

Principles and Particularity: The Roles of Cases in Bioethics

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INTRODUCTION

Twenty-five years ago, when I was a graduate student in philosophy, the study of ethics had fallen on hard times. Some of the leading exponents of ethical theory had succeeded, for the time being, in showing either that all ethical judgments were reducible to emotive reactions—and hence irrational and indefensible¹—or that the study of ethics, properly understood, had more to do with probing the nuances of the “language of morals”² than with reflecting on the normative moral experience of real people in their mundane or professional capacities. The study of ethics had become a rarefied, specialized, technical, and, above all, dry discipline. Given the sad state of the field, many had begun to wonder whether political philosophy was dead. To be sure, books and articles continued to be written, and courses continued to be taught, but for many of us at the time such behaviors might have resembled the residual motions of patients in a persistent vegetative state more than genuine signs of life. The real “action” in philosophy lay elsewhere, around the “linguistic turn”³ or in continental theory, but certainly not in ethics.

Not coincidentally, during my undergraduate and graduate years I was never exposed to anything remotely resembling a “case study” in ethics. If ethics was ever to establish itself as an intellectual enterprise worthy of respect, students were told, it would have to ignore the grubby world of everyday moral concerns and concentrate instead on theory, abstraction, and the meaning of various moral terms.⁴ In my work today, however, I am mired in cases, both at the hospital, where the exigencies of clinical problems preclude leisurely invocations of philosophical theory, and even in my university classes on bioethics and the philosophy of law. This Article inquires how this dramatic shift from theory-driven to case-driven ethics came about and

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1. See, e.g., ALFRED J. AYER, *LANGUAGE, TRUTH AND LOGIC* (2d ed. 1946); C.L. STEVENSON, *ETHICS AND LANGUAGE* (1944).

2. R.M. HARE, *THE LANGUAGE OF MORALS* (1972 reprint).

3. *THE LINGUISTIC TURN* (Richard Rorty ed., 1967).

4. Felicitous exceptions in my own education were the courses of Professor Henry B. Veatch, which, while not “applied” in the contemporary sense, were rooted in the normative quest for goods and virtues.

attempts to chart some of its implications for the practice and teaching of ethics.

I. EXAMPLES IN THE SERVICE OF THEORY

Although neither classical nor contemporary moral philosophers dealt with what is now called a "case study," they frequently cited *examples* designed to substantiate their theoretical points. Thus, Mill deployed the example of someone inciting an angry mob poised on the corn dealer's doorstep in connection with his theory of the limits of free expression;⁵ and Kant mentioned, less helpfully, examples of honest dealing, suicide, and failure to develop one's talents as illustrations of his "categorical imperative."⁶ The partisans of "linguistic ethics" would also occasionally cite an example of moral behavior, though these tended to be uniformly unimaginative and trivial.⁷

There was, to be sure, an occasional philosophical example sketched with some detail and literary flair, such as Sartre's memorable reference to a young man tragically torn between the incompatible demands of caring for his mother and joining the Free French struggle against fascism.⁸ Indeed, Sartre produced not merely a few apt examples, but also a remarkable literary corpus of novels and dramatic works, much of which was self-consciously devoted to the illustration of the philosopher's theories of freedom, identity, and responsibility.⁹

The common thread uniting these examples, both the trivial and the tragic, is their subservience to philosophical theory. The philosophers' examples and hypotheticals were designed to make theoretical points, not to shed light on various moral problems independently articulated by practical people enmeshed in the realities of everyday personal and professional life. Indeed, to the proponents of linguistic ethics, the true task of moral philosophy simply involved the clarification of moral language; while, to the philosophical emotivist, the yearning for a normative theory of responsibility or justice stemmed from a failure to acknowledge the non-cognitive status of all moral values. The ethical concerns of spouses, lovers, parents, legislators, workers, revolutionaries, doctors, nurses, lawyers, and social workers thus were condescendingly delegated to parties occupying lower rungs on the

5. JOHN S. MILL, ON LIBERTY 53 (David Stitz ed., 1975).

6. IMMANUEL KANT, KANT'S GROUNDWORK OF THE METAPHYSICS OF MORALS 89-90 (H.J. Paton trans., 1961).

7. Indeed, a review of the ethics literature produced in the 1950's and 1960's could easily give a present-day reader the impression that civilization had in those days been brought to its knees by hordes of ruthless pedestrians bent on violating posted warnings not to trespass on the grass.

8. JEAN-PAUL SARTRE, L'EXISTENTIALISME EST UN HUMANISME (1946). For another memorable example of a story in the service of philosophy, see SOREN KIERKEGAARD, FEAR AND TREMELING (1843).

9. JEAN-PAUL SARTRE, WHAT IS LITERATURE? (1948). Typical examples of Sartre's philosophical fiction include the novel, LA NAUSÉE (1938), and such plays as LES MOUCHES (1941) and HUIS CLOS (1944).

academic/intellectual food chain, such as journalists, ministers, and politicians.¹⁰ In view of this cleavage between the goals of moral philosophy and the practical world, it is not surprising that the practice and teaching of ethics did not refer to case studies.

II. THE RISE OF "APPLIED ETHICS"

The current revival of interest in "practical ethics"—that is, the use of the concepts and methods of ethical theory towards the resolution of concrete moral problems—is generally credited to the publication of John Rawls' monumental work, *A Theory of Justice*.¹¹ For serious intellectuals struggling with issues of race and the moral dilemmas occasioned by the Vietnam war, Rawls' book rekindled hope that reason—rather than emotion, custom, or sheer political force—might be fruitfully applied to clarify and resolve real ethical-political problems in public life. Although Rawls' book was exclusively concerned with the explanation and justification of a morally *ideal* blueprint for just social institutions, and even though it contained no actual case studies and few examples of how his theory might be applied,¹² *A Theory of Justice* nevertheless generated a heady optimism regarding the potential of moral theory to solve real world problems. In no time, it seemed, a fledgling "industry" had been launched, complete with its own journals and think-tanks. For those working in the field at that time, it seemed that the rational, definitive resolution of some of the most vexing social conflicts merely awaited the proper formulation and application of the best ethical theory that moral philosophy could provide.¹³ The heyday of "applied ethics" had dawned.

Different styles of moral analysis eventually emerged under this rubric of applied ethics. By far the most theoretically confident, and the most problematic style might be described as a kind of moral deductivism.¹⁴

10. See STEVENSON, *supra* note 1, at 1:

The purpose of an analytic or methodological study, whether of science or of ethics, is always indirect. It hopes to send others to their tasks with clearer heads and less wasteful habits of investigation. This necessitates a continual scrutiny of what these others are doing, or else analysis of meanings and methods will proceed in a vacuum; but it does not require the analyst, as such, to participate in the inquiry that he analyzes. In ethics any direct participation of this sort might have its dangers. It might deprive the analysis of its detachment and distort a relatively neutral study into a plea for some special code of morals. So although normative questions constitute by far the most important branch of ethics, pervading all of common-sense life, and occupying most of the professional attention of legislators, editorialists, didactic novelists, clergymen, and moral philosophers, these questions must here be left unanswered.

The present volume has the limited task of sharpening the tools which others employ. As we shall soon see, the above project is the exact opposite of contemporary casuistry in every detail.

11. JOHN RAWLS, *A THEORY OF JUSTICE* (1971).

12. Rawls' only deviation from the development of so-called "ideal theory" concerned the conditions for justifying the practice of civil disobedience. *Id.* at 333-91.

13. For example, see RONALD M. DWORKIN, *TAKING RIGHTS SERIOUSLY* 149 (1977).

14. Just as H.L.A. Hart discovered the difficulty of tracking down actual specimens of the legal realists' *bête noire*, the advocates of so-called "mechanical jurisprudence," so is it hard to pin down actual exemplars of so-called deductivistic bioethics. See H.L.A. Hart, *Positivism and the Separation of Law and Morals*, 71 HARV. L. REV. 593 (1958). A deductivistic approach is certainly implied in a

According to this approach, the task of the "applied philosopher" was to start with a philosophical theory—presumably, the best and most comprehensive account available—then to develop various mid-level normative principles, such as those bearing on truth-telling, paternalism, and confidentiality. With the theory and derivative principles firmly in place, the practical philosopher needed only to feed the relevant factual data into the moral equation to yield the appropriate moral conclusion.¹⁵

For reasons that shall be explained presently, this sort of deductivistic appeal to comprehensive moral theory found few adherents, especially among professionals seeking the advice of the applied ethicist. However, a far more theoretically modest approach, focusing on the development, application, and refinement of a small set of mid-level principles, was to prove spectacularly successful. This "principlist" approach (or "bioethical mantra")¹⁶ posited the existence of objective, universal principles that ought to govern moral behavior, social policy, and legislation. Developed and popularized by philosophers Tom Beauchamp and James Childress,¹⁷ this approach soon became the dominant paradigm for serious work in bioethics.

In contrast to the reductionistic tendencies of the more hard-core variety of applied ethicists, principlists neglected ultimate or foundational questions in favor of a more pluralistic and "intuitionistic" approach. The partisans of applied moral theory tended to reduce the sources of normative criticism to a single, overarching value (for example, Kantian respect for persons or the maximization of utility) that would then definitively settle all conflicts between values and principles. The principlists settled for a small cluster of disparate fundamental values (autonomy, beneficence, nonmalificence, and justice), no one of which was granted a priori primacy over the others.

The relationship between these mid-level principles and cases within the theory of principlism has been somewhat ambiguous and subject to historical fluctuation. The basic question is whether one ought to conceive this relationship in uni-directional or in dialectical terms. As a uni-directional relationship, one can hold either that judgments about cases are entirely determined by appeal to governing principles or that principles are merely derivative "summary formulations" of incremental judgments about cases. As a dialectical relationship, one can claim that principles both shape and are shaped by the responses to particular cases. According to this latter interpretation, principles would retain normative dominion over what ought to be done

much-quoted chart in TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 32 (1st ed. 1979), that plots the path of ethical justification from cases to rules to principles to theory. Perhaps the philosophers whose works come closest to a highly theory-laden, deductivist approach are H. TRISTRAM ENGLEHARDT, JR., THE FOUNDATIONS OF BIOETHICS (1986), and PETER SINGER, PRACTICAL ETHICS (1979).

