues, using procedures 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 circumstances of action. [20]

According to Jonsen and Toulmin, the casuistic approach to applied ethics proceeds in exactly the same manner as clinical medicine; both casuistry and clinical medicine operate on the premise that one's experience and familiarity with certain features of past cases serve as the justification for one's present diagnostic process. In an attempt to further bring out the methodological similarities, they claim that:

> Formally a medical condition is defined by the classical description, and this is a useful guide in identifying diseases that are met comparatively rarely. But a description is clinically fruitful only when it is based on perceptive study of actual cases, and it is practically effective only if paradigmatic cases exist to *show* in actual fact what can otherwise only be *stated*; namely, the actual onset, syndromes, and course typical of the condition. Given this *taxonomy* of known conditions and the paradigmatic cases that exemplify the various types, diagnosis then becomes a kind of perception, and the reasons justifying a diagnosis rests on appeals to analogy. As new cases present themselves for examination the physician collects details from each patient's history, his own immediate observations, and the results of laboratory tests and uses these facts to "place" a particular patient's condition in one or more of the recognized "types". Forced to choose among alternative diagnoses, he must decide how close (or analogous) the present case is to each of the possibilities.[21]

Whether this type of approach can be as fruitful for applied ethics as it is for doing clinical medicine, is a question to be taken up shortly. However, at this time, there is still need for clarification of some of the concepts that have been used to define casuistry thus far.

1. Practical Reasoning: Central to the casuistic approach to applied ethics, or more aptly, the framework on which casuistry hangs, is the notion of practical reasoning or *phronesis*. *Phronesis* is a Greek term that traces back to Aristotle's *Nichomachean Ethics*. Aristotle's account of ethics calls for a distinction between *episteme* - scientific wisdom and *phronesis* - practical wisdom. This is probably the most distinguishing feature of Aristotle's approach to ethics. It is his contention that the field of ethics is a practical one, not a scientific one and only a person who has acquired *phronesis* can determine the ethically proper course of action. Like Aristotle, Jonsen and Toulmin maintain that morality or moral reasoning is a practical endeavour, not a theoretical one. To comprehend what is meant by practical reasoning or practical argumentation, it is best to contrast it with theoretical reasoning - that which was attributed to the engineering models. In their chapter entitled "Theory and Practice", Jonsen and Toulmin suggest that:

> Instead of aiming at strict entailments, [practical arguments] draw on the outcomes of previous experience, carrying over the procedures used to resolve earlier problems and reapplying them in new problematic situations. Practical arguments depend for their power on how closely the present circumstances resemble those of the earlier precedent cases for which this particular type of argument was originally devised.[22]

2.Paradigms, Analogies and General Maxims: Paradigm cases of moral or immoral conduct are the starting points in the casuistic process which also ultimately define the general maxims we use as "rules of thumb"in unambiguous cases. Take for example an instance of one human being intentionally inflicting pain, and subsequently killing another person, for no

apparent good reason. In this case, our collective moral reaction will be that this action is clearly and unequivocally wrong, entrenched in a high degree of moral certainty. From this, we can derive the maxim stating that unprovoked infliction of pain and killing is wrong and it can be used in the future as a general rule for similar cases that lack elements of controversy or extenuating circumstances. More importantly, this case will also serve as a paradigm case of immoral killing, which can act as a starting point for moral comparison with the *ambiguous and controversial* cases that applied ethics typically faces. In other words, such paradigm cases serve as the end point on a moral continuum and the casuist's job is to decide where and how close the case at hand falls in relation to the paradigm case and this, in turn, decides the level of moral certainty we want to assign to the particular case.

3. Circumstantial Analysis: This is an obvious feature of any "case method" which simply demands an account all of the relevant details and particular circumstances surrounding a case. More specifically, it is answering the "who, what, why, where and how" of a case. This is often more difficult to assess than one might think, presumably because of the susceptibility of such questions to various points of view and interpretations. For instance, in many biomedical scenarios, physicians will often differ in regard to the assessments of risks, prognoses, and diagnoses for a given patient and this usually will result in further complication of the ethical process trying to be carried out. Or similarly, we can imagine concerned family members of a comatose patient offering very different points of view with respect to judgments what that patient really "would want done" if he/she was in a position to express his/her wishes.

4. Presumptive conclusions: Lastly, there is the concept of presumptive conclusions in the contemporary casuistic model. Unlike some theoretical moral reasoning processes, casuistry makes no claim to "decisive conclusions". "They [the casuists] would say, for example, 'In these circumstances, you can with reasonable assurance act in such-and-such a way. By doing so, you will not be acting rashly, but can be of good conscience.'"[23] Casuistry insists on moral resolutions being more or less probable and in the end, always up for revision in light of further considerations or extenuating circumstances. As mentioned before, the degree of assurance one ought to have in a moral judgment depends on where the case at hand falls on the casuistic continuum when all of the above considerations have been taken into account.

II. CASUISTRY IN MORE FAMILIAR TERMS

Given a general outline of the concepts involved in modern day casuistry, one might still be somewhat unclear as to how it will actually proceed as an applied ethics methodology, so perhaps an example can help make its procedure more clear and at the same time, make explicit its normative, metaethical, and analytic content. Let us stick with the same example used in chapter two which involved Mr. G. To recall, at the heart of this moral quandary was the question of whether Dr. H ought to tell Mrs. G, upon her adamant request, about her husband's prostate cancer.

