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Specified Principlism: What is it, and Does it Really Resolve Cases Better than Casuistry?

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ABSTRACT

Principlism has been advocated as an approach to resolving concrete cases and issues in bioethics, but critics have pointed out that a main problem for principlism is its lack of a method for assigning priorities to conflicting ethical principles. A version of principlism referred to as 'specified principlism' has been put forward in an attempt to overcome this problem. However, none of the advocates of specified principlism have attempted to demonstrate that the method actually works in resolving detailed clinical cases. This paper shows that when one tries to use it, specified principlism fails to provide practical assistance in deciding how to resolve concrete cases. Proponents of specified principlism have attempted to defend it by arguing that it is superior to casuistry, but it can be shown that their arguments are faulty. Because of these reasons, specified principlism should not be considered a leading contender in the search for methods of making justifiable decisions in clinical cases.

Key words: casuistry, coherence, ethical justification, principlism, specified principlism

I. INTRODUCTION

Principlism is an approach to resolving issues in medical ethics that has been put forward in several influential works (Beauchamp and Childress, 1994; National Commission, 1978; Frankena, 1973). Its main feature is that it gives central importance to a set of nonabsolute ethical principles, most commonly autonomy, beneficence, nonmaleficence, and justice. One of the main objections to principlism, however, is that it contains no method of assigning priorities to these principles when they conflict in the context of specific cases and issues (Clouser and Gert, 1990; DeGrazia, 1992; Davis, 1995). Because the ability to help us resolve concrete cases and issues is one of the main characteristics we seek in an ethical frame-

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work, this problem is serious and undermines principlism's claim to be a method of ethical justification.

In response to this objection, a version of principlism referred to as 'specified principlism' has been put forward in articles by Henry S. Richardson (1990) and David DeGrazia (1992) and embraced by principlism's leading proponents, Tom L. Beauchamp and James F. Childress (1994).[1] Some of these advocates of specified principlism not only claim that it provides an approach to assigning priorities to conflicting ethical values, but speak of it with high praise. Richardson states that "… specifying our norms is the most important aspect of resolving concrete ethical problems …" (1990, p. 294). Similarly, DeGrazia claims that "specified principlism is the most promising model of justification in bioethics" (1992, p. 511). In attempting to defend specified principlism, they maintain that it is superior to casuistry because it provides a better account of the ultimate justification of ethical judgments and because of other supposed shortcomings of casuistry, to be discussed below.

In this paper I take issue with these claims. I argue that specified principlism fails the test of usefulness; that is, it does not provide a practical method for arriving at justifiable resolutions of specific cases in which principles conflict. Thus, the claim that specifying principles is the most important element in resolving concrete moral problems is unwarranted. In addition, the proponents of specified principlism overlook the fact that casuistry can take various forms and that it is possible to conceive it in a way that overcomes the objections they raise against it.

II. WHAT IS SPECIFIED PRINCIPLISM?

Specified principlism, its proponents claim, is a method for making justifiable ethical decisions concerning specific cases and policy issues. It retains principlism's framework, consisting of a set of general nonabsolute ethical principles, and it adds the following idea: conflicts between principles are to be resolved by qualifying the principles, making them more specific, so that their modified forms continue to apply to the case (or issue) at hand but no longer conflict. The defense of a particular specification of principles is to be based on a coherence model of justification (Richardson, 1990, pp. 300–302; DeGrazia, 1992, pp. 529–530; Beauchamp and Childress, 1994, pp. 20–40, 100–111), which derives from John Rawls's idea of 'reflective equilibrium' (1971). According to this idea, when our considered judgments about cases conflict with our ethical principles, the judgments and principles should be modified until there is

no conflict – that is, until an equilibrium is reached. Proponents of specified principlism embrace the concept of 'wide reflective equilibrium', according to which background theories are brought into the equilibrium process (Daniels, 1979; 1996). Background theories are construed broadly to comprise empirical, moral, and metaphysical theories and views that have a bearing on moral arguments. Examples include theories concerning the nature of personhood, theories about the nature and point of morality, beliefs about the implications of decision theory and accounts of rationality for morality, and beliefs about human psychology and sociology and their relevance to moral justification (DeGrazia, 1992, p. 530; Daniels, 1996, pp. 6, 23). When there are conflicts, the judgments, principles, and background theories are modified until an equilibrium – a state of coherence – is achieved. Proponents of wide reflective equilibrium claim that the addition of background theories to the equilibrium process enhances the credibility of the final decisions by making them rest less heavily on intuitive judgments, which can sometimes be biased. A coherent set of judgments and principles is characterized by logical consistency and mutual support among principles, in the sense that some principles explain others (Richardson, 1990, p. 300; Rawls, 1971, pp. 21, 579; DeGrazia, 1996, pp. 14–19). Typically, but not always, the removal of a conflict enhances mutual support (Richardson, 1990, p. 302). According to specified principlism's advocates, a specification is rationally defensible if it maintains or increases the mutual support among the total set of judgments, norms, and theories (Richardson, 1990, p. 302; DeGrazia, 1992, p. 529).[2]