15. Implicit in this approach was a rather clear-cut division of labor: the applied philosopher was the expert with regard to moral theory and practical reasoning, while "the facts" would be furnished by others, such as physicians, social workers, or business executives.

16. I believe I might have actually coined this derogatory epithet at a lecture on "Methodology in Bioethics" at the University of Texas Medical Branch, Galveston, 1986.

17. BEAUCHAMP & CHILDRESS, *supra* note 14.

in specific circumstances, while the developing intuitive responses to cases would add content to principles and help formulate their proper boundaries.

During the early, heroic phase of applied ethics, the principlists were partisans of a decidedly "top down" orientation devoted to applying principles to the moral data of concrete cases.¹⁸ Moral objectivity and justification were found, not in the messy details of the cases, but rather in "the principles of bioethics." Although many clinicians continued to complain that even this more modest version of applied ethics was too abstract to be well suited to clinical decision-making, many others viewed principlism as a source of objective moral knowledge and useful advice. These physicians tended to view the bioethicist as a kind of "moral expert," and as a purveyor of "principled" moral judgments.

During this early period in the development of bioethics as a field, the case study emerged as an object of serious consideration. At first, case studies were often employed in the traditional manner as illustrations of how a particular ethical theory might bear on moral problems. For example, a case involving the use of placebos in medical research would be used as a prism through which to view the salient features of Kantian or rule-utilitarian reasoning. Many, however, increasingly used case studies not just as illustrations, but as objects of interest in their own right. Case studies posed intellectual and moral problems that called for a solution. It was important to get the right (or at least an acceptable) answer, not simply in order to exhibit the properties of one's favorite theory, but to help determine the fates of living, breathing individuals, many of whom posed moral dilemmas of excruciating difficulty. The moral philosopher was fast becoming an "applied ethicist," and the ethicist was no longer an isolated theorist, but was now enmeshed in the problems, dilemmas, and crises of professional life. Indeed, the theorist was well on his or her way to becoming a consultant, moving from being a detached observer to a player in the professionals' drama.

The case studies that developed in the literature of this period shared two salient features. First, professionals tended to define them.¹⁹ Second, the case studies were brief and "thin." Except for legal cases, the cases presented for consideration in the bioethics literature rarely exceeded a few paragraphs. Crucial medical facts (for example, the patient's diagnosis, options, and prognosis as affected by various treatment choices) would be presented, the shape of the ethical quandary would be sketched, and the care provider's position clarified. Such cases seldom painted a more fleshed out portrait of

18. See *supra* notes 16-17 and accompanying text.

19. Recall the established division of intellectual labor within the applied ethics movement. See *supra* note 15 and accompanying text. The philosopher/ethicists would be responsible for the application of theory and principles, while the factual "case material" would be provided by doctors, nurses, or social workers. The problems thus tended to be shaped according to the conceptual, axiologic, and linguistic frameworks of the caregivers. A good example of this phenomenon is the packaging of difficult issues in obstetrics under the heading of "maternal/fetal conflicts." Although I disagree with those who would deny or minimize the possibility for such conflicts, I think that this way of framing many of these issues obscures other conflicts (for example, maternal/professional) and often ignores or legitimates unjust or discriminatory background conditions of the conflicts.

the various actors and the implications of the choices before them. The audience of such case studies often had extremely limited information about, for example, the patients' perception of their disease and the meaning of treatment options as mediated by their social and family history, race, economic class, prior medical encounters, and psychological characteristics.

A typical example of this "bare bones" approach to case studies, drawn from the experience of my colleague Nancy Dubler, might have gone something like this:

The medical housestaff at a public hospital in the Bronx confronts a difficult case involving a "problem patient." Mr. Jones is an IV drug user who also happens to be infected with HIV and tuberculosis. The TB has been diagnosed as being of the multi-drug resistant variety, and thus poses a serious threat of potentially lethal infection to anyone coming into casual contact with Mr. Jones. The problem is that the patient insists upon leaving his room so he can be free to wander the corridors and lobby of the hospital. The staff are extremely upset and worried that these expeditions outside of his room will lead to the infection of other patients, caregivers, or hospital visitors.

As presented, this case poses a conflict among the patient's individual rights, the public's legitimate interest in protection from harm, and the hospital's fiduciary obligations to its patients and employees. Where should the line be drawn between civil liberties and public health? Would it be ethically justifiable to lock the patient in his room against his will? I shall return to this case later in this Article.

III. THE DECLINE OF THEORY IN BIOETHICS

Notwithstanding the initial wave of enthusiasm that followed in the wake of Rawls' theory of justice, attempts to yoke moral theory into the service of practical ethics were destined to founder on philosophers' ambivalence and on the intrinsic limitations of ethical theory for practical purposes.

While some applied ethicists immediately embraced the role of practical consultant to professional colleagues,²⁰ many ethical theorists continued, even during the salad days of applied ethics, to view the application of moral theory primarily as a vehicle for enriching philosophical moral theory.²¹ Thus, even when they were ostensibly addressing a medical audience, many philosophers appeared more concerned with how other philosophers and theorists of medicine would receive their views. Indeed, many philosophers working in ethics during this period were profoundly ambivalent towards applying their theories to practical affairs. While the revival of normative ethical theory in the 1970's was to a great extent fuelled by philosophers' expectations of "making a difference in the real world," many of these same

20. See, e.g., Albert R. Jonsen, *Can an Ethicist Be a Consultant?*, in *FRONTIERS IN MEDICAL ETHICS* 157 (Virginia Abernethy ed., 1980).

21. Good examples of this ambivalently practical and heavily theory-laden work in ethics can be found in such journals as *Philosophy & Public Affairs* and *Journal of Medicine and Philosophy*.

theorists instinctively recoiled at the thought of becoming mere "moral valets" in the service of some other profession.²² Their work was thus "theory driven" in yet another sense: in addition to being governed by the application of philosophical or theological theories, their work had been yoked primarily to the service of ethical theorizing as an activity in its own right. Needless to say, clinicians had very little use for this genre of applied ethics.

Although most philosophers working in this field would eventually overcome their residual discomfort with the practical domain, variants of applied ethics based primarily on the invocation of philosophical ethical theory were doomed to fail for reasons internal to such a project. Recall that the "theory driven" model assumes that the proper task for the applied ethicist is to assemble all the relevant ethical theories, with their corresponding principles and likely implications for a particular case, and deploy them for those seeking the ethicist's counsel. But what then? Two possibilities suggest themselves.

First, the ethicist could offer advice in the vein of a "Consumer Reports" service.²³ "Well, in this situation a Kantian would do 'X,' a utilitarian would promote 'Y,' and a natural rights theorist would advocate 'Z.'" Needless to say, such "advice" might not prove enormously helpful to those doctors, nurses, and social workers who haven't yet quite figured out where they stand in the ongoing debate between the partisans of Kant, Mill, and Locke.

Second, the ethicist could attempt to vindicate her favored theory and then apply it to the case at hand. The obvious problem with this gambit is the seemingly interminable nature of philosophical argument about the foundations of morals. To put the point bluntly, after more than two thousand years of ethical debate among philosophers with rival views, no clear winner has emerged, and clinicians cannot be blamed for doubting that one ever will. As eminently practical people, they cannot afford the luxury of awaiting the development of an ethical theory capable of routing this contentious field by force of argument alone.

Even if the theory-driven applied ethicist were miraculously to establish the philosophical supremacy of a single, comprehensive theory of morals, her project would have foundered on the emergence of disagreements among adherents to that very theory. Thus, a utilitarian would have to worry not merely about the challenges posed by rival theories, but also about profound intramural disagreements among adherents to the theory of utility. What shall count as the true meaning of "utility?" How will it be measured? Which form of utilitarianism (for example, act or rule) is correct? These seemingly intractable questions, along with many more, would continue to vex even the champions of the dominant ethical theory before they could begin to apply their doctrine to cases.

22. See Annette Baier's translation of Hegel's phrase, "Kammerdiener der Moralität." Annette Baier, *Doing Without Moral Theory?*, in *POSTURES OF THE MIND* 228, 236 (Annette Baier ed., 1985).

23. See *id.*

Suppose further that, per impossibile, philosophers could agree upon both the general outlines of the correct theory as well as on its precise formulation. Even with the unlikely advent of this particular millennium, theorists would still be unable to provide clinicians and policy experts with unambiguous moral solutions derived from the theory. This is because many disputes in clinical bioethics and health policy turn, not on theoretical differences, but on such nettlesome issues as the value that should be accorded to different forms of human and animal life, the factual prediction of likely consequences, and the most rational attitude towards risk.

The problem of active euthanasia provides a good illustration of all three problems. Theorists who agree entirely on the moral theory level may yet part company on the crucial issue of how we should value biological human life.²⁴ Even theorists who agree on that difficult question may disagree on the likelihood of bad consequences ensuing from a shift towards a more permissive policy and on the question of who should bear the burden of proof.²⁵

The more theory-driven approaches to applied ethics suffer a further liability embedded in widespread notions of what an ethical theory ought to look like. The common wisdom is that an ethical theory ought to be a large body of ethical propositions derivable from one or a few basic moral principles. When people speak of ethical theory in this way, they are usually thinking of some version of Kantian deontology,²⁶ utilitarianism,²⁷ or Lockean natural rights.²⁸ The theorists who support these different ethical theories are responding to the question, "What is *the* rational foundation of moral philosophy?" As philosophers such as Thomas Nagel, Bernard Williams, and Charles Taylor have convincingly argued, however, this enterprise is problematic.²⁹ It assumes that the chiaroscuro of our moral experience can be reduced to one or two overarching sources of moral value, such as maximization of happiness or respect for human freedom. While such an assumption is likely to please theorists bent upon achieving simplicity and efficiency, it will not do justice to the rich diversity inherent in the moral lives of individuals and societies. Consequently, even if the proponents of theory were to agree upon a moral theory so defined, and even if they could apply unambiguously the theory to concrete moral problems, the end result of

24. RONALD M. DWORKIN, *LIFE'S DOMINION* (1993).

25. See, for example, the contrasting views of Daniel Callahan, *When Self-Determination Runs Amok*, HASTINGS CENTER REP., Mar.-Apr. 1992, at 52; and Margaret P. Battin, *Voluntary Euthanasia and the Risks of Abuse: Can We Learn Anything from the Netherlands?*, L. MED. & HEALTH CARE, Spring-Summer 1992, at 133.

