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Casuistry as bioethical method: an empirical perspective

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Abstract

This paper examines the role that casuistry, a model of bioethical reasoning revived by Jonsen and Toulmin, plays in ordinary moral reasoning. I address the question: 'What is the evidence for contemporary casuistry's claim that every-day moral reasoning is casuistic in nature?' The paper begins with a description of the casuistic method, and then reviews the empirical arguments Jonsen and Toulmin offer to show that every-day moral decision-making is casuistic. Finally, I present the results of qualitative research conducted with 15 general practitioners (GPs) in South Australia, focusing on the ways in which these GP participants used stories and anecdotes in their own moral reasoning. This research found that the GPs interviewed did use a form of casuistry when talking about ethical dilemmas. However, the GPs' homespun casuistry often lacked one central element of casuistic reasoning — clear paradigm cases on which to base comparisons. I conclude that casuistic reasoning does appear to play a role in every-day moral decision-making, but that it is a more subdued role than perhaps casuists would like.

Keywords: Casuistry; Bioethics; General practice; Decision-making

Introduction

In recent years there has been a lively debate between sociology and bioethics about the nature and role of moral theory in every-day moral reasoning. Most bioethicists assert that the theories they articulate do match real-life moral decision-making, in the sense that they see their task as moral theorists, in part, as systematising every-day moral activity (Beauchamp, 1995; Childress, 1994; Green, Gert, & Clouser, 1993; Jonsen & Toulmin, 1988). Against this view, critics of mainstream bioethics, particularly from the social sciences, argue that the forms, language and styles of reasoning in bioethics bear little relationship to the ways in which ordinary people describe and explain their moral problems (Elliot, 1992a; DeVries & Subedi, 1998; Hoffmaster, 1992; Jennings, 1990; DuBose, Hamel, & O'Connell, 1994).[1]

This same debate can be traced within specific approaches in bioethics. In particular, Jonsen and Toulmin have made much of the connection between their approach to bioethics, casuistry, and every-day moral reasoning, asserting that casuistry describes how moral reasoning does in fact occur (Jonsen & Toulmin, 1988).

This paper explores Jonsen and Toulmin's assertion. I address the question: 'What is the evidence for contemporary casuistry's claim that every-day moral reasoning is casuistic in nature?' To do this, I first provide a brief account of contemporary casuistic reasoning. Then, I review the empirical arguments Jonsen and Toulmin present to show that every-day moral reasoning is indeed casuistic and argue that their conclusion requires stronger evidence. Finally, I offer a

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[1] The phrase 'ordinary people' comes from Elliott (1992a). Elliot argues that "the practical difficulty with applying ethical theories is that ordinary people pay little attention to theories when they make their moral decisions" (p. 30); see also Hoffmaster (1992), whose view is that "moral philosophy simply does not fit the experience of those who have spent time in clinical settings" (p. 1424). I use the phrase 'ordinary people' to refer to all those who are not specialists or formally trained in moral philosophy, bioethics or like disciplines.

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different empirical perspective on the place of casuistry in every-day moral reasoning using qualitative research conducted with a group of general medical practitioners (GPs) in South Australia. Specifically, I explore the role that stories and anecdotes played in the GPs' talk about moral problems and suggest that the telling of these stories represents a version of homespun casuistry, albeit a version that underplays one of the central elements of casuistic reasoning — the paradigm case.

Casuistic reasoning as a bioethical method

Modern casuistry has had a significant impact on contemporary bioethical theory. In the model articulated by Jonsen and Toulmin, it has presented a challenge to the hegemony of approaches based on general principles (Arras, 1991), and a method of philosophical analysis appropriate to the reasoning style and practice of health professionals (Elliot, 1992b; Siegler, Pellegrino, & Singer, 1990; Jonsen, Siegler, & Winslade, 1992). While there have been important critiques of casuistry (Wildes, 1993; Arras, 1991; Kopelman, 1994), they seem to have done little to diminish the popularity of this approach to moral reasoning.

Jonsen and Toulmin have written prolifically on contemporary casuistry. Their sentinel work is *The Abuse of Casuistry*, a thickly textured history of casuistry that aims to demonstrate the relevance of casuistry for modern times (Jonsen & Toulmin, 1988; Toulmin, 1981; Jonsen, 1986, 1991, 1995a, b). Jonsen and Toulmin begin this work by suggesting that there are two, quite distinct, ways to discuss ethical issues. The first frames issues in terms of principles, rules and generalities, whereas the second focuses on the particularities of specific cases. In the former, a universal major premise provides the starting point for argumentation that leads deductively to a conclusion. Jonsen and Toulmin liken this mode of reasoning to that which occurs in classical geometry. The case-based approach is closer to practical reasoning, and it "draw[s] on the outcomes of previous experience, carrying over the procedures used to resolve earlier problems and reapplying them in new problematic situations" (Jonsen & Toulmin, 1988, p. 35). Although *The Abuse of Casuistry* is an account of the history of casuistry, Jonsen and Toulmin's central thesis relates to the present:

> Practical moral reasoning today still fits the patterns of topical (or 'rhetorical') argumentation better than it does those of formal (or 'geometrical') demonstration (Jonsen & Toulmin, 1988, p. 326).

