CHAPTER 3

Philosophy: Ethical Principles and Common Morality

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What distinctive contributions does philosophy provide to medical ethics? Philosophy's most prominent contribution, on which this chapter focuses, is to provide the critical resources of ethical theory and methodology in ethics.[1] The ambition of ethical theory is to provide an adequate normative framework for addressing the problems of moral life. Usually such a framework takes the form of a theory of right action, but it may take the form of a theory of good character. The ambition of methodology in ethics is to provide a procedure or method for producing such a normative framework, using such a framework once it has been identified, or navigating the complexities of moral life in the absence of such a framework.

This chapter examines a range of philosophical methods in medical ethics. We explore five leading methods, or models, of moral reasoning, with special attention given to the problems of medical ethics. In contrast to other approaches presented in this book, the methods discussed here place a strong emphasis on ethical principles, common morality, and ethical theory. Our discussion of particular ethical theories is relatively compressed because the application of established ethical theories represents only one of the five methods we explore.

The chapter begins with a section titled "Description of Methods of Philosophical Medical Ethics," in which each method or model is described in a subsection and then subjected to one or more important criticisms in a separate subsection. The next section provides a critique of philosophical methods in medical ethics in general. The chapter ends with a section on philosophical training in medical ethics and on leading scholarly resources in the field.

Description of Methods of Philosophical Medical Ethics

Moral philosophers have traditionally aspired to normative theories of what is right or wrong that are set out in the most general terms. But it is increasingly questioned whether such general theories can be fruitfully applied in specific cases and contexts.

It is also controversial which philosophical methods best achieve the objectives of "applied ethics" or "practical ethics"—terms that came into vogue as philosophical ethics increasingly addressed such practical issues as abortion, physician-hastened death, human research, access to health care, and genetic engineering.

Several methods have been prominent in philosophical medical ethics. Among those influential methods, we will focus on these five: medical tradition and practice standards; principles, common morality, and specification; ethical theory as the basis of applied ethics; casuistry (case-based reasoning); and reflective equilibrium (a form of coherence theory). The terrain of philosophical methods in ethics is broader than the large area that we will sketch here. We will omit, for example, feminist ethics, virtue ethics, narrative ethics, and pragmatist approaches to medical ethics. Several of these approaches are discussed elsewhere in this book. Some philosophers might regard one or more of the methods just mentioned as ethical theories that could serve as the backbone of "applied ethics," but these approaches are also widely regarded as alternatives to the "applied ethics" model.

APPEALS TO MEDICAL TRADITION AND PRACTICE STANDARDS

Among the most influential sources of medical and nursing ethics are traditions: the concepts, practices, and norms that have long guided conduct in these fields. Some scholars of medical ethics find them to be a logical starting point in reflecting on professional ethics. Great traditions such as Hippocratic ethics clearly deserve respect, but they also often fail to provide a comprehensive, unbiased, and adequately justified ethics. Philosophers ought to take this history seriously while raising questions about the moral authority of oaths, prayers, codes, published lectures, and general pamphlets and treatises on medical conduct. One approach is to reconstruct traditional norms in a more perspicuous and defensible manner while remaining largely faithful to those norms (see, e.g., Pellegrino 1985; Arras 1988). Sometimes, however, it is preferable to propose new norms.

It is sometimes unclear whether statements made in documents of great historical influence were primarily descriptive, exhortatory, or self-protective. Some writings describe, for educational purposes, conduct that conformed to prevailing professional standards. Other documents aim at reforming professional conduct by prescribing what should be established practice. Still others seem constructed to protect the physician from suspicions of misconduct or from legal liability. Accordingly, to view prescriptions in codes and similar material at face value as if they capture proper professional norms may cause moral confusion or distortion. Moreover, philosophers want to do more than understand the concepts, practices, and norms found in medical traditions. Although historical understanding is a worthy goal, it is no substitute for careful moral analysis. The ultimate philosophical goal is to defend or criticize the concepts, practices, and norms under investigation—an exercise in normative ethics.

A traditionalist might argue that appreciating the history of medicine is a crucial part of normative ethics, by enabling one to grasp the essential nature (or essence) of medicine and of the physician–patient relationship. From this perspective, one can

extract an understanding of the ethics of medicine. Edmund Pellegrino, for example, has argued that the nature of illness, the historically validated fact that medical knowledge is not individually owned, and the physician's public act of taking the Hippocratic Oath together entail that physicians have an obligation to serve patients even when doing so requires effacement of self-interest (Pellegrino 1987).

