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CONTENTS

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Clinical Decision-Making: The Case Against The New Casuistry

Mahesh Ananth, Ph.D.*

ABSTRACT: Albert Jonsen and Stephen Toulmin have argued that the best way to resolve the complex issues in medical settings is to focus on the actual details of cases and then determine what to do in the given cases. This approach to medical decision-making, labeled "casuistry," has met with much criticism. In response, Carson Strong has attempted to save much of Jonsen and Toulmin's version of casuistry. This analysis reveals that Strong's recent salvage efforts fail to deflect the major criticisms. The upshot of this analysis is that Jonsen and Toulmin's version of casuistry is not an appropriate framework from which to resolve complex issues in clinical settings.
Key Words: Casuistry, moral judgments, medical decision-making, paradigm cases
Discipline/Topic: Bioethics/Medical Casuistry

That advances in the biological sciences coupled with progress in medical technology have had and continue to have profound effects on both ends of the spectrum of life is fantastically clear. It is safe to say with some confidence that medical advances have put both medical professionals and those patients and families that may be the recipients of recent biomedical gains in the position of making decisions that range over bringing about life, sustaining life, and terminating life.[1]

Despite this wealth of medical knowledge and the concomitant advances in medical technology that continue to come our way at groundbreaking speed, decisions regarding how to employ or whether or not to employ such knowledge and technology to actual medical situations/cases has proven to be a notoriously difficult task. The moral status

*Associate Professor, Department of Philosophy, Indiana University–South Bend, 1700 Mishawaka Avenue, South Bend, IN 46634; e-mail: mananth@iusb.edu.

[1] Consider the advances in the field of synthetic biology, where new species can be created in the laboratory. For more on the moral and political dimensions of this budding science, *see* Ananth, Mahesh. 2014. Review of Kaebnick and Murray, eds., Synthetic Biology and Morality: Artificial Life and the Bounds of Nature. 2013. *Journal of Value Inquiry.* DOI 10.1007/s10790-014-9432-2.

of many of the decisions made by medical practitioners, employing various sorts of medical technology, at all regions of the spectrum of life, has come under a great deal of scrutiny in the last thirty years. More specifically, it is the moral reasoning of medical practitioners in medical settings that has been "under the moral microscope" as a result of the decisions that have been and continue to be made in the wake of our current frenzy of scientific and medical headway.

Today, three broad procedures or methodologies are being employed by bioethicists and clinicians to address the many complex medical decisions that are now part of our "brave new world." First, there is the theory school of medical ethics. Those who pledge allegiance to this camp apply general moral theories (e.g., utilitarianism, contractarianism, virtue ethics, deontology, etc.) to the specific problems that have emerged as a result of the advances made in medical and biological research (e.g., organ transplantation, gene manipulation, fetal tissue research, euthanasia, abortion, etc.). The second method for resolving decisions in clinical settings is the principle approach. Those who embrace this method eschew the difficulties associated with constructing a moral edifice, but move directly to a set of principles (e.g., autonomy/self-rule, beneficence, justice, rights, nonmaleficence, probity, etc.) that are applied to particular biomedical cases. Then, justification is given as to why a particular subset of these principles and the corresponding weight and hierarchy attached to each principle within a chosen subset is appropriate to the case at hand.[2] The third methodology, which is comprised of a few variations, is what is called the case-based or casuistic method of moral decision-making

[2] The exemplars of this camp are Beauchamp, Tom and James Childress, eds. 1989. *Principles of Biomedical Ethics*. Third Edition. New York: Oxford University Press. For a critique of this approach, see Clouser, K. Danner and Bernard Gert. 1990. A critique of principlism. *The Journal of Medicine and Philosophy*. 15.2: 219-235 and Green, Ronald. 1990. Method in bioethics: A troubled assessment. *The Journal of Medicine and Philosophy*. 15.2: 179-197. I have not included pragmatism as a distinct methodology within bioethics, because many of its faces are quite akin to either (or both) principlism or casuistry (or vice versa). Of course, much more would have to be offered to defend this claim successfully. I have not the luxury to do so in this essay. Nonetheless, in an attempt to distance themselves from principlism and casuistry *and* lay claim to a unique methodological framework for bioethics, a host of "new pragmatists" have taken both principlism and casuistry to task. Yet, Arras makes the point quite nicely when he says that the claims offered by the new pragmatists are "anything but clear. As it has been since the very beginning of American pragmatism, there appear to be several distinct versions vying for our attention and allegiance..." *See* Arras, John. 2002. Pragmatism in bioethics: Been there, done that. *Social Philosophy and Policy*. 19.2: 30. For more on the recent renaissance in pragmatism as a distinct methodology in clinical decision-making, see Arras, John. 2001. Freestanding pragmatism in law and bioethics. *Theoretical Medicine and Bioethics*. 22.2: 69-85; McGee, Glenn. 1999. Pragmatic method in bioethics. In *Pragmatic Bioethics*. Nashville: Vanderbilt University Press. 18-29; Miller, Franklin, Joseph Fins, and Mathew Bachetta. 1999. Clinical pragmatism: A model for problem solving. In *Pragmatic Bioethics*. Nashville: Vanderbilt University Press. 30-44; and F. Miller, J. Fins, and M. Bachetta. 1996. Clinical pragmatism: John Dewey and clinical ethics. *Journal of Contemporary Health Law and Policy*. 13.1: 27-51; Jansen, Lynn. 1998. Assessing clinical pragmatism. *Kennedy Institute of Ethics Journal*. 8.1: 23-36; Wolf, Susan. 1994. Shifting paradigms in bioethics and health law: The rise of a new pragmatism. *American Journal of Law and Medicine*. 20.4: 395-415.

in medical settings.[3] Adherents of this practice insist that both of the first two methods, the theory approach and the principle approach, are not at all efficacious (by themselves) in resolving concrete problems in clinical settings. Rather, casuists declare firmly that the only way to resolve the complex issues in medical settings is to focus simply on the actual details of specific cases and then determine what to do in the given cases.

This essay will focus on the casuistic approach. To make this inquiry tractable, after providing a brief historical backdrop for this discussion, I will provide an account of a version of casuistry offered by Jonsen and Toulmin (hereafter JT). Next, I will provide some of the central criticisms of this approach that would appear to render it rather moribund. I will then explain and evaluate Carson Strong's recent attempt to defend the JT strategy. My analysis will reveal that Strong's defense of the JT version of casuistry is not nearly as puissant as he purports.[4] The upshot, which includes two overlooked criticisms, will make clear that JT's version of casuistry is inadequate as a serious methodological framework from which to make difficult decisions in clinical settings.

Historical Background

It is no secret that moral theorists disagree vehemently as to what constitutes the correct framework from which to evaluate what kinds of acts are good and what kinds of acts are bad. As Richard Brandt quite succinctly notes: "A problem that has vexed philosophers from the very beginning is how to determine the truth or justification of normative beliefs, especially whether a certain kind of action is *morally wrong* or *morally permissible*."[5] There are radically different ways of making moral judgments. The renaissance of casuistry[6] or case-based reasoning during the 1980s can be viewed as a response to this lack of general agreement on the part of moral theorists.

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[3] For a concise overview of each of these variations of casuistry, see the following: Kuczewski, Mark. 1994. Casuistry and its communitarian critics. *Kennedy Institute of Ethics Journal*. 4.2: 99-116; Kuczewski, Mark. 1997. *Fragmentation and Consensus*. Washington, D.C.: Georgetown University Press; Kuczewski, Mark. 1998. Casuistry and principlism: The convergence of method in biomedical ethics. *Theoretical Medicine and Bioethics*. 19.6: 509-524. For some of the original works, see Jonsen, Albert and Stephen Toulmin. 1988. *The Abuse of Casuistry: A History of Moral Reasoning*. Berkeley: University of California Press.; Brody, Baruch. 1988. *Life and Death Decision Making*. New York: Oxford University Press.; Strong, Carson. 1999. Critiques of casuistry and why they are mistaken. *Theoretical Medicine and Bioethics*. 20.5: 395-411.

[4] Surprisingly, there has been little critical response to Strong's intriguing analysis. Additionally, Coleman, Kari Gwen. 2007. Casuistry and computer ethics. *Metaphilosophy*. 38.4: 471-88 has attempted to draw on the insights from medical casuistry and employ them in the field of computer ethics. Moreover, Cherry, Mark J., and Ana S. Iltis, eds. 2007. *Pluralistic Casuistry: Balancing Moral Arguments, Economic Realities, and Political Theory*. Dordrecht: Springer, have edited a collection of essays that attempt to navigate a "pluralistic" rendering of casuistry distinct from the JT and Strong renditions. Finally, hints of salvaging some version of casuistry can also be found in some of the essays edited by Rasmussen, Lisa, ed. 2005. *Ethics Expertise: History, Contemporary Perspectives, and Applications*. Dordrecht: Springer. These works are a reminder that casuistry has not at all disappeared from the ethics landscape.

[5] Brandt, Richard. 1996. Science as a basis for moral theory. In *Moral Knowledge? New Readings in Moral Epistemology*. New York: Oxford University Press. 200-214.