26. See, e.g., IMMANUEL KANT, *FOUNDATIONS OF METAPHYSICS OF MORALS* (Oskar Priest ed. & Lewis W. Beck trans., 1959); RAWLS, *supra* note 11.

27. See, e.g., JOHN S. MILL, *UTILITARIANISM, LIBERTY, AND REPRESENTATIVE GOVERNMENT* (1910); SINGER, *supra* note 14.

28. See, e.g., ROBERT NOZICK, *ANARCHY, STATE, AND UTOPIA* (1974); ENGLEHARDT, *supra* note 14.

29. THOMAS NAGEL, *MORTAL QUESTIONS* 128 (1979); BERNARD WILLIAMS, *ETHICS AND THE LIMITS OF PHILOSOPHY* (1985); Charles Taylor, *The Diversity of Goods*, in *UTILITARIANISM AND BEYOND* 129 (Amartya Sen & Bernard Williams eds., 1982).

this reductivist enterprise would still leave us with an impoverished understanding of the problems, solutions, and sources of moral value.

IV. PRINCIPLISM UNDER SIEGE

As I have shown, the "principlist" version of applied ethics was able to virtually corner the methodological market in bioethics by abandoning the foundationalist pretensions of reductionist ethical theory while elaborating a network of principles that offered the hope, or at least the appearance, of ethical objectivity. Without having to bother with the Sisyphean task of grounding their ethical judgments in ultimate theoretical norms, clinicians could pronounce them justified by appealing to such objective and universal principles as autonomy, beneficence, and justice. By the late 1980's, however, this approach to practical ethics was coming under fire from two diametrically opposed camps.

A. Principlism Not Theoretical Enough

From one flank, the partisans of a comprehensive philosophical theory attacked principlism for its relative insouciance regarding first principles,³⁰ that is, for not being theoretical enough. This group of critics found especially galling principlism's inability or unwillingness to provide a rationally defensible framework for settling conflicts between competing principles. Clearly, the critics had a point. Utilitarians or Rawlsians, unlike principlists, could settle, at least to their own satisfaction, the inevitable conflicts of the moral life through appealing to some overarching principle of "lexical ordering."³¹ The principlists forthrightly admitted that the moral principles came with no pre-established theoretical weights and, consequently, that conflicts arising among these principles would have to be settled through a subtle process of weighing and balancing *in medias res*.³² Although the partisans of theory find this approach to conflict resolution to be unacceptably subjective or "intuitionistic,"³³ there is wisdom in the principlists' modesty. Their critics have neither established the clear superiority of any monistic theory, such as utilitarianism, nor have they produced a convincing account of why within more pluralistic systems certain lexically favored values, such as utility or liberty, should *always* prevail over all other competing values in a myriad of convoluted real world situations.

30. K. Danner Clouser & Bernard Gert, *A Critique of Principlism*, 15 J. MED. & PHIL. 219 (1990); Ronald M. Green, *Method in Bioethics: A Troubled Assessment*, 15 J. MED. & PHIL. 179 (1990).

31. Utilitarians are supposed to resolve all such conflicts by bringing them under the common metric of "utility." Rawlsians give moral priority to liberty in conflicts with "welfare." See RAWLS, *supra* note 11.

32. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 51 (3d ed. 1989).

33. RAWLS, *supra* note 11, at 34-40.

B. Principlism Too Mechanistic

From the opposite flank, the partisans of a more case-driven approach to practical ethics began to attack principlism for being too formal, mechanistic, and deductive. Although the nuanced ethical analyses of its founding expositors were anything but simplistic or mechanistic, principlism's epigones, many of whom lacked even the equivalent of "basic training" in ethics, often did convey the impression that one merely had to slap one or more principles on a given set of facts to derive the morally correct result. More often than not, their "method" was to recite what each of the principles seemed to require, even if they conflicted with one another, then simply to *announce* a conclusion. Allusions to the "bioethical mantra" were in large measure a reaction to precisely this kind of bastardized principlism.

1. From Deductivism to Reflective Equilibrium

The broad-based dissatisfaction with the regnant paradigm harbored two more serious contentions about principlism and its way of configuring the relationship between principles and case judgments. First, the partisans of casuistry or case-based reasoning objected to the apparently uni-directional movement from principles to cases within principlism.³⁴ A careful analysis of Beauchamp and Childress' early editions of *Principles of Biomedical Ethics*³⁵ might suggest a more complicated relationship between principles and cases in the process of moral justification, but an oft-cited chart in that book gave the distinct impression that theory justified principles, that principles justified moral rules, and that rules justified moral judgments in particular cases.³⁶ According to the critics, this uni-directional picture distorted or totally ignored the pivotal role of intuitive, case-based judgments of right and wrong. To be sure, the judgments in question were not to be confused with just any responses to cases, no matter how prejudiced, ill-considered, or subject to coercion they might be. Rather, the critics had something in mind more akin to John Rawls' notion of "considered" moral judgments³⁷—the judgments about whose genesis and moral rectitude we feel most confident, such as our sense that slavery is wrong. It is precisely these judgments, they claimed, that give concrete meaning, definition, and scope to moral principles and that provide critical leverage in refining their articulation.

The critics were claiming, in effect, that principles and cases have a dialectical or reciprocal relationship. The principles provide normative guidance, the cases provide considered judgments. The considered judgments, in turn, help shape the principles that then provide more precise guidance for

34. ALBERT R. JONSEN & STEPHEN TOULMIN, *THE ABUSE OF CASUISTRY* (1988).

35. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* (2d ed. 1983).

36. *Id.* at 5.

37. *See* RAWLS, *supra* note 11, at 47-48.

more complex or difficult cases. Following Rawls' terminology, principles and cases exist together in creative tension or "reflective equilibrium."³⁸

The principlists responded to this line of criticism by simply embracing it, over time, with increasing forthrightness and enthusiasm. Although they may have been slower than others to discern the formative and critical roles of case analysis with regard to principles and theories, Beauchamp and Childress now embrace reflective equilibrium as *the* methodology of principlism and emphatically denounce deductivism for precisely the same reasons given by their critics.³⁹ One can view principles as the primary substance of ethical analysis, they conclude, without being a deductivist.

2. Principlism, Indeterminacy, and Moral Justification

A large part of the initial appeal of principlism lay in its promise of providing *principled* solutions to moral problems, solutions that could claim to be more than the "merely subjective" biases of practitioners or consultants. As one physician-graduate of the Kennedy Institute's week-long bioethics seminar explained to me, "This [method] is what our student-doctors need. It's really objective, based on principles, just like a science." This promise of objectivity appeared to be based on the expectation that individual actions or social policies could be justified by applying the enumerated principles.

In some very simple moral situations consisting, for example, of a clear and uncontested moral rule and a fact pattern that contradicts it, this promise could be vindicated. Suppose, for example, that a physician decides to lie to her patient in order to improve his spirits and possibly facilitate his recovery. One could say that this doctor's act violates the principle of autonomy and the law of informed consent. Indeed, one could deploy reasoning in this case as a deductive syllogism: "It is wrong to lie to patients. Dr. Jones has told a lie. Therefore, Dr. Jones has done something wrong."

The problem, of course, is that even in a simple, straightforward case, this reasoning has suppressed a conflicting principle—the principle of beneficence. This is precisely the principle that Dr. Jones would appeal to should she try to defend her lie. ("I did it for his benefit. I was just following my Hippocratic impulses!") At first glance, this opposing principle may not be noticeable because the principle of autonomy has prevailed within the biomedical ethics community over the principle of beneficence in this type of case. One should remember, however, that the predominance of the autonomy principle was not always this clear, that the debate between autonomy and paternalistic medicine rages on in other countries,⁴⁰ and that the eventual victory of autonomy in

38. *Id.* at 48-51. Rawls' notion of reflective equilibrium, somewhat sketchily drawn in his book, is clarified and defended in Norman Daniels, *Wide Reflective Equilibrium and Theory Acceptance in Ethics*, 76 J. PHIL. 256 (1979).

39. See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* (4th ed. 1994).

40. See Nicholas A. Christakis, *The Ethical Design of an AIDS Vaccine Trial in Africa*, HASTINGS CENTER REP., June-July 1988, at 31; Antonella Surbone, *Letter from Italy: Truth Telling to the Patient*,

the areas of truth-telling and informed consent, at least in theory, was won after a protracted ideological struggle.⁴¹ As a result, the biomedical community now assigns much greater weight to respecting patients than to easing their psychological burdens.

Principlism may provide the kind of moral justification sought in the easy cases, but what about the complicated cases in which battles between competing principles continue to rage—the cases in which clinicians and policy-makers seek the advice of bioethicists? The “tough” cases will inevitably present not one clear-cut and uncontested principle, but rather two or more conflicting values that require some sort of reconciliation. Precisely what kind of moral justification can principlism offer in the face of serious moral ambiguity and conflict? To what extent does the “application of principles” actually *justify* the moral choices that we make, both individually and collectively?

Another way to formulate these questions is to ask about the capacity of principlism to generate *determinate* answers to moral quandaries. Doubts about the justificatory power of principlism’s principles arise on several levels of moral reflection.

Interpreting the principles. The principles themselves require a great deal of interpretation and ordering before they can begin to shape the conclusion of a moral argument. The bioethical literature abounds with superficial claims to the effect that “the principle of autonomy (or of beneficence, or of the ‘best interest’ of the patient) *requires* that we do such and such.” The problem with this common formulation is that it ignores the difficulty (or the vacuousness) of passing immediately from very abstract statements of principle to very concrete conclusions about what to do here and now. Quite apart from the vexing problem of rank-ordering *competing* principles in morally complex situations, a problem I shall treat separately, one first must determine exactly what these abstract formulations of principle actually mean.