PROBLEMS WITH APPEALS TO MEDICAL TRADITION AND PRACTICE STANDARDS

The essential problem with attempts to base applied ethics in practice standards and traditional oaths and guidelines is that such resources are not self-justifying. Whether a particular practice standard or oath is justified must be determined by careful ethical reflection, which may conclude that the prevailing norm is morally inadequate. Even ethicists and physicians working largely within a traditional framework accept the need for some degree of independent ethical reflection.

One variant of the traditional approach might seem less susceptible to this line of criticism. Suppose that the history of medical practice reveals the essential nature of medicine, the understanding of which allows us to extract a viable medical ethics. Pellegrino, for example, maintains that medicine must be understood entirely in terms of the end of medicine, which is healing. Accordingly, the category of medical benefits cannot include items such as fertility controls (unless for the prevention and maintenance of health and bodily integrity), purely cosmetic surgery, or active euthanasia (Pellegrino 1999, 2001).

The claim that medicine has some single, essential nature is debatable. Arguably, medicine is an evolving set of practices with no intrinsic limits to the possibility for change. Moreover, even if medicine has a fixed essence or purpose, it is doubtful that ethical norms other than highly abstract statements of general purpose can be derived from facts about this essence. It has become more apparent during the last forty years that traditional codes and practices of medical and nursing ethics are inadequate to address problems arising from modern scientific research, clinical practice, biomedical technology, health policy, and related social developments. The history of medical ethics emanating from the practices of two thousand years ago is disappointing from the perspective of today's concerns in medical ethics about the rights of patients and subjects and the ways in which society should promote the health of its members. Most topics in medical ethics that are of major concern today have been ignored or given but passing notice until the second half of the twentieth century. In conclusion, although there is no reason for philosophers to discount appeals to tradition, it is very doubtful that today's medical ethics can be reconstructed from this source alone.

PRINCIPLES, COMMON MORALITY, AND SPECIFICATION

Once many observers came to regard medical traditions of ethics as outmoded by modern developments in medicine, representatives of various disciplines sought to identify basic ethical principles that could help determine which clinical practices and human experiments are morally questionable or in need of reform. Because basic moral principles are of great interest to moral philosophers, there was a turn to

philosophy to identify and analyze the principles that could serve as a moral framework for medical ethics. But on what are these principles to be based?

One possibility is that just as tradition can be a resource, so can common morality—the morality shared by morally committed persons. Common morality, so understood, is not merely *a* morality in contrast to *other* moralities; it is normative for everyone, and all persons are rightly judged by its standards. The content of common morality may be understood in various ways (which need not be mutually exclusive). It may be understood in terms of the broad ethical principles to which, as just noted, philosophers turned their attention in their dissatisfaction with medical tradition. Such principles include respect for autonomy (one ought to respect the decision-making capacities of autonomous persons) and nonmaleficence (one ought to avoid causing harm to others). Alternatively, common morality may be understood as comprising basic rules of obligation such as "do not kill," "do not cause pain or suffering," and "keep your promises" (Beauchamp and Childress 2009). In recent years the favored category to express the norms of common morality has perhaps been human rights (see, for example, Dworkin 1977, Thomson 1990, Macklin 1992).[2]

Many people, including many philosophers, are skeptical about the idea of a common morality. They think that virtually nothing is shared across cultures and different moral traditions. However, the notion of the common morality is simply intended to capture the moral norms that we all accept. Some critics also object that general principles, rules, and rights are sometimes validly overridden by other norms with which they conflict. But this well-known feature of morality does not constitute an objection to common morality theories. We should expect that general norms will be validly overridden in circumstances in which there is conflict with other moral claims. For example, one might not tell the truth in order to prevent someone from killing another person; and protecting the liberty or rights of one person may require interfering with another's autonomous choice. When a conflict of two or more principles or rules occurs, the conflict must be addressed to extract the proper content from each. Alternatively, as the context requires, one precept may be found to override the other.[3]

How, then, does one fill the gap between abstract principles and concrete judgments to guide moral decision making? The answer is that principles must be specified to suit the needs of particular contexts. Specification is the progressive filling in of the abstract content of principles, shedding their indeterminateness and thereby providing action-guiding content (Richardson 1990, 2005).[4] In managing complex cases involving conflicts, we should begin with the effort to specify norms and eradicate conflicts between them. Many already-specified norms will need further specification to handle new circumstances of indeterminateness or conflict. Incremental specification will continue to refine one's commitments, gradually reducing the circumstances of conflict to more manageable dimensions. Increase of substance (normative content) through specification is essential for decision making in clinical and research ethics, as well as for the development of institutional rules and public policy.