[6] Note that I will not here discuss the history of the concept of casuistry that emerged out of the early Middle Ages as an attempt to apply Christian religious doctrines to particular situations. For some inter-

Indeed, the traditional "top-down" approach taken by medical ethicists is to insist that some ethical theory must be constructed and then employed in determining what medical actions are morally permissible to pursue. For example, deontology/Kantianism and consequentialism are two traditional moral theories that offer quite different substantive procedures for determining what is a good or bad thing to do. Notably, such determinations of morally good and bad actions do not rely on particular scenarios, examples, or events. Rather, these moral theories rely on the rational construction of a monolithic measure of value that is decisive for all human agents, irrespective of their particular circumstance. In short, many moral theorists insist that theory guides what one ought to do in particular scenarios and not vice versa. For example, Immanuel Kant most forcefully notes the primacy of theory over circumstance. He says:

> Worse service cannot be rendered morality than that an attempt be made to derive it from examples. For every example of morality presented to me must itself first be judged according to principles of morality in order to see whether it is fit to serve as an original example, i.e., as a model. . . . Examples serve only for encouragement, i.e., they put beyond doubt the feasibility of what the law commands and they make visible what the practical rule expresses more generally. But examples can never justify us in setting aside their true original, which lies in reason, and letting ourselves be guided by them. . . Such a procedure turns out a disgusting mishmash of patchwork observations and half-reasoned principles in which shallowpates revel because all this is something quite useful for the chitchat of everyday life.[7]

It is rather difficult to mistake Kant's points in the above quotation: The foundation of morality cannot reside in the details of human activities because (1) one must first have some "moral principle" in mind in order to judge that a particular example is an appropriate example, (2) examples only serve to reveal the applicability of a moral theory and the practical principles that are generated from such a theory, (3) examples cannot be used as a justification for eliminating the moral theory/principles from which these examples were determined to be moral examples, and (4) if examples are used in place of a moral theory, then the result will be rather emaciated moral principles due to poor observations and flawed reasoning inherent in people. For Kant, then, examples merely reinforce and motivate one to embrace a moral theory that is in no way grounded in examples.

This theory-driven approach,[8] the emphasis on a common or univocal view of the good, however, has supposedly fallen out of favor as of late, especially by many of

esting discussions of the history of casuistry, see A. Jonsen and S. Toulmin. *Supra* note 3; Keenan, James and Thomas Shannon, eds. 1995. *The Context of Casuistry*. Washington, D.C.: Georgetown University Press.; Leites, Edmund. 1974. Conscience, casuistry, and moral decision: Some historical perspectives. *Journal of Chinese Philosophy*. 2.1: 41-58; Biggar, Nigel. 1989. A case for casuistry in the church. *Modern Theology*. 6.1: 29-51.; Mehl, Peter. 1996. William James's ethics and the new casuistry. *International Journal of Applied Philosophy*. 11.1: 41-50.

[7] Kant, Immanuel. 1993. *Grounding for the Metaphysics of Morals*. Third Edition. James W. Ellington, trans. Indianapolis: Hackett Publishing Company, Inc. 20-21.

[8] Jonsen, Albert. 1991. American moralism and the origin of bioethics in the United States. *Journal of Medicine and Philosophy*. 16.1: 113-130, has called this theory-driven approach "secular fundamentalism."

those in the field of bioethics. Daniel Callahan quite nicely describes the contemporary "moral atmosphere" that has fueled this resistance to and skepticism of moral theorizing that is at its apogee today:

> The most striking change over the past two decades or so has been the secularization of bioethics. The field has moved from one dominated by religious and medical traditions to one increasingly shaped by philosophical and legal concepts. The consequence has been a model of public discourse that emphasizes secular themes: universal rights, individual self-direction, procedural justice, and a systematic denial of either a common good or a transcendent individual good.[9]

This cloud of moral skepticism has been made manifest in bioethics in the form of what John Arras has called "The New Casuistry."[10] Before diving into the details of this discussion, however, I must explain more fully the procedural details of this "New Casuistry." It is these fine points of casuistry, through the work of JT, to which I now turn.

The JT Brand of Casuistry

In what can be viewed as a direct reaction against the principle approach and Kant's rejection of empirical facts about the human condition (i.e., examples) as guides to morality and moral judgment, Toulmin responds as follows:

> In ethics, moral wisdom is exercised not by those who stick by a single principle come what may, absolutely without exception, but rather by those who understand that, in the long run, no principle—however absolute—can avoid running up against

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[9] Callahan, Daniel. 1990. Religion and the secularization of bioethics. *Hastings Center Report*. 20. Supplemental: 2. Similarly, Audi claims, "[r]eflective people who want moral guidance have often noted that the help they get from moral theories, particularly Kantianism and utilitarianism, is quite limited. From Kant's categorical imperative or Mill's principle of utility, for instance, there is often a long, uncharted distance to moral decision...virtue ethics seem to their critics unclear in application to action, lacking in principles needed to justify moral decisions, or at best derivative from rule theories...many philosophers regard intuitionism as dogmatic or consider it inadequate because it lacks a comprehensive moral theory as a basis for its disparate principles. It also shares with virtue theories—and arguably with other rule theories—great difficulties in providing a way to resolve conflicts of duties..." *See* Audi, Robert. 2001. A kantian intuitionism. *Mind*. 110.439: 601. For an attempt to resolve this problem between moral theory and medical practice, see "The Wide Reflective Equilibrium" methodology offered by Kushner, Thomasine, Raymond Belliotti, and Donald Buckner. 1991. Toward a methodology for moral decision making in medicine. *Theoretical Medicine*. 12.4: 281-293.

[10] Arras, John. 1991. Getting down to cases: The revival of casuistry in bioethics. *The Journal of Medicine and Philosophy*. 16.1: 30. Of course, casuistry has not been the only contender to the theory approach. Indeed, the Callahan quotation might best capture the principle approach to bioethics offered by Beauchamp and Childress, *supra* note 2. The point here is to make clear the shift away from ethical theory. Nonetheless, this change in the moral landscape has also been thought by some commentators to be caused by the attention given by moral philosophers to the various decisions made in the field of medicine itself. This change of focus was a counter-response to the shift to metaethics that dominated most of moral philosophy in the first half of the twentieth century. *See* Toulmin, Stephen. 1988. The recovery of practical philosophy. *The American* Scholar. 57.3 (Summer): 337-352.; Toulmin, Stephen. 1982. How medicine saved the life of ethics. *Perspectives in Biology and Medicine*. 25.4: 735-750.; Toulmin, Stephen. 1981. The tyranny of principles. *The Hastings Center Report*. 11.6: 31-39.

> another equally absolute principle; and by those who have *experience* and *discrimination* needed to balance conflicting considerations in the most humane way.[11]

Jonsen offers much the same reply as Toulmin when he claims the following:

> Circumstances are not, as the etymology of the word suggests, things that 'stand around'; they are as integral to the moral analysis as are principles. . . Moral judgment is a patterned whole into which principles, values, circumstances, and consequences must be fitted. The particular judgment itself must be fitted into a larger set of judgments about moral suitability of behavior and practice.[12]

It should be evident from the above two passages that JT embrace the very element that Kant thought was extremely deleterious to moral judgment. That is, JT insist that the particular details, events, and circumstances (i.e., "examples" in Kant's framework) that make up human existence are ineliminable as a means of producing particular moral judgments. Notice that this method of moral reasoning does not rely on abstract principles (e.g., Kant's Categorical Imperative or Utilitarianism's "greatest happiness for the greatest number"), but rather it "consists of thinking and talking about how the circumstances of this or that case of moral perplexity fit the general norms, rules, standards, and principles of morality. This is casuistry in life."[13]

Of course, all of this is rather vague, and provides very little in terms of understanding casuistry as a procedure for determining what to do in particular circumstances. Fortunately, JT provide seven features that capture their version of casuistry. They are as follows:

1. Similar type cases ("paradigms") serve as final objects of reference in moral arguments, creating initial "presumptions" that carry conclusive weight, absent "exceptional" circumstances.
2. In particular cases the first task is to decide which paradigms are directly relevant to the issues that each [paradigm] raises.
3. Substantive difficulties arise, first, if the paradigms fit current cases only ambiguously, so the presumptions they create are open to serious challenge.
4. Such difficulties arise also if two or more paradigms apply in conflicting ways, which must be mediated.

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[11] S. Toulmin. The tyranny of principles. *Supra* note 10: 34 (emphasis added). A variation of this resistance to moral theorizing is offered by Jonsen, Albert. 1991. Of balloons and bicycles; or, the relationship between ethical theory and practical judgment. *Hastings Center Report*. 21.5: 15. He says: "The weight of any ethical consideration comes, not from the principles or maxims invoked, but from the more fact-like considerations that are piled onto practical judgment." *Also, see* Kymlicka, William. 1996. Moral philosophy and public policy: The case of new reproductive technologies. In *Philosophical Perspectives on Bioethics*. Toronto: University of Toronto Press. 244-270. His analysis of reproductive technologies and public policy suggests that he would side with both Toulmin and Jonsen. Note, however, that Jonsen appears to be more sympathetic to the concerns of the moral theorist than is Toulmin.

[12] Jonsen, Albert. 1996. Morally appreciated circumstances: A theoretical problem for casuistry. In *Philosophical Perspectives on Bioethics*. Toronto: University of Toronto Press. 40 and 45.

[13] Jonsen, Albert. 1995. Casuistry: An alternative or complement to principles? *Kennedy Institute of Ethics Journal*. 5.3: 237.

5. The social and cultural history of moral practice reveals a progressive clarification of the "exceptions" admitted as rebutting the initial moral presumptions.
6. The same social and cultural history shows a progressive elucidation of the recognized type cases themselves.
7. Finally, cases may arise in which the factual basis of the paradigm is radically changed.[14]

In what follows and for the scope of this essay, I will provide an explanation of elements 1-4 of JT's casuistic approach by means of two examples. This will suffice to give the reader a clear sense of their casuistic method.

To begin, much like Aristotle did,[15] JT claim in their first point that there are acts or scenarios (i.e., paradigm cases) that are obviously good or bad, which are used as reference points to assess the goodness or badness of other acts. The closer a given case resembles the paradigm case, the more reason one has for resolving the given case like the paradigm case. The following two cases will help make clear how to understand JT's analysis. They are as follows:

Case One: The Foot-Stabbing Nurse

Imagine a nurse who randomly stabs his terminally ill cancer patients under their feet with an empty syringe simply for the enjoyment of watching them scream. Plead as they will, the nurse pays no attention to them and continues to inflict much pain on these people, who are unable to fend for themselves due to their many ailments. The nurse's only reply to the supplications of his cancer patients is, "What does it matter to you? You will be dead soon anyway."

