

Empirical Ethics, Context-Sensitivity, and Contextualism

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In medical ethics, business ethics, and some branches of political philosophy (multi-culturalism, issues of just allocation, and equitable distribution) the literature increasingly combines insights from ethics and the social sciences. Some authors in medical ethics even speak of a new phase in the history of ethics, hailing “empirical ethics” as a logical next step in the development of practical ethics after the turn to “applied ethics.” The name empirical ethics is ill-chosen because of its associations with “descriptive ethics.” Unlike descriptive ethics, however, empirical ethics aims to be both descriptive and normative. The first question on which I focus is what kind of empirical research is used by empirical ethics and for which purposes. I argue that the ultimate aim of all empirical ethics is to improve the context-sensitivity of ethics. The second question is whether empirical ethics is essentially connected with specific positions in meta-ethics. I show that in some kinds of meta-ethical theories, which I categorize as broad contextualist theories, there is an intrinsic need for connecting normative ethics with empirical social research. But context-sensitivity is a goal that can be aimed for from any meta-ethical position.

Keywords: *context-sensitivity, (epistemic) contextualism, empirical ethics*

I. INTRODUCTION

In medical ethics, business ethics, and some branches of political philosophy (multi-culturalism, issues of just allocation and equitable distribution) the literature increasingly combines insights from ethics and the social sciences.

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Some authors in medical ethics even speak of a new phase in the history of ethics, hailing “empirical ethics” as a logical next step in the development of practical ethics after the turn to “applied ethics.” The name empirical ethics is ill-chosen because of its associations with “descriptive ethics.” Unlike descriptive ethics, however, empirical ethics aims to be both descriptive and normative. Empirical ethics differs from morally relevant empirical research as well as from empirically well-informed practical ethics. Empirical ethics combines doing empirical—usually qualitative—(social) research with philosophical (normative ethical) analysis and reflection.¹ An outsider to the field, I became interested in empirical ethics because it takes seriously the intention of all practical ethics, not only to prescribe actions, but also to actually guide people in their behavior. This is, in my view, the truth of empirical ethics.

I am not going to present or defend a particular conception of empirical ethics. My aim is more hermeneutical. I want to understand what empirical ethics is, what it is meant to do and why people think it necessary for ethics to become empirical. In addition, I analyse the meta-ethical presuppositions of conceptions of empirical ethics. I concentrate on two questions. The first one is: What kind of empirical research is used by empirical ethics and for which purposes? I argue that the ultimate aim of all empirical ethics is to improve the context-sensitivity of ethics. The second question is whether empirical ethics is essentially connected with specific positions in meta-ethics. I show that in some kinds of meta-ethical theories, which I categorize as broad contextualist theories, there is an intrinsic need for connecting normative ethics with empirical social research. But context-sensitivity is a goal that can—and should—be aimed for from any meta-ethical position.

In Section II, I analyze and categorize views of authors in medical ethics and in medical sociology on the relevance of social research for ethics. In general terms, social research is held to be relevant for furthering the context-sensitivity of ethics and for doing justice to its contextuality. In Section III, I discuss the meaning of the need for ethics to become (more) context-sensitive and whether the demands of context-sensitivity can be met from every meta-ethical theory.

Sections IV to VI discuss the contextualist approaches to empirical ethics. Contextualists view “context” not only as *a field for applying ethics*, but also as *a source of morality*. Contextualist ethics starts from the opinions and the conduct of those involved in a social practice and rejects importing alien, external principles into a context. For purposes of this article, I use a broad definition of contextualism that encompasses both coherentism and strong epistemic contextualism. Coherentist theories need the social sciences in order to find out what peoples’ intuitions or well-considered judgements are. Epistemic contextualist theories need to know what the basic judgements in a practice are and how people justify their judgements in that

practice. Thus, contextualist empirical ethics depends on social research; from a contextualist point of view the relation between ethics and the social sciences is intrinsic.

II. DIFFERENT VIEWS ON THE ROLE OF EMPIRICAL RESEARCH IN ETHICS

Before the term empirical ethics was introduced, ethicists as well as empirical researchers already reflected on the role of social research in (mainly medical) ethics. A review of their publications reveals four different goals that are regarded as necessitating the introduction of empirical research into (practical) ethics:²

1. description and analysis of the actual conduct of a group with respect to a morally relevant issue;
2. identification of moral issues that escaped the attention of ethicists, but are relevant in a specific context;
3. description and analysis of the cultural and institutional aspects of a context or practice – procedures, processes, nature of the relations between subjects, their beliefs, attitudes, and so on – relevant for evaluating the practicality of ethical guidelines and principles;
4. description and analysis of the actual moral opinions and reasoning patterns of those involved in a practice.

A. Research into Actual Conduct

Participants in discussions about the desirability of moral or legal regulations often start from assumptions about the actual conduct of (one of) the parties. A major assumption in the Dutch debate on “legalising” euthanasia was that doctors would be more willing to report euthanasia cases once they would no longer be prosecuted, on condition that they complied with the so-called “rules of due care.”³ Honest and reliable reporting by doctors who apply euthanasia is now the only means to keep a public eye on the practice. Should research show that doctors’ willingness to report remains low (because of the bothersome bureaucratic paper work) this could be a reason to reconsider changing the law.

B. Identification of Relevant Moral Issues

Medical ethicists tend to focus on issues that are high on the public agenda. However, it often happens that in public debate such issues are abstracted and isolated from their context. To give an example, doctors rarely have to

choose between prolonging life and euthanasia. The primary decision is whether or not to do everything that is possible to prolong a life. If it is clear that an aggressive treatment aimed at the prolongation of life is not justifiable, the question arises whether or not the dying process should be alleviated or perhaps accelerated. That is to say, euthanasia—the active termination of a life on request—is merely one option. Other options are stopping a treatment and palliative care.

However, public debate and medical ethicists usually focus on the most extreme option, euthanasia. On the one hand, this has led to lack of attention to other options such as palliative care and, on the other hand, to exaggerating the differences between e.g. euthanasia and stopping a treatment. Pearlman et al. (1973) remarked that empirical studies on early Do-Not-Resuscitate (DNR) orders demonstrated that early DNR policies did not address many of the complex ethical issues beyond resuscitation that arose in caring for critically ill patients. This finding led to more expansive discussions of the selective use of life-sustaining treatments. Many other examples can be given illustrating that the issues attracting public interest are often only a part of a larger complex of questions. The views of the public on what issues need to be discussed do not necessarily correspond with the views and experiences of practitioners. Empirical research is then needed to redress the imbalance.