The famous case *Tarasoff v. Regents of University of California* (1976) illustrates specification (as well as the related concept of balancing). Psychotherapeutic practice

has long honored the principle—or rule—of confidentiality, which states that the information divulged in psychotherapy by a patient to the therapist may not be shared with other individuals without the patient's prior consent. This rule is grounded in the need for the patient to trust the therapist as a condition for fully open discussion of the patient's personal difficulties and in respect for the patient's autonomy. But what if a patient divulges the intention to kill an identified third party? Another commonly accepted rule, even if less often explicitly stated, is that one should take reasonable steps to prevent or warn of major harm to another individual if one is uniquely situated to do so and can do so relatively easily. The strength of this obligation may increase if one occupies a professional role such as that of psychiatrist, psychologist, or social worker. Clearly we have a conflict, because maintaining confidentiality is inconsistent with the second rule; taking steps to warn the prospective victim would violate the rule of confidentiality.

How should one manage this conflict? Consistent with the legal judgment rendered in the case, many therapists and ethicists hold that a serious threat of consequential bodily injury to an identified third party warrants an exception to the rule of confidentiality. Efforts to balance the relevant considerations suggest that the importance of helping the endangered person is weightier than that of confidentiality. So long as balancing is understood as involving a judgment adequately supported by justifying reasons—and not as a purely intuitive act—the metaphor of balancing fits well with the idea of specification. The reason justifying the resolution can, in effect, be incorporated into a specification of one of the principles or already specified rules (assuming they are regarded as nonabsolute).

The original rule is thus modified by this process and can then be specified as follows: The information divulged in psychotherapy by a patient to the therapist may not be shared with other individuals without the patient's prior consent, unless the patient expresses an intention to cause severe harm to an identified third party. This specification eliminates the dilemma that originally existed because of a contingent conflict between two rules.

But how are particular specifications to be justified since more than one specification is always possible? In the case just described, an alternative way to remove conflict would be to preserve confidentiality as an absolute rule and revise the other norm as follows: "One should take reasonable steps to prevent major harm to another individual ... unless one's professional duties prohibit the only available means for doing so." Given that such competing specifications will often arise in practical contexts, can the resolution in terms of making a disclosure to a third party be shown to be more defensible than this competing specification? Is there always only one best specification?

A particular specification, or any revision in moral belief, can reasonably be said to be justified if it maximizes the coherence of the overall set of beliefs that are accepted upon reflection.[5] This is, admittedly, a very abstract thesis, and employment of the criteria that together constitute "coherence" in the relevant (rather broad) sense is a subtle and unresolved affair (Arras 2007). Although we believe at least some of these criteria of coherence—such as logical consistency, argumentative support, and intuitive plausibility—are implicitly accepted by nearly anyone who engages in

serious moral reflection and discourse, we cannot further explore the criteria of coherence here. We note, however, that the present approach often employs the technique of "reflective equilibrium," as described below.

PROBLEMS WITH PRINCIPLES AND THE COMMON MORALITY

Several concerns about principles drawn from the common morality have been raised by contemporary writers in medical ethics. Clouser and Gert (1990), for example, maintain that general "principles" function more as book chapter headings than as directive rules or normative theories (see also Herissone-Kelly 2003).[6] Principles, they argue, highlight important moral themes by providing general labels for them but do not furnish a method for medical ethics. Receiving no clear guidance from the principle, a moral agent confronting a problem may give the principle whatever weight he or she wishes when it conflicts with another principle.

These writers allege that these deficiencies are especially pronounced in the area of justice. We know that justice is important and concerns distribution, but invoking "justice" amounts to little more than a checklist of moral concerns. Lacking any definite normative content with which to guide actions or establish policies where we have concerns about justice, the agent is free to decide what is just and unjust, without constraints. Other moral considerations besides the principle(s) of justice, such as intuitions and theories about the equality of persons, must be called upon for real normative guidance. Clouser and Gert think the same problem afflicts all general principles, which alert us to issues but, lacking an adequate unifying theory, offer no real guidance on their own (Gert 2005, 2007; Gert, Culver, and Clouser 2006).

Do principles lack specific, directive substance? The charge is most plausible in the case of unspecified principles. Any principle—and any rule, for that matter—will have this problem if the norm is underspecified for the task at hand. A basic principle is necessarily general, covering a broad range of circumstances; in this regard, principles contrast with specific norms. As the territory governed by any norm (principle, rule, paradigm case judgment, and so on) is narrowed, the conditions become more specific—for example, shifting gradually from "all persons" to "all competent patients"—such that it becomes less likely that the norm can even qualify as a principle. For example, although the principle of respect for autonomy applies to autonomous actions generally, the narrower norm of respecting informed refusals by competent patients is more likely to be considered a rule than a principle.