As was the case with the UEM, the first step towards resolving this issue is to gather all of the relevant facts of the case, i.e., the who, what, why, where, when, and how. Who are the individuals concerned with Mr. G's well being? What are the risks that Mr. G faces if he does not seek help immediately? Why is Mr. G determined to keep his condition confidential?

When did Mr. G's condition begin severely to impede urination? Is there a way Mrs. G can help her husband without turning to Dr. H? Once we have acquired the answers to these questions and combined them with the facts given in the initial set-up (see ch.2), the casuist is now in the position to compare this "case type" with precedent cases of the same type. This entails a comparison of this case with other doctor-patient-confidentiality-based cases. If it turns out that there are few or no significant features to this case that differentiate it from past, similar cases, then we can simply treat like cases alike and apply the relevant general maxim (derived from collective reflections of past, similar, cases) . However, if it so happens that there are relevant features to this case that lend to ambiguity in the comparison of it to past cases, we must then turn to the *paradigmatic* cases of the adherence to (or the deviation from) the rule of doctor-patient confidentiality and then try to determine how closely this present case resembles the respective paradigm. Once again, it is the degree of resemblance to the paradigm case that determines the moral assurance we ultimately assign to the case at hand and the moral resolution to this problem holds presumptively, not absolutely.

Given what has been discussed thus far, we are now able to make explicit the *normative content* of casuistry. Generally, casuistry suggests that what we presently *ought* to do depends on what we *have* done in past, similar circumstances (some might insist that instead of an "is-ought" move, casuistry makes a "was-ought" ethical maneuver). At first glance, this might seem like a rather crude normative view, but for all intent and purpose, this is what casuistry is advocating. Accordingly, it may be argued that the normative content is made up of *moral precedents* not unlike the precedents, customs and traditions that serve as the source of appeal in common law. However, unlike the engineering model, casuistry's

normative content is not monistic in nature, but rather, made up of *various* moral precepts bound only by the limits of our moral experience.

In order to make explicit the *metaethical content* of casuistry, we must do a little more speculation than that which was done with its normative content. We must try to reveal the source of justification for these various moral precedents in the first place. In other words, we need to ask: What grounds determine the unequivocal moral rightness or wrongness of these so-called paradigm cases of morality/immorality? Jonsen and Toulmin are relatively silent on this issue as far as I can tell, nonetheless, my suspicion is that Jonsen and Toulmin rely upon some form of *intuitionism* to justify the epistemic priority of the cases themselves. Intuitionism can be defined as a foundational theory of the nature of moral justification such that "our basic principles and value judgments are intuitive or self-evident and thus do not need to be justified by any kind of argument, logical or psychological, since they are self-justifying or, in Descartes's words, 'clearly and distinctly true'."[24] This theory of the nature of moral justification best describes the metaethical underpinnings of Jonsen and Toulmin's casuistry given the way in which they view the nature of paradigm cases. In their own words, the paradigm cases are "clear and simple", and also enjoy an "'intrinsic and extrinsic certitude': all authors would concur that there is no reason not to consider that act an offense."[25]

III. FACILITATIVE AE AND CASUISTRY

I begin the evaluative discussion of casuistry in the context of a facilitative model of applied ethics because its key supporters, Jonsen and Toulmin, emphasize its strength mainly in this capacity. In several publications over the last ten years, Jonsen and Toulmin have urged

that there is reason to think that casuistry is well suited for doing (what I have called) facilitative applied ethics. The fact of the matter is that over the years, Jonsen and Toulmin have done extensive work with The National Commission on Human Experimentation and have observed first hand that when faced with a variety of moral issues, its members inevitably adopted a casuistic/taxonomic approach to applied ethics and time and time again, this process yielded a very high degree of consensus amongst them.

The Commission, formed in 1974 by the U.S. Congress, was made up of eleven people in total. It was a diverse group made up of men and women, blacks and whites, Catholic and atheists, lawyers and behavioural psychologists. Their specific purpose was to:

> review the federal regulations about research with an eye to the protection of the 'rights and welfare' of those persons who were involved as research subjects in either biomedical or behavioural investigations...The Commission was also required to study the ethical issues arising in scientific research using vulnerable research subjects of different sorts - prisoners, children and the mentally disabled, in addition to human fetuses - and to develop general statements of ethical principle to serve as a guide in the future development of biomedical and behavioural research.[26]

In an article commenting on the Commission's procedures Toulmin maintains that:

> All of the questions on the commission's central agenda could be construed as being of the form, "Just what kinds of experimental procedures, involving just what subgroups of human subjects, conducted in just what kinds of circumstances, with just what consent procedures, etc., are and are not open to solid objections on moral grounds?" The commissioners came to see their task as being to identify the factors relevant to questions of this form, and they accordingly set out to develop systematic classifications by distinguishing different sorts of experiments, different sorts of loci of research, different procedures of consent, assent, toleration or refusal, different immediate and long-term scientific goals, and so on. All the factual material, site visits, public presentations and the rest, that provided the mass of the material for the commissioner's definitive debates were finally digested and brought to bear on the commissioner's mandate by considering what light they threw on those central taxonomic issues and how they could help the commissioners to draw more refined, perceptive, and discriminating distinctions between "morally acceptable" and "morally questionable" classes of research projects.[27]

To summarize, the commissioners proceeded case-by-case, starting by classifying each case according to its "moral type". For example, cases involving drug experimentation on prisoners, were initially classified as cases of the "protection-from-exploitation-by-unethical-researchers" type. Once this, along with all of the facts surrounding the case had been ascertained, casuistry really began to rear its head, as through the use of paradigms and analogies, the commissioners were able to determine the most suitable course of action. Jonsen and Toulmin conclude that the upshot of this methodology was the vast (almost unanimous in some cases) agreement amongst the commissioners on the eventual recommendations to be put into practice, and on this basis, argue that casuistry makes for good applied ethics.