An illustration will be helpful in further explaining specified principlism. Among the several examples provided by Richardson, one is a bioethics case, so let us consider it. Richardson poses a hypothetical situation involving a decision about "whether to withhold nutrition and hydration from a severely malformed newborn so as to let it die" (1990, p. 303). Few details about the case are provided, as acknowledged by Richardson. He does not inform us, for example, about the nature of the malformation. He only tells us that "the mother and father want to let their baby die," but that "it does not appear that the infant in question would be better off dead" (pp. 303–304).

The process of resolving the case by specifying principles begins by identifying the main ethical principles in conflict. Richardson claims that there are three principles: (1) a prohibition on directly killing innocent persons;[3] (2) a duty to respect the reasonable choices of parents concerning their children; and (3) a duty of medical personnel to benefit the persons over whom they have responsibility – in this case, the infant and

the mother. Richardson states that there is a conflict between the first principle and the other two, and he attempts to resolve this conflict by specifying the principles. The first principle is specified as follows: "It is generally wrong directly to kill innocent human beings who have attained self-consciousness, and generally wrong directly to kill human beings with the potential to develop self-consciousness who would not be better off dead, but it is not generally wrong directly to kill human beings who meet neither of these criteria" (p. 304).[4] The second principle is specified as requiring "that one respect the reasonable choices of parents regarding their children so long as they respect the children's rights" (p. 305). These more specific versions of the principles continue to cover the case at hand but do not conflict. Giving the infant nutrition and hydration is now consistent with the specifications of the first and second principles, assuming that the infant has the potential to develop self-consciousness and has a right to life, assumptions that Richardson seems to make. These specifications of the principles yield the conclusion that the proper way to handle the case is to provide nutrition and hydration, according to Richardson.

The fact that Richardson does not present a detailed case example is consistent with his claim to be presenting a *schematic* example (p. 302). His goal, apparently, is not to provide a detailed resolution of a specific case, but rather to suggest how the reasoning would go if one used specified principlism. This interpretation of his example is supported by the fact that he never fully explains how the supposed conflict between the first and third principles is to be eliminated by further specification.[5]

III. PROBLEMS WITH SPECIFIED PRINCIPLISM

One important test of a method of resolving concrete cases is to see how it works in actual practice. Perhaps the most basic requirement is that the method actually be able to deliver justifiable answers in specific cases. The inability to yield justifiable answers in concrete cases is one of the main shortcomings of traditional ethical theories such as Kantianism and utilitarianism (Strong, 1988) and is precisely the problem with principlism that specified principlism seeks to address. It is interesting to note, therefore, that Richardson does not attempt to explore whether his method actually works by applying it to a detailed concrete case. Moreover, as far as I know, none of the proponents of specified principlism has published an illustration showing that their method actually works in resolving concrete detailed clinical cases.

Because Richardson's example does not consider and attempt to resolve a detailed case, some serious problems with specified principlism go unrecognized. When one attempts to carry out his proposed method of decision-making in specific detailed cases, two important points become evident: (1) one must choose between alternative ways of specifying principles, and this choice requires a prior decision concerning how priorities ought to be assigned to the conflicting ethical principles in the context of the case in question; and (2) the actual work in the assigning of priorities is not done by the specification itself, but by some other method or methods, which can include casuistic reasoning. When casuistry is used (and is successful), for example, it is the *casuistic reasoning* that brings one to a decision about how to assign priorities; only then is one in a position to proceed with the task of deciding how the principles ought to be specified.

Defenders of specified principlism might regard these points as benign because they believe that casuistry is unable to provide a discursive justification of the decision reached. After casuistry (or some other method) suggests how to assign priorities, they maintain, specification of principles is necessary to obtain a discursive justification. The fatal flaw with their position, however, is the failure to recognize that casuistry *is* able to provide discursive justifications, as I shall argue below. Thus, if one specifies the principles after casuistry brings one to a decision about how to assign priorities (assuming that justifiable specifications of the principles *can* be identified), those specifications would only provide an alternative way of *expressing* a justification for a decision that had already been reached and justified by casuistic reasoning. Specifying the principles would not constitute any part of the decision procedure.