Much of *The Abuse of Casuistry* is devoted to an account of the methods of moral reasoning used by classical casuists. Although these casuists were prolific writers, they did not leave behind explicit accounts of their methodology. The best we can do, say Jonsen and Toulmin, is to infer the method from their practice. That method involves 'steps' consistently taken but seldom reflected on (Jonsen & Toulmin, 1988, pp. 250–265). On the basis of a close analysis of the work of these classical casuists, Jonsen and Toulmin venture a definition of casuistry:

> the analysis of moral issues, using procedures of reasoning based on paradigms and analogies, leading to the formulation of expert opinions about the existence and stringency of particular moral obligations, framed in terms of rules or maxims that are general but not universal or invariable, since they hold good with certainty only in the typical conditions of the agent and circumstances of action (Jonsen & Toulmin, 1988, p. 257).

Jonsen's later work explicitly takes up the question of the methodology of casuistry. In his review article for the *Encyclopedia of Bioethics*, Jonsen questions the use of the term 'methodology' for casuistry, for he thinks it may be too formal a word for casuistry's way of dealing with moral problems (Jonsen, 1995a). Nonetheless, he goes on there, and elsewhere, to describe the characteristic features of casuist methodology, by filling out some of the terms that he has previously mentioned and putting them in some kind of step-by-step order (Jonsen, 1991, 1995b). The actual steps vary between papers: in some papers, the first step in casuistic analysis is the identification of paradigm cases; in others, it is the identification of the topic. The account below is that which offers the most complex interpretation of the casuist's method (Jonsen, 1995b).

Throughout Jonsen's discussion of the method of casuistry, the notion of rhetorical analysis is central. Rhetoric is:

> . . .the art of making a persuasive argument in favour of the just, the good, and the right. . .the art of encouraging citizens to decide rightly about civic matters and courts to decide fairly about legal ones. Finally, rhetoric [is] the art of reasoning with contingent facts and drawing plausible conclusions (Jonsen, 1995b, p. 241).

Rhetoric starts with 'topics' — those invariant features that constitute the framework of an activity. The casuist's first task is to site his case within the appropriate topic. In political science, Jonsen suggests the topics might begin with the form of government, the locus of authority, and common welfare. The topics that Jonsen recommends for clinical ethics are medical indicators, patient preferences, quality of life and

contextual features, such as allocation of resources (Jonsen, Siegler, & Winslade, 1992).

From topics the casuist moves to a thorough description and evaluation of the circumstances or particulars of the case. One of the central features of casuistry is its focus on the particular: Jonsen and Toulmin's view in *The Abuse of Casuistry* is that "*moral knowledge is essentially particular*, so that sound resolutions of moral problems must always be rooted in a concrete understanding of specific cases and circumstances" (Jonsen & Toulmin, 1988, p. 331). Concrete understanding of cases leads the casuist to construct a case in terms of time, place, person, actions and affairs (Jonsen, 1991, 298). These details stand around the core of the case, which is a maxim, rule or value that defines the case as a certain 'type'. The maxim is, in a sense, a 'cut-down' version of those principles that are relevant to the topic under consideration. For example, the principle of autonomy cut-down for use in a particular case might become "persons have a right to take their own risks" (Jonsen, 1995b). The maxim is important in that it establishes the base from which one moves to compare the case under scrutiny with other cases.

The third step in casuistic analysis is the comparison of cases. In comparing the case with other cases, one seeks to identify 'paradigm' cases. A paradigm case is:

> A case in which the circumstances were clear, the relevant maxim unambiguous and the rebuttals weak, in the minds of almost any observer. The claim that this action is wrong (or right) is widely persuasive. There is little need to present arguments for the rightness (or wrongness) of the case and it is very hard to argue against its rightness (or wrongness) (Jonsen, 1991, p. 301).