C. Description and Analysis of “the Context”

Description and analysis of context covers much of the empirical research held to be relevant for ethical reflection. I start with research that draws attention to the nature of the context, to the nature of the relations between the different actors, and to these actors’ own beliefs and values.

Robert Zussman, who conducted extensive field research in the intensive care units of two American hospitals, said that in concentrating on questions of how medical decisions *should* be made, medical ethicists have paid surprisingly little attention to how they are *in fact* made. “As a result, medical ethics, and consequently the public policies that medical ethics have helped to shape, have been characterized by striking omissions” (Zussman, 1992, p. 2). Medical ethics, Zussman remarked, has fairly consistently ignored the social context in which medical decisions are made. Here he referred to Renee Fox (1989) who observed that medical ethicists often conceptualise medical decisions as if they were based on contracts by independent individuals—rational and voluntary agreements, usually between doctor and patient. They stress the importance of formal procedures for obtaining “informed consent,” thereby ignoring the social forces shaping patients’ values and the imbalance of influence between doctor and patient, the often non-rational matters that account for patients’ willingness to give consent (Fox, 1989, p. 2). In investigating how decisions are made one has

to search for the values underlying the decisions and “how those values articulate with other values, how they emerge from the interests and influence of different groups and organizations, and what in the organization of medicine or American society frustrates the realization of other values” (Fox, 1989, p. 3).

Zussman’s distinction between “how decisions should be made” and “how they are in fact made” drew attention not only to the real-life characteristics of decision making and to the difficulties of applying principles and values in practice; he also used it to point to a conflict between the evaluative perspective of medical ethics as a social movement and that of established medical practice. He found that medical ethics is insufficiently aware of the fact that it emerges from a distinctive set of values and concerns—such as self-determination—which are alien to medical traditions. The fact that medicine ‘has a long history of turning to its own purposes the attempts of others to regulate it’ is reason enough to study how the values of medical ethics are dealt with in medical practice. That is why a “sociology of medical ethics” is needed in addition to “a philosophy of medical ethics” (Zussman, 1992, p. 3).⁴

The issue of ethicists’ lack of attention to the social context recurs in many other publications dealing with the relation between social sciences and ethics. Robert Pool, a medical anthropologist who studied the practice of euthanasia in a Dutch hospital, also saw discrepancies between the view of medical ethics on euthanasia decisions and the actual decisional practice. Medical ethicists seem to think that such decisions are taken by an individual actor at a specific point in time. In reality, decisions on euthanasia are processes in which several actors play a role: patients, their families, doctors, and nurses (Pool, 1996, pp. 201–202). The process is also influenced by legal requirements and the specific protocols and procedures of the hospital. Anne-Mei The, another Dutch medical anthropologist who did research on nurses’ dilemmas in decisions concerning terminal cases, came to the same conclusion: Such decisions are not individual but collective, and have the character of a process. They are the outcome of what can be described as “a process of growth and maturation” (The, 1997, pp. 94–95).⁵

Another example of research on actual decision-making processes is that by Van Luijn et al. regarding the decisions of Institutional Review Boards (IRBs) on the acceptability of phase II and III-oncology experiments. The Declaration of Helsinki and other international and national regulations oblige IRBs to assess the ratio between the risks and benefits of medical research. This risk/benefit ratio (RBR) must be “favorable,” “in balance,” or “proportionate” in the IRBs’ opinion; otherwise the study cannot be approved.

Although there is some knowledge about the decision making of IRBs and the risk/benefit assessment of research protocols, little is known about how IRB members actually assess the risk/benefit ratio and ethical acceptability of

experimental treatments in oncology. Results of the first stage of the study showed that a substantial minority of IRB members believed that phase II cancer protocols provide too little information relevant to evaluating various cost/benefit and scientific issues, and felt less than fully competent in carrying out such evaluations. Only a small minority of IRB members indicated that they weighed risks and benefits against one another in a systematic way. More typically, such evaluations are made at a general level, based on individual judgments regarding the acceptability of the trial (whether one would participate oneself) and on the results of the decision-making process of the IRB as a whole. The fact that approximately one-third of IRB members do not make a risk/benefit calculation but leave the evaluation to the patient, suggests, according to the authors, that they lack criteria for adequately assessing risks versus benefits (van Luijn, Musschenga, Keus, Robinson, & Aaronson, 2002).

D. Description of Moral Opinions and Reasoning Patterns

The last category comprises research that aims at discovering the moral opinions and reasoning patterns of people who are directly involved in specific issues, mostly as participants in a certain practice, institution or context. For example, in an old people's home the people involved are the residents, their family, and the doctors, nurses and other associated professionals. The research I have in mind here is motivated by an intrinsic interest in the moral views of participants. Accordingly, context or practice is not merely a field of application of ethical "expertise," but (also) a source of moral beliefs. Knowledge of the views of participants is not just factual, but normative-ethical knowledge. In this approach, social science is more than "a handmaiden to philosophers."⁶

The significance of information about the moral beliefs of participants in a practice depends on the nature of the meta-ethical paradigm that guides the descriptive research. Epistemic contextualists may want to reconstruct the internal morality of a practice. They will use this morality for evaluating actions, guidelines and policies that affect the practice. In the Netherlands, this approach is defended by Henk ten Have and Annique Lelie (1998) and by Guy Widdershoven (2000).

The other paradigm found in descriptive-cum-normative research is that of the theory of reflective equilibrium. This research aims at revealing participants' "intuitions" or "well-considered judgements." Adherents of this approach in the Netherlands are Hans van Delden and Ghislaine van Thiel (van Thiel & van Delden, 1997; van Delden and van Thiel, 1998). I clarify and elaborate these approaches in more detail in Section IV.⁷

Almost all researchers who think that empirical research is needed to determine or to implement what should be done in a particular situation, agree that context matters. They differ in their view on the role context has

to play. Some of them think that ethics should become *context-sensitive*, which means that ethics can do its job properly only if its recommendations and prescriptions are fine-tuned to the particularities of the context and if it seeks the active cooperation of the “target group”—those who have to execute the demands of ethics as actors or are affected by the prescribed actions as “patients.” I explore this role of context in the next section. Others—the broad contextualists—regard context (also) as *a source of morality*. I deal with the relevance of context as a source of morality in Sections IV–VI.