What does it mean, for example, to invoke the “best interests” principle in the case of a severely impaired newborn? What content can one give to this expression? How are the interests of such a child to be assessed, and according to which conception of the good?⁴² Some might argue that a vitalist’s conception of the good should shape our understanding of the child’s interests; others might advocate a hedonistic conception of the good that would restrict the notion of interests to the qualia of pleasure and pain; while still others might advance a conception of the good based on conceptions of

268 JAMA 1661 (1992). A recent television documentary provided a riveting portrayal of cultural differences regarding the practice of truth-telling. The physicians and nurses in a Japanese cancer ward were shown grappling with a cultural surd: a cancer patient who not only wanted to know the truth about her condition, but actually had the unbridled temerity to *talk to other patients* about their common plight. Their temporary solution: send the woman on lots of long walks in the hospital gardens! See *The Art of Healing* (David Grubin Productions, Inc. & Public Affairs Television, Inc.), reproduced in *Healing and the Mind: The Art of Healing* (Ambrose Video Publishing, Inc. 1993).

41. JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984).

42. See EZEKIEL J. EMANUAL, *THE ENDS OF HUMAN LIFE: MEDICAL ETHICS IN A LIBERAL POLITY* (1991).

human flourishing and dignity, which might lead to nontreatment decisions even in the absence of pain and suffering.

Whatever the merit of these individual suggestions, the point is that unless one *interprets* "the principles of bioethics," they will merely play the role of empty "chapter headings,"⁴³ doing little if any actual work in moral analysis. Unless one furnishes principles with a definite shape and content, they will merely lend a patina of objectivity to bioethical debates while masking the need to make arguments and choices regarding the substance of those principles.⁴⁴

It is important to recall that the meaning of principles is shaped, not simply by explicit and constructive ethical theorizing, but also by the largely implicit influences of culture.⁴⁵ The seemingly univocal "principle of autonomy" will mean different things and have different weights in different cultural settings. Compare, for example, the way in which the right of reproductive self-determination functions in the abortion debates of the United States and Germany. In this country, longstanding legal traditions of rugged individualism have yielded, albeit after many years of bloody and ongoing conflict, a right that has been aptly characterized as nearly absolute but entirely asocial.⁴⁶ So while a woman's claims to (nearly) absolute personal sovereignty have trumped the interests of husbands, parents, and the values of a large countervailing segment of the community, women remain largely isolated in their freedom, unsupported by the community's resources and concern. In Germany, by contrast, the principle of autonomy exercises considerable force, to be sure, but its meaning and scope have been mediated by a public philosophy, traceable back to Rousseau, that stresses the complimentary nature of individual freedom and social responsibility. Thus, Germans significantly curtail, by American standards, a woman's right to obtain an abortion, but German women who obtain abortions are given community services and abortion funding.⁴⁷ Such differences in the presentation of various principles in diverse cultural settings have prompted Mary Ann Glendon to speak, not of "rights talk" tout court, but rather of different "rights dialects."⁴⁸

Interpreting conflicting principles. In hard cases, principles conflict. That is why they are hard. Can principlism provide a means to justify resolutions to moral conflict? What help can principlism provide, for example, when the principle of autonomy is at odds with the so-called "harm principle," as in cases involving maternal-fetal conflict or cases involving decisions to

43. See Clouser & Gert, *supra* note 30, at 221.

44. Precisely the same critical point can be made with regard to the other "principles of bioethics." "The" principle of justice is, if anything, a highly contested concept, not a univocal principle. In the words of Alasdair MacIntyre, one might well ask, "Whose Justice, Which Rationality?" See generally ALASDAIR C. MACINTYRE, *WHOSE JUSTICE? WHICH RATIONALITY?* (1988).

45. See, e.g., Robert M. Cover, *Nomos and Narrative*, 97 HARV. L. REV. 4 (1983).

46. See MARY ANN GLENDON, *RIGHTS TALK: THE IMPOVERISHMENT OF POLITICAL DISCOURSE* 55-61 (1991).

47. *Id.* at 61-66.

48. *Id.*

reproduce in a context of genetic disease or AIDS? According to the principlists, the only available remedy for such conflicts of principle is to judiciously weigh and balance the competing moral claims as they arise in different circumstances.⁴⁹ If a woman is overwrought and her judgment skewed by excessive fear and faulty reasoning, and if her choice would impose severe and irreparable harm on her offspring, then a principlist might find the harm principle to outweigh the claims of self-determination.

This weighing and balancing, some critics contend, is inherently subjective and unpredictable.⁵⁰ Suppose two observers—for example, an ardent feminist and a staunch “pro-lifer”—happen to disagree about the above outcome? The latter approves, while the former sees it as a violation of the woman’s integrity and as reducing her to the demeaning status of “fetal container.” Can principlism help sort out, according to some canon of rational justification, the rival “intuitions” of the disputing parties?

According to Clouser and Gert, these kinds of intuitive conflicts will only be resolved on the higher plane of philosophical theory.⁵¹ Until the principlists develop a more robust ethical theory, a theory that would ultimately assign determinate weights to such competing values, these critics contend that its resolutions of hard cases must remain ad hoc, fundamentally *unprincipled*, and therefore unjustified.⁵²

Philosopher David DeGrazia has developed a more constructive critique of principlism.⁵³ While DeGrazia shares Clouser and Gert’s worries about the ad hoc and unprincipled character of the weighing and balancing required by principlism, he adopts a strategy of amendment rather than abandonment.

Drawing on Henry Richardson’s influential article on specification in moral reasoning,⁵⁴ DeGrazia contends that in many hard cases what is really going on is not the weighing and balancing of *conflicting* principles by unsupported intuition, but rather the progressive *specification* of more abstract norms. According to this view, initial abstract formulations of principles will become increasingly concrete, specified, and delimited as one approaches the level of the particular case. Thus, what begins as a straightforward, abstract, and seemingly absolute principle—that women (and men) have a right to make reproductive choices unfettered by government or medical professionals—might end as a complex and richly nuanced principle with built-in exceptions for factors such as compromised rationality and severe and irreversible harm, as in the above example. The advantage of thinking of moral reasoning in terms of specification rather than balancing is, according to DeGrazia and Richardson, that one’s final practical judgments remain

49. See, e.g., BEAUCHAMP & CHILDRESS, *supra* note 32, at 228-47.

50. See Clouser & Gert, *supra* note 30; see also David DeGrazia, *Moving Forward in Bioethical Theory: Theories, Cases, and Specified Principlism*, 17 J. MED. & PHIL. 511 (1992).

51. Clouser & Gert, *supra* note 30.

52. Given the importance of this theoretically justified balancing scale for the principlist project, one wonders why Clouser and Gert have not simply loaned one to Beauchamp and Childress.

53. DeGrazia, *supra* note 50.

54. Henry S. Richardson, *Specifying Norms as a Way to Resolve Concrete Ethical Problems*, 19 PHIL. & PUB. AFF. 279 (1990).

tethered to a single principle capable of bestowing rational justification upon them.⁵⁵

Although DeGrazia's amendment to principlism is much richer than this short synopsis will allow, and although his theory of moral justification ultimately hinges on the sort of justification that reflective equilibrium affords,⁵⁶ this particular aspect of his amendment simply re-describes, rather than solves, the problem of indeterminacy. Indeed, the specter of indeterminacy that haunts the project of balancing within principlism threatens specification as well. If weighing and balancing competing principles in the above reproductive case falls short of rational justification for want of a hierarchy of values that is theoretically justified, then the specification of abstract principles through the process of reflective equilibrium will also fall short. Just as the competing principles of reproductive autonomy and "nonmaleficence" appear to require ad hoc, context specific, nuanced judgments unsupported by higher level, lexically ordered principles, so too will efforts to specify the principle of reproductive freedom down to the level of the particular case. Indeed, what motivates and guides the modification and specification of abstract principles, what compels one to lard them with qualifying clauses, if not precisely the sort of countervailing values and principles encountered by the principlist? Thus, whether one calls this balancing or specification, the respective weights of competing considerations must be sorted out. Unless DeGrazia has a rationally defensible, higher level, lexical ordering principle at his disposal, his "specifiers" are in the same boat as the principlists' "weighers and balancers." Neither, in short, can vindicate the claim to rational justification that gave to principlism much of its initial appeal.

Interpreting types of cases. Apart from the indeterminacies involved in balancing and specifying principles, the corresponding moral situation requires extensive, non-rule bound interpretation as well. In some contexts, this might mean developing an appropriate moral vocabulary to describe what is happening in certain kinds of situations. It seems that moral progress often depends as much on finding (or fashioning) the right words as on applying the right principles. This is especially the case in the areas of bioethical investigation defined by rapid technological change—such as genetic engineering, prenatal interventions on the fetus, and the withholding of life-sustaining treatments. For example, the tentative search for compelling descriptions has created much of the recent perplexity over the withholding of artificial food and fluids. One questions what is really going on in such cases. Is the withholding of artificial nutrition through a nasogastric tube an example of intentional "killing" or an example of a humble, merciful withdrawal of ineffective medical treatments?

Those who breezily claim that bioethics is the application of principles to "the facts" forget that, apart from the indices of bioethics periodicals, the

55. DeGrazia, *supra* note 50; Richardson, *supra* note 54.

56. That is, not on a straightforwardly foundationalist or deductivist approach.

facts do not come neatly labelled. Cases and issues must be described, individuated, and labelled well before any principles can be applied.

Interpreting the case. Even after developing a vocabulary to describe a particular moral situation, the application of moral principles must await the results of yet another layer of interpretation: the interpretation of actions, gestures, and relationships *within* the case. Even if one decides that a specific refusal of treatment does not necessarily amount to a form of suicide or intentional killing, one still must determine the meaning of that refusal in the context of its own setting and history. Indeed, some of the most illuminating writing in the field of bioethics has dealt precisely with this type of searching hermeneutic of the individual case.

Recall Robert Burt's brilliant and disturbing psychoanalytic interpretation of a burn patient's adamant refusal to be treated and articulate request to die.⁵⁷ While Burt acknowledged the validity of the principle of autonomy as well as the sincerity of the patient's request to die, he enlarged the understanding of this case by attempting to place the patient's treatment refusal in its emotional context. Perhaps, Burt suggested, the patient's refusal was less an unambiguous thrust of freedom than a plea for recognition, acceptance, and love from those surrounding him.⁵⁸ Instead of being a statement, perhaps the refusal was a question in disguise: "Do you still care for me? Would you banish me from your sight?"

Clearly, the relevance of the principle of autonomy for this case depends upon whether one interprets the patient's refusal as a statement or as a query. For example, if the patient is in fact testing the commitment of those around him, a mechanical application of the principle of autonomy to his expressed refusal could lead to a tragic result. Whether or not one agrees with Burt's controversial gloss on this case, his work shows that one can do creative and exciting work in bioethics while paying scant attention to the analysis or application of moral principles.