If general principles can be specified and rendered more useful for particular contexts, why continue to think in terms of general principles at all? One practical reason is that principles must be learned by everyone—not just philosophers, but health professionals, ethics committee members, and laypeople. If individuals thought only in terms of specified principles, the latter's specificity and proliferation would make them very difficult to remember, master, and internalize for practical use.

ETHICAL THEORY AS THE BASIS OF APPLIED ETHICS

Once the notion of "applied ethics" gained a foothold in philosophy, it was commonly understood as requiring that general moral principles or ethical theories should be applied to particular moral problems or cases. This vision suggests that ethical theory

develops general principles, rules, and the like, whereas applied ethics treats particular contexts by applying these general norms—either directly to particular cases or through the intermediary of more specific norms.[7] In this account applied work does not generate novel ethical content. Applied ethics requires only a detailed knowledge of the areas to which the ethical theory is being applied (e.g., medicine, nursing, public health) and perhaps some skill in drawing out a theory's implications.

Sometimes called "deductivism" or "top-down application" of general norms, this model is inspired by justification in disciplines such as mathematics, in which claims can often be shown to follow logically (deductively) from credible premises. In ethics the parallel idea is that general principles or rules, together with the relevant facts of a situation (in the fields to which the theory is being applied), support an inference to justified moral judgments. In short, the method of reasoning involves the application of a norm to a clear case falling under the norm. One version of this approach would feature two or more basic moral principles arranged in a strict hierarchical ordering, so that conflicts between principles are always resolved in the same way. However, there is no significant example of an ethical theory that has been successfully constructed along these lines.[8]

A more prominent version of this approach features a single overarching or supreme principle that is presented as foundational for morality. The most widely discussed theory of this kind is utilitarianism, which defends the "principle of utility" as the supreme principle of ethics. According to this principle, the right action or policy is that which maximizes the balance of good (beneficial) consequences over bad (harmful) consequences. By contrast, deontological theories assert (in different ways, depending on the particular theory) that the right action or policy is to be identified by reference to one or more principles that cannot be equated with, or fully derived from, the principle of utility.[9] During the 1970s and 1980s, utilitarian and deontological approaches exerted enormous influence on the literature and discourse of medical ethics, and their characteristic patterns of reasoning are still common today. Accordingly, a closer look at these theories is warranted.

Utilitarian theories

The principle of utility demands production of the maximal balance of good consequences over bad consequences.[10] But what characteristics determine the value of particular consequences? The answer offered by a particular version of utilitarianism represents that version's value theory. These value theories (or theories of the good) point to happiness, the satisfaction of desires or preferences, and the attainment of such conditions or states of affairs as autonomy, understanding, various kinds of functioning, achievement, and deep personal relationships. Whatever its value theory, any utilitarian theory decides which actions are right entirely by reference to the consequences of the actions, rather than by reference to any intrinsic moral features the actions may have, such as truthfulness or fidelity. Finally, in the utilitarian approach all parties affected by an action must receive impartial consideration.

There has long been a dispute among utilitarians regarding how to apply the principle of utility. Act utilitarianism and rule utilitarianism are distinguished by their different attitudes towards rules of common morality such as "do not cheat"

and "if someone is drowning in the vicinity, try to save him or her." Education in and compliance with such rules usually promote utility. Automatic compliance further promotes utility by obviating complex utility calculations, enabling efficient and reliable decision making. Although *act utilitarians* often follow such rules (without deliberating about utility), they also frequently apply the principle of utility directly to actions. When direct application of this principle entails breaking a moral rule, act utilitarians treat the latter as a dispensable "rule of thumb." *Rule utilitarians*, by contrast, place greater stock in these utility-promoting rules and only rarely would regard violating such a rule as worthy of consideration.[11]

Kantian theories

Deontological theories are increasingly called Kantian because of their origins in the theory of Immanuel Kant.[12] In this theory, morality provides a rational framework comprising a universal principle and derivative rules. Kant's supreme principle, called "the categorical imperative," is expressed in several ways in his writings. His first formulation may be roughly paraphrased in this way: "Always act such that you can will that everyone act in the same manner in relevantly similar situations" (Kant, 1785, sect. 421). Kant maintained that wrongful practices, such as lying, theft, cheating, and failure to help someone in distress when you can easily do so, involve a kind of contradiction. Consider cheating on exams. If everyone behaved as the cheater did, exams would not serve their essential function of testing mastery of relevant material, in which case there would effectively be no such thing as an exam: Faculty would not bother giving exams. But cheating on exams presupposes the background institution of taking exams, so the cheater cannot consistently will that everyone act as she does.

Kant also offered another formulation of his categorical imperative that is today frequently invoked in medical ethics. It may be paraphrased in this way: "Treat every person as an end and never solely as a means" (Kant, 1785, sect. 429). This principle requires us to treat persons as having their own autonomously established goals; persons may not be used as mere tools for promoting other people's or society's goals. Thus, for example, deceiving prospective subjects to obtain their consent to participate in nontherapeutic research violates this principle.