According to Jonsen and Toulmin, the explanation for this result was simply that by keeping the moral discourse focussed on morally significant differences and similarities between the various types of research, i.e., "moral taxonomies", the commissioners were thus not inclined to shift the discussion to the level of universal principles or rules which would most certainly set them apart. As they explain in *The Abuse of Casuistry*,

> The *locus of certitude* in the commissioners' discussions did not lie in an agreed set of intrinsically convincing *general* rules or principles, as they shared no commitment any such body of agreed principles. Rather it lay in a shared perception of what was *specifically* at stake in particular kinds of human situations. Their practical certitude about specific types of cases lent to the commission's collective recommendations a kind of conviction that could have never been derived from the supposed theoretical certainty of the principles to which individual commissioners appealed in their personal accounts.[28]

This brings us to the question: Are Jonsen and Toulmin right about the prospects of a so-called "reincarnation" for casuistry in applied ethics, specifically facilitative applied

ethics? Although I certainly do not dispute Jonsen and Toulmin's findings with the commission, I must insist that before we begin to toast the triumph of modern day casuistry, we must take a closer look at what exactly the commissioners were supposedly agreeing about. In casuistic terms, the commissioners seemed to be agreeing about the *paradigm* cases of morally acceptable and morally unacceptable modes of research of that specific moral type, (e.g, under conditions x, y, and z, voluntary medical research on prisoners is perfectly morally acceptable) and in addition, on how close (or far) specific cases presented to them were, relative to that paradigm case type. With this, I find little difficulty believing that such consensus could exist. However, with the employment of casuistry, one must wonder how decision-makers could ever reach substantial agreement on what I would suspect would be the most controversial and problematic casuistic task of all: categorizing cases into "moral types" in the first place. It is difficult to believe that there would be much consensus at all with respect to this initial categorization. Perhaps the following example can help explain why.

Consider Mrs. Y, a twenty-six year old single mother with a history of PKU in her family, now in her second pregnancy (phenylketonuria - a recessively inherited disorder where untreated children show failure to attain milestones and exhibit progressive impairment in mental function, seizures, rigidity and chorea). Just before Mrs. Y was married, her doctor informed her about the importance of diet (specifically avoiding high protein foods) in the case of pregnancy. During her first pregnancy, faced with some problems of nausea, eventuating in a feeding gastrostomy to give diet, she managed to adhere to the diet and give birth to a healthy normal baby. However, during her second pregnancy, she refused the PKU diet despite the fact her phenylalanine levels continued to rise.[29] With health care providers

seriously and immediately concerned here, I ask the casuist: How exactly is this ethical problem to be approached? Is it clear what "type" of moral problem this is in the first place?

It seems fair to say that in this case, it is by no means clear as to how this case ought to be categorized. In fact, there are likely several competing categorizations for which one could quite realistically argue. Firstly, this could be construed as an autonomy issue - simply the mother's right to do what she wants with her own body. Just as plausibly, this could be seen as a-right-to-protect-unborn-life issue. Others might even suggest, on the grounds that the fetus is just as much the doctor's patient as the mother, that this is an issue of physician-obligation.

In all fairness, it is not that Jonsen and Toulmin suggest that categorizing cases into their appropriate moral paradigm will never be ambiguous. However, because they never clearly and directly attempt to explain how to get around this problem when we are faced with the more ambiguous cases, despite their work with the National Commission (which provides most, if not all of the argumentative force for a casuistic approach) their conclusiona about applied ethics inevitably lacks persuasiveness.

IV. PRESCRIPTIVE AE AND CASUISTRY

Unfortunately, casuistry fairs no better as a prescriptive applied ethics model. Its most obvious difficulty is that its moral resolutions, albeit presumptive and revisable in nature, will be far too *indeterminate* to provide adequate moral justification. Unlike the UEM, where problems stemmed from its normative content, casuistry's difficulties as a prescriptive applied ethics model essentially derive from the nature of its moral justification/reasoning. To recall, according to casuistry, the cases alone can fuel the moral reasoning process and thus

according to Jonsen and Toulmin, casuistry denies any "theoretical dependence", unlike the UEM which was totally theory dependent. Now, without any theoretical considerations to cling to, we need to consider how the casuist will handle those cases, like the example with Mrs. Y given above, where there is clearly more than one plausible moral paradigm that can be associated with the given case. Many authors, including myself, have found this to be the major stumbling block for casuistry. After all, without any specific moral principle or principles of obligation (prima facie or not) at our disposal, what could posiibly bind these problems into their respective primary "moral types" except some moral precept itself? It seems that Jonsen and Toulmin are fooling themselves if they sincerely believe that what would guide us here is something free from one or other morally binding precept. John Arras expresses a similar suspicion in an article discussing the "revival" of casuistry. He writes: "In a manner somewhat reminiscent of pre-Kuhnian philosophers of science clinging to the possibility of 'theory free' factual observations, to a belief in a kind of epistemological 'immaculate perception', the casuists appear to be claiming that the cases simply speak for themselves."[30] So long as the process surrounding the initial categorization of moral "types" remains theory neutral or theory independent, casuistry surely will not be able to provide clear, unambiguous moral resolutions that are necessary for moral justification. Consequently, casuistry is also not an adequate prescriptive applied ethics model.