The casuist looks for paradigm cases that bear some sort of family resemblance to the case under investigation. Both Jonsen's early work and *The Abuse of Casuistry* note that the classical casuists "read each others' works assiduously and commented on others' ideas incessantly", generating in turn a form of continuous self-correction (Jonsen, 1986, p. 70). Their paradigm cases were public cases with a long history of debate, discussion and correction. Jonsen's efforts to rehabilitate the method of casuistry led him to cite Karen Ann Quinlan, Baby Doe of Bloomington, and "Debbie" (discussed in *Journal of the American Medical Association*) as paradigm cases for the contemporary casuist. He thinks that, as for the classical casuists, these cases have generated a body of discussion and criticism, an awareness of general agreement and points of difference and, most importantly, some consensus about 'the right thing to do'.

Jonsen and Toulmin's detailed and nuanced account of medieval and renaissance casuistry would be of little more than historical interest if they did not make clear that they think the casuistic method expounded in it is relevant for us today. In fact, one of the reasons that *The Abuse of Casuistry* has become such an important work in contemporary bioethics is precisely because Jonsen and Toulmin suggest that their theory of moral reasoning mirrors ordinary moral judgment. It is worthwhile examining how they arrive at this conclusion.

Jonsen and Toulmin and the national commission

In the prologue to *The Abuse of Casuistry*, Jonsen and Toulmin offer an argument for their assertion that casuistry describes every-day moral reasoning based around a number of empirical examples of what they take to be every-day moral reasoning at work. The examples are intended to illustrate the tyranny of principles in public discourse about moral problems and to make plain that moral reasoning does not proceed merely through application of principles (Jonsen & Toulmin, 1988, pp. 1–20).

The most important of Jonsen and Toulmin's examples is an autobiographical account of their work on the United States National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research that spawned the *Belmont Report* (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1978; Jonsen & Toulmin, 1988, pp. 16–19).[2] They suggest that their work on the Commission gave them both a

> striking first-hand experience of what 'the new casuistry' holds in store for moral reflection and discussion, and compelled us to think about its methods (Jonsen & Toulmin, 1988, p. 16).

They believe the day-to-day activity of the Commission exemplified casuistry at work, for they found that the commissioners and their consultants could agree on what recommendations to make, even though they did not agree on why they thought they should make them.

> So long as the debate stayed on the level of particular judgments, the eleven commissioners saw things in much the same way. The moment it soared to the level of 'principles,' they went their separate ways (Jonsen & Toulmin, 1988, p. 18).

[2] Indeed, the 'story' of Jonsen and Toulmin's involvement in the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research is often related in introductions to casuistry in support of the casuistic method (Elliot, 1992b).

Jonsen and Toulmin imply that their experience on the Commission provided evidence that people really do reason as casuists, rather than as principlists. Although they do not draw the conclusion explicitly, one might infer that they think their experience was an example of how people "in the middle", to use Jonsen and Toulmin's phrase, argue about moral problems, one that they believe can contribute to an accurate account of moral reasoning.

What Jonsen and Toulmin recollect about the work of the National Commission is less important here than the assumption they appear to make that the work of the Commission provided an example of ordinary moral reasoning. However, if it is to be construed as evidence of how people "in the middle" argue, then it is a rather peculiar form of evidence, for it is based on the experience of a quite select group of people, with considerable experience between them in medical science, psychology, philosophy, law, theology and the 'public interest' (Jonsen & Toulmin, 1988, p. 17). In addition, the commissioners and their consultants were arguing about moral problems that people "in the middle" rarely have to consider. Furthermore, the account we hear of the moral deliberation of this select group is filtered through the experiences and perceptions of Jonsen and Toulmin themselves. They do not tell us what the other commissioners thought they were doing, only what Jonsen and Toulmin observed them to be doing.

Jonsen and Toulmin appear to fall into the trap of assuming that examples of their own moral activity provide the empirical evidence we need to state that ordinary moral reasoning is casuistic. To be fair to Jonsen and Toulmin, their account of the *history* of casuistical reasoning in *The Abuse of Casuistry* does not fall into the same trap. They provide many examples of the historical casuists' reasoning, and draw their conclusions about the general forms of that reasoning from those examples. Nonetheless, their empirical defence of modern casuistry does not display the same careful and analytical approach.

If Jonsen and Toulmin's empirical justification for the relationship between their model of casuistry and ordinary moral reasoning is not convincing, where else can we go for evidence? Hoffmaster and others have noted the importance of a social science perspective on these issues (Hoffmaster, 1992; Elliot, 1992a; DeVries & Subedi, 1998; Jennings, 1990; DuBose, Hamel, & O'Connell, 1994). A number of scholars in the social sciences have explored, in a variety of settings, the forms that moral reasoning appears to take.[3] The focus in this scholarship, however, has not been primarily on the fit between moral theories and every-day moral reasoning. The remainder of this paper addresses this question directly, as it relates to casuistry, using qualitative research conducted with general practitioners. This research found that the GPs interviewed did use a form of casuistry when talking about ethical dilemmas, grounded in the telling of stories and anecdotes. However, the GPs' homespun casuistry often lacked one central element of casuistic reasoning — clear paradigm cases on which to base comparisons.