PROBLEMS WITH ETHICAL THEORY AS THE BASIS FOR APPLIED ETHICS

Ethical theories such as utilitarianism and Kantianism today hold a diminished stature in medical ethics, compared with their influence in the 1970s and 1980s. The reasons for the demotion of utilitarian and single-principle deontological theories concern the disadvantages of any approach that attempts to provide a foundation for the entire domain of morality with one supreme principle or general viewpoint. Three disadvantages are noteworthy.

First, there is a problem of authority. Despite myriad attempts by philosophers in recent centuries to justify the claim that some principle is morally authoritative—that is, correctly regarded as the supreme moral principle—no such effort at justification has persuaded a majority of philosophers or other thoughtful people. Thus, to

attempt to illuminate problems in medical ethics with a single-principle theory has struck many as misguided as well as presumptuous or dogmatic.

Second, even if an individual working in this field is convinced that some such theory is correct (authoritative), he or she must deal responsibly with the fact that many other morally committed individuals do not embrace this theory. Thus, problems of how to communicate and negotiate in the midst of disagreement do not favor appeals to rigid theories or inflexible principles, which can generate a gridlock of conflicting principled positions, rendering moral discussion hostile and alienating. In our experience—and we believe generally in the experience of teachers of medical ethics—even if people disagree at the level of basic theory, they commonly agree at the level of the principles of medical ethics. These principles, then, may be a more fruitful starting point for discussion than ethical theories.

Third, there is the problem that a highly general principle functioning as the centerpiece of an entire theory is indeterminate in many contexts in which one might try to use it. The content of the principle itself will usually not identify a unique course of action as right. Single-principle theories frequently seem to depend on independent moral considerations in order to serve as effective guides to action.

CASUISTRY (CASE-BASED REASONING)

In contemporary medical ethics, clinicians and ethicists often focus not on principles or theories as the basis of their moral reasoning, but instead on practical decision making in particular cases and on the implications of those cases for other cases (Jonsen 1995, 2000).[13] We can make reliable moral judgments, some philosophers say, only when we have an intimate understanding of particular situations and an appreciation of the record of relevantly similar situations.

This approach, casuistry, proceeds by identifying the particular features of and problems present in the case. The authority operative in case law furnishes a helpful analogy. When the decision of a majority of judges becomes authoritative in a case, the decision is positioned to become authoritative for other courts hearing cases with similar facts. This is the doctrine of precedent. Defenders of casuistry see moral authority similarly: Social ethics develops from a social consensus formed around cases, which can then be extended to new cases without loss of the accumulated moral wisdom. As a history of similar cases and similar judgments grows, a society becomes more confident in its moral judgments, and the stable elements crystallize in the form of tentative generalizations about how to handle similar cases. For example, if the case at hand involves a problem of medical confidentiality, analogous cases are considered in which breaches of confidentiality were deemed justified or unjustified in order to see whether such a breach is justified in the present case. So understood, casuistry overlaps with the method of appeals to tradition: certain cases serve as the focal points of an evolving tradition of ethical reflection and practice.

The leading cases, often called "paradigm cases," become enduring, authoritative sources for reflection and decision making. Cases such as the Tuskegee syphilis study—in which a group of African American men were intentionally not treated for syphilis in order to follow the course of the disease—are invoked to illustrate

unjustified biomedical experimentation. Moral judgments regarding this case provide authority for decisions in new cases. Such cases influence our standards of fairness, negligence, unjustified paternalism, and the like. Just as case law (the set of legal rules) develops incrementally from legal decisions in cases, so the moral law (the set of moral rules) develops incrementally. From this perspective, principles are less important for moral reasoning than cases. Indeed, principles may be expendable because moral authority rests in the paradigm cases and the traditions of their interpretation and extension to new cases.

Casuists sometimes write as if cases lead to moral paradigms, analogies, or judgments entirely by their facts alone, but this picture is inaccurate. No matter how many salient facts are assembled, some value premises will be needed to reach a moral conclusion. The properties that we observe to be of moral importance in cases are picked out by the values that we have already accepted as morally important. In short, the paradigm cases are value-laden.

The best way to understand paradigm cases is as a combination of facts that can be generalized to other cases—for example, "The patient refused the recommended treatment"—and settled values—for example, "Competent patients have a right to refuse treatment." For a casuist to reason morally, one or more settled values must connect the cases. Hence the necessity of what casuists sometimes call "maxims," which are moral generalizations derived from a string of relevantly similar cases.