CHAPTER 4

PRINCIPLISM: A PLURALISTIC APPROACH

I. PRINCIPLISM (INTRODUCTION)

Principlism, the third and final methodology to be discussed here, has been most notably defended by Tom Beauchamp and James Childress, co-authors of the four editions of the now "standard" bioethics text, *Principles of Biomedical Ethics*. It is in their latest edition, published in 1994, where they truly make their methodology and competing methodologies explicit. (It should be noted that although other "principlist" moral theories historically have been forwarded by philosophers such as Frankena and Ross, for the purposes of this paper, the term "principlism" refers exclusively to Beauchamp and Childress' four-principle approach).

Like the UEM, principlism starts from a theoretical structure and works down to the case level, and in this sense it might be said that principlism is also a top-down approach to applied ethics. However, unlike the UEM, principlism's theoretical structure is *pluralistic* in nature not monistic. In other words, principlism does not appeal merely to one general principle of obligation, but rather, to four separate, mid-level, prima-facie principles of obligation. Specifically, the four principles of principlism are: (1) *Autonomy* - a norm for respecting the decisionmaking capacities of autonomous persons. (2) *Beneficence* - a group of norms for providing benefits and balancing benefits against risks and costs. (3) *Non-maleficence* - a norm for avoiding the causation of harm. (4) *Justice*- a group of norms for distributing benefits, risks, and costs fairly. [31]

1. THE PRINCIPLE OF RESPECT FOR AUTONOMY

Generally when we think about the concept of autonomy, we think about freedom, liberty, self-determination and ultimately the right to choose our own course in life so long as we do not cause harm to others in the process. When we think about autonomy in a biomedical context, we think of patients' right to choose the form and extent of the treatment they wish to receive, including the option of no treatment at all in some cases. For a physician, or any health care worker for that matter, to do anything but that which the patient requests, is to disrespect the patient's right to act autonomously. Therefore, even if respect for a patient's wishes requires that the acting physician not treat at all (or perhaps discontinue treatment already initiated), the physician has an obligation, according to the principle of respect for autonomy, to refrain from treating that patient, irrespective of his/her own personal convictions.

From the perspective of health care professionals, the principle of respect for autonomy goes beyond respecting the patient's particular wishes in terms of their treatment options. Once admitted into a health care setting, those health care workers also have an obligation to respect the patient's right to privacy, confidentiality, truthfulness and full disclosure of pertinent medical information. All of these moral obligations are derivative from the principle of respect for autonomy. Of course, it goes without saying, that the principle of respect for autonomy only applies fully to competent autonomous agents. Those who are *incompetent,* for example, are not entitled to the rights that follow from this principle and in most cases, decisions regarding their treatment are made by others who can make the proper decisions on their behalf. There is much debate surrounding how we are to determine who is

competent and who is not, and consequently, uncertainty regarding the agents to which the principle of respect for autonomy is applicable to. However, for the purposes of this paper, I will assume that an autonomous agent is one who has "the capacity to understand the material information, to make a judgment about the information in light of his or her values, to intend a certain outcome, and to freely communicate his or her wish to caregivers or investigators."[32]

2. THE PRINCIPLE OF BENEFICENCE

The principle of beneficence can be broken down into three more specific norms dedicated to providing benefits to others: (1) One ought to prevent evil or harm. (2) One ought to remove evil or harm. (3) One ought to do or promote good. These norms are as straightforward as they appear and I suspect that very little else needs to be said on their behalf. Nonetheless, a distinction between the concepts of beneficence, benevolence and utility - three similar, yet distinct notions - can help avoid some possible confusions. As Beauchamp and Childress explain, "*Beneficence* refers to an action done for the benefit of others; *benevolence* refers to the character trait or virtue of being disposed to act for the benefit of others."[33] These two notions are distinct from the concept of utility (see ch.2), which is a separate norm that calls for the balancing of benefits against potential costs and risks of harm.

3. THE PRINCIPLE OF NON-MALEFICENCE

The principle of non-maleficence simply requires that we do not act in such a way that we directly or indirectly cause harm to others. Traditionally, definitions of "harm" have been difficult to qualify and have varied in scope. A harmful action can vary from causing physical

injury to verbally offending someone to causing a setback to someone's goals. Beauchamp and Childress seem to have in mind all three of these notions of harm and everything in between. This is evidenced as they list off several, more specific moral rules that are derivative of the principle of non-maleficence. They are: "do not kill", "do not cause pain or suffering to others", "do not incapacitate others", "do not cause offense to others" and "do not deprive others of the good life".

4. THE PRINCIPLE OF JUSTICE

Like the principle of beneficence, the principle of justice can be broken down into more specific principles of obligation. Beauchamp and Childress opt for a very broad conception of the principle of justice which essentially embodies the six most common principles of distributive justice. Accordingly, the benefits and burdens of society ought to be distributed in the following ways: (1) To each person an equal share. (2) To each person according to need. (3) To each person according to effort. (4) To each person according to contribution. (5) To each person according to merit. (6) To each person according to free-market exchanges.