Case Two: The Cleaning Nurses

Imagine another case in which a 70-year-old bed-ridden patient named Mary is diagnosed with a severe case of osteoporosis, and is currently on full oxygen support. Moreover, it is feared that she will not live for more than two years. Mary demands (in writing because she cannot speak with the breathing tube down her throat) that the cleaning of her oxygen apparatus be stopped. She insists that such cleaning is excruciatingly painful and earnestly entreats the nurses and doctor(s) to stop. The medical staff pays no heed to the patient's request and continues to clean her breathing apparatus on the hour, by the hour. The medical staff, as well as the patient, knows that death will be hastened, if this cleaning is not continued, in light of the patient's acute respiratory condition. In fact, as a final resort, Mary exclaims (in writing of course) in response to the continued cleaning of her breathing apparatus, "You might as well stab syringes in

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[14] A. Jonsen and S. Toulmin. *Supra* note 3, at 306-07.

[15] Aristotle says: "not every action nor every passion admits of a mean; for some have names that already imply badness, e.g., spite, shamelessness, envy, and in the case of actions adultery, theft, murder; for all of these and suchlike things imply by their names that they are themselves bad. . . It is not possible, then, ever to be right with regard to them; one must always be wrong." *Nicomachean Ethics*. Second Edition. 1999. Terence Irwin, Trans. Indianapolis: Hacket Publishing Company, Inc. Book II, ch. 2, 1107a9-15.

my foot!" Finally, the medical staff consents to Mary's wish. After a week, Mary dies of respiratory failure due to lung tissue deterioration.

Mary, the border-line terminally ill patient in Case Two, appears to be suggesting that her current plight is no different than that of those patients who are victims of the foot-stabbing nurse in Case One. Put another way, the actions of the nurses who are caring for Mary are morally indistinguishable from the actions of the foot-stabbing nurse, argues Mary. Is this possible? Put differently, are the nurses committing a violent act against a defenseless person, as the foot-stabbing nurse does against his patients? Should these nurses be punished like the foot-stabbing nurse?

No doubt, it is the case that Mary is defenseless. She barely has enough strength, given her respiratory difficulties and other physical ailments, to do anything more than write a few lines on a piece of paper. Both she and the medical staff agree on this point. The two parties part company, however, on their views about the moral status of the actions of the nurses. From the medical staff's perspective, the pain caused by the medical care they provide cannot be helped. Phlegm build-up in the breathing tube, they argue, makes breathing very difficult and will eventually render breathing impossible if left unattended. If the long-term benefits of comfortable breathing for the patient are to be ensured, the cleaning procedures must be continued, despite the accompanying suffering.

The patient's riposte, however, to the medical staff is that she is terminally ill. She suffers enough with her more pressing osteoporosis. This palliative care and its corresponding pain only increase her overall suffering. Even if a lack of care of the breathing tube increases the likelihood of respiratory failure, the patient insists that such maintenance must cease. The patient makes it clear in no uncertain terms that a hastened death is far superior to the hourly torture of breathing-tube cleaning. From the patient's perspective, then, to continue with this care in the face of her protestations is as wicked as the actions of the foot-stabbing nurse.

Let us now employ JT's casuistic approach to help resolve what is, admittedly, a rather contrived set of cases. Note that Case One is designed to capture the first of the seven elements stated above. It is supposed to be one of those cases that is obviously morally bad and will be referred to as "demarcation cases." As JT determine, these kinds of cases "are the markers or boundary stones that delimit the territory of 'moral' considerations in practice."[16]

First, we would want to know what criteria JT employ for determining what cases are obvious demarcation cases which "serve as final objects of reference in moral arguments."[17] In fact, they provide the following four "factors" (for lack of a better term), which generate what are presumed to be morally bad cases:

(1) willful physical harm/violence [against innocent and defenseless people];

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[16] A. Jonsen and S. Toulmin. *Supra* note 3: 307.

[17] Now one might think it is odd that there would be criteria to which JT want to appeal. Specifically, it seems like if JT are allowed to appeal to criteria as exemplifying the demarcation cases, why would not the criteria, rather than the demarcation cases, be the point of interest for ethicists? The upshot of this query would be that one would not need to depend on casuistry *qua* actual cases. One would have higher

(2) disloyalty to one's community;
(3) deception by lying;
(4) inconsiderate behavior toward another.[18]

Case One is of the sort that JT would consider being an obviously immoral act because it is a presumed case of "violence against innocent *defenseless* human beings."[19] In fact, such a case is so obviously morally degenerate that JT claim that "[n]o complex moral argument is needed to demonstrate that [it] is wrong."[20]

I will now explain features 2, 3, and 4 of JT's brand of casuistry (p. 149) in what follows, and will use Case Two, The Cleaning Nurses, for assistance. With regard to 2, we need (a) to determine what salient issues arise in this particular case so that (b) it is then possible to provide the paradigms relevant to the case. Of course, Jonsen is well aware that difficulties will arise in making such determinations and suggests what these difficulties might look like in features 3 and 4. First, then, how are we to determine the salient issues? Although not specified in detail in JT's groundbreaking *Abuse of Casuistry*, Jonsen has provided in his more recent efforts three concepts—(1) morphology, (2) taxonomy, and (3) kinetics—that are designed to answer this question.

Morphology

The morphology of a case consists of (a) descriptive elements, (b) maxims, (c) a structure, and (d) a substructure. The descriptive elements of a case include the "who, what, when, where, why, how, and by what means."[21] For example, in Case Two the descriptive elements would include the relationship between the medical staff and the patient, the current status of the terminal illness of the patient, the nurses' actual routine of cleaning the patient's breathing tube, the mental and physical distress of the patient, the patient's request for the termination of the cleaning of her breathing tube, the death of the patient, etc.

The maxims or important propositions related to Case Two could be "patient requests should be honored based on autonomy," "killing is strictly prohibited by medical practitioners," "relief of pain is the medical practitioner's main focus in caring for a terminally ill patient," etc.

The structure of a case includes both (i) the interplay between the descriptive elements of a specific case and the various relevant maxims and (ii) the structure of moral

principles guiding moral judgments, and one could simply assess these principles rather than the cases. In my critical section, I will return to this concern.

[18] A. Jonsen and S. Toulmin. *Supra* note 3: 306-307.

[19] *Ibid.*, 307-308 (emphasis added).

[20] *Ibid.*, 308. The example that JT use is that of child abuse. What, however, actually constitutes child abuse—from strong verbal reprimands to actual physical punishments—is a highly contentious issue. Nonetheless, we can assume that they are referring to cases of parents punishing their children through the use of a hot iron, for example. They seem to be suggesting that regardless of the details, such an act of punishment of a child on the part of any parent would be deemed morally unacceptable behavior.

[21] Jonsen, Albert. 1991. Casuistry as methodology in clinical ethics, *Theoretical Medicine* 12.4: 298. Note that Jonsen employs the famous "Debbie Case" to explain his views. *See* Anonymous 1998. It's over, Debbie. *Journal of the American Medical Association* 259.14: 272.

reasoning germane to a particular case. With regard to (i) and Case Two, it is the job of the casuist to figure out which maxims and descriptive elements are most pertinent to Mary's case (I will return to this point). Moreover, Jonsen claims that (ii) is a kind of reasoning that is "an invariant pattern of reasoning in which certain claims are related to grounds, warrants, backing, and modal qualifiers."[22] The moral reasoning in particular cases can be understood to have the following form:

> I *judge* that person(s) V should or should not perform act(s) W *because* of reason(s) X, *unless* circumstance(s) Y bears on the case Z.

Case Two, for example, might appear like this:

> I *judge* that the nursing staff should stop their breathing tube cleaning routine as Mary has requested *because* of the unbearable pain it causes her and the fact that she is terminally ill, *unless* there is a change in her diagnosis.

So, what Jonsen calls "the structure of practical discourse"[23] includes a moral claim(s), the moral claim's corresponding justification, and qualifications that might render the moral judgment inapplicable to the case.

Finally, the substructure of a case is "the invariant patterns of discourse." This element of morphology is what Jonsen calls the "topics" or "loci" that "provide familiar ground amidst the variable, complex circumstances of particular cases. Regardless of the specific content of the case (the circumstances), the forms of argument called topics remai[n] invariant."[24] The kinds of topics to which Jonsen is referring include both general and specific topics. The general topics include: physical causation vs. moral causation, killing vs. letting die, intention vs. foresight. These are topics that could be relevant to basically any act performed by an agent. The more specific topics involve: quality of a patient's life, preferences of the patient, economic considerations, and a patient's current clinical condition. These specific topics revolve around the details that relate to the particular medical condition of a patient. We could imagine that all of this substructure could be included in Case Two. That is, if the nurses do abide by Mary's wishes, they either killed her or let her die; they either did or did not cause her death, depending on whether an omission of care could be considered a relevant aspect of the concept of causation (either moral or medical); and they also may have intended to relieve Mary's pain, while foreseeing that she would die. With regard to the specific topics, Mary's quality of life could have been determined to be extremely poor; her preferences were made quite clearly to the medical staff; Mary is quite poor and is being financially supported by the state; and her clinical condition is that she has osteoporosis that has reached an advanced stage—that is, she is terminally ill and has no more than two years to live.

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[22] A. Jonsen. *Supra* note 21: 299.
[23] *Ibid.*, 299.
[24] *Ibid.*, 300.