PROBLEMS WITH CASUISTRY

Several challenges confront casuistry. First, it is less independent of principle-based reasoning than its proponents suggest. Casuists claim that moral certainty is to be found in particular cases. But grasping the ethical significance of a case may not be distinguishable from grasping a moral generalization (principle or rule) under which the case falls. When we perceive that a man's harsh slap of a child without cause is wrong, we also perceive the wrongness of some kind of action, such as harming the innocent or hurting children; after all, something about the action makes it wrong. Thus, there is no basis for claiming that judgments about particular cases are more certain than judgments about more general norms governing the cases; indeed, it is doubtful that the two kinds of judgment can be entirely separated.

Casuistry sometimes faces difficulties in justifying judgments in particular cases. For example, it is now widely accepted that a competent patient may refuse medical treatment, and courts and commentators have largely agreed that competent patients may also refuse food (nutrition) and water (hydration)—presumably because the latter refusal is relevantly similar to refusals of medical treatment. But what supports the claim of relevant similarity here? The casuist is likely to vest authority in community judgment or consensus within the evolving practices and traditions of American and other traditions of medicine. But it is not self-evident that one should accept the ethical judgments woven into these practices and traditions.

Finally, by focusing so heavily on cases, casuistry risks being both unable to make progress on controversial issues, since consensus on particular cases is elusive, and overlooking very general and fundamental issues, the resolution of which may be

relevant to specific cases. As an example of the first problem, casuistry offers little help in illuminating fundamental questions regarding the moral status of animals. Since consensus about the moral status of animals is lacking, any case involving animals to which a casuist might appeal will either elicit incompatible moral judgments from those who consider the case, or elicit agreement to vague or relatively trivial judgments (for example, "It is wrong to cause animals to suffer unnecessarily"). For an example of the second problem related to focusing on cases, consider a casuist who attempts to determine, by examining relevant government funding decisions, whether some new medical treatment should be publicly funded. This approach may miss broader questions of social justice and access to health care, the resolution of which might vindicate major reform of our health care system, implying different answers to specific funding questions than the answers at which the casuist would arrive.

REFLECTIVE EQUILIBRIUM (A FORM OF COHERENCE THEORY)

Many philosophers now defend the view that the relationship between general moral norms and particular moral judgments is bilateral (neither a unilateral "application" of general norms nor a unilateral abstraction from particular case judgments). John Rawls's (1971, as revised 1999) celebrated account of "reflective equilibrium" has been the most influential model.

In developing and refining a system of ethics, he argues, we should start with the broadest possible set of considered judgments (see below) about a subject and erect a provisional set of principles that reflects them. Reflective equilibrium views investigation in ethics (and theory construction generally) as a reflective testing of moral principles, theoretical postulates, and other moral beliefs to render them as coherent as possible. Starting with paradigms of what is morally right or wrong, one searches for principles that are consistent with these paradigms and one another. Such principles and considered judgments are taken, as Rawls puts it, "provisionally as fixed points," but also as "liable to revision."

Considered judgments are judgments in which our moral capacities are most likely to be presented without a distorting bias. Examples are judgments about the wrongness of racial discrimination, religious intolerance, and sexual oppression. By contrast, judgments in which one's confidence level is low and judgments that may reflect self-interest or other forms of bias do not qualify as considered judgments. The goal is to match, prune, and adjust considered judgments and principles so that they form a coherent moral outlook.

This model seeks the best approximation to full coherence—while recognizing the possibility of unanticipated situations that force reconsideration of earlier-accepted judgments. From this perspective, just as hypotheses in science are tested, modified, or rejected through experience and experimental thinking, principles and other moral norms are tested, revised (sometimes by specification), or rejected. This outlook differs greatly from deductivism, because the method of reflective equilibrium regards ethical theories as never complete, always standing to be informed by practical contexts, and susceptible to testing by the theories' practical implications.

PROBLEMS WITH REFLECTIVE EQUILIBRIUM

The central problem with the reflective-equilibrium model is that the flexibility associated with its bilateral approach is a double-edged sword: While avoiding some difficulties associated with (top-down) application of ethical theories and with the case-focused method of casuistry, reflective equilibrium also gives relatively little specific guidance about how to engage in moral reasoning. Several philosophers have endeavored to characterize reasoning within this model in a nontrivial manner (see, for example, Rawls 1971; Daniels 1979, 1996, 2003; Holmgren 1989; Nielsen 1991, chs. 9–11; DeGrazia 1996, ch. 2; and Arras, 2007). But, theoretically, the model needs further development, and, practically, it remains uncertain how helpful this model will be to nonphilosophers seeking moral guidance.