II. SPECIFIED PRINCIPLISM

It is these four "clusters" of prima facie principles of obligation that make up the *normative content* with which principlism starts. Beauchamp and Childress make it quite clear that this group of principles is just that - a starting point for reaching moral conclusions. At no point do they claim nor imply that doing bioethics simply involves the rote application of one or all of these principles to the problem at hand. Rather, Beauchamp and Childress have

the following in mind:

> Our method in this book is to unite principle-based, common-morality ethics with the coherence model of justification...This strategy allows us to rely on the authority of the indispensable principles in the common morality, while incorporating tools to refine and correct its weaknesses and unclarities and to allow for additional specification. Because our strategy accepts the goal of reflective equilibrium and, in part, constructs principles and rules from considered judgments in the common morality, while also specifying principles and rules, we will not end with the identical content with which we began.[34]

Before I begin to unpack some of the concepts Beauchamp and Childress put forth in their most recent methodology, one must realize that this approach does make significant strides towards recognizing the true moral complexity involved in bioethics and the seemingly inherent problem of conflicting obligations that a *pluralistic* approach, like principlism, must confront in many cases. This most recent principlist methodology is (supposedly) an attempt to remedy the problems found in their previous accounts of principlism. In past editions of *Principles*, the principlist methodology appears to be merely the direct application of a plurality of principles, where in cases of conflict, the principles are to be balanced and weighed (and some eventually overridden) according to case circumstances and intuition. For example, in their third edition of *Principles*, they write:

> The theory we defend may be called a composite theory. It stands in opposition to monistic or absolutistic theories such as utilitarianism, Kantianism and libertarianism (a monism based on the principle of respect for autonomy). A composite theory permits each basic principle to have weight without assigning a priority weighting or ranking. Which principle overrides in a case of conflict will depend on the particular context, which always has unique features.[35]

In their fourth edition, it is apparent that Beauchamp and Childress have discovered that a case's "particular context" and its "unique features" are often not adequate tools for yielding determinate moral resolutions. In light of this, they have come up with the above

methodology dubbed "specified principlism"[36], which relies on several features, including "common-morality ethics", "reflective equilibrium", "specification" and "the coherence model of justification" .

To understand fully specified principlism, we need to start with the source of the principles. Where do the four clusters of principles originate from? For Beauchamp and Childress, the principles of autonomy, beneficence, non-maleficence and justice are all derived from the "common morality" which they describe as "the morality shared in common by the members of a society - that is, unphilosophical common sense and tradition...[The common morality] is a pretheoretic moral point of view that transcends merely local customs and attitudes. Analogous to beliefs in the universality of basic human rights, the principles of the common morality are universal standards."[37] They urge that a common morality theory of ethics, as opposed to other, abstract ethical theories such as utilitarianism, egalitarianism, etc., is the most appropriate theoretical perspective with respect to approaching normative and applied ethics. However, their insistence on this can only be fully understood in conjunction with their theory of the nature of moral justification in ethics, i.e., the *metaethical content* they bring to bear on applied ethics.

In the Rawlsian tradition, Beauchamp and Childress adopt a *coherence* theory of moral justification whereby a justified moral judgment is one which can strike a balance between our *considered judgments* and the specific moral obligations that ultimately make up our "theory". Rawls calls this process "reflective equilibrium" which aims to "match, prune and adjust considered judgments so that they coincide and are rendered coherent with the premises of the theory"[38]. But what exactly are *considered judgments* and in what sense are

they required to *cohere* with our theory of biomedical ethics?

In many instances, considered judgments are thought of as credible intuitions or self-evident moral beliefs that act as a starting point in moral justification. However, as Beauchamp and Childress correctly state, considered judgments, like the four clusters of (unspecified) principles they have given, are much more than this and are in fact judgments that have been *considered* by those who hold them:

> These considered judgments typically have a rich history in moral experience that underlies our sense that they are credible and trustworthy; considered judgments are therefore not merely a matter of individual intuition. Any moral certitude associated with these norms is likely to derive from beliefs that are acquired, tested, and modified over time in light of the purposes served by the norms. Coherence among these initial norms is essential to their acceptability, and incoherence is a sound reason for rejecting one or more such "foundational" but fallible propositions.[39]

What becomes clear from their account thus far is that these four clusters of principles are justified starting points in biomedical ethics and that justification comes from the high level of *coherence* among them. What Beauchamp and Childress mean by *coherence* is surely nothing new here and find that it can best be summarized by Bonjour's definition of the bare concept of coherence given in *The Structure of Empirical Knowledge :*

> Intuitively, coherence is a matter of how well a body of beliefs "hangs together": how well its component beliefs fit together, agree or dovetail with each other, so as to produce an organized, tightly structured system of beliefs, rather than either a helter-skelter collection or a set of conflicting subsystems.[40]

Of course the role for coherence does not end with the initial considered judgments. Recall that according to Beauchamp and Childress, the "bigger picture" of this principlist account reveals the need for its principles to be *specified* and if need be, modified or corrected as new and more complex moral experiences present themselves and the tool which they rely on to provide warrant for such specifications is, of course, coherence.

The concept of *specification* used by Beauchamp and Childress is borrowed from

Henry Richardson, author of the article, "*Specifying Norms as a Way to Resolve Concrete Ethical Problems*". Like Richardson, Beauchamp and Childress support the idea that while a particular specification can be introduced on any grounds - specifically they make mention of intuitive grounds - coherence ultimately provides justification for one specification over another. They maintain that "a particular specification is justified only if it is more coherent with the whole set of relevant norms than any other available specification."[41] Or, in Henry Richardson's words, "a specification is rationally defensible, then, so long as it enhances the mutual support among the set of norms found acceptable on reflection."[42] An example can perhaps shed some light on how Beauchamp and Childress' specified principlism will actually proceed.