Taxonomy

The second aspect of Jonsen's elaborated casuistic procedure is taxonomy. Taxonomy refers to the general "lineup" of cases to which a specific case will be compared. This lineup of cases includes a paradigm case that is generally agreed upon by most people to be morally wrong or right. The paradigm case is a case in which the maxim governing it is clearly thought to be correct with few people objecting to the chosen maxim. Additional cases are added with different circumstances to form a lineup of cases. These additional cases, which deviate from the original obvious paradigm case due to their different circumstances, are also judged to be morally good or bad cases. After a sufficient number of cases and the relevant moral judgments about the cases are gathered by the casuist, she then compares her current case to the lineup of cases. Then, she determines which case in the lineup most closely mirrors or approximates her current case under examination. The moral evaluation of the case in the lineup (i.e., the moral maxim generated from the case) that most closely resembles the case under examination will be the moral evaluation of the new case.

Case Two will help illustrate Jonsen's meaning of taxonomy. To begin, we need to know what general category Case Two falls under. It could be deemed a case that fits into the lineup of cases that has to do with killing, considering that the medical staff is well aware that the termination of care would hasten Mary's death. Alternatively, Case Two might be thought of as a case that should be couched within the lineup of cases that has to do with the hiring of medical personnel, since the people who acquiesced to Mary's request are involved (to some degree) in the events that ensued. Further still, Case Two might be a case that fits into the lineup of cases that deal with care for a patient. How do we decide to which category Case Two belongs? As I understand Jonsen, the answer is that a good ethicist who is familiar with many kinds of cases and who is educated and trained well "has the knack of doing this well and of showing others how to do this."[25] So, let us accept that the skilled ethicist has judged that the first category is more plausible as the appropriate category than is the second, since Mary's premature death was the result of a lack of medical attention that otherwise would have allowed her to live longer than she did (I will have more to say about this point in the critical section of the article). So, the ethicist determines that the category of killing is the appropriate general category from which a lineup of cases can be constructed.

A lineup of cases would reveal that at one end of the spectrum of killing are completely unjustified killings and at the other end of the spectrum are completely justified killings. In the former type of case, the maxim might be: "One ought never kill a person against his will—that is, murder is strictly prohibited." In the latter type of case, the maxim could be: "One may justifiably kill a person, if it is the only means of self-defense possible." As Jonsen notes, the casuist will eventually be confronted with a case of euthanasia and must decide where on the spectrum it lies. To do this, Jonsen suggests that the casuist should ask whether (1) a patient's competent request to have

[25] *Ibid.*, 307.

certain medical procedures terminated, along with (2) the patient's intractable pain or terminal illness, are acceptable conditions that allow for the patient to be assisted in being killed. If the answer is yes, then the corresponding maxim might be: "One ought not kill another person, except in those situations of self-defense and those circumstances in which a (near) terminally ill competent patient requests assistance in dying due to unbearable suffering."

As additional cases are provided in detail, they too are fit in along this spectrum. Some of these cases will lie more at the unjustified killing end of the spectrum, while others will fall closer to the justified killing end of the spectrum. If Case Two does not seem to be a case of unjustified killing, the casuist would then compare Case Two with the paradigm case of justifiable killing and other close cases of justified killing to see where Case Two fits into this spectrum. The closer Case Two is to the paradigm case, the more justified the casuist is in prescribing a course of action in Case Two that parallels the features of the chosen case on the spectrum. Although Case Two is not a case of self-defense, it does resemble those instances of euthanasia that are thought by Jonsen to be justifiable killings. So, a casuist like Jonsen would probably conclude that the actions (or omissions) of the medical staff in Case Two were morally acceptable, given the details of the case. Let us, however, look at Jonsen's last element, kinetics, to be sure how the casuist would handle Case Two.

Kinetics

Jonsen tells us that by "kinetics" he means "the way in which one case imparts a kind of moral movement to other cases. . . the motion is a shift in moral judgment between paradigm and analogous cases, so that one might say of the paradigm, 'this is clearly wrong' and of an analogous case, 'but, in this case, what was done was justified, or excusable.'"[26] It appears that kinetics is the change in judgment that corresponds to the change(s) that are perceived in a given case when compared to the paradigm case. Restated, the casuist is looking for a certain degree of, for example, autonomy, suffering, or patient-doctor closeness when compared to the paradigm case that has the right degree of each of these elements. For example, the casuist might judge that a terminally ill incompetent person, who is suffering greatly, cannot have his request for assistance in death honored because he is not competent to the right degree (which is determined in relation to the paradigm case). It might be thought, however, that Mary in Case Two should have her wish honored, because she has all the necessary degrees of the relevant circumstances. The obvious question is: "On what basis is one able to make such a judgment across cases?" Jonsen says that the answer is through "the wisdom of experience. . . [t]his knowledge is not deduced from principles but learned from reflective experience."[27]

Again, employing Case Two might prove helpful in understanding kinetics *qua* movement from a paradigm case to another case. In Case Two, the kinetics might move

[26] *Ibid.*, 303.
[27] *Ibid.*, 304.

from a paradigm case that would address the personal autonomy of a patient and the nature of a patient's illness to a case about the degree to which a patient is competent or clinically depressed and the degree of a patient's suffering. So, the casuist might judge in Case Two that the crucial movement is from a paradigm case concerned with the nature of Mary's illness and Mary's autonomy to the degree of Mary's competency and the degree of her suffering. Then, the casuist might determine ("moving" from the paradigm case) that, although Mary is not quite terminally ill, she is ill to a great enough degree and is both competent and suffering to a high enough degree such that the decision of the medical staff to withhold care is justified.

To summarize briefly, Jonsen argues that morphology, taxonomy, and kinetics are crucial aspects of the casuistic process that fill in the details of the following features mentioned earlier:

1. In particular cases the first task is to decide which paradigms are directly relevant to the issues that each [paradigm] raises.
2. Substantive difficulties arise, first, if the paradigms fit current cases only ambiguously, so the presumptions they create are open to serious challenge.
3. Such difficulties arise also if two or more paradigms apply in conflicting ways, which must be mediated.

It appears that Jonsen's elaborated account of casuistry is designed to handle features 2-4 (p. 149). First, the casuist *qua* morphologist is able to determine the circumstances, maxims, structures, and substructure of a particular case. After determining the structure of a case, the casuist *qua* taxonomist is able to determine which cases within a lineup of cases are most relevant to a particular case at hand. This resolves the problem of competing paradigms rendering conflicting resolutions to the case at hand. These abilities of the casuist should resolve, according to Jonsen, any difficulties or objections that present themselves in 2-4. Moreover, the casuist *qua* kineticist is able to "double-check" his efforts by being able to move from the particulars of a paradigm case—specifically, the maxim(s) and concepts such as autonomy, utility, competency, etc. that are generated from it—and determine to what degree the same relevant features are present in the case under scrutiny. Indeed, Jonsen is confident enough in his version of casuistry that he thinks that it "will be able to locate the case in a taxonomy of cases, recognize the similarities and differences and appreciate the shift from moral certainty to moral doubt. Above all, casuistic reasoning is prudential reasoning: appreciation of the relationship between paradigm and analogy, between maxim and circumstances, between the greater and less of circumstances as they bear on the claim and the rebuttals."[28] With these details in place, I will turn to a few obstacles to the JT brand of casuistry (and the details Jonsen has offered) that, at the very least, will dampen the fecundity that JT attribute to their casuistic method.

[28] *Ibid.*, 306.

Criticisms of JT's Brand of Casuistry

In this section, I will provide five standard objections, which are provided by Strong, to JT's brand of casuistry.[29] In the next section, I will provide Strong's confutation to these objections and my own reply to Strong. Recall that I will conclude, despite Strong's attempted rescue, that the JT version of casuistry cannot be salvaged as a legitimate method for resolving the moral difficulties that surround bioethics cases.

To begin, JT claim that their version of casuistry "resembles its medieval and Renaissance precursors, in both substance and methods of argument."[30] The first objection is that there is no agreed-upon moral foundation for the modern secular version of casuistry defended by JT that can be effective in the way that the version of casuistry defended in the late Middle Ages was. The older version of casuistry relied on interpretations of Christian doctrine to construct paradigms and resolve disputes. For instance, there was a concern as to whether or not it is morally permissible for Christians to eat meat that was offered to false idols by non-believers. 1 Corinithians 8 does not entirely forbid the consumption of such meat, but warns that doing so with full knowledge that the meat was presented to false idols could lead oneself and others into weakness regarding religion's rule-following. In these sorts of cases where the answer is not straightforward, a follower of the Catholic faith could endorse the interpretation of scripture taken by one theologian over another, even if such a position contradicted the fathers of the church. In some cases, the consumption of such meat was allowed, while in other cases it was prohibited. Such interpretations relied on textual ambiguity (e.g., some of the writings of Paul) or absence of textual rules entirely regarding the circumstances of a particular case. In these instances, theologians offered moral guidance on a case-by-case basis, drawing upon both their own insights and how related cases were historically resolved.[31]

Given that we live in a society that is comprised of a whole host of "philosophies" that range from organized religions to secular worldviews of all sorts—which can offer fairly detailed guidelines for how to live in the world—it will be quite common that these different "ways of living" will come into conflict. Indeed, issues concerning health and life-and-death medical procedures are areas where these differences in "ways of living" are most likely to clash.[32] For example, imagine a Jehovah's Witness who chooses to

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[29] C. Strong. *Supra* note 3: 404-408. I wish to make clear here that part of Strong's defense of JT's brand of casuistry is connected with his own two-paradigm version in this same article. I will not here evaluate the effectiveness of Strong's own version. Rather, in this essay, I restrict my analysis to why he thinks that the JT version should be exonerated of all but one of the criticisms leveled against it.

[30] A. Jonsen and S. Toulmin. *Supra* note 3: 306-307. For a variation on this criticism, see Wildes, Kevin. 1993. The priesthood of bioethics and the return of casuistry. *The Journal of Medicine and Philosophy.* 18.1: 36 and 43.