These points can be illustrated by attempting to use specified principlism by applying it to a more detailed version of Richardson's case. Although the detailed case I shall use adds facts, it preserves all the features stated by Richardson: it involves a newborn with severe malformations for whom the issue of withholding nutrition and hydration arises; the parents do not want aggressive treatment to be provided; and it does not appear that the infant in question would be better off dead. To illustrate the usefulness (or lack of usefulness) of the methods to be discusssed, I have tried to select a case in which it is not immediately obvious whether the parents' request to withhold nutrition and hydration should be honored. The additional facts are as follows:

Case 1. A female newborn was diagnosed by karyotype to have trisomy 18 syndrome. A heart murmur and an X-ray showing an enlarged heart suggested a heart defect, possibly a ventricular septal defect[6] or a coarc-

> tation (narrowing) of the aorta. Also, the infant had an esophageal atresia, a condition in which the esophagus does not extend to the stomach. Infants with trisomy 18 syndrome have a poor prognosis. Thirty percent die within the first month and 50 percent by two months. Approximately 10 percent survive the first year but are severely mentally impaired, and long-term survival is rare (Jones, 1988, p. 20; Geiser and Schindler, 1969). Several life-support measures had been provided while waiting for the karyotype results. These included giving water containing dextrose and essential electrolytes (such as potassium and sodium) by intravenous line and monitoring the concentrations of various electrolytes in the blood to prevent harmfully abnormal levels. Other life-support measures were being considered: it was possible surgically to correct the esophageal atresia, enabling the infant to take fluids and nutrition by mouth; also, the heart defect would probably be amenable to surgical correction when the infant was older, if she survived. The parents have requested that surgical correction of the esophageal atresia not be performed and that fluids and nutrition not be provided. Should their wishes be respected?[7]

Now that we have added details, the first point to be made is that Richardson's particular choice of specified principles does not seem to resolve the case. Withholding nutrition, hydration, and surgical correction of the esophageal atresia seems to be consistent with Richardson's specification of the first principle because the infant probably lacks the potential for self-consciousness. It is reasonable to believe that the neonate probably lacks this potential because the cognitive impairment is probably severe enough to preclude self-consciousnesss and, even if it is not, the infant likely will not survive long enough for self-consciousness to develop. Also, withholding these procedures is consistent with Richardson's specification of the second principle *provided* that such withholding of treatment would not violate any of the neonate's rights. However, it is not clear what rights we should say the neonate has. Should we say that the infant does not have a right to the expensive surgery and intensive care that will extend life only temporarily? Or should we say that the infant has a right not to be starved to death? Such questions have been controversial for a number of years. Even if it is acknowledged that there is no duty to provide all possible life-preserving measures in this case, it still can be asked how far one must go in providing nutrition and hydration to an infant with trisomy 18 syndrome.[8] Thus, Richardson's specifications of the two principles do not clearly remove the conflict between them. It seems that additional, or perhaps entirely different, specifications are needed.

When we attempt to explore other specifications, we soon discover that there are various forms they could take. The first principle might be specified as follows: "It is generally wrong to withhold nutrition and hydration from sentient handicapped newborns." In addition, the second principle might be specified as requiring "that one respect the reasonable choices of parents regarding their children so long as they respect the child's rights, which include the right of sentient handicapped newborns not to be allowed to starve to death." These specified versions of the first and second principles do not conflict, and they yield the conclusion that the parents' request should not be met.[9]

On the other hand, the first principle could be specified as:

> It is generally wrong to withhold life-preserving treatment from handicapped newborns, so long as the infant's anomalies are compatible with long-term survival and the treatment would provide more than minimal benefit to the infant, but it is not generally wrong to withhold life-preserving treatment from handicapped newborns if either of these criteria is not met.

Also, the second principle could be specified as follows:

> The reasonable choices of parents concerning their children should be respected so long as they respect the child's rights, which include a right of handicapped newborns not to be allowed to starve to death unless the anomalies preclude feeding by mouth, the anomalies are incompatible with long-term survival, and aggressive treatment to provide nutrition and hydration would produce only minimal benefit for the infant.

Again, the specified versions of the first and second principles do not conflict, asssuming that aggressive treatment in this case would provide no more than minimal benefit to the infant, but now they yield the conclusion that the parents' request should be honored.

How are we to decide which of these (or other possible) specifications we ought to accept? How do we decide which side of the issue the specifications should endorse – should they support or oppose providing nutrition and hydration in this case? Proponents of specified principlism would reply that we should choose the specifications that best enhance coherence among our total set of judgments and norms. However, how do we decide which specifications do this? Herein lies the main difficulty with specification as a decision process: it requires some method, other than or in addition to the specification itself, for deciding which of the possible

judgments about the case at hand yields the greatest coherence with our other judgments and norms.