Homespun casuistry: an example from general practice

The empirical work reported in the remainder of this paper is part of a larger study of moral reasoning undertaken using semi-structured interviews with 15 general medical practitioners in South Australia during 1993 (Braunack-Mayer, 1998).[4] This paper focuses on the ways in which the GP participants used cases, stories and anecdotes in their moral reasoning. To situate the research, a brief description of the study design and conduct are provided.

The study design and conduct

The general practitioners who took part in this study were volunteers, recruited through the networks of the Royal Australian College of General Practitioners. They were invited to express an interest to take part in an 'Ethics in General Practice' study through the pages of the (then) Royal Australian College of General Practitioners-Family Medicine Program newsletter, which is mailed to about 1000 general practitioners in South Australia.

Eighteen general practitioners indicated either a willingness to take part in the study or an expression of interest. I contacted all general practitioners by telephone to describe the nature of the interviews, procedures for taping and transcribing the interview data, possible uses of the data and the means by which confidentiality and privacy would be protected. Fifteen of the GPs agreed to be interviewed. I mailed each a leaflet that contained the material I had discussed with them over the telephone and a letter confirming the details of their participation.

The interview schedule was designed to encourage the GPs to explore, in detail, at least one ethical dilemma they had faced in their working life. The interviews began with a general question — 'Please tell me about an

[3] See, for example, the work of Anspach (1993), Bosk (1979) and Chambliss (1996). For earlier work in the same genre, see Fox (1979).

[4] A detailed account of the methodology of this study is found in Braunack-Mayer (1998). For a discussion of semi-structured interviews, see Crabtree and Miller (1991), McCracken (1988), Denzin (1970), Gilchrist (1992) and Bernard (1988).

ethical problem you have encountered in your work as a general practitioner' — followed by a series of prompts designed to fill out the initial story — Who was involved? What information was known about them? Where? When? What was the context or setting? I also asked questions about choice and action, outcomes, reasons for decisions, how the GPs would have responded had the situation been different, and why the problem they were describing was a problem, and specifically an ethical problem.[5] We dealt explicitly with influences on the GPs' moral decision-making using questions about beliefs and values that had already been identified in the interviews (for example, honesty), what those values meant for the GPs and how they thought they had come to hold them.

I interviewed the GPs between January and June 1993. Nine GPs were interviewed in their surgeries, four in their homes and two at my work place. The average interview length was just over 1 h, and they varied in length from 45 min to 1 h and 45 min. The interviews were taped, and I also took very brief notes. Two interviews were conducted in difficult circumstances and yielded very poor transcriptions. Data from these two interviews have been excluded from this analysis.

The interviews were transcribed by two administrative staff and checked twice by me. Names and other identifying information were altered to protect the GPs' privacy. I used NUDIST, a qualitative analysis software package, to help analyse the data (Richards & Richards, 1991).

During preliminary analysis of the data I summarised the types of problems the GPs reported, coding every problem reported, and splitting and splicing codes as needed (Dey, 1993, pp. 94–112). I repeated the process for the problems the GPs chose to talk about in detail and their talk about why these issues were ethical problems. With these preliminary tasks completed, the largest part of the analysis focused on examining the ways in which the GPs described, analysed and resolved their moral problems. To assist in handling the volume of data, I prepared summary sheets for each GP based around two organising questions: 'what did the GP do?' and 'Why did the GP do it?' I reviewed these sheets and the corollary interviews carefully, continually moving backwards and forwards between data and classification, until I settled on a new classification scheme with which to tell the story of how these GPs dealt with their moral problems. I transformed my two organising questions into two major themes encompassing two types of explanation for the GPs' actions: 'what did you do?' changed to 'what tactics did the GPs use to deal with their problems?' and 'why did you do it?' became 'what approaches to moral reasoning did the GPs use?'