[31] For more on this history of Christian casuistry, see Vallance, Edmund and Harald Braun, eds. *Contexts of Conscience in the Early Modern World, 1500–1700.* New York: Palgrave McMillan.

[32] Recall the uproar over the Terri Schiavo persistent vegetative state case in Florida. For a brief reminder, see Quill, Timothy E. 2005. Terri Schiavo—A tragedy compounded. *New England Journal of Medicine.* 352.16: 1630-1633. *See also* Ananth, Mahesh. 2008. *In Defense of an Evolutionary Concept of Health* Aldershot: Ashgate Press. for a detailed account of the contentious debate surrounding the concept of health.

watch her child die rather than seek the requisite blood transfusion that would save her child's life (more on this example later). What is the paradigm case from which to judge this case? Recall that JT offer criteria that help demarcate "obviously bad" cases. Given these criteria, maybe the correct answer is that the Jehovah's Witness case is a paradigm case of "willful harm/violence to another," since the mother could have allowed the requisite medical attention to be given to her ailing child. No doubt, some people do think that there is very little moral difference between this case and the foot-stabbing nurse case as far as the notion of harm/violence is concerned. But it could be a case of "disloyalty to one's community," if the Jehovah's Witness were to allow the requisite medical treatment for her child. For she might be completely ostracized by her fellow Witnesses for contaminating her child's soul.

The point is that it is not at all clear how the JT method of casuistry can help determine which criteria should be given precedence when determining paradigm cases in such scenarios like food consumption and allowing a loved one to die. Without an authoritarian foundation or a shared morality to which most members of society are willing to acquiesce, it does not seem possible for the modern version of casuistry to provide justification for what will count as legitimate paradigms from which other cases will be judged. So, JT cannot rely on the medieval Christian version of casuistry, some critics have argued, in the context of a pluralistic society.

The second criticism, which is closely connected to the first, against the JT casuistic method is that it is not able to achieve extensive social concurrence on *all* issues. Strong claims that those who oppose casuistry insist that the supporters of this methodology think they can achieve consensus on all issues, but have failed to live up to their claims.[33] According to this criticism, casuists see themselves as offering a methodology that can resolve cases in the clinical setting that ranges over the most straightforward cases (e.g., the foot-stabbing nurse), the somewhat complicated cases (e.g., cases related to informed consent), and the most complicated cases (e.g., cases related to medical triage), because they can achieve consensus on the moral issues that lie behind this spectrum of cases. Regardless of how controversial a case may be, the casuistic method is seen by its opponents as claiming to be able to achieve unanimity amongst most people in society on all moral issues anywhere on the spectrum of cases noted here—a feat it cannot achieve in reality, claim the opponents.

The third objection against casuists is that they are unable to justify the values to which they adhere because they rely on a form of moral intuitionism—the ethical theory that certain values or moral concepts are directly known to be true through some kind of special insight or moral faculty. Specifically, Strong suggests that opponents of casuistry insist that the casuist's justification for why a particular paradigm case is thought to be the correct paradigm from which to evaluate some other case is based on

[33] Strong is referring to John Arras' critical commentary on the JT version of casuistry. *See* J. Arras. *Supra* note 10: 29-51.

an appeal to an intuition, either about the paradigm case simpliciter or about certain features of the paradigm case.

We can understand this third objection by briefly examining how JT handle the framework of the abortion case in the last chapter of their *The Abuse of Casuistry*. First, JT point out that neither conservatives nor liberals in the abortion debate distinguish the moral standing of a zygote from the moral standing of an advanced fetus. They go on to explain that the former conclude that an abortion is almost never permissible, while the latter insist that an abortion is almost always permissible. In contrast to both of these extreme views, JT insist that a more moderate middle-ground view should be embraced such that (all other details being equal) the abortion of a newly formed fetus is morally permissible in a way that the abortion of a late-term fetus is morally impermissible.

How do JT come to this conclusion? In general, they argue that the values of charity (being respectful of the details of a case) and equity (balancing one's moral decisions in the light of the details of a case) regarding the differences in the biological development of a newly formed zygote and a late-term fetus should move one to see that such differences make a moral difference. Additionally, in terms of both charity and equity, JT claim that the correct moral resolution is amplified once additional details (beyond biological development of the fetus) of a particular case of abortion are considered. For instance, if the parents of a newly pregnant thirteen year-old female insist that their daughter's pregnancy be terminated because the newly formed zygote is the product of rape, then termination of this pregnancy may very well be morally permissible once all other relevant details are in place. In contrast, if a woman chooses to terminate the life of her eight-month old fetus to spite her philandering husband, then these details (along with other details) may reveal that the desired termination is morally impermissible. As JT stress, "before we take a 'principled' stand toward particular cases of abortion, charity and equity require that we be informed about the circumstances of the particular case."[34]

In response to this account of the abortion debate, Kopelman points out that:

> conservatives and liberals also claim it is they alone who are truly charitable and equitable, and identify the relevant features embedded in the situation. The conservative finds a developing human life most significant, the liberal sees the woman's right to decide what happens to her body as most important, and the moderate sees an important value conflict requiring compromise.[35]

Kopelman's point is that even if we assume that charity and equity are the correct principles that govern the abortion debate, how these principles are applied to particular cases ends-up relying upon conflicting intuitions. For instance, as Kopelman points out above, the conservative will focus both charity and equity on the some perceived salient features of a particular case (e.g., likely long-term regret on the part of the parents and the mother or the moral innocence of the growing fetus), while the liberal will focus on a different set of perceived salient features (e.g., the autonomy of the mother or the

[34] A. Jonsen and S. Toulmin. *Supra* note 3: 337.

[35] Kopelman, Loretta M. 1994. Case method and casuistry: The problem of bias. *Theoretical Medicine.* 15.1: 32 (emphasis added).

lack of rights of the fetus relative to the rights of the mother) also employing the principles of charity and equity. *And* the moderate will choose a yet distinct set of perceived salient features (e.g., age of pregnant person and/or the origin of the pregnancy) via the principles of charity and equity. It is JT's inability to reconcile these conflicting sets of perceived salient features valued by these different camps in the abortion debate that moves Kopelman to conclude that JT's "*intuitions* about what is relevant, charitable and equitable, therefore, do not settle the abortion debate."[36]

The fourth objection to casuistry that is noted by Strong is that conflicting paradigm cases can always legitimately be generated so as to produce different conclusions about what to do in a given case. The result is that a medical practitioner is left paralyzed regarding what to do in a given case. For instance, what would be the correct paradigms under which an infant with anencephaly—that is, an infant born with large sections of its cranium, forebrain, and brainstem missing—would be evaluated for medical treatment, given that the mother of the child insists that the child receive medical care to the fullest extent? Would paradigm cases of justified killing be invoked if it were deemed a futile case? If so, the result would be the death of a child partially due to the omission of treatment on the part of the medical staff. Maybe, however, the correct paradigm cases are those in which proxy decision-making (in this case, the proxy is the mother of the child) is observed. If so, then all medical means would be provided with the result that the child lives a few days. Notice that despite the fact that the outcome—the death of the child—is the same, regardless of which decision is followed, the actions themselves are radically different. Under one set of paradigms, life-sustaining medical care is provided to the child. Under a different set of paradigms, the child receives no medical attention. The point, as far as this criticism is concerned, is that medical practitioners are left bewildered as to what to do, given the results of the different paradigms. So, practically speaking, casuistry is considered by some to be ineffectual in clinical settings.[37]

The final objection against casuistry is that "casuists cannot articulate the grounds of their decisions. Specifically. . . when casuists assert that a given case is close enough to [a] paradigm case to be decided in the same way as the paradigm, there are no fully articulated grounds for that judgment."[38] I take the criticism here to be that of a threshold problem—that is, it is not clear how many features or what percentage of the relevant features of a case under evaluation must be shared with the chosen paradigm case. As Strong makes clear, JT provide no help on how to determine what the line of demarcation would be. This justificatory silence on the part of JT even has one of their champions (namely, Strong himself) admitting that "it is not clear to me how Jonsen's

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[36] *Ibid.*, 337.

[37] As Tomlinson puts it, "the appeal to paradigm cases assumes that the proper ones have been selected for comparison, and in any contentious ethical question, where there are competing ethical considerations or maxims, there will also be alternative sets of paradigm cases to which analogies can be drawn." *See* Tomlinson, Tom. 1994. Casuistry in medical ethics: rehabilitated or repeat offender? *Theoretical Medicine*. 15.1: 13.

[38] C. Strong. *Supra* note 3: 407.

approach can be defended against this objection."[39] Given that Strong thinks that this objection cannot be overcome by the JT approach, it is reasonable to turn to Strong's defense of JT's version of casuistry against the first four objections and the reasons why his attempt to deflect them is unsuccessful.