Deciding which resolution of the case is most coherent with our judgments about other cases would involve considering, among other things, cases that are similar to this one in some ways yet different in other respects. Differing judgments about cases would need to be based on morally relevant differences between the cases. Thus, in seeking a coherent set of judgments about such cases, we would need to consider morally relevant factors that can vary from case to case. For example, the likelihood that aggressive treatment would result in long-term survival can vary from case to case, depending on the nature of the anomalies in a given case. Other things equal, the lower this likelihood, the weaker the argument for providing the aggressive treatment. Another factor is the infant's prognosis concerning cognitive deficits; extremely severe deficits would diminish the potential benefits of survival for the infant and make the argument for aggressive treatment weaker. Similarly, the degree of suffering that the treatment itself might cause the infant should be considered; the greater the burden on the infant, the weaker the argument for treating. But to make decisions by taking into account these factors that vary from case to case is to use casuistic reasoning.

I have argued elsewhere that a particular version of casuistry provides a practical method that helps us decide, at least sometimes, how we should assign priorities to conflicting principles in clinical cases, including the type of cases being considered here (1988; 1997, pp. 71–79; 1999). This version of casuistic reasoning also has the effect of helping us see which decision concerning the case yields the greatest coherence with our considered judgments about other cases. Moreover, it yields conclusions that are discursively justifiable. To illustrate these points, let us consider how this casuistic method might be used in the case at hand.

IV. AN EXAMPLE OF CASUISTRY

To explain what I mean by casuistry, let me first discuss some of its general features and then describe the particular version that I shall use.[10] To begin, casuistry is a method of arriving at justifiable decisions about what to do in specific cases. Unlike Kantianism, utilitarianism, coherentism, and contractarianism, it does not claim to be an 'ethical theory'. That it, it does not attempt to provide a comprehensive account of ethics or an account of the 'ultimate' grounding of ethical decisions, as the theories mentioned above try to do (Strong, 1988; Jonsen 1991). This is not to say

that casuists must reject all theories, only that casuistry is not itself one, in the sense noted. Also, casuistry is not a deductive approach; it does not 'apply' principles to cases in the sense of attempting to deduce conclusions from premises consisting of ethical principles and factual descriptions of cases (Jonsen, 1987). Rather, it is a case-based approach in which an argument is developed by comparing the case at hand with *paradigm* cases in which it is reasonably clear what course of action should be taken (Jonsen, 1987; Jonsen and Toulmin, 1988). In addition, the comparisons of cases are made in terms of certain morally relevant factors, which I refer to as 'casuistic factors' (Strong, 1997, p. 74; 1999) and which can vary from case to case. The decision that is best will depend on the extent to which these factors are present in the given case (Jonsen, 1987). Moreover, casuistry does not generally claim to reach certainty in its conclusions (Jonsen, 1987). The strength of the conclusions depends on the plausibility of the comparisons with the paradigm cases. In casuistic argumentation, there is room for disagreement concerning a number of matters, such as whether a case is more similar to one paradigm or another, and whether the morally relevant factors are present in a case to sufficient degree to warrant a given conclusion. Furthermore, casuistry does not claim to be able to resolve all cases (Strong, 1988). When disagreements of the kinds mentioned above cannot be resolved, it might sometimes be appropriate to conclude that several alternative courses of action are permissible, or that casuistry simply does not provide an answer in that case.

The version of casuistic reasoning that I shall use was described previously and consists of several elements (Strong, 1988 and 1999). First, one should identify the main ethical values that are relevant to the case. I use the term 'values' broadly, to include the plurality of ethical concerns relevant to biomedicine. Values can be expressed in a variety of ways, including but not limited to appeals to ethical principles (including specified principles), ethical rules, respect for persons, consequences, rights, duties, and virtues. For our case example I shall accept, for the sake of argument, Richardson's three principles as the main relevant ethical values.

Second, one should identify the main alternative courses of action that can be taken. One option in the case at hand would be to take steps necessary to bring about provision of nutrition and hydration for the infant. This might involve efforts to persuade the parents or an attempt to obtain a court order if the parents persist in refusing nutrition and hydration for the infant. Another main option would be to respect the parents' request to withhold nutrition, hydration, and surgery.[11]

The third element is to identify the *casuistic factors* – that is, the morally relevant ways in which cases of this type can differ from one another.

Consideration of the ethical values previously identified can help one identify these factors. For example, in the type of case being considered, there are several casuistic factors related to benefiting the child (some of which were mentioned above): the likelihood that aggressive treatment would result in long-term survival; the infant's prognosis concerning cognitive deficit; the degree of harm likely to occur to the child if aggressive treatment is not provided; and the degree of suffering that the life-preserving treatment might cause the infant. Another casuistic factor is related to the well-being of the family; namely, the degree of emotional and psychological harm expected to occur to the family if their wishes are overruled and treatment is provided.

Fourth, for each option under consideration, one should try to identify a case in which that option would be justifiable. I refer to these as paradigm cases; they should be of a type that is similar to the case at hand, and they can be actual or hypothetical cases. In addition, for each paradigm, one should identify the ethical values and arguments that justify the selection of the option in that case. To apply the reasoning process to our case example, we need to identify two paradigm cases, one in which it is justifiable to take steps to bring about the provision of nutrition and hydration, and one in which it is justifiable not to do so. The following is a case in which a strong argument can be given for taking steps to bring about the providing of nutrition and hydration.