Let us consider once again the case involving Mrs. Y - the pregnant mother with a history of P.K.U. in her family (see ch. 3). In this case, the principlist will suggest that the deliberators consider the following principles: (1) the principle of non-maleficence - avoiding undue harm to the fetus (2) the principle of autonomy - the respect for the mother's autonomous decisionmaking capacities and (3) the principle of beneficence - the physician's duty to balance benefits against risks and costs. Now suppose that at first glance, the deliberators find all, or more than one of these considerations equally significant and in the end are not somehow able to "balance" these principles in favor of one overriding obligation. According to specified principlism, our deliberators must then examine more closely each principle and then ask themselves how one or all of these principles can be made more specific. For example, they might: (1) consider whether the principle of non-maleficence subsumes all persons, both present and future, (2) consider the various circumstances where

one's "style of living" is morally required to change as a result of potential harm to others or (3) consider whether we can distinguish morally acceptable and unacceptable levels of harm to others. What this process boils down to in many instances is the taking stock of the *exceptions* to the general rule and then drawing out the commonalities among those exceptions, thus eventuating in a more accurate specification of the true content of our moral principle. At any rate, the hope is that by specifying one or more of these principles, the apparent conflict of obligations we faced at the outset will eventually dissolve. To summarize, the process of specified principlism using the example above, might look like this:

NON-MALEFICENCE PERSPECTIVE

(GP) 1. One ought to avoid causing harm to other persons.

(CF) 2. The refusal of P.K.U. diet will in all likelihood result in significant harm to her future child.

(PO) 3. Mrs. Y has an obligation to adhere to the P.K.U. diet.

AUTONOMY PERSPECTIVE

(GP) 4. One ought to respect the decisionmaking capacities of autonomous persons.

(CF) 5. Forcing Mrs. Y to adhere to P.K.U. diet does not respect her capacity for autonomous decisionmaking.

(PO) 6. Mrs. Y has the (moral) right to refuse the P.K.U. diet.

[GP= General Principle, CF= Case Fact, and PO= Principle-Based obligation.]

Directly applying both the principle of non-maleficence and the principle of autonomy leads to the contradiction found in 3 and 6. However, if we specify 1 and 4 in the following manner, the conflict can be resolved:

1a. One ought to avoid causing undue harm to all persons, present and future, especially in cases where doing so requires relatively little personal sacrifice.

4a. One ought to respect the decisionmaking capacities of autonomous persons except in cases where the decision will in all likelihood result in physical harm to those that are directly affected by that decision.

Again, for Beauchamp and Childress, what is required to justify specifications 1a and 4a for our deliberators is the fact that these specifications maximize the mutual support among all other relevant norms, over and above other possible specifications.

III. PRESCRIPTIVE AE AND SPECIFIED PRINCIPLISM

To this point, I have attempted to clarify all of the various notions Beauchamp and Childress bring forth in their explanation of "specified principlism" and it now seems we are finally in a position to evaluate the prospects of this approach as a prescriptive model of applied ethics. In the following, I shall argue that not unlike casuistry and the UEM, Beauchamp and Childress' specified principlism also fails to meet the criteria for moral correctness set out at the beginning of this paper. In this case, the weakness is that its resultant moral resolutions, i.e., its *specified* principles, ultimately lack *discursiveness.* One might wonder how this type of specification can lack discursiveness, given that Beauchamp and Childress obviously cite coherence as the justificatory mechanism that lies behind any and all particular specifications. While this might appear to be the case with specified principlism, I want to suggest that, upon closer inspection, the justification for one specification over another is more ambiguous and arguably more arbitrary than Beauchamp and Childress care to admit.

My scepticism towards their coherence mode of specification begins with their lack of explanation surrounding the notion of "maximum coherence among all relevant norms". What do Beauchamp and Childress (or Richardson for that matter) mean by "relevant norms"? If we turn to Beauchamp and Childress on this issue, we find three places where this is explicitly discussed, all in their initial chapter that deals with moral justification. Firstly, just

before they give some examples of specification, they write: "In tightening our principles, we must take into account various factors such as efficiency, institutional rules, law, and clientele acceptance. Eventually we need to provide a practical strategy for real-world problems involving the demands of political procedures, legal constraints, uncertainty about risk, and the like."[43] Secondly, in the same section introducing specification they state that "An adequate specification requires that one justify the claim that the proposed specification is coherent with other relevant moral norms."[44] Lastly, in a somewhat redundant manner, they add that "A particular specification is justified only if it is more coherent with the whole set of relevant norms than any other available specification."[45]

If we attempt to make sense of their first statement about what ought to be considered when one tries to specify one's principles, it seems that they are arguing that all sorts of norms, not just *moral* norms, play a role in specification. More specifically, they are suggesting, at least here, that one ought to seek maximum coherence among relevant legal norms, institutional norms and generally, norms of practicality. This however is quite different from what is asserted in the second passage. Here, they are arguing for maximum coherence strictly among relevant *moral norms*, which is itself an unclear notion, as we are never really told what counts as a "relevant moral norm". For example, if we were to go back to the case with Mr. G given in chapter one, what would Beauchamp and Childress say to Dr. H about trying to justify one specification over another? In other words, what norms are required to be called upon in an attempt to maximize coherence among them? Would he be required to consider and make coherent, say, just those "formal" moral norms dictated by the Hippocratic Oath and the Canadian Medical Association Code of Ethics, or is he compelled to employ all

of his moral beliefs, including those outside the Code of Ethics? Further, one can imagine other cases where deliberators may also wonder whether they ought to consider norms outside of the law, especially if the law is silent on this type of case. From what Beauchamp and Childress do say on this matter, it certainly is difficult to tell what range of norms they are after and because this remains ambiguous throughout the course of the book, I have serious misgivings about assigning a large degree of discursive value to their attempt to specify principles.