A Rejoinder to Strong's Salvage Effort

Assessment of Objection #1

Now that we have what Strong takes to be the objections to casuistry, we can consider his defense of JT's version of casuistry against the first four criticisms. He says in reply to the first objection, which is the criticism that the JT brand of casuistry cannot be aligned with the medieval version of casuistry because the former is not privy to the agreed-upon moral infrastructure (i.e., Christian doctrines) embraced by the latter:

> [The Critic] overestimates what is needed in order for casuistry to be a useful method of reasoning. Admittedly, *some* shared moral assumptions are necessary; specifically, agreement is needed concerning the ethical values held to be relevant to cases and concerning moral judgments for at least *some* paradigm cases. Agreement over paradigm cases need not hold for every case we attempt to resolve, but only *enough* for casuistry to be generally helpful. However, this *amount* of agreement seems to be possible despite the existence of contemporary moral pluralism. People from diverse moral communities *generally* acknowledge and accept the main ethical values of secular bioethics, such as beneficence, autonomy, honesty, fidelity, fairness, and so on.[40]

Strong's reply to the first objection is not as effective as he thinks, for the following reasons. First, Strong does not make clear the difference between (a) "some moral assumptions" and (b) "ethical values," and he slides from (a) to (b) as if they were identical. Moral assumptions are generally related to issues and ethical concepts concerning duty, consequences, intuitions, and sentiments. In contrast, ethical values (or what are called principles) are captured by what Strong lists above (namely, beneficence, autonomy, etc.). The point here is that Strong is conflating the level of moral theory with the level of principles. If it is the case that Strong makes this conflation, then he would be suggesting that JT take seriously the importance of moral concepts (e.g., duty, intuitions, consequences, etc.) that are thought to be deeply embedded in moral theories. As I

[39] *Ibid.*, 407. At this point in the discussion, it might be thought that there is no need to belabor the analysis, since Strong concedes that the fifth objection cannot be overcome by JT. Restated, why care about the status of the first four objections, when the fifth objection cannot be met by JT's version of casuistry? I think the answer is three-fold: First, by employing a principle of charity, it seems only fair to give JT's analysis a philosophical fighting chance. It may be the case that a few or even all of the objections could be overcome with the help of Strong's critical salvage efforts. Second, Strong goes on in his own analysis to offer a way to get around the fifth objection confronting JT's account, but first he must show that the other four objections can be thwarted. Yet, I hope to make clear that even if Strong's version of casuistry were to overcome objection five, it still would need to overcome the other four objections, which I will argue are not so easy to dismiss. Third, by laying out all of the objections and rejoinders, I hope to offer a few additional criticisms that further debilitate the JT approach. The force of these additional criticisms are felt only upon examining both JT's and Strong's arguments.

[40] C. Strong. *Supra* note 3: 405 (emphasis added).

indicated in my earlier discussion, however, this adherence to moral theory is precisely what JT want to avoid. I submit that this conflation of (a) and (b) by Strong undermines JT's brand of casuistry, rather than supports it.

It might, however, be thought that Strong is using (a) and (b) synonymously, and this would discredit my above criticism. Charitably, I will grant this point. Even granting Strong this point, however, does not save him from what I will call the "threshold problem." Strong claims that agreements in paradigm cases need hold only for "enough" cases in order to see that casuistry is effective. The problem is that "enough" is a very cryptic term. He does not bother to spell out exactly what he means by "enough." Let us assume that the practitioners of the medieval version of casuistry were able to generate 98 percent agreement on paradigm cases. The question would be: What percentage must the current brand of casuistry successfully achieve, relative to the medieval version, in order to make sense of "enough"? Is 50 percent or 90 percent enough? Unfortunately, Strong provides no answer.

Moreover, Strong does not make clear what he means by "most cases." Again, let us assume that the medieval version of casuistry is able to generate 100 percent agreement on paradigm cases in straightforward cases and 95 percent agreement over controversial cases. Putting aside for the moment the added difficulty of determining what criteria distinguish a straightforward case from a controversial case (e.g., diet cases vs abortion cases), what kind of percentages over these two classes of cases must the new casuistry achieve in order to be considered "enough"? Restated, what is the percentage threshold that constitutes "enough" and why is that percentage acceptable? The point is that much more needs to be said in terms of percentages and how those percentages range over the two classes of cases in order for this claim to be an effective reply to the first criticism. So, as it stands, Strong's attempt to save the first criticism is not successful because he does not address adequately the threshold problem.

Still, Strong could reply to this threshold problem by stipulating a fairly high percentage (e.g., 80 percent) and the corresponding empirical evidence (e.g., statistical evidence that shows agreement between doctors and patients) that constitutes "enough" and thus brush aside this problem as well. Again, I will concede this reply and offer what I take to be a rather damaging criticism that Strong cannot so easily evade. To the point, Strong gives the impression that agreement on ethical values will be easy to come by, which will in turn make paradigm cases easy to generate.

The above reply that Strong could make misses the point of the actual criticism in a few ways. First, the concern is not *primarily* whether or not casuistry is a useful method. The concern is that of justification and generation of moral values and paradigm cases. With regard to the medieval version of casuistry, conflict resolution had its origin ultimately in the authority of biblical interpretations provided by the religious figures of the day (e.g., the eating of meat offered to false idols by non-believers). These religious figures provided claims of the sort: "Values W and X are more relevant than values Y and Z because W and X reflect doctrines A and B of the Bible on our inter-

pretation of passages C and D of the Bible." Moreover, moral values could be further justified in relation to a specific eschatology—i.e., the potential survival of the soul into one of two realms, heaven or hell, based on one's doings in the earthly realm. It is this background—the idea of "meeting one's Maker"—that ultimately could be relied upon by medieval religious figures in justifying the adherence to a particular decision. It is the combination of (1) the affirmed authority of religious figures, (2) the word of God as put forth in the Bible, and (3) the consequences of not obeying the commands given by (1) and those "divine laws" in (2) that both generates and justifies particular moral judgments and paradigms about specific cases. The secular modern version of bioethical casuistry has no such infrastructure upon which to rely, due to the moral pluralism that permeates contemporary society. Thus, Strong's attempt to argue for a reasonable connection between medieval casuistry and contemporary casuistry is, at best, underdeveloped.

Assessment of Objection #2

The second objection is the claim that casuistry is not able to achieve consensus on all moral issues. Strong's reply to this objection is rather straightforward. He says that anyone who offers this criticism

> greatly over-estimates the ambitions of casuistry and. . . places unreasonable demands upon it. Casuists neither seek nor expect *society-wide consensus* concerning *all* conclusions reached by casuistic argumentation. Casuistry could be described as seeking conclusions that are hypothetical rather than categorical: they are reasonable if one accepts certain assumptions about ethical values and paradigm cases.[41]

To begin, Strong has misrepresented the JT version of casuistry. I take it that the possibilities are as follows with regard to the scope of casuistry:

A. If one accepts the tenets of the JT brand of casuistry, then it can help resolve *all* cases in medical settings.
B. If one accepts the tenets of the JT brand of casuistry, then it can help resolve *most* cases in medical settings.
C. It is possible to convince society as a whole, given all the details of any medical case, that a particular conclusion about a particular case is *most likely* the correct decision.
D. It is possible to convince society as a whole, given all the details of any medical case, that a particular conclusion about a particular case is *absolutely* the correct decision.

As I understand Strong's position, he thinks that either (A) or (B) is the correct way to understand the JT version of casuistry. Jonsen, however, is quite clear about the

[41] C. Strong. *Supra* note 3: 407 (emphasis added). This point is supported by Hunter, who explains, "This ingrained awareness of the potential variability of the individual case is also related to what philosophers on occasion have described as physicians' unwillingness–some have said their inability–to generalize about ethical issues. Pressed for a solution to a moral dilemma, a physician is likely to answer, 'It depends–'." *See* Hunter, Kathryn M. 1989. A science of individuals: medicine and casuistry. *The Journal of Medicine and Philosophy.* 14.2: 201-202.

scope of his version of casuistry.[42] The following three claims made by Jonsen are rather telling on this point:

1. "[T]he ordinary course of moral judgment—and I mean even the difficult cases that arise within settled practices and institutions—are resolved by casuistry rather than by recourse to theory."[43]
2. "The prudent person also appreciates the way in which certain actions, under certain circumstances, correspond to the ideals that he or she credits. In both the social and personal realm, prudent judgment apprehends the fit of maxims and circumstances."[44]
3. "Justification of any particular moral claim comes rarely from a single principle, as many theories would like, but usually from the convergence of many considerations, each partially persuasive but together convincing with plausible probability."[45]

Taken together, these three claims by Jonsen reveal that he thinks casuistry can handle the difficult cases in medical settings (better than traditional moral theories can), which the prudent person is able to determine by employing the appropriate maxims for both herself and society as a whole, and can come to a decision that is "convincing with plausible probability." If this interpretation of the JT thesis is correct, then I submit that it resembles interpretation (C) above. That is, JT do think that it is possible to convince society as a whole, given all the details of any medical case, that a particular conclusion about a particular case is *most likely* the correct decision. Contrary to Strong's interpretation, the JT version of casuistry should not be interpreted in the conditional sense of (A) or (B).

Now that we have an accurate account of the scope of the JT version of casuistry, we are in a position to see why the second original objection still holds. The second original objection is that we live in a society that is fragmented fundamentally with regard to the justifications that underlie controversial issues in the medical arena. Is it unjust that people not be given a basic level of medical care? Is it acceptable for a woman to do with her body as she wishes? No doubt, the plethora of religions, cultures, and secular viewpoints that coexist in the United States will result in diametrically opposed answers to these and other controversial questions. The possibility of "most likely" convincing religious fundamentalists, who make up a fairly large association in the United States, that abortion or euthanasia is sometimes acceptable does not at all appear to be an end that can be achieved by the JT casuistic method. For no discussion on paradigm cases can compete with "the word of God." As Arras articulates it: "Contrary to the assuranc-

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[42] The reader should note that possibilities (A) and (B) concern the truth of the entire conditional—not merely the truth of the consequents.

[43] A. Jonsen. *Supra* note 13:246.

[44] A. Jonsen. *Supra* note 21: 304.

[45] A. Jonsen. *Supra* note 11:15.

es of Jonsen and Toulmin, the new casuistry is an unlikely instrument for generating consensus in a moral world fractured by conflicting values and intuitions."[46]

Assessment of Objection #3

The third objection to the JT version of casuistry is that it relies on a version of intuitionism in which moral judgments depend on a prudent person's own "moral insights" regarding what actions are either right or wrong. Strong replies to this criticism that "it fails to consider [Jonsen's] comments on the structure of moral argument in casuistry."[47] Unfortunately, Strong does not say much more about this point. In order to make sense of Strong's claim, I will recapitulate briefly my interpretation of Jonsen's views about the structure of moral argument in casuistry that I provided earlier.