> *Case 2*. An infant was born with Klinefelter syndrome, an esophageal atresia, and no other detected anomalies. Klinefelter syndrome is a condition in which the sex chromosome configuration is XXY, resulting in a male who typically has dull mentality, long legs, small penis, and infertility associated with small testes and low testosterone production (Jones, pp. 66–67). The average IQ of children with Klinefelter syndrome is 10 to 15 points below that of their normal siblings, with about 15 to 20 percent of affected persons having an IQ below 80. There is also a tendency to have behavioral problems, including immaturity, shyness, poor judgment, and unrealistically boastful and assertive behavior. The parents have requested that surgical correction of the esophageal atresia not be performed and that fluids and nutrition not be provided.

The ethical justification for taking steps necessary to bring about surgical correction of the esophageal atresia and provision of nutrition and hydration in this case draws upon consideration of the casuistic factors. These factors make it justifiable to assign priority to preservation of life over

parental authority in the context of this particular case. The aspects of the casuistic factors that support this prioritization are the following: aggressive treatment is expected to result in long-term survival; the likely degree of cognitive deficit is not great enough to justify the claim that the child would not be benefited by being kept alive; and because of the above two aspects, the degree of harm that would occur to the child if treatment is not provided is great. Moreover, it can be argued that the right of parents to make medical decisions for their children should be overridden when those decisions are likely to result in serious harm to the child.

On the other hand, the following is a case in which a justification can be given for respecting the parents' request to withhold surgery, nutrition, and hydration:

> *Case 3*. An infant was born with anencephaly and an esophageal atresia. In anencephalic infants, the top of the skull and the cerebral cortex are absent. Therefore, these infants do not have the brain structures necessary for consciousness. In addition, the prognosis for survival is poor. Stillbirth is common, and among those born alive, death usually occurs within 24 hours if there are no aggressive interventions such as respirator support. In the absence of such interventions, death almost always occurs within two weeks (Medical Task Force on Anencephaly, 1990, pp. 669–674; Baird and Sadovnick, 1984, pp. 268–271). The parents have requested that nutrition, hydration, surgery, and respirator support not be provided.

The ethical justification for not providing nutrition, hydration, or other aggressive treatment draws upon the casuistic factors in this case. Specifically, several aspects of these casuistic factors make it justifiable to assign priority to parental authority rather than preservation of life. First, the child's anomalies are incompatible with long-term survival. Second, because of the irreversible lack of consciousness, prolongation of life would not benefit the infant. Third, aggressive treatment might postpone the infant's death, thereby prolonging the period of emotional distress for the family. It can be argued that there is no obligation to the infant to provide treatments that lack any chance of being beneficial. Moreover, treatments that seem likely to cause harm to the family and that cannot benefit the infant should not be carried out against the parents' wishes.

The fifth and final element in the reasoning process is to compare the case at hand with the paradigm cases that have been identified. One should try to ascertain which of the paradigms it is "closest to" in terms of the casuistic factors. Selection and justification of an option are based on this

comparison.[12] When the case at hand is closer to one paradigm than to the others, the course of action justifiable in that paradigm would also be justifiable in the case at hand. If the case at hand is in the "gray zone" between paradigms – not seeming to be closest to any one of them – then more than one option might be ethically permissible.

Let us apply this method to case 1. We need to consider the features of the casuistic factors in case 1 and ask whether they are more similar to the factors in case 2 or the factors in case 3. This comparison suggests that case 1 is more similar to case 3 than to case 2. To see this, let us note that in both cases 1 and 3 the infant has anomalies incompatible with long-term survival, whereas in case 2 the prognosis for survival is good with aggressive treatment. In both cases 1 and 3 the cognitive deficit is severe enough to preclude self-consciousness. In case 2, by contrast, there is a potential not only for self-consciousness but a life that is beneficial for the child. In addition, in cases 1 and 3 aggressive treatment would prolong the dying process, thereby extending the period of acute emotional distress for the family. In case 2, with aggressive treatment there likely would be no dying process, much less an extended one. All things considered, the casuistic factors in case 1 are more similar to the factors in case 3 than they are to the factors in case 2.

This comparison helps us to see that it is more reasonable to resolve case 1 in the manner that case 3 should be resolved than to resolve it in the manner that case 2 should be resolved. Thus, it is reasonable to conclude that the parents' wishes should be respected. In summary, the justification for the decision reached is the principle (using Richardson's terminology) that there is a duty to respect the choices of parents concerning their children, plus the argument (just given) that this principle has priority in this particular case. This illustrates that casuistry is capable of providing discursive justifications.

