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GUEST EDITORIAL

Moral reasoning – the unrealized place of casuistry in medical ethics

Introduction: the demands of deductivism

If the practice of ethics consists of the justifiable application of moral principles, then the challenge will always be to ensure, first, that the principles are well chosen and, second, that their application to the case in point is overtly justifiable. In this editorial, having briefly mentioned "principlism", which itself involves the application of ethical principles in practice, we shall make the case for casuistry (case-based) reasoning.

Most of us like to think that our decisions are the result of *logical deductions* – that we consider ethical principles germane to a given clinical problem and we deduce the correct course of action. In reality this is seldom the case, because strict deductive reasoning is extremely taxing. It requires an unbroken chain of syllogistic reasoning – carefully crafted and open to scrutiny, internally consistent and advancing in minute steps – just like the proof of a mathematical theorem. This demanding process is not feasible in clinical practice: most ethical discussions rely heavily on *inductive* reasoning, interspersed perhaps with elements of "nested deductivism", i.e. short strands of tight, logical argument.

Murray (1994) has cogently criticized deductivism. He argues, amongst other things, that: (a) since moral theories are generally too abstract to be directly applicable to specific moral judgement, there is a temptation in deductivism to be inattentive to the particularities of cases – hence, rules may be applied insensitively; (b) most situations are complex enough to invoke more than one fundamental principle and unless some definitive scheme for ordering principles is provided, no conclusive answer seems possible; (c) deductivism typically pays little or no attention to the social or historical context in which moral problems appear.

Moral theories and principles

Most clinicians are familiar with the key principles derived from moral theories. Four of these (beneficence, nonmaleficence, autonomy and justice) have become pre-eminent, reflecting Beauchamp and Childress' successful argument that these "clusters of moral principles" could serve "as an analytical framework that expresses the general values underlying rules in common morality" (Beauchamp and Childress, 2001). O'Neill (2001) has rigorously defended this approach,

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known as “principlism”. She helpfully observes that in clinical decisions, ethical and professional principles (such as having to gather clinical information accurately and comprehensively) should be considered side by side.

Whilst the principles of medical ethics have become well ingrained in our vocabulary, clinicians are less familiar with other modes of ethical reasoning. Several frameworks for moral reasoning have been proposed (see, for example U.K. Ethics Network). These can incorporate both deductivism and the case-based approach. Typically, ethicists draw on a variety of moral theories in analyzing a case. As with mathematics, some approaches are more suited to a given problem than others (e.g. trigonometry rather than algebra in surveying). Utilitarianism may seem the appropriate approach when tackling questions of resource allocation. For instance, Quality Adjusted Life Years (QALYs) are a way of calculating happiness and deciding on this basis how to allocate resources (Lockwood, 1988). On the other hand, issues of patient choice will often be debated in terms of autonomy, which can arguably be regarded as Kantian on the grounds that respect for autonomy is inherent to being a rational agent (Gillon, 1986).

Casuistry

In their book, *The Abuse of Casuistry*, Jonsen and Toulmin describe an alternative, powerful technique of moral reasoning, which is gradually gaining ground in medical ethics (Jonsen and Toulmin, 1988). This is known as *casuistic* (case-based) reasoning. Casuistry suggests the compilation of a lexicon of cases which have been carefully considered and are widely recognised as “sentinel cases”. Such cases would then form the basis for the evaluation of subsequent, similar cases. The ethical exercise involves *immersion* in the detailed circumstances of the particular case and a careful comparison with the precedent case for which the moral position has already been established.

Casuistry allows the idea that an ethics case-lexicon might be solely for the individual. In a sense, it gives us an explanation of how we might make ethical decisions in practice, whether or not we recognize the process. Approaching a new case in the light of previous experience is simply to show practical wisdom. Judgements about the ethical aspects of the case will be dealt with alongside the more biomedical decisions. Each clinician will have a store of cases to draw upon. Such cases are paradigms and they form the individual clinician’s lexicon, whether they relate to pharmacology or the application of values to practice.

For instance, given that we have decided to continue to treat Mrs A. with a cholinesterase inhibitor, even though she is now moving into long-term care, why is it that we are being reticent about starting the same treatment for Mr B., seemingly because he is already in long-term care? To answer this question, we need to immerse ourselves in the detail of Mr B.’s case over against the case of

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Mrs A. There will be important similarities and dissimilarities at a factual level, but there will also be important values, some of them perhaps conflicting, and a broader context that is, nonetheless, individual to this particular case. Clinicians will have their own lexicons of such cases upon which they can draw. Awareness of casuistry at an individual level helps to make this process more overt and more critical.

The public lexicon

However, the standing of an individual's lexicon will be surer if it has had public exposure and can be shown to square in a rational way with accepted norms. Hence, there are arguments in favour of developing the lexicon as an international project. This would clearly be a lengthy process, with careful attention to the requirements for confidentiality, but the rewards could be huge. Developing the sentinel cases for the lexicon would require detailed analysis, by immersion in the particularities of key cases by appropriately experienced and trained individuals. Indeed, with respect to cases relating to the practice of old age psychiatry, what better body than the International Psychogeriatric Association to initiate such a venture?