Recall that moral reasoning in particular cases, according to Jonsen, would be as follows:

> I *judge* that person(s) V should or should not perform act(s) W *because* of reason(s) X, *unless* circumstance(s) Y bears on the case Z.

So, the Jehovah's Witness example provided earlier might be constructed as follows:

> I *qua* doctor judge that the refusal of blood transfusion treatments for the father of this family be honored *because* patient autonomy and the voluntary nature of the father's request must be respected, *unless* it is known that the father is the sole provider of his family.

The immediate question that comes to mind is "Why should one accept patient autonomy as an acceptable justification to let this patient die?" Moreover, if patient autonomy is the correct principle that governs this case, what justifies abandoning the patient's request when it comes to be known that he is the only "bread winner" in the family? Keep in mind that the concern here is an epistemic one—that is, how does the doctor *know* that reason(s) X and mitigating circumstance(s) Y are those that should be relied upon in this particular case? Although Jonsen does not directly address this case, he does give a general answer. He says:

> The prudent person has *the knack of recognizing* that following this or that maxim, in these or those circumstances, contributes to the support of strengthening of the relevant social institutions or that, contrariwise, certain actions will undermine or modify the institution in certain ways. . . The prudent person can be quite ordinary, but is marked by *'common sense'* joined to experience and linked to the ideals that makes [*sic*] possible good judgments. In addition [he] must be educated in the issues of his field. Such education consists, in great part, in knowing the cases. Knowing the cases means familiarity with the circumstances, maxims and arguments that make each case unique and, at the same time, make it fit into a taxonomy. If there is any sense in which [he] can rightly be called an expert, it is because [he] has *the knack of doing* this well and of showing others how to do it.[48]

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[46] J. Arras. *Supra* note 10:43.

[47] C. Strong. *Supra* note 3: 406.

[48] A. Jonsen. *Supra* note 21: 304 and 306. In another article, Jonsen similarly says: "Moral judgment is a patterned whole into which principles, values, circumstances must be fitted. The particular judgment

According to what Jonsen tells us in the above quotation, the prudent man has a knack for recognizing and doing the right thing in a particular case based on (1) "common sense," (2) relevant education, and (3) knowledge of cases. Relevant education is fairly clear. The prudent person *qua* doctor surely must have the requisite medical training and medical education in order both to determine the health status of her patients and to provide the appropriate medical care to her patients. Additionally, as part of the doctor's education, she must also have knowledge of the "issues" of her field, which includes the ability to fit correctly her current cases into the appropriate taxonomy of cases. This knowledge and ability to fit cases correctly, Jonsen tells us, is "learned from reflective experience" and "comes from the wisdom of experience."[49] "Common sense," given Jonsen's account, emerges as a result of wisdom and reflection based on experiences.

These are lofty expressions but they actually convey very little. To see this, let us return to the Jehovah's Witness case. Imagine that the doctor has had several Jehovah's Witness cases in the past. Given these past cases, one could argue that the doctor was able to determine that patient autonomy and the relevant family circumstances were essential in her reasoning. However, this does not really solve the epistemic concern. The problem is that the doctor had to make a decision concerning *the first* Jehovah's Witness case, where the patient waved off life-saving treatment, in which the doctor was not able to rely on any past experiences or cases that were similar to it. What was the justification of *that first decision* on the part of the doctor? Did it "fit" into a freedom of religion category? Did it fit into a case of patient autonomy? Was the psychological well-being of the patient called into question in that first case? Given the fragmented nature of society on moral issues, the doctor could not rely on what "society thinks is right." The point is that the doctor would have had to rely on *something* in order to determine the right decision. It seems, at first glance, that the doctor would have had to rely on her own *intuition* about what is the right thing to do in this first Jehovah's Witness case. More generally, every straightforward case and complex case will have a corresponding first case in which a doctor will not be able to rely on any past specific cases. In the end, the casuist has recourse only to her own intuitions so that the process of paradigm recognition and the development of "common sense" can get off the ground. Notice that Strong's reference to Jonsen's understanding of the structure of casuistic reasoning does not support the JT thesis against the charge of intuitionism. Thus, the objection of intuitionism still holds against JT's version of casuistry.

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itself must be fitted into a larger set of judgments about moral suitability of behavior and practices. Fittingness suggests how we 'morally appreciate' the circumstances of a case. Appreciation is, originally, an esthetic concept: we appreciate a painting, a landscape, a symphony, a good play, whether drama or a throw from shortstop to second to first. This sort of esthetic appreciation arises, in part, from the harmonious fitting together of various elements that may be, in themselves, heterogeneous. A moral judgment about a case is, I think, similar. Principles, values, circumstances, and consequences must be seen as a whole. The judgment about them comprises all of them." *See* A. Jonsen. *Supra* note 12:45.

[49] A. Jonsen. *Supra* note 21: 304-305.

Assessment of Objection #4

The fourth objection to JT's "new casuistry" is that alternative sets of paradigms can be chosen by medical practitioners and these sets of paradigms can result in conflicting conclusions about what to do in a given case. Strong's attempt to avert this criticism offered by Tomlinson[50] is as follows:

> The proper reply, I believe, is to express skepticism that there is such a problem. It is important to note that Tomlinson does not succeed in illustrating this supposed problem. [In a particular case] Tomlinson asks whether an alternative taxonomy is possible, involving a paradigm case of 'care of the patient,' rather than killing. However, Tomlinson does not actually put forward such a paradigm, much less show that using it would lead to a different solution.[51]

Rather than providing an actual criticism of the fourth objection, Strong's reply in the above passage could be interpreted as a challenge. The challenge could take the following form: If it can be shown that alternative sets of paradigms can be determined for a particular case and that these sets of paradigms lead to conflicting decisions, then Tomlinson's criticism will have been vindicated. I will take this challenge and confirm Tomlinson's worry.

I will employ one of Strong's own cases as part of my response to him. The case is as follows:

> An eight-day-old female infant was diagnosed as having erythroblastosis fetalis, or Rh disease. The conditions that cause this disease arise when fetal blood containing a specific antigen enters the bloodstream of a mother whose blood lacks that antigen. Maternal antibodies are then produced, and in subsequent pregnancies the antibodies cross the placenta and attack fetal blood cells that have the antigen. In this case, the infant was rapidly losing her red blood cells due to hemolysis caused by the antibodies. The physician informed the parents that the child needed blood transfusions to survive. However, the parents were Jehovah's Witnesses and refused to permit transfusions for the infant. Without transfusions, it was highly probable that the patient would die. In the unlikely event that she would survive without transfusions, she probably would have brain damage and mental retardation caused by hypoxia resulting from the low red blood cell count. Blood transfusions are effective in treating Rh disease and would likely result in the survival of a healthy child. For this type of case, the transfusion therapy itself has a risk of mortality estimated to be three deaths per 1000 cases.[52]

To begin, this case is fundamentally about whether or not care (i.e., blood transfusions) should be provided for this child. If blood transfusions are performed, then the chances are rather high that the child will develop in a healthy fashion. If blood transfusions are not performed, then the chances are high that the child will die or will suffer brain damage/retardation. There is one very important element missing from this description—an element that Strong himself omits. If the blood transfusion is *not*

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[50] *See* T. Tomlinson's criticism. *Supra* note 37.

[51] C. Strong. *Supra* note 3: 406.

[52] *Ibid.*, 401.

performed, then not only is it the case that the child will die or suffer brain damage, *but*, according to a Jehovah's Witness, she will also have *a soul* that is completely pure. This second conjunct is crucial in order to describe the case as carefully as possible, an indispensable criterion for the casuist. What should the attending physician(s) do in this case? Let us turn to the JT approach in order to determine what to do.

I will not here provide all the details of the morphology of this case. Recall that morphology is the descriptive elements of a case that includes the "who, what, when, where, why, how, and by what means." Strong describes the case robustly enough so that the reader could easily determine these details.

I will now turn to Jonsen's criterion of taxonomy. To begin, we need to know the general taxonomy under which this case falls. A doctor could claim that this case fits under the paradigm case of *care of a patient*. The spectrum of cases can range from justified care of a patient to those cases of unjustified care of a patient. Within this spectrum, the well-being of a child versus parental authority is relevant, for parents do have some degree of authority over the lives of their children. Along the spectrum of cases that fit this general paradigm could be the punishment of children, the education of children, the health care of children, and so on. Given that medical treatment is the concern in this case, the health care of children would be the appropriate specific category from which to judge this case. Further, there is a spectrum of cases that range from justified parental intervention with regard to their child's health and unjustified parental intervention with regard to their child's health. This doctor could argue that given the potential harm that could befall the child as a result of omission of care, the well-being of the child is more important than the authority of the parents.

Furthermore, the doctor could argue, given Jonsen's account of kinetics—that is, the shift in moral judgment from paradigm cases to analogous cases based on perceived features of the particular case at hand—that the decision of the parents not to allow care for their child in this case is much like a very severe case of child neglect. The result is that this case is more on the unjustified-parental-intervention-with-regard-to-their-child's-health end of the spectrum. The doctor in this case could conclude that a court order forcing the parents to allow the transfusions to be performed is the correct decision. So, under the general classification of patient care and the much more specific paradigm of the health care of children, the blood transfusions should be given to the child. The results of this decision would be that the child would probably live without any major health problems and would live (in the eyes of a Jehovah's Witness) along with a damaged soul.