III. MAKING ETHICS CONTEXT-SENSITIVE

The more traditional ethicists are inclined to think that it is the task of legislators and policy-makers to reflect upon how to introduce and to implement moral principles in concrete settings. Empirical ethicists reject this view. They think that the input of social research is already relevant in the phase of ethical theorizing. Ethicists should not limit themselves to formulating abstract and general principles. They have to specify and operationalize principles for particular contexts. *Specifying* a principle qualifies it by adding clauses describing the what, where, when, why, how, by whom, or to whom of a contemplated action. These qualifications add information about the scope of applicability of the principle or the nature of the act enjoined.⁸ Principles newly introduced into a particular context often conflict with already established principles. When they do, specification is an important tool for resolving conflicts between these principles. For example, specification can render a principle that forbids experiments on animals compatible with a *prima facie* conflicting principle demanding that everything should be done to save human life. A possible specification is that experiments on animals are allowed for testing drugs or treatments only if no alternative is available. *Operationalizing* a principle implies looking at those who are to be involved in the decision to act on that principle and at the procedures that have to be designed to ensure that due care attends the decision.

Most authors who want ethicists to pay more attention to the process and the procedural aspects of ethical decisions are sociologists. However, sociology is not the only discipline that is relevant for providing data needed in specifying and operationalizing principles. Psychology is at least as important. In his article “Ethics and Social Science: Which Kind of Cooperation?,” Dieter Birnbacher (1999) offered a useful scheme for discussing what is meant by improving the context-sensitivity of practical ethics and for identifying what kind of data is required to do that job. Birnbacher did not speak of specifying and operationalizing principles, but of the “translation” of basic principles into “practice rules.” What kind of empirical elements are needed for this?

1. Practice rules must take into account limitations in available information, information retrieval, information processing capacities, and the capacity to reflect on what basic principles imply for a given situation. The extent of these limitations and the kind of adaptation needed to cope with them is an empirical matter (Birnbacher, 1999, pp. 324–325).

A lot of empirical research on informed consent confirms the relevance of this demand for medical ethics. Let it suffice to mention one of my publications in which I refer to empirical research showing that the conditions for informed consent are often not met and are also very difficult to fulfill in practice (Musschenga, 1999, p. 201). The most important condition for giving informed consent is substantial understanding. Sometimes it is almost impossible to meet this condition. For example, a patient who is asked to participate in a phase-II study, for example, to test a new drug, needs to understand the information about the risks, drawbacks and benefits of the use, not only of the experimental drug, but also of the standard treatment—if such a treatment is available. However, medical experiments are often very complicated and patients sometimes may be swamped with information beyond their grasp. Moreover, they often have to decide under stress. Patients often overestimate the benefits for themselves that participation in an experiment might bring. My conclusion in that article is that one should seriously doubt whether the consent given by some categories of patients in medical experiments, such as terminal-phase cancer patients, does meet the condition of substantial understanding in the interpretation prevalent in authoritative bioethical literature

2. To be able to guide action, practice rules must be accepted. Therefore, they should be formulated in a way that stresses the continuity with traditional moral beliefs (Birnbacher, 1999, p. 325).

Unlike legal rules, moral rules and principles guide action by appealing to the internal motivation of the actors. Thus, when introducing “new” principles, it is important to show that they relate to people’s way of thinking. These beliefs might have receded to the back of their mind, but even then they are still there. Birnbacher’s thesis can also be interpreted in a slightly different way. If doctors want to achieve that treatment decisions reflect the wishes of their patients—if they want to further patient autonomy—they should take into account how patients themselves conceive of autonomy. This was the aim of a study on “[i]ndividualized evidence-based decision support and the ideal of patient autonomy,” conducted by Molewijk and colleagues in a Dutch academic hospital (Molewijk et al., 2004).

3. Psychological hypotheses underlie judgements on the extent to which practice rules can be expected to motivate appropriate attitudes and action. Practice rules should demand neither too much nor too little (Birnbacher, 1999, p. 325).

Here too, the point is that rules should be able to motivate subjects to appropriate action. Birnbacher held that rules lack the capacity to motivate

when they demand too much. This reminds one of Owen Flanagan's feasibility criterion. For Flanagan the observation that most people do not comply with principles that are supposed to guide their actions indicated probable non-feasibility of those principles. Flanagan argued that almost all traditions of ethical thought are committed to "psychological realism." This core commitment, he says, can be formulated in terms of a meta-ethical principle, which he calls the "Principle of Minimal Psychological Realism" (PMPR): "Make sure when constructing a moral theory or projecting a moral idea that the character, decision processing, and behaviour prescribed are possible, or are perceived to be possible, for creatures like us" (Flanagan, 1991, p. 32). PMPR is meant to be both descriptive and prescriptive. It singles out an aspiration common to almost all ethical theories and sets out a criterion for evaluating theories in terms of this aspiration (Flanagan, 1991, p. 33). His PMPR applies to human capacities of reasoning, deciding, and motivation, but Flanagan only considered motivation.

I have argued elsewhere that Flanagan's feasibility criterion is less relevant for evaluating supererogatory principles than for evaluating principles of social morality (Musschenga, 1999, pp. 192ff). In contrast with supererogatory theories, theories of social morality explicitly aim at laying down principles and rules for the social interaction between average human beings whose rationality, sympathy, and strength may be limited, but they are neither morally bad nor morally perfect. Narrow social morality is restricted to rules and principles that regulate the social interactions between members of a society. The criterion of feasibility is not neutral regarding these different types of ethical theories. In supererogatory theories, low compliance is not an indication of the non-feasibility of a principle or an ideal, but of humans' weakness of will or moral imperfection.

Medical ethics is not about supererogatory action. It is about regulating the interactions between medical professionals and their patients. Hence the criterion of feasibility is relevant to medical ethics. But it is not at all clear how the criterion can be put into practice. What kind of data can verify or falsify psychological hypotheses underlying judgements about the extent to which practice rules can be expected to motivate appropriate attitudes and action?

4. To translate basic principles into practice rules, one needs sociological hypotheses for evaluating the degree to which these rules are immune to potential misuse and abuse, immune also to the threat of "slippery slopes" leading to applications that are no longer covered by the basic principle (Birnbacher, 1999, p. 325).