My descriptions of casuistry given here and previously (1988; 1997; 1999) are not expressed explicitly in terms of coherence. Nevertheless, the casuistic reasoning process illustrated here seems to yield a set of coherent judgments about the cases considered. Thus, casuistry can help us decide which prioritization of values in a case is most coherent with our other judgments. Although the relationship between casuistry and coherence theory deserves further exploration, I make no claims at this time concerning what that relationship might be, except to say that the two seem to be compatible.

Die-hard defenders of specified principlism might claim that the casuistic decision process I just described is simply an example of specified principlism. To bolster their claim, they might assert that the following

statements that appeared in my arguments are specified principles: "the right of parents to make medical decisions for their children should be overridden when those decisions are likely to result in serious harm to the child;" "there is no obligation to the infant to provide treatments that lack any chance of being beneficial;" and "treatments that seem likely to cause harm to the family and that cannot benefit the infant should not be carried out against the parents' wishes." Even if we assume, for the sake of argument, that these statements are specified principles, the claim that my argument is a form of specified principlism is incorrect. Specified principlism, as described by Richardson and DeGrazia, seeks specified principles that are *applicable* to the case to be resolved. However, the above statements that appeared in my argument were used to justify the decisions reached in the *paradigm* cases, not the case under consideration. None of these three statements is applicable to the case to be resolved, involving the infant with trisomy 18 syndrome. To hold that they are applicable would involve one or the other of the following assumptions concerning that case, depending on which of the statements in question is being considered: that nutrition and hydration would not provide *any* benefit to the infant; or that withholding nutrition and hydration likely would cause *serious* harm to the infant. However, I made neither of these assumptions, nor do they appear to be justifiable. Thus, a close examination of the use I made of the specified principles in question shows that the casuistic method is not a version of so-called specified principlism. Casuistry can make use of specified principles, but the case was not resolved by further specifying Richardson's principles so that they still apply to the case at hand but do not conflict.

Nevertheless, after this casuistic reasoning helps us arrive at a resolution of the case, we can address the question concerning how Richardson's principles ought to be specified so that they are applicable to, yet do not conflict in, the case at hand. However, it seems fair to ask what is to be gained by seeking such specifications at this point. After all, we already have arrived at a justifiable decision concerning how the case should be handled. Moreover, we can state the justification in terms of the casuistic argument, as I did above. Perhaps the answer is that it promotes understanding to try to reword justifications in terms of specified principles that do not conflict in the case at hand (DeGrazia, 1996, p. 35). However, having some explanatory value of this sort is not the same as being a practical decision procedure.

V. OBJECTIONS TO CASUISTRY

The proponents of specified principlism have raised a number of objections to casuistry, arguing that specified principlism is superior to casuistry in part because of the latter's shortcomings. However, satisfactory responses can be given to their objections, and this provides additional reasons to reject their claim that specified principlism is preferable. They have stated five main objections arising from a particular concept of casuistry, and they overlook the fact that casuistry need not have the undesirable features they ascribe to it.[13]

One objection is that casuistry relies excessively on intuitive judgments about cases (DeGrazia, 1992, p. 517). This is believed to be a problem because we might lack clear intuitions about novel cases and, more importantly, appealing to intuitions is question-begging because it forecloses discursive justification (DeGrazia, 1992, p. 517; Richardson, 1990, pp. 282–283, 287–288, 305; Levy, 1996, p. 23). The problem with this objection is that it assumes that casuistry at bottom is nothing more than the 'intuitive balancing' of conflicting principles. This assumption is made by almost every critic of casuistry. And yet, the assumption is false, for several reasons. First, casuistry need not be a form of old-fashioned intuitionism, which is the view that moral judgments rest ultimately on one's 'moral perceptions' of the rightness of actions, perceptions that are made by some mysterious faculty we possess for identifying those things "out there" that are right or wrong. Certainly, casuists need not accept this view or its metaphysical implications. The version of casuistry presented above, for example, is not such a form of intuitionism. Second, casuistry need not rely excessively on 'intuitions' in the more modern sense of the term, according to which intuitions are simply our considered moral judgments about specific cases, rules, principles, or other subjects of moral scrutiny. Again, the version of casuistry presented above can serve as an example. In this approach, our moral intuitions play a role in identifying paradigm cases, but more is involved in identifying them than mere appeal to intuitions. A main feature of a paradigm case, according to my approach, is that one can give an argument for resolving it a certain way; a case is not suitable for use as a paradigm unless a justification can be given for the course of action that is claimed to be ethically preferable. When this requirement is placed on use of paradigms, it is difficult to maintain that intuitions are being used excessively.