The required analysis would involve several domains, including issues relating to the patient (to do with diagnosis, the pros and cons of treatment, the prognosis, along with the wishes of the patient and family, etc.), and to the clinic generally (its policies, norms of practice and its constraints, etc.). Thereafter a process of *interpretation* would be carefully conducted, drawing on moral theories and moral principles, which should be considered as they apply to the particular case. Unlike deductivism, the theories and principles would be treated as *informative* (i.e. how do they actually help in this case?), and not as axiomatic.

Casuistry takes a fundamentally different stand on the place of ethics in social life – the discipline assumes that morality lies in the realm of practice, not of theory. Once again, casuistry resembles the form of reasoning used in clinical medicine, since it relies on analogical reasoning (e.g. to what extent is research on children similar to research on people with cognitive impairment?). Likewise, casuists use agreed paradigms, or type cases, from which they survey their way analogically to less understood, still disputed cases. Unlike other frameworks of moral reasoning, casuists emphasise that conclusions are *presumptive* and revisable in the light of future developments and understanding. This should promote a resistance to dogma and openness to experience.

Casuistry and law

While the above description of case-based moral reasoning may attract the criticism that the method seems to be an example of subjectivism (that the validity of a moral principle is entirely determined by individual choices – a

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subset of relativism), its validity is well established in judicial systems of case law. The judge considers the minute details and circumstances of the case before her; she considers previous, similar, precedent cases and discusses the similarities between the present case and the precedent case. She may comment on the appropriateness of the previous judgement in the context of modern times. She gives her judgement and might then, crucially, give leave to appeal against her own decision.

In medical ethics we lack (as yet) a lexicon of precedent or paradigmatic cases (though every Clinical Ethics Committee soon develops their own lexicon). By contrast, in countries with a case-law tradition, the legal profession has developed an extensively analyzed library of precedents. Some of these cases fall somewhere between jurisprudence and medical ethics, hugely enriched by their tour through the courts.

Bournewood

To illustrate casuistry in practice, we shall describe the essential elements of a now celebrated and controversial case in the U.K., the case of *Bournewood*, which has caused varying amounts of consternation to psychiatrists in England and Wales during its passage from the High Court and Court of Appeal in 1997 (Regina v. Bournewood Community and Mental Health N.H.S. Trust, 1998), to the House of Lords (Lords of Appeal, 1998) and the European Court (European Court, 2004). The case concerns a man, *L*, then in his late 40s, with a learning disorder. He had spent most of his life in a psychiatric institution, but prior to the start of the case he had lived in the community for about three years. He then exhibited agitated and self-harmful behavior and he was admitted back into the psychiatric hospital (Bournewood). However, because he did not appear to resist his admission, he was not admitted formally, using the powers of the Mental Health Act 1983. He was regarded as an informal patient who, lacking capacity, was being kept in hospital in his best interests.

The case becomes relevant to thousands of people with dementia who are in institutions without having given consent (because they lack the capacity to do so), but who have no formal (i.e. legal) safeguards. The worry in the Bournewood case has been that such informal detention is illegal, in which case, in England and Wales a huge and costly change in practice would be required, which might (it is asserted) be unnecessary and stigmatizing.

Any of the numerous judgements in the case show the judges aptly demonstrating casuistry's concept of *immersion*. In the House of Lords, for instance, Lord Goff described *L*'s personal characteristics and diagnosis, his lack of capacity, his behavioral and social history, along with the events of his

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hospital admission, all in great detail. The background law was also set out – in the European Court this included comparisons with cases from other countries. The further context of the case was clarified by considering the views of other parties and the background context, with an acknowledgment of the extra costs if all such patients had to be formally detained. In the event, the House of Lords did not find that *L* had been falsely imprisoned, as was alleged.

Nevertheless, just as classical practitioners of casuistic reasoning qualified their conclusions as more or less probable and *rarely as 'certain' or conclusive*, the House of Lords granted leave to appeal. And in the European Court it was held that there *had been* a violation of Article 5 of the European Convention for the Protection of Human Rights: *L* had been deprived of his liberty in an unlawful manner. The European Court was struck by "the lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted" (European Court, 2004 (2)).

So the case is a good exemplar of the casuistic process. In turn, it will be regarded as a paradigm case with respect to the "detention of compliant incapacitated persons". In addition, however, the arguments of the case can be regarded as pertinent to the ethical decisions, in which old age psychiatrists are routinely required to participate, concerning "placement" for people with dementia. How we care for "compliant incapacitated persons" in our different legal jurisdictions is crucial to our standing as humane practitioners. The lessons that might be drawn from the case concern the need (where formal detention is not appropriate) for overt, multidisciplinary care planning, with the involvement of family or main carers and the use of independent advocates with some process of review. These lessons should form part of the lexicon that guides clinical and ethical practice.

Conclusion

In conclusion, we would contend that although case-based reasoning (casuistry) is widely used in law and clinical medicine, its place in medical ethics is not fully realized. The casuistry project entails building up a lexicon of well-debated "sentinel cases", which could fulfil the same function as landmark legal cases. Thus, practical medical ethics might become an organic enterprise, whose growth could be formally traced, and whose stature and standards would be open to examination by all.

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