In the philosophical literature, a distinction is made between the logical or conceptual version of the slippery-slope argument and the empirical or psychological version (Van der Burg, 1991, p. 43). The first holds that once one allows *A*, there is a high probability that one will end up

allowing *B*—which is regarded as undesirable—as one cannot make a relevant distinction between *A* and *B*. The second version, also called “the falling dominoes argument” (Feinberg, 1985, pp. 92–93), holds that allowing *A* will causally lead to allowing *B*.

Slippery-slope arguments occur in many medical-ethics discussions. Critics of selective abortion after prenatal diagnosis fear that this practice will eventually lead to a form of eugenics. The best-known case in which slippery-slope arguments are used is that of euthanasia. Many people outside the Netherlands fear that the Dutch euthanasia practice in which euthanasia is allowed under certain conditions when requested by the patient, paves the way for permitting involuntary euthanasia (see Keown, 2002).

In the context of a discussion about the relevance of the social sciences for ethics the empirical version of the argument is especially relevant. In many cases it will be impossible to prove whether this type of argument is valid or not. The validity depends on the correctness of predictions about—always uncertain—future developments. But the argument might be corroborated by referring to empirical research on developments in similar cases. If it were established that a law allowing abortion under very strict conditions is misused on a large scale, this could be used as an argument if similar euthanasia legislation were to be proposed. Whether the slippery-slope argument in its empirical version is valid does not just depend on general psychological features of human beings. More important are the culture and the attitudes of the people involved, and the nature of the institutions within the society/practice that has to be regulated by a rule. Thus, to be relevant, a slippery-slope argument has to be contextualised.

The kind of data which in Birnbacher’s view is needed to translate principles into practice rules clearly belongs not only to the domain of sociology but also to that of psychology. It seems to me that the one-sided interest of sociological research in discussions about enlarging ethics’ context-sensitivity within the field of medicine is simply due to the fact that there are more sociologists than psychologists working in the area of medicine and health care.

One of the questions I want to discuss in this article is whether empirical ethics is essentially connected with certain meta-ethical positions. Birnbacher made some remarks that are relevant here. At the beginning of his article he mentioned two reasons for taking empirical matters into account in normative practical ethics. The first reason is one that the ethicist has in common with the jurist:

...the jurist’s task is not only to make sure that a particular proposal of legislation is compatible with constitutional norms and the general principles recognised in the system of law concerned, but also to look

to the practicability and effectiveness of the proposed piece of legislation (given its aim). The applied ethicist has the same dual responsibility. His role is not only to inquire into theoretical merits of a proposed norm of practical morality (in terms of internal consistency, coherence with other rules of social morality, and compatibility with underlying principles) but also to consider its practical feasibility, its psychological acceptability and its potential effectiveness in changing the attitudes and behaviour in the desired direction (Birnbacher, 1999, p. 321).⁹

A further reason for taking empirical data into account is, according to Birnbacher, “relevant to all those approaches which conceive of applied ethics as the “application,” literally understood, of theoretical principles to real-life cases via maxims, middle-range principles, or practice rules. According to this conception, applied ethics deals with the “translation,” as it were, of theoretical principles into workable practice rules, making them available for everyday judgements and decisions” (Birnbacher, 1999, p. 321).

Birnbacher argued that the “translation problem” is inherent to and specific for a deductivist-foundationalist conception of ethics. However, his subsequent account does not deal so much with problems involved with the “translation of basic principles into practice rules” that are specific for foundationalist conceptions of ethics, but rather with the more general problems connected to “testing the feasibility of practice rules.” The translation or specification problem may be inherent to a conception of ethics in which the foundation consists of basic principles, but the feasibility problem is inherent to any conception of ethics in which principles play a role—irrespective of whether they are intuitively known, deduced from more basic principles, or reconstructed from an actual practice. It might appear that the acceptance problem is unique for deductivist conceptions of ethics in which justified critical principles have to be applied to a practice which is still regulated by traditional, uncritical moral beliefs and rules. But I think this problem may also occur within, for example, a hermeneutical, interpretive approach. When someone using the method of analogical reasoning concludes that slaughtering animals is not different from murdering humans, this judgement will not be widely accepted. This person does not impose a critical principle on a practice, but only enlarges the extension of a principle already familiar to human ethics. This is what happened in medical ethics: Recall what Zussman said about medical ethics being insufficiently aware of the fact that it emerges out of a distinctive set of values and concerns—such as self-determination—which are alien to medical traditions (Zussman, 1992). These values and concerns were not the product of philosophical theorizing; they were already present in other social spheres.

The kind of adaptations which according to Birnbacher are needed for operationalizing basic theoretical principles into workable practice rules resemble very much the tests that he thinks are needed to determine the

practical feasibility, psychological acceptability and potential effectiveness of “norms.” My conclusion is that the task of translating principles into practice rules is a specific instance of the more general problem of making ethics more feasible. Lack of context-sensitivity is not a problem that is characteristic of deductivist-foundationalist theories alone.

IV. CONTEXT AS A SOURCE OF MORALITY

Some studies in empirical ethics aim at describing the moral opinions and conduct of people who participate in a particular social practice. They derive their concept of practice from Alasdair MacIntyre (MacIntyre, 1981). MacIntyre and other moral philosophers from the Wittgensteinian tradition think that a society’s morality is not a general, overarching, and coherent system of beliefs, but an interlocking whole of moralities embedded in particular practices. Empirical research into the morality of a practice can be done for several reasons. For example, for politicians and policy makers who want to introduce a new law or policy it is imperative to know how people think about these measures and what their attitudes with respect to them are. It is impossible to implement laws or policies that completely lack public support. In this kind of research the researchers or their clients are not interested in the target group’s moral opinions and moral conduct as such, but only insofar as they are conducive to the aims of the law or the policy, or might be a barrier to their realization. The researcher and/or his or her client already know what is the right thing to do. How they arrived at this knowledge or whatever its source might be is irrelevant.

Another reason for doing research into people’s moral opinions and conduct is intrinsic interest in the content of their convictions and their moral source. This is the position of the authors I mentioned in part D of Section II. In their view, the common sense of ordinary moral people, as reflected in their actions, discussions and decisions, is a source of morality. In describing and reconstructing ordinary people’s common-sense morality, empirical research uncovers their moral sources. I have lumped together all the meta-ethical positions that necessitate empirical research into common-sense morality under the heading of contextualism. Since contextualism is a polysemous term, I have to clarify the sense in which I use it.