The search for moral justification through the application of principles thus proves to be a far more complicated matter than the followers of principlism appear to have initially discerned. While it still makes sense to talk about the "application" of principles to cases, this application is no simple matter of deduction but actually involves multiple layers of interpretation and substantive moral reflection. The crucial point, however, is that each of these interpretative layers—of the principles, of their relative weights, of case description, and of the meaning of individual gestures—is a locus of interpretive *conflict*. Bioethics requires one to articulate and attempt to resolve the conflicts at all of these levels. This is a difficult task. Reference to the "application" of principles to cases tends to mask these difficulties. It gives the impression that the task is "merely" one of intellectual procedure rather than substance.

57. ROBERT A. BURT, *TAKING CARE OF STRANGERS: THE RULE OF LAW IN DOCTOR-PATIENT RELATIONS* (1979).

58. *Id.* at 10-11.

Likewise, when people speak of this sort of "application" as *justifying* particular moral judgments, they appear to assume that, from among a welter of serious yet conflicting views at all levels, a justified choice must select the correct principles, their correct formulation, their correct weight, the correct typology of the situation, and the correct "reading" of the case details. This assumption places inordinate demands upon the notion of moral justification, especially since there are no clear and uncontested criteria for making precisely these kinds of judgments.

This picture of what moral justification entails, a picture that early confidence in principlism seems to have assumed, simply cannot bear the weight that has been put on it. Indeed, as the principlist partisans of reflective equilibrium now admit, the conception of moral justification as a *correspondence* between individual judgments and theoretically validated moral principles must be abandoned. In its place, a conception based upon the overall *coherence* of our case-based judgments, mid-level principles, and theoretical and cultural commitments would seem a more realistic goal. That is, instead of seeking ultimate justification in an appeal to some rock solid, freestanding principle, the quest should be for answers to how well an action or policy comports with the considered judgments, principles, and values already embedded in the web of our collective moral life.⁵⁹ Sometimes such an inquiry will yield a clear-cut answer, but most of the time it will create genuine controversy that will be played out over time. Some arguments will be more or less plausible, more or less rational than others.⁶⁰ They will never, however, be purely objective "just like a science."

V. THE PARTICULARIST PROJECT IN BIOETHICS

As the initial promise of principlism began to fade, a small cluster of alternative methodological approaches in bioethics emerged.⁶¹ They pressed the critique of the dominant paradigm while attempting to articulate a more "particularist" moral vision. Much of this critique has already been adumbrated in the short history of principlism. Examples include: the attack on the reductionist and foundationalist aspirations of ethical theory, understood as

59. See MICHAEL WALZER, *INTERPRETATION AND SOCIAL CRITICISM* (1987); see also GEORGIA WARNKE, *JUSTICE & INTERPRETATION* (1993).

60. See RICHARD J. BERNSTEIN, *BEYOND OBJECTIVISM AND RELATIVISM* (1983).

61. In addition to casuistry and narrative ethics, the two alternative methodologies that I shall discuss, a complete account of challenges to principlism would have to include feminist theory as well. Feminist theories in bioethics have much in common with casuistry and narrative ethics: All three approaches are skeptical of standard ethical theories, attempt to root their moral analyses in the particularities of complex situations, and give greater weight to the role of emotions and relationships in moral life. While I would argue that feminist theory adds little, if anything, to the particularist critique of principlism, feminist theorists have convincingly argued that the reigning paradigm of bioethics has been insufficiently attentive to problems of power and domination. See, e.g., *FEMINIST PERSPECTIVES IN MEDICAL ETHICS* (Helen B. Holmes & Laura M. Purdy eds., 1992); *SUSAN SHERWIN, NO LONGER PATIENT: FEMINIST ETHICS AND HEALTH CARE* (1992); *FEMINISM AND BIOETHICS: BEYOND REPRODUCTION* (S. Wolf ed., forthcoming 1994).

some version of Kantianism or utilitarianism;⁶² the insistence upon the multiple layers of difficult interpretive work that are obscured by talk of "applying" principles; and the dialectical role of cases in generating, specifying, and reformulating ethical principles. My aim in this section is to give a brief but more positive account of these new directions in bioethics. Then, in conclusion, I will reflect on the implications of this methodological shift for the role of case studies in the practice and teaching of bioethics.

A. Casuistry

The renaissance of casuistry, or case-based reasoning, in practical ethics has stressed the pivotal role of cases while de-emphasizing the role of theory and routinized appeals to "the principles of bioethics."⁶³ According to its leading proponents, a casuistical method must begin with a typology or grouping of cases around a paradigm of a moral rule or principle. In the area of research ethics, for example, the atrocities of Nazi medicine still are an exemplar of unethical dealing with human subjects. From this signal case one then branches out by a method akin to "moral triangulation" to analogous cases of lesser or greater difficulty, such as research on children or the demented elderly. As one proceeds from case to case responding to the particular settings, treatments, and categories of research subjects, the principle becomes increasingly refined and complex.

Crucially, the casuists contend that whatever "weight" a principle has vis-à-vis competing principles, one must determine that weight, not in the abstract, but in response to the details of individual cases.⁶⁴ Suppose, for example, the medical director of a reputable nursing home wishes to study the causes and treatment of the refusal to eat by elderly patients with Alzheimer's disease. Suppose further that informed consent to participate in the study cannot be expected from this patient population. According to the dictates of our paradigm case—for example, the infamous hypothermia experiments of the Nazi doctors—the principle of respect for persons always requires the free and informed consent of the research subject. According to the casuists, to determine whether the principle of autonomy should prevail over the principle of beneficence in nursing home research requires a more nuanced investigation into the "who" (enslaved ethnic populations vs. patients with Alzheimer's disease), the "what" (lethal hypothermia experiments vs. studying and filming patients' eating behaviors), the "where" (death camps vs. a regulated nursing

62. See, e.g., Barry Hoffmaster, *Can Ethnography Save the Life of Medical Ethics?*, 35 SOC. SCI. & MED. 1421-31 (1992); Barry Hoffmaster, *The Theory and Practice of Applied Ethics*, 30 DIALOGUE 213-34 (1991).

63. See, e.g., BARUCH A. BRODY, *LIFE AND DEATH DECISION MAKING* (1988); JONSEN & TOULMIN, *supra* note 34; John D. Arras, *Getting Down to Cases: The Revival of Casuistry in Bioethics*, 16 J. MED. & PHIL. 29 (1991); see also A. Mackler, *Cases and Judgments in Ethical Reasoning: An Appraisal of Contemporary Casuistry and Holistic Model for the Mutual Support of Norms and Case Judgments* (1992) (unpublished Ph.D. dissertation, Georgetown University).

64. See Albert R. Jonsen, *Of Balloons and Bicycles; or The Relationship Between Ethical Theory and Practical Judgment*, HASTINGS CENTER REP., Sept.-Oct. 1991, at 14.

home with a competent research review board), and the “when” (after capture and before execution vs. after the loss of capacity, the consent of family, and approval and ongoing oversight of an ethics committee). Casuistry holds that rather than assigning a timeless relative weight to a certain principle, details should determine the weight. Thus, in this hypothetical, the facts and setting of the proposed study might be so far removed from our paradigm of unethical research that they justify moral approval even without the patient’s consent.

Presented in this way, the casuistical method obviously has much in common with the method of the common law. Indeed, given the pivotal and ubiquitous role of legal cases in the recent history of bioethics—a history punctuated by such names as Karen Quinlan,⁶⁵ Claire Conroy,⁶⁶ Nancy Cruzan,⁶⁷ Helga Wanglie,⁶⁸ and Baby M⁶⁹—it was entirely natural for bioethicists to begin seeing parallels between case-based reasoning in ethics and law. On both fronts, ethicists seem to reason from the “bottom up” (from cases to fleshed-out principles) rather than from the “top down” (as most versions of applied ethics imply). The principles themselves are consequently “open textured” and always subject to further revision and specification, and the final judgments usually turn on a fine-grained analysis of the particularities of the case.

To many working in the field, this account of reasoning in both ethics and law accurately describes how ethicists actually think, both in clinical situations and in the classroom. That is, they tend to think in terms of cases, which serve as exemplars—a kind of shorthand for moral analysis and assessment: “This is a Cruzan-type case, except here, instead of a feeding tube, the issue is antibiotics” (or minimal conscious awareness, or a family insisting that everything be done, etc.). How do these different facts alter one’s perception of the case? Are they so different as to dictate an alternative result? Instead of ritualistically invoking the mantra, these ethicists propose that normative accounts of ethical reasoning should more closely conform to actual practices.

Just as the casuists insist that the weight of principles resides in the details, so they insist that moral certainty resides in our responses to paradigmatic cases, rather than in appeals to theory or principle. One is, in fact, much more confident in the knowledge that torturing and killing Jews to learn about hypothermia is wrong than in the assessment of which moral theory or principles best describes why. One is much more likely to switch allegiance to a different moral theory or conception of principles than to change his or her mind about what the Nazi doctors did. Indeed, if an alternative moral theory were to approve of the Nazis’ experiments, most would reject the theory based on that approval.

65. *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

66. *In re Conroy*, 486 A.2d 1209 (N.J. 1985).

67. *Cruzan v. Director, Missouri Dep’t of Health*, 497 U.S. 261 (1990).

68. *Wanglie v. Minnesota*, 398 N.W.2d 54 (Minn. Ct. App. 1986).

69. *In re Baby M*, 537 A.2d 1227 (N.J. 1988).

This emphasis on the case as the locus of moral certainty reveals an important split within the casuistical camp. On the one hand, some "hard core" casuists have little, if any, use for either principles or higher level theory.⁷⁰ According to this view, the principles invoked in moral argument are nothing more than tidy summaries of moral thought as it grapples analogically with cases. Such principles might serve as useful shorthand, these critics concede, but they might also mislead by allowing one to impute normative significance to mere summaries of what one has already decided.