Moreover, the claim that casuistry cannot provide discursive justifications is mistaken. As illustrated in the casusitic method I discussed above, discursive justification is possible not only for the paradigms but also for

the resolution of the case at hand. In addition, the claim that our lack of intuitions about novel cases poses a special problem for casuistry is mistaken. When a novel case is being decided, the above version of casuistry does not depend on intuitions about that case; rather, it seeks intuitions about *paradigm* cases that are relevant to resolving the case at hand. A lack of intuitions about novel cases is no more a problem for casuistry than it is for any other approach to justification in ethics. Of course, for novel cases we sometimes might be unable to identify helpful paradigms, but as explained above, casuistry makes no claim to resolve all cases.

A second objection is that casuistry involves the erroneous view that moral reasoning can be and often is carried out without appealing to principles, rules, rights, or virtues; casuistic reasoning frequently is based simply on our intuitions about cases (Beauchamp and Childress, 1994, p. 94). This objection is also mistaken. No casuist in bioethics has argued for ethical reasoning that fails to consider principles, rules, and the plurality of ethical concerns relevant to biomedicine.[14] The approach I have put forward explicitly includes identification of the ethical values relevant to the case. In justifying decisions in paradigm cases, it can appeal to principles, specified principles, rules, duties, virtues, and other expressions of ethical values. In rejecting specified principlism as a decision-making procedure, one does not reject the use of principles in ethical reasoning, much less deny their importance. Moreover, although casuistry often is interpreted as holding that judgments about cases are more fundamental and important than principles and rules, it need not hold this view. In the version I have defended, judgments about cases are among the ethical components to be considered, along with principles, rules, etc. There is no need to assign an epistemic priority either to judgments about cases or to principles. This shows that casuistry as a case-based decision procedure can be separated from the meta-ethical view that intuitions about cases provide the grounds for rules and principles, the so-called "bottom-up" view. Casuists need not hold this bottom-up view.

A third purported difficulty is that casuistry, in focusing on cases, risks missing global issues that might be relevant to the resolution of specific cases (DeGrazia, 1992, p. 518). For example, it is claimed that casuists would address the question of whether Medicaid should pay for heart transplants solely by looking for precedents in which expensive high-technology treatments have been paid by Medicaid, without addressing the global issue concerning how our vision of what society should be like might bear on decisions about allocating resources (Arras, 1991, pp. 46–47). In reply, casuistry need not be put forward as the only way to reason ethically, and therefore it can be compatible with the addressing of broad

social issues. Case-based reasoning can be regarded as one of the available tools in ethical decision making, along with reasoning that deals with the question of what our broad social policies should be. Such policy considerations might support resolving a certain type of case the same way every time it arises, rather than tailoring the decision to the specific case as a strict casuistry would do. Casuistry can accept such policies, when they are justifiable, as posing constraints for case-by-case decision making. It can accept, for example, justifiable policies concerning Medicaid funding of expensive high-technology treatments. Openness to questions of broad social policy is necessary so that our methods of reasoning are sufficiently flexible to deal with the complexities of ethics. One way to combine case-based and broader social reasoning is to say that there is a presumption in favor of deciding cases on an individual basis but that this presumption can be overridden when broad social considerations provide good reasons for doing so. In being open to such broad considerations, casuists are just as able as anyone else to take broad social issues into account.

A fourth supposed problem is that casuistry is too accepting of prevalent beliefs and practices (DeGrazia, 1992, pp. 517–518). Because casuistry takes intuitions about cases as a given, it is unable to examine those intuitions critically. Thus, casuistry cannot challenge established social views, including the values of the male-dominated medical profession (Arras, 1991, pp. 38–39, 44–45). In response, this objection, like the third one, assumes that those who use case-based reasoning are unable to think in any other terms. But as pointed out above, use of casuistry to resolve specific cases can be compatible with use of reasoning that examines broader social issues. Thus, it is a mistake to believe that those who use casuistry must accept prevalent attitudes and intuitions about cases uncritically. In the version of casuistry discussed above, one must justify one's claims about how paradigm cases should be resolved. Such justifications can and should be open to the questioning of current attitudes and beliefs. These justifications should include consideration of values other than, for example, those of the male-dominated medical profession. In being open to such considerations, this approach is able critically to assess intuitions about cases, making possible the rejection of previously held intuitions when there are adequate reasons for doing so. There is nothing about case-based reasoning that makes those who use it inherently less able than others to critique prevailing ideologies.

A fifth objection is that casuistry does not provide an adequate account of ethical justification. As DeGrazia puts it, "A successful ethical theory… must provide a valid justification procedure that extends to the highest possible level of generality while retaining plausibility… The weak-

nesses of casuistry, I think, concern its failure to meet this standard adequately" (1992, p. 517). Specified principlism meets this standard, it is asserted, because it is joined to a coherence theory of justification. In response, linking specified principlism to a coherence model does not give it any advantage over casuistry. As noted above, casuistry seems to be compatible with coherence theory, and therefore it seems possible to be a casuist and also subscribe to a coherence model of justification. If it turns out that coherentism is justifiable, that would not be a reason to prefer specified principlism over casuistry.