Marc Timmons (1999) made a useful distinction between circumstantial, normative and epistemic contextualism. *Circumstantial* contextualism is analogous to what in ethics is called situational or environmental relativism. It holds, roughly, that the rightness and wrongness of beliefs, actions, practices, and so on, depends in part on facts about the agent’s circumstances—internal psychological features such as the evidence he has or social facts about his community. To give an example: we do not blame someone who cannot swim for not trying to save a child that has fallen into a canal.

Normative contextualism holds that knowledge and justification are relative to the epistemic standards of one's group or community. It is analogous to ethical relativism, a normative ethical theory that reduces moral truth to the moral standards of a group. *Epistemic* contextualism is a thesis about the structure of justification, intended as a response to the regress-of-justification problem. We usually justify beliefs by inferring them from other more basic beliefs. Such beliefs form an epistemic chain. The regress of justification is infinite, unless it is stopped. In epistemic foundationalism, the regress stops with a certain class of beliefs that are somehow non-inferentially justified. Epistemic coherentism does not have a regress problem since it regards justification as a matter of the interconnectedness of a finite set of beliefs. Epistemic contextualism says that the regress of justification ends with beliefs that, in a particular context, are not in need of justification (Timmons, 1999, p. 182ff).¹⁰

What normative and epistemic contextualism have in common (I leave circumstantial contextualism aside), is that they take people's actual beliefs and reasoning practices seriously. The same is true of epistemic coherentism. Epistemic moral coherentism regards well-considered moral beliefs as initially credible, that is, before a reflective equilibrium is reached. While each of the three theories need empirical research for mapping a group's or community's actual beliefs and reasoning practices, the role played by such data differs. To determine whether a person's belief is justified, normative contextualists need to find out what his community's moral beliefs and epistemic standards are. Epistemic contextualists do not deny that it may be legitimate in some contexts and for some purposes to evaluate the epistemic status of an individual's beliefs relative to the epistemic norms of that person's community. However, Timmons's version of epistemic contextualism—structural contextualism—holds that “there are contexts in which we intend to make non-relativized, categorical epistemic evaluations, even if, in doing so, we obviously employ epistemic norms that we accept” (Timmons, 1999, p. 186).¹¹ In order to determine whether someone's considered judgements cohere with a set of principles, coherentists need to find out what his considered judgements are.

For my purposes in this article, I refer, without distinction, to normative and epistemic contextualism and coherentism as “broad contextualism.” In these theories, people's actual beliefs have at least initial credibility. In the following sections, I describe two kinds of contextualist empirical ethics. The first one works within the framework of a reflective equilibrium theory, the second one within the framework of epistemic contextualism.

V. REFLECTIVE EQUILIBRIUM

A coherence theory of justification in ethics holds that one's moral belief *p* is justified insofar as *p* is part of a coherent system of beliefs, both moral

and non-moral, and p 's coherence at least partially explains why one holds p . According to coherentism, justification is inferential, but it need not be linear and deductive. One's belief p is justified by one's belief q , which is justified by one's belief r , which is ultimately justified by one's belief p .

Central to any coherence theory of justification in ethics is the method of reflective equilibrium. John Rawls first made the distinction between narrow and wide reflective equilibrium, which was subsequently further elaborated by Norman Daniels (Rawls, 1974, 1975; Daniels, 1979, 1980). A narrow reflective equilibrium consists in a good fit between a person's well-considered judgements and a set of principles. This equilibrium is reached in a process of mutually adjusting judgements and principles. However, alternative sets of principles might also fit the well-considered judgements. In the view of Rawls and Daniels, in that case, one has to determine the relative strengths and weaknesses of the alternative sets of principles by considering their relevant background theories. That is how one arrives at a "wide reflective equilibrium."

"The method of wide reflective equilibrium is an attempt to produce coherence in an ordered triple of sets of beliefs held by a particular person, namely

- (a) a set of considered moral judgements,
- (b) a set of moral principles, and
- (c) a set of relevant background theories" (Daniels, 1979, p. 258).

The primary purpose of Rawlsian versions of reflective equilibrium is theory building and the construction of moral or political principles. They tend to focus on the more abstract theoretical levels (van der Burg & van Willigenburg, 1998). Assuming that the method roughly follows the way in which ordinary people think and reason morally, it can also be used as a framework for mapping the moral system of a person or group. The goal of such mapping need not be purely descriptive. It may also aim at determining the degree of coherence between a person's or a group's well-considered judgements, principles, and background beliefs.

Empirical ethicists usually want to go further than theory building and the construction of principles. They want to contribute to finding the right answers to practical problems arising in a particular context. One way is by helping people whose moral beliefs they have mapped, in forming a well-considered judgement on a particular issue, given their own principles, background beliefs, and well-considered judgements on other issues. Another way to help them find an answer to a practical moral issue is by giving advice that is maximally in line with their moral beliefs and principles.

The problem with reflective equilibrium theory is that a reflective equilibrium is not an objective state of affairs that can be determined from a third-person point of view. It usually is a first-person judgement. Assuming

that I am in the best position to know my own beliefs, principles, and background theories, I am usually the only one who can see whether there is reflective equilibrium between them. Even a small community, confronted with a particular issue, will not easily find a standpoint that is in reflective equilibrium with the possibly diverse beliefs, principles, and background beliefs of all the members. This will also complicate the task of an empirical ethicist who wants to give advice that coheres with the community's other views.

Empirical ethicists can also use the method of reflective equilibrium for determining whether a set of principles that forms the core of an ethical theory is in alignment with the well-considered judgements of a particular community. Several theorists noted that Rawls's account of justice is out of step with popular opinion, especially in American society. Whereas Rawls rejects merit as a proper moral basis for the distribution of wealth, income and other good things as incompatible with justice as fairness (Rawls, 1972, pp. 10–15), there is, at least in the United States, a broad consensus on the opposite position (see e.g., Miller, 1991). Although it is difficult to find out by empirical research precisely what peoples' well-considered judgements are (Swift, 1999), and although people might come to reject these judgements (convinced by the cogency of Rawls's argument), it could also turn out that, at least in American society, a reflective equilibrium between principles of justice and well-considered judgements can only be reached by revising Rawls's principles of justice.

However, the nature of revisions depends on the degree of a subject's commitment to the propositions involved, on the logical and evidential relations among them and with other propositions he accepts or rejects (DePaul, 1993, p. 20). If in American society the commitment to the principle of merit is as strong as some studies suggest, revision of Rawls's principles could be the most probable outcome.