This hard-core version of casuistry has little in common with the great historical tradition of casuistry, and it presents a problematic account of moral reasoning. As Jonsen and Toulmin's historical chapters on the rise and fall of casuistry attest, the adherents of the casuistical method have always seen their task as one of fitting the abstract principles of moral doctrine's sources, such as the Bible, ancient philosophers, moral theology, or international law, to the circumstances of cases.⁷¹

Moreover, doing without moral principles that not only summarize past behavior but also guide future conduct may be the equivalent of throwing the baby out with the bathwater. This radically anti-principlist stance derives its plausibility from the fact that, according to the theory of reflective equilibrium, moral principles originate as summations of responses to experience of particular cases. If this is so, one might reason, then it is intuitive responses alone, not the principles, that do the real work in moral decision-making. Moral principles, on this view, are thus nothing more than factual summaries incapable of providing positive moral guidance.

This radically particularistic account of moral decision-making seems to assume that if principles initially grow out of individual responses to situations, then they will be incapable of transcending the domain of the purely factual. But this assumption may give too much credit to the supposed dichotomy between facts and values. The principles that gradually emerge from one's experience with cases might be more profitably viewed as repositories of congealed value judgments. They are expressions of what is valued and devalued in the world of moral experience. Thus, the principle of confidentiality that prohibits health care providers from exposing the secrets of their patients (apart from certain compelling exceptional circumstances) can serve as a general, action-guiding norm: Unless you have a good reason, it is generally wrong to violate a patient's confidence. It makes perfect sense to say that such principles can and do guide deliberations in particular cases. Even though general moral principles must usually be supplemented by a fine-grained, particularistic assessment of a morally complex situation, they still

70. See, e.g., Stephen Toulmin, *The Tyranny of Principles*, HASTINGS CENTER REP., Dec. 1981, at 31. Toulmin's position on principles is echoed by Richard Rorty who claims that the legacy of Hegel, Marx, and Dewey is the realization that "the search for principle is a primitive stage of moral development. What counts as moral sophistication is the ability to wield complex and sensitive moral vocabularies, and thereby to create moral relevance." Richard Rorty, *Method and Morality*, in SOCIAL SCIENCE AS MORAL INQUIRY 174 (Norma Haan et al. eds., 1983).

71. See JONSEN & TOULMIN, *supra* note 34, at 1-228.

provide a kind of general orientation or moral compass. They provide, that is, reasons for acting certain ways. In depriving ethicists of the grounds for this kind of reason-giving, the radical particularists fundamentally distort one of the most basic features of ordinary moral experience.

Another problem with this view is that it appears to embrace the dubious notion that one can grasp the moral essence of individual cases through a kind of "immaculate perception" unmediated by reference to general propositions. It assumes that agents can traverse the field of their moral experience, moving from case to case, unaided by appeals to principles, theory or other abstract notions. The problem, however, is how one might decide to align any particular case against a paradigm or series of precedent cases. In order to determine that a certain case belongs to this line of cases rather than that, the casuist will require norms, whether implicit or explicit, of moral relevance. Thus, the casuist's efforts to categorize cases are necessarily "theory laden," at least in the sense that they implicate some kind of more general moral appeal.⁷² Thus, following MacIntyre, one might say that cases elucidate ethical "theory," while theory is a kind of story about how cases are to be described.⁷³

More moderate versions of casuistry make room for principles, theories, and cultural norms, while still insisting on the priority of the particular. Instead of imposing a false choice between responses to cases and principles, these ethicists envision, in the words of Martha Nussbaum, a "process of loving conversation between rules and concrete responses, general conceptions and unique cases, in which the general articulates the particular and is in turn further articulated by it."⁷⁴ These more general propositions play a role, but rarely, if ever, as mere axioms from which moral conclusions might be deduced. Whatever validity or usefulness these general notions might have will depend upon the ethicist's insight, moral sensitivity, and casuistical skill in applying them to a case.

At this point in the history of principlism and the emerging paradigm of casuistry, it should be clear that these two approaches are not as antithetical as their respective partisans often suggest. On the contrary, reformed principlists who have abandoned deductivism and moderate casuists who admit a role for principles and general notions could endorse Martha Nussbaum's dictum with equal enthusiasm. Her dictum is, after all, just another way of calling for reflective equilibrium between principles and cases.

72. See Arras, *supra* note 63.

73. See MACINTYRE, *supra* note 44, at 7-11. For additional criticisms of "radical particularism," see Jeffrey Blustein, *Principlism and the Particularity Objection* (unpublished manuscript on file with author).

74. MARTHA C. NUSSBAUM, *LOVE'S KNOWLEDGE: ESSAYS ON PHILOSOPHY AND LITERATURE* 95 (1990).

B. *The Ascendancy of Narrative*

The casuists' emphasis upon the particularities of moral situations is also a recurring theme within the emerging literature of "narrative ethics."⁷⁵ Although this classification harbors an array of writers with widely divergent viewpoints on the relationship between ethics and stories, they would agree, in common opposition to a top-down "applied ethics" model, that the story or history is the most appropriate form of representing moral problems.

To support this claim, the partisans of narrative can point to the history of contemporary bioethics, which is in a sense a history of the "big cases." Whatever the so-called principles of bioethics might mean at this juncture, they have achieved their meaning through collective reflection upon a set of compelling stories. While the two dominant theoretical paradigms in ethics, Kantianism and utilitarianism, have been consistently indifferent or hostile to the role of narrative in ethical reasoning, the field of bioethics has moved the story or case study to center stage.

While some partisans of narrative ethics advance very strong and controversial claims,⁷⁶ I think all would agree that a complete story or history is a prerequisite to any responsible moral analysis. Before one can attempt to judge, one must understand, and the best way to understand is to tell a nuanced story.

Thus, to debate the issue of assisted suicide, for example, one should not rely on abstract, asocial, and timeless propositions, but rather begin within the context of a full-bodied case. Dr. Timothy Quill's well-known case study of Diane, a patient requesting assisted suicide, provides an excellent illustration of this narrative approach.⁷⁷ Instead of focusing on the derivation and specification of principles, Dr. Quill gives us a rich picture of the "players" and their characters. First, there was Diane, a courageous but fearful cancer patient seeking control of her dying process, a woman who had already overcome a previous cancer threat and her own debilitating alcoholism. Next, there was Dr. Quill himself, a competent and clearly compassionate physician torn between loyalties to his patient and professional ethics, a man courageous enough to "take small risks for people [he] really know[s] and care[s] about."⁷⁸ Then Dr. Quill explores the roles that the players occupy: a doctor trained to preserve life rather than end it; a patient who is also a wife, mother, and respected friend. He tells us about their prior and ongoing relationship: how he had witnessed and rejoiced when Diane triumphed over adversity, and

75. See, e.g., HOWARD BRODY, *STORIES OF SICKNESS* (1987); ALASDAIR C. MACINTYRE, *AFTER VIRTUE* (1984); NUSSBAUM, *supra* note 74; Margaret U. Walker, *Keeping Moral Spaces Open: New Images of Ethics Consulting*, HASTINGS CENTER REP., Mar.-Apr. 1993, at 33; David Burrell and Stanley Hauerwas, *From System to Story: An Alternative Pattern for Rationality in Ethics*, in KNOWLEDGE, VALUE, AND BELIEF 111-52 (H.T. Englehardt, Jr. & Daniel Callahan eds., 1977).

76. Nussbaum, for example, argues that narrative is the *only* proper medium for some philosophical issues. See NUSSBAUM, *supra* note 74, at 3.

77. Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691 (1991).

78. *Id.* at 694.

how he anguished with her over the current threat. He describes his own doubts and hopes for Diane's future and the future of their relationship. He wonders whether prescribing a lethal dose might restore her spirits and give her more emotional comfort in her final struggle. He also alludes to the institutional and social context, albeit in my opinion not sufficiently,⁷⁹ with references to the current state of the law.

Although a reconstructed principlist might object at this point that all the above matters can and should be folded into a principlistic analysis as components of "the case," I think it remains true that the partisans of moral theory and principlism have not given many of these issues their due. This is especially true of Quill's concern to sketch the moral character of his players, the nature of their past and future relationships, and the fine details of their institutional and social context. As Bernard Williams has argued, most received moral theories operate with impoverished or empty conceptions of the individual.⁸⁰ To bring the moral individual into clearer focus, he claims, one must attend to his or her differential particularity, to the desires, needs, and "ground projects" that coalesce into the *character* of the person. But if one is concerned with the depiction, understanding, and assessment of character, one can do so only by telling and retelling stories.⁸¹

Finally, note that there is an important pedagogical value of narrative approaches to ethics. A common thread uniting these "new paradigms" in bioethics is their emphasis upon particularity—of persons, character, situations, and histories. Both the casuists and narrativists insist that if one is to "do ethics" well, one must be, in the words of Henry James echoed by Martha Nussbaum, "finely aware and richly responsible"⁸² to precisely these particularities.

It may be that the study of ethical theories and a concern for properly defining and specifying principles will make one a better judge of moral problems and policies. But without an equal if not greater concern for the particularities and nuances of specific situations, the "applied ethicist" will be operating as if in the dark. One very important way for students of morality, both young and old, to acquire and refine this sensitivity is to encounter complex narratives of real or fictional characters, situations, and events. Whereas philosophers' examples and at least one philosopher's⁸³ fiction tend to present narratives clearly in the service of some doctrine or rule, stories cultivate, in Nussbaum's fine phrase, "our ability to see and care for

79. Indeed, in my opinion, Quill's major failing is to have inadequately considered the implications of introducing the *practice* of assisted suicide within the context of a society that fails to provide adequate health care, including pain relief and treatment for depression, to millions of potential candidates.

80. Bernard Williams, *Persons, Character and Morality*, in *MORAL LUCK* 1, 1-19 (1981).

81. For a more fully developed statement of the fit between narrative and the depiction of character, see TOBIN SIEBERS, *MORALS AND STORIES* 15 (1992).

82. NUSSBAUM, *supra* note 74, at 148.

83. See generally SARTRE, *supra* note 8.

particulars, not as representatives of a law, but as what they themselves are⁸⁴

VI. THE ROLE OF CASES RECONSIDERED

What are the implications of these challenges to the reigning paradigm for the understanding and use of case studies? As has been seen, the "applied ethics" movement, while continuing the long tradition of viewing cases as mere illustrations of more theoretical propositions, began to envision cases as problems in their own right that required the assistance of philosophical theory. The particularist critique of this "applied ethics" model suggests two additional roles for case studies within the practice and teaching of bioethics.