VI. CONCLUSION

According to the version of casuistry defended in this paper, an adequate account of justification in ethics should recognize the importance of ethical principles as well as casuistic reasoning. Moreover, my arguments are not intended to imply that there is no role for the specification of principles. On the contrary, casuistry can appeal to values expressed in terms of specified principles, and in policy-level decision making the specification of principles can play a role in identifying policy options. However, the claim that specified principlism provides the most promising method for resolving concrete cases and issues in medical ethics is unwarranted. It does not constitute a useful decision procedure for resolving concrete cases, and the claim that it is preferable to casuistry for such a purpose is unfounded.

It might be asked whether the proponents of specified principlism could defend it by incorporating into it some version of casuistry. In fact, several advocates of specified principlism acknowledge that they understand it as making use of casuistry (Richardson, 1990, pp. 280–281, 308; DeGrazia, 1992, pp. 528, 531). According to DeGrazia, "…casuistry operates within specified principlism. Careful examination of real and hypothetical cases allows us to specify norms…" (1992, p. 531). In reply, there is no apparent reason why *principlism* could not use casuistry to remedy the problem of how to assign priorities to conflicting principles in the context of specific cases. I suspect that there are versions of principlism and casuistry that are mutually compatible.[15] It is less obvious that casuistry can salvage *specified principlism* as a decision procedure in clinical cases. No one has shown that it is feasible, or even possible, to arrive at justifiable resolutions of concrete cases by specifying principles within wide reflective equilibrium, whether using casuistry or not. In the absence of a demonstration that specified principlism actually works, the claim that it is the most promising method for resolving cases is unjustifiable.

NOTES

1. The term ‘specified principlism’ is suggested by DeGrazia (1992); Richardson (1990) does not employ this term but uses the expression ‘specifying norms’.
2. DeGrazia (1996, pp. 14-19) also claims that one’s overall set of beliefs in wide reflective equilibrium should have certain characteristics in addition to coherence as I described it, including simplicity, clarity, power, and plausibility.
3. Richardson assumes, for reasons that are not stated, that the distinction between killing and letting die is not applicable here.
4. Richardson states that, according to the formal definition of specification he provides in his paper, this rewording does not specify the first principle, strictly speaking, but can be understood as specifying the underlying norm of respect for life.
5. In particular, Richardson does not explain how the conflict between the first principle and the duty to benefit the mother is removed.
6. A ventricular septal defect is an opening in the wall separating the two ventricles of the heart. The opening permits blood to flow directly from the right ventricle to the left ventricle, bypassing the lungs.
7. This is an actual case presented in Ackerman and Strong (1989, pp. 100–103). The original description placed the decision point prior to the diagnosis of trisomy 18 syndrome, but the description here places the decision point after the diagnosis. In some cases involving esophageal atresia there is an anomalous connection between the esophagus and trachea, but there was no such connection in this case. The parental wish to withhold treatment has been added to make the case conform to Richardson’s example.
8. The fact that there is a lack of potential for self-consciousness does not, in itself, settle this question. Consider, for example, a ten-year-old profoundly mentally retarded child who lacks the potential for self-consciousness but is otherwise healthy. It would be wrong to starve such a child to death (although Richardson’s specification of the first principle would permit this).
9. No doubt, there are other ways to word the specifications of the first and second principles so as to yield the conclusion that the parents’ wishes should not be respected. The wording presented here is merely intended to be an illustration. Similarly, the wording of specifications in the text that follows is not intended to be the only possible wording.
10. Two versions of casuistry, one stated by Albert R. Jonsen and one that I put forward, are described in Strong (1999).
11. The first option could be divided into several more specific ones, depending on the method of providing nutrition and hydration. These include: surgical correction of the esophageal atresia, which would permit feeding by mouth; provision of total parenteral nutrition (intravenous infusion of a specially prepared solution containing specified proportions of protein, carbohydrates, fat, vitamins, and minerals); and surgical placement of a gastrostomy tube (a tube connecting the stomach to an opening in the abdomen through which infant formula could be put into the stomach). However, to make this illustration of casuistic reasoning more concise, I shall focus on the two main options stated in the text.
12. In this case there are two main options being considered, but in other cases there might be three or more options. In that event, one would compare the case at hand with three or more paradigm cases.
13. Parts of this section are adapted from Strong (1997, pp. 76-77; 1999).
14. Casuists sometimes use the term ‘maxims’, which can refer to principles, rules, and other rule-like statements.
15. This view is also stated in Beauchamp (1995) and Beauchamp and Childress (1994).

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