Critique

This chapter has presented an overview of several prominent philosophical methods in medical ethics. It began with a characterization of five major methods, or models, for conducting the work of moral reasoning, with special emphasis on the problems that arise in medical ethics. It is one thing to know what a method is, another to judge its adequacy. Therefore, each subsection describing a method was followed by a subsection identifying one or more leading criticisms of that method.

We now conclude the body of this chapter with a few remarks about the limits of philosophy in medical ethics and some comments indicating common ground amid the diversity of philosophical contributions to medical ethics. One limit to what philosophy can accomplish in medical ethics is implicit throughout the above discussions of methods and the criticisms they face. Despite the merit of much work in ethical theory and methodology in ethics, no approach has proved so convincing and resilient in responding to criticisms as to convince all philosophers and ethicists—or even a majority of them—to adopt it as the preferred method. This means that everyone interested in methodological issues of medical ethics must think critically about the strengths and weaknesses of leading approaches.

A second limit of philosophy derives from its nonempirical nature. Philosophy involves a critical perspective from which to evaluate theses, arguments, and viewpoints as well as (in ethics) actions, motives, practices, and institutions. Philosophy must depend on empirical disciplines in a joint effort of critically evaluating any specific domain of human knowledge and practice, whether it be medicine, law, international relations, or another. Philosophy can contribute to medical ethics through ethical theory and, more broadly, methodology in ethics (and can make other contributions [see note 1]), but philosophy can provide reliable moral guidance only to the extent that its empirical assumptions are accurate.

If, for example, one argues that physician-assisted suicide is justified—based on the conviction that currently legal means of pain control and the alleviation of suffering are ineffective for many patients—one's argument depends on clinical data that are relevant to assessing the adequacy of legal methods of pain control and alleviation of suffering. Philosophy itself cannot address the factual issues without relying on other fields that provide relevant empirical data.

Philosophy's nonempirical nature motivates what may be the only significant point of methodological consensus among the wide variety of methods in ethics. One might suppose that all of the approaches agree that a theory is rightly tested by the intuitive plausibility of its moral implications (by their resonance with our lived moral experience), yet deductivism is not committed to this criterion. Alternatively, one might presume that all of the approaches agree that the evaluation of actions is central to moral reasoning, yet proponents of virtue ethics (or at least some variants of this approach) would dissent. At the same time, all approaches must accept this requirement: The factual assumptions underlying moral reasoning must be reasonably supported by empirical evidence and observation.

Finally, there seems to be more agreement about how to write strong papers in philosophical medical ethics than there is on questions of method. Because the present chapter has focused on the latter, we here enumerate a few agreed-upon criteria of excellence for papers in philosophical medical ethics: (a) clarity of expression and organization (so that, for example, papers are not unnecessarily difficult to read); (b) rigorous argumentation, making it clear to the reader that conclusions are strongly supported by the arguments presented in their defense; (c) a firm command of leading work that has already been published on the topic; (d) novelty, so that the author is not simply duplicating work already published; and (e) an important topic, so that the work is well motivated and stands to make a contribution to the field.

Notes on Resources and Training

What sorts of training are available to those who aspire to work in ethical theory or other philosophical areas of medical ethics? Is such training necessary or merely desirable? The answers to these questions turn on an individual's specific goals.

To make significant scholarly contributions to philosophical medical ethics—in contrast to various contributions to medical ethics made by other disciplines—or to teach effectively in this area, there is no substitute for graduate training in philosophy. One possible strategy is to seek admission to a strong philosophy graduate program while planning to take several courses in medical ethics (prioritizing strength in philosophy). Another possible strategy is to apply only to philosophy graduate programs that have a medical ethics track or concentration (making medical ethics more central to one's studies). Both strategies reflect viable paths to philosophical work in medical ethics.

For those seeking basic competence (as opposed to expertise) in specific philosophical areas of medical ethics, less intensive courses of study are available. One or more courses in ethical theory—preferably, but not necessarily, at the graduate level—would be appropriate training for competence in that area. Ideally, such courses would be taken as part of a more extensive graduate training—in a master's program in medical ethics, for example—but they could also prove invaluable to the professional who is auditing courses.

In addition to courses at colleges and universities, other opportunities for education in philosophical medical ethics include intensive "short courses" taken over several days, workshops, conferences, and self-education through reading. Such educational experiences can enrich one's reasoning and discourse about philosophical

issues in medical ethics. They can also enable one to learn more from scholarly writings.

There are several leading scholarly resources to which one may turn for information about or work in philosophical contributions to medical ethics. First, one may search journals for articles of particular interest. Leading journals from the standpoint of philosophical medical ethics include *American Journal of Bioethics, Bioethics*, *Cambridge Quarterly of Health Care Ethics*, *Ethics*, *The Journal of Medical Ethics*, *The Kennedy Institute of Ethics Journal*, *Philosophy and Public Affairs*, and *Theoretical Medicine and Bioethics*. Sometimes one can find valuable articles in strong philosophy journals that do not focus on medical ethics or ethical theory.