First, the critique of deductivism, endorsed now by reformed principlists and casuists alike, assigns an important role to cases in the dialectic of reflective equilibrium. Instead of viewing cases as entirely subordinate to theory and/or principles, there is now common agreement that cases provide the considered judgments from which principles eventually evolve. There is also widespread agreement that while principles may continue to exercise normative force over judgments in particular cases, those very judgments can serve to test, specify, and even disprove particular formulations of principle and theory.

The analysis and assessment of case studies thus assumes a much more integral role in the process of moral reflection and theorizing than either the standard applied ethics model or the philosophical tradition had envisioned. Indeed, in such a constructivist model the very notion of "applied ethics" is redundant, since all ethics is "applied" in the sense that it grows out of particularities and is constantly tethered to them in a process of perpetual readjustment.

A second new role for case studies within particularized bioethics is to serve as a laboratory for students and teachers alike to learn how to perceive, comprehend, and judge ethically. Whereas the more mechanistic variants of applied ethics simply assumed that all the ethical heavy lifting went into the formulation of theory and principles and that the process of "application" was only a matter of bringing factual particulars under the rule of normative principle, the emerging paradigms in bioethics draw attention to neglected aspects of moral reasoning and to skills that can be developed and nurtured through narratives and case analysis. Importantly, again in contrast to the nearly exclusive emphasis on principles and rule-governed behavior within applied ethics, most of these skills are not rule-governed and do not fit within a paradigm based upon a correspondence theory of ethical truth.

Consider, for example, what I have elsewhere called the skill of "moral diagnosis."⁸⁵ The very first step in moral analysis is the question: "What kind of case is this?" Confronted with a particular case, one must immediately

84. NUSSBAUM, *supra* note 74, at 184.

85. Alan R. Fleischman & John D. Arras, *Teaching Medical Ethics in Perinatology*, 14 CLINICS IN PERINATOLOGY 395 (1987).

start casting about for an appropriate general description. Since cases do not come pre-labelled, and since different observers can and do disagree about what certain cases are “really about,” an essential part of one’s “moral education” should involve the process of “diagnosing” morally problematic aspects of cases. Although some judgments are clearly better than others in this domain, the process is anything but rule-governed. Indeed, it requires a great deal of moral imagination and creativity to plot where the most important problems lie or to reframe the terms of a protracted debate in a way that both sides can accept and use as the platform for a fruitful compromise.⁸⁶

The development of this sort of diagnostic skill or art is crucial in clinical and policy settings, especially in view of the temptation for consultant ethicists to simply accept at face value the presuppositions of professionals in their labelling of cases. Although I am not advocating a return to heavily theory-driven examples and cases, it is naive to think that moral problems exist independently of theory, broadly understood to encompass views of the good, principles, virtues, or professional ideology. Without careful attention to developing this skill of collaborative moral diagnosis, consultant ethicists will be reduced to playing the role of Jeeves to their respective employers.

In addition to the art of moral diagnostics, exposure to cases and narratives fosters other non-rule-governed skills crucial to ordinary moral reasoning. As Martha Nussbaum emphasizes, exposure to stories (especially the novels of Henry James) develops the ability to discern the particularities of morally charged situations, to be “finely aware and richly responsible.”⁸⁷ Likewise, observing skilled clinical casuists at work can hone one’s capacities for analogical reasoning—the engine that drives most practical reasoning—and for judiciously weighing and balancing competing values. Finally, exposure to case studies can acquaint students of ethics with various practical strategies for coping with risk and uncertainty,⁸⁸ and with exemplars of morally necessary (and unnecessary) compromise among equally well-informed and well-meaning participants.⁸⁹

86. During the course of a heated case conference in our Intensive Care Unit (“ICU”) at Montefiore Medical Center regarding a case involving a family’s request to wind down aggressive treatments, my colleague Nancy Dubler made the suggestion that this case was “really” about how to offer a patient hospice care in the context of an ICU. Both sides of the argument, those who favored the gradual withdrawal of life-sustaining treatment and those who opposed it on the ground that the mission of the ICU is to provide precisely this kind of aggressive care, welcomed this “reframing” of the issue as a way out of their quagmire. There is nothing rule-governed about this skill; it grows out of experience, imagination, and good judgment.

87. NUSSBAUM, *supra* note 74, at 148.

88. Nancy K. Rhoden, *Treating Baby Doe: The Ethics of Uncertainty*, HASTINGS CENTER REP., Aug. 1986, at 34.

89. MARTIN BENJAMIN, *SPLITTING THE DIFFERENCE: COMPROMISE AND INTEGRITY IN ETHICS AND POLITICS* (1990).

VII. THE RECALCITRANT PATIENT RECONSIDERED

To bring the form of this Article into closer conformity with its point, I shall conclude with a case and commentary that illustrate the value of enhanced particularity for ethical analysis. The case concerns the same recalcitrant TB patient encountered earlier, presented this time with a semblance of the detail demanded by the "emerging paradigms" in bioethics:

The patient AB is a 42 year old Hispanic male. He has known that he is HIV-positive since 1989. He has been and continues to be an intravenous drug user. He was found by the Emergency Medical Service team in early April 1992, wandering and disoriented with a tourniquet still attached to his arm. He was brought to the hospital to rule out TB and endocarditis because of an active cough and a temperature of 105 degrees.

Upon admission to the hospital, the patient's previous admissions were not immediately discovered because his two prior chart histories in the record room were linked to two different names and sets of personal data. Because of his admitting condition, however, and an X-ray that showed severe upper lobe infiltrates, he was placed in a single room and initially begun on INH, RIF, PZA, and EMB.

Once the patient's medical history was reconstructed from the previous admissions, he was shown to have had two admissions in the previous three months and to be HIV-positive. He had received three or four weeks of therapy during that time, although none of it was consecutive. TB had been first diagnosed in January, it was sensitive to all drugs. A drug-resistant strain was confirmed upon sputum culture in March during his second admission; the organism was identified as resistant to INH and PZA. Upon the third admission, as on the prior two admissions, AB was placed in a negative pressure isolation room and ordered not to leave this space. When his prior drug sensitivities became available, he was placed on a six-drug regimen that included parenteral amikacin.

The patient refused to stay in his room. He had been promised that a television and a telephone would be connected. When neither happened, he went in search of both. He also complained that the room was very cold and uncomfortable. After he had been found in the elevators and in the lobby of the hospital, the nurses took away his clothes. He was again found wandering in the hall. At that point the resident on duty called the guard and had the patient handcuffed to the bed by his hands and feet. He was also "posied", confined by a bed jacket with straps that were tied to the bed.

The room was in fact quite cold, as is often the case with negative pressure, highly ventilated rooms. In addition, blankets were in very short supply in the hospital. As some patients were being given a stack of sheets in lieu of blankets, the nurses did not feel that they could give this particular patient more blankets. Even if the supply had been adequate, staff might not have been forthcoming. Once he had been gowned, cuffed, and posied, AB was quite cold and miserable.

The next morning after the patient had been released from restraints for breakfast and was again found in the lobby, the resident called for a guard and asked the Department of Health for a detention order; it was issued.

During this time the staff caring for the patient had no special protections. No "microspore" masks were available. The rumor in the hospital was that some would be available soon. The most effective masks, however, would be available only for special technicians such as those

doing induced sputum cultures. Masks at the next level of effectiveness would be available to the general staff. At this point, none were available except for those "liberated" from a nearby hospital. The resident in charge of the patient was pregnant and very afraid of contracting TB; she had, therefore, not actually seen or spoken to him.

Once the detention order was issued, the hospital placed the patient under "one-to-one" surveillance with a guard beside the door at all times. The cost of such supervision is approximately \$100,000 per year.

Once the guard had been posted, the patient began refusing medications selectively. Some of the refusals seemed random. Some, however, were comprehensible. For example, he refused to take amikacin. The administration of this medication can be either intramuscular or intravenous. Assuming that there were no available veins to administer the drug intravenously, the staff had begun the intramuscular administration that he regularly refused because of the pain and discomfort. They then discovered that it was, indeed, possible to administer the medication intravenously. He did not refuse the medication in this form.

Approximately one week after admission, AB was shifted to a different single room that was less cold. He was also provided with a television and a working telephone. After four weeks of treatment, his fever abated, and he felt much better. He began to talk about leaving the hospital. He also began pulling out the intravenous drips used to administer the amikacin. His last three smears were negative, but his X-ray continued to show a large upper lobe infiltrate.⁹⁰

In the first encounter with Mr. AB, the issue was simple: Should the patient be permitted to roam the corridors and lobby of the hospital where he might infect others with a potentially lethal strain of TB, or should he be forcibly detained in his room or, if necessary, on his bed? While the above "thicker" description of the case poses the same question, it reveals particularities about the patient's life in the hospital and his relations with others that might fundamentally alter one's attitude towards the case and the patient.

The second version of the case tells the story of a patient who exists, and is expected to tolerate existing, in near total isolation from the outside world. He has no phone, no radio, and no TV. Because his virulent strain of TB might be easily communicated to the staff, Mr. AB's own physician, a pregnant resident, refuses to enter his room. In addition, his room is now described as exceedingly cold and uncomfortable. Blankets would help, but they are unavailable. This is, after all, a chronically underfunded and ill-equipped public hospital. Clothes would help too, but they have been taken away by nurses to prevent him from wandering.

The relationship between Mr. AB and the hospital nursing staff emerges as a distinct theme in the second version. It is a terrible relationship. Mr. AB is no doubt acting in an irresponsible and disrespectful manner towards the nurses, and the nurses regard him, an HIV-infected drug abuser, as the classic "hateful patient." The narrative implies that even if the nurses had the

90. NANCY DUBLER ET AL., A SPECIAL REPORT, THE TUBERCULOSIS REVIVAL: INDIVIDUAL RIGHTS AND SOCIETAL OBLIGATIONS IN A TIME OF AIDS app. C, at 33-34 (United Hospital Fund of New York, 1992).

requisite blankets, they may not have given him some, just to punish him for his ongoing bad behavior.