In a study conducted in nursing homes, Ghislaine Van Thiel and Hans Van Delden used the method of reflective equilibrium to determine the conception of respect for autonomy which takes into account not only the inhabitants' limited capacities for autonomous decision making, but also fits the moral experience of the staff who are, in this context, the primary addressees of the principle. They developed four views on patient autonomy, each based on an interpretation of autonomy available in ethical literature. In a questionnaire they asked nurses and physicians which view or views they would prefer for their own nursing home. Van Thiel and Van Delden noted that the ostensibly preferred view did not correlate with the approach chosen when confronted with descriptions of concrete cases (van Thiel & van Delden, 1997; van Delden & van Thiel, 1998).

An important question which has to be answered when using the method of reflective equilibrium is: Who should be interviewed? What is the relevant moral community? Van Delden and Van Thiel only interviewed

nurses and physicians. Why not the residents' family members or people from the general public? Their first reason is a strategic one. Nurses and physicians are the ones who have to implement the principle of respect for autonomy. The second reason is that by doing so the "normativity embedded in the practice itself," is taken seriously. They derive this view on the normativity of practices from MacIntyre. To my mind, this concept of practice is alien to the method of reflective equilibrium.

Can the use of reflective equilibrium by empirical ethicists ever lead to finding the right answer to a practical moral question? Van Thiel and Van Delden used the method to arrive at guidelines for feasible and acceptable policies concerning respect for autonomy in nursing homes. Adam Swift argued that the main reason for Rawls to claim that "we should take seriously certain fundamental ideas seen as implicit in the public political culture of a democratic society" is not that they represent "the way we live now," but his democratic ideas about public justifiability (Swift, 1999, pp. 353ff). Rawls wanted his conception of justice to be legitimate, not so much justified or true. Analogously, one could argue that the appropriate aim of empirical ethics using the method of reflective equilibrium is to further the legitimacy or public justifiability of ethical guidelines, recommendations and so on. But the public justifiability of a guideline need not keep anyone from criticising its moral rightness. In Rawls's theory, "the public" are the members of the democratic society. Van Thiel and Van Delden might say that their "public" consists of all the competent members of the community of a nursing home. Other definitions would have been defensible too. If their aim had been to arrive at policies that are feasible and acceptable for society at large, society would have been the relevant public.¹²

VI. EPISTEMIC CONTEXTUALISM

Whereas van Delden and van Thiel only used the concept of practice for solving a problem arising in their version of empirical ethics, it is central to another version. In this version, the aim of empirical ethics is to analyse and reconstruct the moralities of particular practices. Although one might think that in this version of empirical ethics the focus is on identifying the actual moral beliefs of the participants in a practice, the aim is to *reconstruct* the practice's internal morality. Central to the work of some authors in medical ethics such as Edmund Pellegrino, Howard Brody, Frank Miller, Henk ten Have, and Anniëke Lelie, is the distinction between "internal" and "external" morality (Pellegrino, 1981;¹³ Brody & Miller, 1998; ten Have & Lelie, 1998; Miller & Brody, 2001). Ten Have and Lelie defined internal morality as "specific values, norms and rules intrinsic to the actual practice of medical care" and external morality as "values, norms and rules prevailing in social, cultural

and religious traditions that function as external determinants of medicine” (Ten Have & Lelie, 1998, p. 268). A practice’s internal morality, however, is not the actual morality of its participants. Internal morality is a normative concept.

Unlike the authors I discussed in the previous section, the above-mentioned authors themselves do not articulate the meta-ethical presuppositions of their version of empirical ethics. Such articulation is not in keeping with their style of doing ethics. However, I think that articulation is imperative to explain why we are justified in regarding context as a source of morality. In my view epistemic contextualism offers the best framework for articulating the meta-ethical presuppositions of the practice-theoretical version of empirical ethics. To clarify this view, I return to the work of Timmons.

Timmons described the fundamental tenets of his version of epistemic contextualism—structural contextualism—as follows:

1. One may be epistemically responsible in holding certain beliefs at time *t*, even though one has no justifying evidence or justifying reasons for holding those beliefs at *t*.
2. Such beliefs may serve as an epistemic basis for being justified in holding other beliefs.
3. Which beliefs need justification crucially depends on certain facts about one’s context, including certain social dimensions of one’s context (Timmons, 1999, p. 206).

Further on, instead of context, he speaks of “one’s goals and purposes that are operative on some occasion—goals and purposes that may not be operative, or operative in quite the same way, on a different occasion” (Timmons, 1999, p. 210). Timmons gave the example of believing in the existence of a mind-independent external world. In ordinary contexts one is justified in believing that there is such a world, but not in the context of an inquiry into the justification for believing our common-sense picture of the world (Timmons, 1999, p. 210). What is basic in one context may not be basic in another (Timmons, 1999, p. 218). The other examples Timmons gave also build on the difference between professional and non-professional contexts. To give an example of my own: Within the context of medicine I am justified in believing that doctors are allowed to cut into the bodies of living human beings, but not in the context of, say, religion.

In my view, in the practice-theoretical version of empirical ethics the concept of practice fulfils a role similar to that of context in Timmons’s epistemic contextualism. Timmons also has a concept similar to that of internal morality: moral outlook. Part of the context within which one ordinarily comes to have justified beliefs is having some particular moral outlook (Timmons, 1999, p. 217). For Timmons a moral outlook is a point of view from which one looks at or reacts to the environment. Only within a process of education can one appropriate such a point of

view or perspective. A similar characterization can be given of internal morality.¹⁴

The distinction between internal and external morality raises some questions that are relevant for the kind of empirical research required by this view. It is not evident that the practice of medicine's internal morality can only be reconstructed by taking the perspective of those having the right training, expertise and moral experience. The direct participants in a medical practice—doctors and nurses—are not the only ones who have an interest in that practice. Medicine and health care belong to the collective goods of a community. One can argue that the definition and interpretation of its goals, basic beliefs, and so on, has never been the exclusive business of the direct participants in that practice. But that would fail to explain the changes that have taken place and still take place in the practice's goals and basic beliefs.