I will offer a plausible alternative interpretation of this case. Let us assume that the doctors have tried with all their might to persuade this couple to allow the transfusions to occur. Yet, in the end, the couple refuses to accept their medical advice, offering a detailed account of how their child's soul will be damaged from such medical care. Let us further assume that the child dies partially due to not receiving the blood transfusions (I say "partially" because causation is a complicated issue, given that both

proximate and distal causes play contributory roles in effects). The doctor involved in this case could claim that this is a case of justified killing. Let me explain. After a long discussion with the parents and upon much reflection about their beliefs, the doctor could claim that the correct paradigm case from which to judge this case is that of killing. Within the paradigm of killing, there is a spectrum that ranges from both justified killings to unjustified killings. More specifically, the spectrum ranges from the justified to the unjustified killings of infants. For example, at one end of the spectrum, it might be morally justifiable to kill an infant if it may save the lives of many other infants and, at the other end of the spectrum, it might be morally unjustifiable to kill an infant to spite one's morally bankrupt spouse. As I understand Jonsen's procedure, the trick is to figure out where this case fits along this particular spectrum.

Now, we have to include Jonsen's notion of kinetics. Within this spectrum of killings, it could be argued by the doctor involved in this case that the religious beliefs of the parents take precedence over any secular notions of harm. On this view, it is true that the parents will have allowed their child to die, but their justification is that the next life of the soul of their child will be blessed truly. On this interpretation, the allowing of one's child to die for the sake of one's child's soul is more on the justified side of the spectrum than on the unjustified side. (For the sake of this discussion, I will ignore the killing versus letting die distinction.) So, the added details of the religious beliefs of the parents has "moved" this case to a case of justified killing from that of unjustified killing. It follows, then, that under the general paradigm of killing, the correct decision is to abide by the wishes of the parents not to administer the blood transfusions and not to acquire a court order against the parents. The results of this decision are that the child will probably die or suffer severe brain damage and will be in possession of an uncontaminated soul.

To summarize what has transpired in this Jehovah's Witness case, I provided one scenario in which the correct decision is to proceed with the blood transfusions in order to save the life of the child. The justification for this decision is the result of a combination of the general paradigm case of patient care and the more specific case of excessive parental authority in the health of a child from which this case was judged. On the other hand, I provided another scenario in which the paradigm case was killing. Given the religious beliefs of the parents, I argued that this case was more along the lines of justified killing, specifically justified killing of an infant. I then concluded that the correct decision in this case is that the doctors should respect the wishes of the parents and that the child should not be given the blood transfusions.[53] The result of this

[53] Although he does not go in this direction, Strong could reply that Jehovah's Witness cases do not really pose a societal threat because such cases are really outlier scenarios. Thus, his defense of JT's casuistic approach need not have to reconcile such medically recondite scenarios. This is a reasonable rejoinder, but legal precedent, even in outlier cases, can have genuine mainstream implications. Consider, by analogy, the *Yoder* decision (*Wisconsin v. Yoder, et al.* 1975) that it is not compulsory for Amish communities to have their children publically educated beyond the eighth grade. As a result of this decision made in favor of an "outlier group," many religious groups have pursued legal recourse in order to seek religious exemptions from standard applicable law (*see* Shulman, Jeffrey. 2014. *The Constitutional Parent: Rights, Responsibilities,*

analysis is that I have met Strong's challenge and have vindicated Tomlinson's criticism that alternative sets of paradigms can generate alternative conflicting decisions on what to do in a given case through the use of the JT casuistic method.

Further Concerns

Before concluding this essay, I would like to provide two additional criticisms of JT's version of casuistry that have been overlooked in the literature to this point. Throughout this essay, I have avoided mentioning any of the major philosophical problems that are frequently debated by philosophers in the field of medical ethics. I am referring to debates surrounding the understanding of concepts such as "harm" or "pain," the debate about whether there is a meaningful distinction between "killing" and "letting die," or the concern over whether or not act-omission is a relevant feature of causation, and so on. The reason for the absence of an analysis of these issues in this essay is the result of the specific nature of Jonsen's subdivisions within his basic category of morphology. Specifically, it is the subcategory of *substructure* that I want to evaluate.

Recall that Jonsen thinks that there are "invariant patterns of discourse" within practical discourse (see morphology discussion, pp. 152-53). As Jonsen says, "Regardless of the specific content of the case (the circumstances), the forms of argument called topics [remain] invariant." For example, imagine a case where a doctor gives his (consenting and requesting) terminally ill patient a large dosage of morphine knowing full well that this amount will cause his patient to die (i.e., the doctor knows that respiratory suppression and then death of the patient will ensue as a result of the morphine injection). Is this a case of killing or letting die? Jonsen claims the following regarding the doctor's actions:

> Certain points must be covered in order to make the case for or against his moral accountability. Among these points, *intention is always relevant.* [In the above case], the [doctor's] intention, whether to kill or to assuage pain, must be reviewed, since he used a means, morphine, which will do both. Is he killing or merely helping her to be more comfortable and only allowing her to die? The casuists' distinction between direct and indirect killing was crafted for this situation. This distinction, and its larger formulation as the so called Principle of Double Effect, has fallen into disfavor with philosophers in recent years. However, that disfavor stems, I believe, from thinking of the distinction as *a principle* rather than as *a general topic*, an invariant form of argument that fits within any discourse about moral accountability and moral causality.[54]

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and the Enfranchisement of the Child. New Haven: Yale University Press and Johnson-Weiner, Karen. 2015. Old order Amish education: The Yoder decision in the 21st Century. *Journal of Amish and Plain Anabaptist Studies* 3.1: 25-44 for more on the legal and social implications—both within and outside of the Amish community—of this landmark decision). Thus, at the very least, it is not obvious that societal harm is not very likely with respect to Jehovah's Witness cases.

[54] A. Jonsen. *Supra* note 21:300 (emphasis added). For an excellent example of some of those philosophers who argue about the killing versus letting die distinction that Jonsen has in mind, *see* Steinbock, Bonnie and Alastair Norcross, eds. 1994. *Killing and Letting Die.* Second Edition. New York: Fordham University Press and Dworkin, Gerald, R. G. Frey, and Sissela Bok. 1998. *Euthanasia and Physician-Assisted Suicide.* Cambridge: Cambridge University Press.

Jonsen's remarks in the above passage are, at the very least, some cause for concern. I will mention two of those concerns, a primary and a secondary concern. The primary concern I have is that Jonsen appears to contradict himself when he stipulates that intention must always be taken into consideration when determining whether or not a doctor is or is not morally culpable for his actions *qua* doctor. It should be the case that nothing (or very little) should be accepted *a priori* by the JT-type casuist without first examining the particular case under consideration. For example, in a particular case of physician-assisted suicide, the most crucial factor in the case might be that *the consequences* of keeping the terminally ill patient alive or terminating the life of the terminally ill patient greatly outweighs taking seriously any other considerations, including the doctor's intentions. I am not insisting that such a case has actually come to be in the case of care for terminally ill patients. Nonetheless, it is a possibility that cannot be ruled out by the JT-type casuist—every case must be judged independently of any other case because nuances may arise in the particular case under investigation that may very well "morally move" the case in one direction or another. So, at the very least, there is an incongruity between Jonsen's claim that "[e]ach case is unique in its circumstances, yet similar in type to other cases and can therefore, be compared and contrasted"[55] and his insistence that certain moral concepts (e.g., intentionality) are always morally relevant.

A secondary concern I have is that closer scrutiny of Jonsen's distinction between (1) a principle and (2) a general topic could very well result in the kind of intractable problems he thought were faced by those who insist that a particular moral theory should guide decision-making in medical cases. Jonsen says that practical (medical) discourse has arguments that "have invariant patterns that can, and must be used, in any substantive argument."[56] What one would want to know is what constitutes an invariant feature such that one could decide that causation and intentionality are invariant features of all cases and belong in the subcategory of "general topic," while features X, Y, and Z are not invariant features of cases and belong in the category of "principle." If a more rigorous account of invariance is not provided, then one could insist that some feature(s) that one holds to be important should be included as an invariant feature. For example, the consequentialist could reply that not only are causation and intentionality invariant features of a case, but so are consequences.

If the above analysis is correct, then exactly the problems faced by those who espouse a particular moral theory will come to haunt the JT version of casuistry as well. For Jonsen now has to give an account of what invariant feature—e.g., intentionality or consequence—is the more important invariant feature in determining the moral culpability of a doctor's action(s) in a particular case. If, as Jonsen thinks, one would be unable to make a morally acceptable decision through the traditional top-down moral-theoretic approach, then one would have just as much difficulty in determining what the morally acceptable course of action would be under his system. Putting aside

[55] A. Jonsen. *Supra* note 13: 241.
[56] A. Jonsen. *Supra* note 21: 299.

any other difficulties with Jonsen's account, his principle/general topic distinction would leave him just as "paralyzed" as the moral theorist.

Final Remarks

In this essay, I provided an analysis of a version of "The New Casuistry" proffered by JT. After providing a brief historical backdrop and the details of the JT version of casuistry, I explicated five criticisms that, when taken together, seem to render this version of casuistry ineffectual in providing a strategy for decision-making in medical settings. Despite the apparent force of these criticisms, Strong offers what he takes to be a definitive reply to four of the five of these criticisms. His conclusion is that, for the most part, the JT brand of casuistry is a rather effective means of determining what to do in medical settings. My analysis, however, has revealed that Strong has not shown satisfactorily that the JT version of casuistry can withstand these four criticisms. Moreover, I offered two criticisms of my own which indicate that the JT brand of casuistry suffers from some of the same difficulties that JT think are deeply problematic with the traditional "top-down" moral-theoretic approach. Finally, let me say that I agree with JT and Strong that matters of life and death require much philosophical reflection. Moreover, there is little doubt that their efforts have revealed that cases in medical ethics cannot be trivialized given that human life hangs in the balance—the details of cases need to be presented in all their complexity. Although I do not think that JT's brand of casuistry can be reduced to Kant's "chit chat of everyday life," I maintain that it is not a serviceable procedure from which to determine what to do in medical settings in the light of such complexity.

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