The second narrative better details the handling of this difficult patient. It spells out in graphic detail exactly what it means for public health concerns to prevail over individual liberty on the floors of this particular hospital. In order to neutralize Mr. AB as a threat to the health of others, he is stripped of his clothing, placed in four point "restraints" (or handcuffs), and posed to the bed. The second account also shows that the patient may not be the irrational maniac suggested by the first description. After he finally gets a new room and some conveniences to occupy his time, he begins to cooperate with his treatment regimen, and some of his aversions are found to have a rational basis: they hurt and other modalities are available.

The thicker account of the case prompts reflection on additional ethical issues. The first issue concerns the meaning of this patient's "noncompliance." The first version does not explain his behavior; the second, expanded version allows one to comprehend and to "deconstruct" the notion of noncompliance. Mr. AB belongs to a class of patients who combine drug use with HIV-infection and TB. Many are homeless and impoverished; most who are noncompliant tend to manifest definite psychiatric disturbances. In the stressed and chaotic setting of the urban, public hospital, the needs of such patients often go unmet. With the lack of adequate social and medical supports, it is not surprising that people like Mr. AB have trouble cleaving to an extraordinarily strenuous and demanding medical regimen.

Who is to blame for Mr. AB's situation—Mr. AB or the social system that makes it nearly impossible for him to succeed? Seen through the "thick" account, the patient's "noncompliance" reveals an unnoticed social dimension of utmost importance both for individual patient care and social policy.

The second set of issues flagged by the thicker description concerns the relationships between Mr. AB and his health care providers. Although nurses, at least in my limited experience, generally tend to be more caring and compassionate with patients than physicians, the nurses in this case may have crossed the line between understandable exasperation with a difficult case and patient abuse. It is one thing to resent the hostile, noncompliant, and dangerous behavior of a patient, but it is something else again to strip him of his clothes in a frigid room, strap him down, and force toxic antibiotics into his body. This episode prompts one to reflect upon how powerful emotional responses can cloud judgment and interfere with professional behavior.

A related issue posed by this version of the case concerns the limits of one's professional obligation to treat difficult or dangerous patients. For the medical team, Mr. AB presents a triple threat: he is a potentially violent drug abuser, is HIV-infected, and is the host of a drug-resistant strain of TB. While the first two threats do not prevent most health care providers from attending to such patients, the third posed a serious problem for Mr. AB's pregnant resident physician.

What are the limits of professional obligation, especially for pregnant professionals, when confronted by serious health risks? In considering this,

also recall the additional element of this case: This hospital failed to provide its physicians and nurses with the kinds of masks needed to protect themselves against the deadly strain of TB. Can the hospital expect its physicians and nurses to fulfill their ethical obligations to patients when it has not provided them with adequate protection? Again, a thicker description reveals the distinct social dimensions of the problem.

Finally, this more robust account of Mr. AB demonstrates the danger for ethical analysis of relying exclusively on certain actors' pictures of "the case." For example, relying on the housestaff and nurses probably would have produced a picture resembling the first sketch. With this limited picture, one sees the patient's vexing and dangerous behavior, but misses the additional issues the second sketch reveals. Thus, the testimony of social workers familiar with society's shocking neglect of such patients is welcome and necessary. To be sure, the perspectives of physicians and nurses involved in a case are indispensable in the construction of an adequate story, but they only provide a part of the story. To develop a larger psychological, social, and ethical context, the ethicist-consultant must actively participate in the development of "the case," rather than play the role of a passive recipient of professionals' stories.

CONCLUSION

What is the role of cases and case studies within the discipline of bioethics? This survey of the emergence of "applied ethics" and of the challenge of "new paradigms" reveals different answers to this question that reflect different conceptions of moral inquiry.

The philosophical tradition, with few exceptions, makes use of "examples" designed to illustrate theory, but has no use for case studies as we know them. The "applied ethics" movement in its early, "heroic" phase embraced case studies not merely as another vehicle for exemplifying theory, but as real-life problems to be solved with the aid of philosophical theory and moral principles.

The critiques of "applied ethics" and principlism by the partisans of casuistry and narrative ethics have further expanded the importance and role of case studies. For the casuists, cases provide the considered judgments and paradigms from which moral principles ultimately are derived and to which they must remain faithful within the creative tension of reflective equilibrium. Cases also put flesh on abstract moral principles, giving them concrete meaning, weight, and specificity. For the partisans of narrative, cases or stories provide the best window into the phenomenon of moral character while sharpening our ability to see particulars, "not as representatives of a law, but as what they themselves are . . ." ⁹¹ For both casuists and narrativists, cases provide a laboratory for the development and nurturing of many important non-rule-governed aspects of moral reflection, such as the ability to reframe

91. NUSSBAUM, *supra* note 74, at 184.

and diagnose moral problems, to reason by analogy, and to engage in the judicious weighing and balancing of competing principles and values in concrete circumstances.

This shift towards the particular as the focus of moral inquiry has been accompanied by a parallel movement towards a different conception of moral justification. The applied ethics movement began in a powerful burst of enthusiasm for theory as the ultimate warrant for the rectitude of moral judgments. With the waning of this theory-driven, top-down, deductivist model of moral reasoning, justification was sought in moral principles derived through a process of reflective equilibrium. Instead of viewing moral justification as a question of correspondence between case judgments and the correct moral principle, justification is now sought in the overall coherence among case judgments, principles, cultural values, and ideals.

Implicit in this shift from correspondence to coherence is a parallel shift in emphasis from the individual to the social group as the focus of moral justification. Instead of searching for moral justification in a connection between an individual's judgment and some objective, universal, moral principle or theory, the particularist paradigms point, either implicitly or explicitly, to the social group as the ultimate "ground" or "foundation" of moral truth. Just as Thomas Kuhn has argued that the authority of scientific judgments resides in the consensus of its practitioners—that there is no transcendent warrant for different pictures of the world or scientific paradigms⁹²—recent developments in bioethics also point to consensus within the community of inquirers, which includes the professions and the general public, as the ultimate but provisional warrant for actions and policies.⁹³

As good Kuhnian paradigms, these particularist movements generate new problems as they challenge old methods. Perhaps foremost among these are the problems of critique and intercultural conflict. Just a few words about each may be in order before closing.

The great virtue of deductivism and of principlism in its early days of methodological slumber was their ability to criticize paternalistic assumptions and practices deeply embedded in the medical community. Of course, the norms on which this critique was based—such as respect for persons, for truth-telling, and justice—did not come from some detached realm of moral truth. Even if they were not embedded in medical practice, they belonged to the moral vocabulary of the larger society, where all the patients lived. What is one's response, however, when skeptics challenge the received wisdom and moral consensus of this larger society? What is the response when, for example, a long line of cases, developed casuistically and analogically, seems headed in the wrong direction? What should be done, in other words, about the problem of "bad coherence"?⁹⁴

92. Gary Gutting, *Paradigms and Hermeneutics: A Dialogue on Kuhn, Rorty, and the Social Sciences*, 21 AM. PHIL. Q. 1, 4 (1984).

93. JONATHAN MORENO, *THE SENSE OF THE HOUSE: BIOETHICS AND MORAL CONSENSUS* (forthcoming 1995).

94. Margaret J. Radin, *The Pragmatist and the Feminist*, 63 S. CAL. L. REV. 1699, 1710 (1990).

This old question continues to haunt the partisans of particularism, including pragmatists and communitarians. One response, explored by Michael Walzer, is to emphasize the richness and diversity of most developed cultures, which usually harbor within themselves sufficient resources for vigorous critiques of existing assumptions and arrangements.⁹⁵ Another suggestion, offered by Tom Beauchamp at this Symposium, is that this task of correcting misguided casuistical analysis naturally falls to moral principles.⁹⁶ Indeed, Beauchamp argued that a continuing emphasis upon principles is necessary in order to steer casuistical analysis in the right direction.⁹⁷ In any case, the partisans of particularity need to grapple more carefully with this problem.

A related issue facing these new paradigms in bioethics is the problem of identifying the "we" that is the subject of moral consensus and devising ways of mediating conflicts between competing communities of inquiry and meaning. In the early years of the "applied ethics" movement, it was basically assumed that the so-called principles of bioethics were objective, timeless, and universal. Given the intellectual indebtedness of this movement to utilitarianism and Kantianism—two theories that fancied themselves as being objective in this sense—this was a thoroughly predictable assumption. The more one probes the particularities of different communities and cultures, however, the more likely one will discern differences in the meaning and weight of various moral principles, values, and ideals—differences that tend to preclude the kind of consensus sought.

Who, then, shall count as a member of the "community of inquiry"? A seventeen-year-old Latina, infected with HIV, who wishes to have a child in spite of the thirty percent risk of infecting her offspring with a lethal disease? Is her behavior "rational" or "responsible" according to her community? Is it rational according to "ours"? In case of a disagreement, how should one proceed?

Although a precarious consensus has emerged on a surprising number of bioethical issues, one must be alert to the fact that a heightened sensitivity to social and cultural particularity will often subvert consensus rather than foster

95. WALZER, *supra* note 59, at 39, 50.

96. Tom L. Beauchamp, *Principles and Other Emerging Paradigms in Bioethics*, 69 *IND. L.J.* 955, 962-66 (1994).

97. *Id.* Although I agree with Tom Beauchamp that principles may serve as a beacon for casuistical analysis—along with notions of the good life, virtues, cultural commitments, etc.—I am skeptical of his claim that principles will be especially useful in keeping casuistical reasoning on the straight and narrow. In the first place, as I have discussed, the way of ethical truth, mediated as it is by community and consensus, is neither particularly straight nor narrow. In many instances in bioethics, the ultimate question seems to be: "What kind of life are we forging together?", rather than: "Is this particular approach, for example, to reproductive technologies, morally correct?". Second, since our principles in large measure stem from our considered judgments about particular cases, they are likely to be "infected" by the same misguided casuistry they are supposed to correct. (The fault will often lie in our considered judgments. The Greeks, for example, found slavery to be perfectly natural.) And third, there is no reason to think that the existence and invocation of moral principles will necessarily serve as reliable correctives regarding moral truth. Casuists have no natural advantage over principlists in their ability to generate bad lines of case judgments. Having moral principles at your disposal does not guarantee that you will "apply" them well. Until principles are joined to the particularities of cases, they will remain abstract "chapter headings" capable of "justifying" contradictory case interpretations.

it. Partisans of the new paradigms of bioethics must prepare to meet this new challenge.