The history of medical ethics proves that changes in the internal morality of medicine, in its epistemic basic beliefs, can be induced by outside influences (Beauchamp, 2001, p. 606). I again recall Zussman's remarks that the present medical ethics emerged from a set of values and concerns, such as self-determination, which are alien to medical traditions (Zussman, 1992). Internal moralities are dynamic. Values and principles that once were external to a practice's morality can become internal to it (Miller & Brody, 2001, p. 587). For example, in the Netherlands the obligation to take considerations of justice and cost-effectiveness into account in deciding about whether to refer a patient to a specialist or in deciding about treatment (which does not mean that such considerations should get most weight) is nowadays becoming part of medicine's internal morality.

How can the epistemic contextualist version of empirical ethics be relevant to solving practical moral problems?¹⁵ Suppose that an empirical ethicist wants to find out whether it is justified to deny liver transplantations to incorrigible alcoholics? He or she has to determine, first, what the relevant context is, second, what epistemic basic beliefs it contains and third, whether the policy can be justified by inferring it from these beliefs. Both the first and the second step require something like Michael Walzer's interpretive examination of the social meaning of social goods, practices, and institutions (Walzer, 1985), and not just research into people's actual opinions. For the third step, in addition to intimate knowledge of a practice, our empirical ethicist needs argumentative skills. In this view of empirical ethics, the ethicist should play the role of a well-informed, philosophically trained participant in the interpretation and further elaboration of a practice's given morality.

A common objection against theories such as epistemic contextualism is that they do not provide room for criticising the internal moralities of practices. I think this criticism is too easy. In Walzer's theory, the well-informed, philosophically trained participant in the interpretation and

further elaboration of a practice's morality might develop into a "connected critic" who delivers criticism from within a practice's morality or from within the broader community's morality (Walzer, 1987, p. 39). Guy Widdershoven, a Dutch empirical ethicist working in the hermeneutical tradition of Hans-Georg Gadamer, has a similar view. From the perspective of this tradition, he held that ethics should start from the actual practice of people faced with specific moral problems. This implied that ethics should join forces with empirical disciplines such as medical sociology and medical anthropology (Widdershoven, 2000, p. 104). The role of the ethicist is to start a dialogue with people involved in a problem, to contribute to the process of explicating and deepening their moral views, and solving their problems. The ethicist is not an expert, he or she can only contribute insofar as he himself or she herself is or gets involved in a problem. His or her contribution to the dialogue is informed by his or her own moral experience rather than his or her expertise. The ultimate goal of the dialogue is, in the language of Gadamer, a "fusion of horizons" or reaching a shared moral understanding. In Widdershoven's approach it remains unclear what the relevance is of the ethicists' philosophical training and knowledge. Does only his or her own moral experience matter or does his or her expertise matter as well?

VII. CONCLUSION

After reviewing the different goals of empirical research in ethics, I showed that all conceptions of empirical ethics have in common a concern with the context-sensitivity of ethical principles, guidelines, and recommendations as an essential part of the job of ethics. Care for context-sensitivity requires that ethics cooperate with the empirical sciences.

I discussed whether a lack of context-sensitivity is characteristic of deductivist-foundationalist conceptions of ethics. Are contextualist theories more favourable to context-sensitivity than other ethical theories? I showed that this is not the case. To be sure, one likely effect of the contextualist focus on actual practice and actual opinions is that ethicists' proposals and recommendations will not be too far removed from the beliefs people already have. In that respect, contextualism favours context-sensitivity. But this does not apply to other demands of context-sensitivity: contextualists are not immune to the dangers of a slippery slope, to overestimating people's capacities to absorb information, to being blind to the dangers of the potential misuse and abuse of moral principles, and so on. Thus, the concern for context-sensitivity as such is not a valid reason for preferring contextualist theories over non-contextualist ones.

In the introduction I stated that I did not intend to present or defend a conception of empirical ethics. I wanted, first of all, to understand what empirical ethics is: why, and for which purposes it is done, and why people

think it necessary for ethics to become empirical. In my view, if ethics indeed intends not only to prescribe actions, but also to actually guide actions, a turn to empirical ethics is inevitable. The main challenge for empirical ethics is how to further the context-sensitivity of ethics without making ethics uncritical. I do not believe that a critical empirical ethics is impossible. But that is the topic for another article.

ACKNOWLEDGEMENTS

The research for this article was carried out within the framework of the incentive program “Ethics and Policies” which is supported by the Netherlands Organisation for Scientific Research (NWO). The article benefited from discussions I had with colleagues active in the field of empirical ethics: Hans van Delden, Lieke van der Scheer, Ghislaine van Thiel, and Guy Widdershoven. I am grateful to Rob de Vries for his comments on an earlier version, and to John Kraay and Nienke Eikelboom for correcting the English.

NOTES

1. This is how the term empirical ethics is used in the Netherlands.
2. I do not claim to have analysed all relevant literature. I used MEDLINE to find the publications in which the term empirical ethics appears in the title, abstract or key words. I also used the Philosophers' Index to identify literature not covered by MEDLINE. Besides that, I analyzed some (older) publications in the field of sociology of medicine. Neither do I claim that I have identified all goals that are mentioned as reasons to introduce social research into practical ethics, only the four most important ones. After completing the first draft of this article I read Daniel P. Sulmasy's and Jeremy Sugarman's *Methods in Medical Ethics* (Sulmasy & Sugarman, 2001). In their opening chapter they mention eight ways in which empirical studies can be important in medical ethics. I classify in terms of *goals* of using empirical material, not in terms of *ways* of using it; except for this the approaches are quite similar.
3. In the Netherlands euthanasia is not allowed by law, but doctors will not be prosecuted if they meet certain requirements of due care, originally formulated by the Dutch Royal Society for Medicine and integrated, in 2001, into the penal law as conditions for exclusion from criminal liability. For the willingness of doctors to report euthanasia prior to the change of the law, see van der Wal and van der Maas (1996).
4. An anonymous reviewer for this journal remarks that, in the history of medical ethics, self-determination was first accepted by British surgeons in the 17th century and brought to a sophisticated level in the 19th century. Even if Zussman was historically wrong in saying that self-determination is alien to medical traditions, he was certainly right in his characterization of established medical practice as it still was at the time he wrote his book.
5. Zussman made a similar observation. Responsibility for a decision on cardiac pulmonary resuscitation cannot be assigned solely to either physicians or family. Both consider the arguments of the other. “Decisions were considered and reconsidered, made and remade, negotiated and renegotiated. Decisions were not an event but a process” (1992, p. 159).