One systematic approach to searching for helpful journal articles is to consult *The Philosopher's Index*, which is published quarterly and lists published articles and books arranged by author and by subject; this source is now also available online at www.philinfo.org/electronic.htm. Two encyclopedias offer valuable short articles and bibliographies: *The Encyclopedia of Bioethics*, third edition (Post 2004), and *The Routledge Encyclopedia of Philosophy* (Craig 1998). Longer articles on a number of subjects can be found in *The Stanford Encyclopedia of Philosophy* (Zalta, continuously updated and still adding new articles in bioethics, at http://plato.stanford.edu/). Some comprehensive textbooks that provide both detailed discussions and leads for further research can also be a useful general resource. In addition, valuable resources, including the unique bioethics database ETHXWeb, are located at the Bioethics Research Library at Georgetown University in Washington, DC. Those cannot visit the library may call 202-687-3885, e-mail bioethics@georgetown.edu, or visit the website, http://bioethics.georgetown.edu. Finally, a new reference-database system is now available: EthicShare, a discovery and collaboration environment for ethics scholars and students, can be accessed at www.ethicshare.org. For more information or assistance, visit the website, e-mail help@ethicshare.org, or call 612-626-4357.

Notes

1. Philosophy makes other contributions to medical ethics, although we cannot canvass all of them here. Examples include the contributions of action theory to a theory of informed consent and of personal identity theory to views about the definition of death and the authority of advance directives.
2. An increasingly influential variant of the human rights approach appeals to human capabilities (see, for example, Nussbaum 2000, 2006).
3. Appeals to the common morality as the source of universal norms are not intended to suggest that moral reasoning should always lead to widely accepted conclusions. Common moral experience provides the starting point of moral discourse, but critical reflection on specific ethical issues may ultimately vindicate moral judgments that are not widely shared (for example, regarding our obligations to the developing world or regarding the moral status of animals). See, for example, Beauchamp (2003), DeGrazia (2003), and Lindsay (2005).
4. For discussions of this method in bioethics, see DeGrazia (1992), Beauchamp (1994, 2007), and Beauchamp and Childress (2009). For discussions of what is now sometimes called specified principlism, see DeGrazia (1992), Davis (1995, esp. 95–102), Levi (1996, esp. 13–19, 24–26), and Strong (2000).
5. Efforts to analyze the idea of justification by coherence include Daniels (1996), DeGrazia (1996, ch. 2), and Arras (2007).

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6. Their views are further developed in later writings. See Green, Gert, and Clouser (1993); Clouser and Gert (1994); Clouser (1995); Gert, Culver, and Clouser (2006); and Gert (2007).
7. Several types of ethical theory have been employed in addressing practical problems, including utilitarianism, Kantianism, rights theory, contract theory, communitarianism, virtue ethics, the ethics of care, feminist ethics, and pragmatism. Many proponents of these theories would argue, however, that specific policy and practical guidelines cannot be simply derived from these ethical theories and that some additional moral reasoning is required. Indeed, several of these theories—at least virtue ethics, the ethics of care, and feminist ethics—are often said to resist articulation in a set of principles (which is not to say that principles are rejected altogether). See Carse (1998) and Callahan (2000).
8. Rawls (1971 and, as revised, 1999) has developed a theory of justice, but not a full ethical theory, that features such a hierarchy of principles.
9. The most classic deontological theory featuring a supreme principle is that of Kant (1959). For twentieth-century representatives of this approach, see Donagan (1977), a book stressing respect for persons, and Gewirth (1978), which stresses individual rights.
10. For a variety of utilitarian theories, see Frey (1980), Hare (1981), Griffin (1986), Sumner (1987), Kagan (1989), Brandt (1992), Singer (1993), and Hooker (2000).
11. For a classic discussion of this divide among utilitarians, see Smart (1956). A rule-utilitarian may favor quite nuanced rules. For example, rather than "do not lie," she may favor a rule that incorporates one or more exceptions such as "do not lie unless lying is the only means to preventing substantial harm" or perhaps a rule building in further exceptions. However, it is extremely difficult, and often impossible, to build all nuances or exceptions into any rule.
12. For prominent contemporary representatives of Kantian ethics, see O'Neill (1989), Herman (1993), and Korsgaard (1996).
13. For a landmark work in the history of the type of reasoning described here, see Jonsen and Toulmin (1988). For additional features of the method, see Jonsen (1996, 1991, and 2000).

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