In the author's opinion, a more accurate description of what is really involved with specification is simply *conceptual analysis and clarification* - the core, general and necessary aspect of what philosophers apply in applied ethics (see ch. 1). Granted, all of the so-called specifications of the principles that are carried out with "the four principles" do prove to clarify many of the norms that fall under those principles, (e.g., withdrawing vs. withholding treatment, obligatory vs. ideal beneficence, weak and strong paternalism, obligatory and optional treatment, etc). However, in the end, except for simply stating that coherence is at work here, they really offer no reason to think that their specifications are more than a series of unrelated, non-discursive attempts at conceptual analysis and clarification.

IV. FACILITATIVE AE AND SPECIFIED PRINCIPLISM

Although specified principlism may not be able to yield discursive moral resolutions for those doing prescriptive applied ethics, this does not preclude the possibility of it being a successful facilitative model. Unlike the UEM, the normative content of specified principlism is quite *complete* and *comprehensive*, essentially by its very nature. Recall, the four clusters of principles are derived from a common-morality view of ethics which will quite

obviously "appeal to the masses" and reflect the majority's moral values. With respect to the common morality, Beauchamp and Childress make this very point, and in addition, suggest that all of the principles that are derivative of the common morality are principles that are usually common to competing moral theories. This aspect of convergence among theories, however, is easily overseen due to varying conceptions of the foundation(s) of ethics. Specifically, they argue that:

> Far more social consensus exists about principles and rules drawn from the common morality (for example, our four principles) than about theories. This is not surprising, given the central social role of the common morality and the fact that its principles are, at least in some schematic form, usually embraced in some form by all major theories. Theories are rivals over matters of justification, rationality and method, but they often converge on mid-level principles.[46]

The upshot of this similarity among mid-level principles is an increased possibility of finding common ground in the initial stages of setting up the moral backdrop for individual cases and eventually finding more similar moral recommendations, i.e., consensus among our decision-makers.

I must admit that I find Beauchamp and Childress' argument here quite convincing and moreover, hold out a lot of hope for specified principlism as a facilitative model of applied ethics. My reasons for optimism are similar to those of Beauchamp and Childress but are also reinforced by anecdotal evidence. Generally, the appeal lies in the fact that by introducing a *plurality* of moral principles, as opposed to one, monistic, supposedly-all-encompassing, moral principle, our decision-makers can more effectively initiate a productive discussion. Surely finding some shred of moral fabric among the four clusters of principles is not an unreasonable expectation. For example, imagine a case involving doctor-assisted

suicide, and for the sake of argument and simplicity, we have only two decisionmakers. Let us say that one is very religious and strongly adheres to the sanctity of life principle. On the other hand, our other decisionmaker clearly believes in freedom of choice on many moral issues, including this one. While it is certainly not reasonable to expect that in extreme (and oversimplified) cases such as this we will ever reach consensus, I want to suggest that at least with principlism, both parties have some moral representation - our religious decisionmaker can at least identify with the principle of non-maleficence and our other decisionmaker can at least identify with the principle of autonomy. Granted, neither parties may agree with the source of these principles, i.e., what their underlying justification might be, but nonetheless, they have some point of departure from which to discuss these issues. Contrast this with an instance of these same two decision-makers employing, say, the utilitarian engineering model. In this scenario, one would suspect that unless they were utilitarians themselves, there would be much less of a point of departure from which to attempt various resolutions and in the end, the discussion would likely center on hopeless attempts at trying to convince both parties of the value of utility.

CONCLUSION

At the outset, it was explained that this new discipline we call "applied ethics", even twenty years after its birth, is an enterprise that has done relatively little reflection upon itself in terms of its content, method and goal. Essentially, the purpose of this thesis was to try to shed some light on these aspects of applied ethics and moreover, to gain a deeper understanding of the various "ethical processes" or "methodologies" that have and are being used to do applied ethics today. For the most part, this was a descriptive project, whereby I have attempted to answer the following two questions: (1) What exactly are we applying in applied ethics? (2) How is ethics being applied, if it is being applied at all? However, in addition to this, I also have attempted to tackle the much bigger, normative question which asks: Which approach to applied ethics proves most "successful", if any at all?

In what precedes, I have argued that there are essentially three elements that are "applied" in applied ethics and they are: (1) Normative ethics - normative rules, principles and theories (2) Metaethics - theories having to do with the nature of moral justification (3) General analytic skills - conceptual analysis and clarification and producing and analyzing argumentation. All three of these aspects have been made explicit with respect to three different approaches to applied ethics: (1) The Utilitarian Engineering Model (UEM) (2) Casuistry and (3) Specified Principlism.

In so far as critically assessing these three approaches, i.e., determining which proves most "successful", it was first explained that in order to do so, we first need to come to grips with what counts as "success" in applied ethics. I insisted that this was not a discussion to be

taken up here for several reasons, including a fear of a never-ending metaethical/epistemological debate and instead, compromised by assessing each of the various approaches in light of both a *facilitative* end and a *prescriptive* end.