Another author who observes negligence on the part of bioethicists in taking (sufficient) notice of social-scientific studies and in addressing the setting, institutional context, and cultural forces relating to the issues they are dealing with, is Bruce Jennings. Bioethical writings keep making large claims or assumptions about setting, context, and culture.

“These claims, in turn, are not harmless asides, sociological *obiter dicta*; they do affect the normative ethical position offered in various ways. For one thing, these sociological claims affect the reasonableness and persuasiveness of the arguments made, since the reasonableness of an ethical argument that balances various conflicting values and weighs benefits often depends on the context and setting within which the balancing and weighing goes on” (Jennings, 1990, p. 262).

Maartje Schermer, who studied patient autonomy in ethical theory and in hospital practice, points to four aspects of the context of decision making that influence the expression of respect for autonomy:

- (i) the nature of the setting: is it a hospital, a psychiatric institution, or a nursing home,
- (ii) the nature of the patient's disease
- (iii) the duration and the quality of the relation between patient and doctor, and
- (iv) the moral views of patients and doctors—how much do they value patient autonomy? (Schermer, 2001, p. 201–202).

6. I found this phrasing in an article by Barry Hoffmaster (1990, p. 241), who is also an adherent of this approach. In a later article he even suggests that ethnography can save the life of medical ethics (Hoffmaster, 1992).

7. Interest in the contribution of social science to ethical reflection is not confined to medical ethics. Since the end of the last century social scientists have developed a growing interest in the issue of distributive justice. There are two types of social-scientific research into justice. The first type focuses on the description and explanation of “justice judgements,” of public opinion about what is just. This research usually investigates judgements about the distribution of income (see Schmidt, 2000). The other type of research focuses not on judgements, but on the criteria for the allocation of particular, indivisible or scarce goods, burdens, services, and opportunities, articulated and used by actors other than the state or the market—usually institutions and organizations in the domain of “civil society.” This is usually called “local justice” research. The term “local” refers to the fact that

- (i) different institutional sectors use different substantive principles of allocation
- (ii) the research wants to find out to what extent allocation is country-specific and to what extent it varies even within the same sector in a country, between different allocators (for a review of social justice research see: Schmidt, 2000).

Although some of the justice researchers limit themselves to pure description and explanation, others explicitly state that their research also has (some) relevance for normative thinking about justice (Miller, 1991).

8. This definition is inspired by Richardson (1994). He discussed the specification of (norm-)ends, not of principles.

9. Following Jürgen Habermas and Karl-Otto Apel, Klaus Günther made a distinction between justification discourse and application discourse. Justification discourse deals with the question whether a norm can be shown valid independently of the situations of its application. Application discourse aims at “relating a norm to a situation by inquiring whether and how it fits the situation, whether there are not other norms which ought to be preferred in this situation, or whether the proposed norm would not have to be changed in view of the situation” (Günther, 1993, p. 11). According to Günther, Richard Hare hardly distinguishes between justification and application:

“Since he often condenses the argumentation situation of a justification to the application situation and thereby attaches his meta-ethical analyses to act-utilitarian positions, the difference between justification and application is only of marginal significance of his position” (Günther, 1993, p. 21).

For hermeneutical thinkers there is no other moral argumentative discourse than application discourse (or interpretation, a term they would prefer). Birnbacher seemed to presuppose this distinction between justification discourse and application discourse. He seemed to suggest that testing norms for feasibility, acceptability, and potential effectiveness is different from justifying them (Birnbacher, 1999, p. 321). In my opinion this testing forms a part of a more broadly conceived justification.

10. Timmons called his own version of epistemic contextualism “structural contextualism,” which he characterised as follows: “SC regresses of justification may legitimately terminate with beliefs, which, in the context in question, *are not in need of justification*. Let us call the latter beliefs *contextually basic beliefs*” (Timmons, 1999, p. 187). SC does not require that all inferentially justified beliefs are based on contextually basic beliefs; rather, it allows that regresses may legitimately end with such beliefs.

11. These evaluations regard the epistemic responsibility of persons having particular beliefs—whether or not they belong to our own tradition. Timmons said that we normally criticise agents whose beliefs are not based on adequate evidence, who have not checked out relevant counter possibilities to what they believe, and who fail to eliminate certain conflicts of beliefs (1999, p. 212).

12. I assume that far more ethicists and political philosophers use a contextualist approach than the few who provide a meta-ethical justification of their method. The political philosopher Joseph Carens is one who did justify his contextualism (Carens, 2000; 2004). For him contextualism “entails the normative exploration of actual cases where the fundamental concerns addressed by the theory are in play” (Carens, 2004, 118). We do not understand what general principles and theoretical formulations mean until we see them interpreted and applied in a variety of specific contexts. Even more important, general principles and theoretical formulations may be radically at odds with actual policies and practices. Existing practices contain embedded wisdom that is missed by prevailing theories (Carens, 2004, 121). Carens did not want to confine “intuitions” to Rawlsian “well-considered judgements.” He also included intuitive judgements about a range of relatively unfamiliar (but real) issues and cases. By reflecting upon these intuitive judgements and asking why we have these views, we will become conscious of moral considerations that are relevant to our general theories but that have been left out because the cases about which we have “considered convictions” do not really bring these considerations to the fore (Carens, 2004, 127). His strategy is Rawlsian in that he moves back and forth between theory and practice, although he prefers calling his approach “reflective disequilibrium,” “the mutual unsettling of complacent certitudes in theory and practice by their juxtaposition against one another” (Carens, 2004, 123). The “real examples” Carens uses as an input for his theorising are partly based on his own anthropological empirical research.

13. Pellegrino elaborated his views on the goals of medicine and the internal morality based on it in a large numbers of subsequent books and articles that I do not mention here.

14. Timmons described a moral outlook as (roughly) a way of viewing and responding to one’s environment from a moral point of view, a perspective from which one takes a moral stance. One comes to have a moral outlook through a process of education. The more salient features of this process include:

- (i) developing a sensitivity to various features of one’s environment,
- (ii) learning to associate various emotional responses with objects of moral evaluation (e.g. feelings of guilt and resentment),
- (iii) becoming acquainted with paradigmatic cases of (im)moral actions, persons, institutions, and so forth,
- (iv) learning moral generalizations and
- (v) learning basic patterns of moral reasoning (Timmons, 1999, 217).

15. I am making a rather free use of Timmons’s theory. His main interest is when an *individual* is doxastically justified in having particular beliefs. I am interested in a *social practice*’s basic beliefs and moral outlook.

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