Ultimately, in terms of a facilitative model of applied ethics, Beauchamp and Childress' specified principlism holds the most promise. This is mainly due to its diverse and comprehensive normative content which allows for more fruitful and productive discussion and thus more room for some agreement, even if in the end, we cannot totally solve the problem of conflicting principles. The UEM and casuistry, on the other hand, do not succeed in this respect because the former is not comprehensive enough to allow for much agreement and the latter, while diverse in its normative content, is lacking the sufficient clarity to actually carry out its goal of reaching consensus.

In terms of a prescriptive model, unfortunately the same praise cannot be extended to specified principlism. As a matter of fact, all three of the approaches discussed here fall short in some way or another in terms of providing morally correct action-guides. However, we need not let this discourage our efforts in this field of ethics. Philosophers need to keep in mind that just so long as the answers they provide are leading to new and more important questions, and forcing people to further consider ethical issues which must be dealt with at some point, what they are doing is nonetheless of value.

NOTES

1. K. Danner Clouser, *Encyclopedia of Bioethics* (New York, 1978), pp. 114-116.
2. Ronald M. Green, "Method in Bioethics: A troubled Assessment", *Journal of Medicine and Philosophy* 15 (1990), pp. 180-181.
3. David O. Brink, *Moral Realism and the Foundations of Ethics* (New York, 1989), pp. 101.
4. Ibid., pp. 103.
5. Ronald M. Green, *Journal of Medicine and Philosophy*, pp. 189.
6. Richard W. Momeyer, "Philosophers and the Public Policy Process: Inside, Outside, or Nowhere at All", *Journal of Medicine and Philosophy* 19 (1994), pp. 393.
7. Arthur Caplan, " Applying Morality to Advances in Biomedicine: Can and Should This Be Done", *New Knowledge in the Biomedical Sciences* (1982), pp. 155-168.
8. Samuel Gorovitz et al, *Moral Problems in Medicine* (New Jersey, 1976), pp. 13.
9. Although Caplan is the first one to dub this "the engineering model", Caplan does not argue in favor of this approach to applied ethics.
10. Arthur Caplan, *If I were a Rich Man Could I buy a Pancreas?* (Indiana, 1992), pp. 7-8.
11. Ibid., pp. xiii.
12. James Rachels, *The Elements of Moral Philosophy* (New York, 1993), pp. 102.
13. John Stuart Mill, *Utilitarianism* (Indiana, 1979), pp. 38.
14. James Rachels, *The Elements of Moral Philosophy* (New York, 1993), pp. 106.
15. For a more complete description of this argument specifically given in the context of the four principles, see Richard M. Hare's article entitled "Utilitarianism and Deontological Principles" in Raanan Gillon's anthology *Principles of Health Care Ethics* (1994), pp. 149.
16. Tom Beauchamp and James Childress, *Principles of Biomedical Ethics* (New York, 1994), pp. 102.
17. Albert Jonsen and Stephen Toulmin, *The Abuse of Casuistry* (California, 1988), pp. 13.
18. Ibid., pp. 13.
19. Ibid., pp. 11.
20. Kevin WM. Wildes, "The Priesthood of Bioethics and the Return of Casuistry" *Journal of Medicine and Philosophy* 18 (1993), pp. 37.
21. Jonsen and Toulmin, *The Abuse of Casuistry*, pp. 40.
22. Ibid., pp. 35.
23. Ibid., pp. 256.
24. William Frankena, *Ethics* (New Jersey, 1973), pp. 102.

25. Jonsen and Toulmin, *The Abuse of Casuistry*, pp. 306.

26. Ibid., pp. 16-17.

27. Stephen Toulmin, "The National Commission on Human Experimentation: Procedures and Outcomes", *Scientific Controversies*, ed. H. Tristam Engelhardt and A. Caplan (Mass., 1987), pp. 610.

28. Jonsen and Toulmin, *The Abuse of Casuistry*, pp. 18.

29. This case was first presented to me by Dr. Cheryl Greenberg, Department of Human Genetics, Health Sciences Center. With her kind permission, I have reprinted some of the notes pertaining to this case with which she was personally involved.

30. John Arras, "Getting Down to the Cases: The Revival of Casuistry in Bioethics", *Journal of Medicine and Philosophy* 16 (1991), pp. 39.

31. Beauchamp and Childress, *Principles of Biomedical Ethics*, pp. 38.

32. Ibid., pp. 135.

33. Ibid., pp. 260.

34. Ibid., pp. 101.

35. Tom Beauchamp and James Childress, *Principles of Biomedical Ethics (3rd. Edition)*, (New York, 1989), pp. 51.

36. "Specified principlism" is a term first introduced by David DeGrazia in his article *Moving Forward in Bioethical Theory*. Beauchamp and Childress do not explicitly refer to their methodology as such.

37. Beauchamp and Childress, *Principles of Biomedical Ethics*, pp. 100.

38. Ibid., pp. 21.

39. Ibid., pp. 24.

40. Lawrence Bonjour, *The Structure of Empirical Knowledge* (Mass. 1985), pp. 93.

41. Beauchamp and Childress, *Principles of Biomedical Ethics*, pp. 31.

42. Henry S. Richardson, "Specifying Norms as a Way to Resolve Concrete Ethical Problems", *Philosophy and Public Affairs* 19 (1990), pp. 302.

43. Beauchamp and Childress, *Principles of Biomedical Ethics*, pp. 28-29.

44. Ibid., pp. 30.

45. Ibid., pp. 31.

46. Ibid., pp. 102.

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