One of the general themes that emerged from the data analysis related to the role of 'experience' in dealing with moral problems. The GPs believed that experience over a lifetime had an important influence on how one dealt with morally problematic situations. Dr. Kingsford[6] was speaking for all of his colleagues when he commented that:

> 62[7]... I think as you get older you tend to — I've had over 30 years in general practice — you tend to get to know how to handle these situations, and I think this just comes with experience, you know it's the science and art of medicine, and it's — you only pick up the art of medicine with experience.
>
> Dr. Kingsford, male, 57, married, partner in three-person rural practice

Experience was not an abstract concept for these GPs. They described and explained it quite concretely with stories and anecdotes drawn from their lives, which they compared and contrasted with the moral problems they were discussing. My preliminary analysis of these experiences, expressed as stories, anecdotes and cases, suggested that the GPs used them in ways that were similar to case-based or analogic reasoning. This observation suggested questions about the extent to which the GPs' case-based reasoning could be described as casuistry, as Jonsen and Toulmin articulate it.

The remainder of this paper focuses on the GPs' stories and explores their use as examples of casuistic reasoning in action. The focus is on those instances in which the GPs related stories and anecdotes in the context of moral decisions and reflection. The only 'stories' excluded with this approach were: (a) the GPs' brief autobiographies at the end of the interviews in response to questions about their background, educational and professional experience; and (b) the stories with which the GPs had responded to the opening question: 'Tell me about an ethical problem in your work as a general practitioner', for my intention was not to analyse how the GPs described these theme-setting stories, but how they used other experiences in moral reasoning.

I use the terms 'story' and 'anecdote' interchangeably. Following Hunter's lead, both designate "...a more or

[5] Brown et al. (1989) used similar interview questions, except that moral conflict and choice there presume decision-making in the face of uncertainty, which I did not want to assume. Behind all these questions sits the assumption that people are moral agents — persons who actively make choices about "the standpoint they take and the concerns they voice and keep silent" (Brown et al. 1989, p. 147).

[6] Pseudonyms are used throughout this paper.

[7] Numbers at the beginning of quotations and in parentheses after a quotation refer to paragraph numbers in the text of the interviews.

less coherent...spoken or (by extension) enacted account of occurrences, whether historical or fictional...used, especially informally, to denote spoken and fictional accounts, where there is a strong sense of the story-teller'' (Hunter, 1996, p. 306, 1986).

Results

The GPs made considerable use of stories and anecdotes in their talk about ethical problems in their work. There were 84 discrete anecdotes scattered through the 13 interviews with wide differences in the usage of stories. At one end of the spectrum, one GP mentioned only two stories in her interview. At the other end, another related 14 different stories drawn from his experiences.

Overwhelmingly, these stories were about medical experiences and medical events. Seventy-nine of the 84 stories that the GPs related were set in either the clinic or the hospital. The GPs also placed themselves, almost always as clinicians, at the centre of the stories they recounted. In half of these stories, the GP was the principal actor or the only actor, and in a further 29 the GP and a patient were the central characters in the story. In the remaining small number of incidents, the patient, another doctor or a friend carried the central roles in the stories.

Just how did the GPs use these stories in their conversations about moral problems? The GPs tended to use their stories as trumps on moral talk, in other words, to provide empirical authorisation for why things should be done in certain ways (Lauritzen, 1996). Their moral trumps worked in two ways: in deontological fashion to illustrate a maxim or rule-of-thumb or in consequentialist fashion to focus on outcomes. Both types of trump were common in the GPs' stories. Ten GPs used deontological trumps in their stories, and 49 of the total of 84 stories had a trump of this type. Ten GPs also told at least one story with a consequence trump, and trumps of this type were present in 25 of the 84 stories.

Outside of the trumping role for stories, there were also a small group of stories that did not carry this trumping role. These anecdotes were descriptive, told to illustrate the nature of work in general practice. Nine GPs told stories of this type, and they accounted for 16 stories in all.

Deontological trumps

The first way in which the GPs used stories in their moral talk was to illustrate a rule-of-thumb or a guideline for dealing with situations. These stories had two features: a maxim or rule was stated and an example to illustrate it was provided. Dr. Winters' definition of confidentiality and one example he gave of the role it played in his work provided an excellent example of the deontological trump.

> 103. Define confidentiality? To me that just means that the relationship that I have with the patient is — there's assumed confidentiality there. It's just, it almost goes without saying. I do not discuss anything with anyone else without that patient's permission... I just don't find it, it's not reasonable for me to divulge any information without permission, even for friends who've had babies, I won't even do that. ''Have they had their baby yet?''. I might tell them that they've had their baby. Then I say, ''if you want to know more about it, call her''. I just don't want to be involved because if you start, it can be like a wedge, once you start with the little things, in my mind, it potentially grows up to before you know it, talking about everything...
>
> Dr. Winters, male, 35, partner in a three-person practice in a large rural town

Dr. Winters' point of departure here was the maxim that ''I do not discuss anything with anyone else without that patient's permission.'' He then described a situation that was not uncommon in his rural practice — whether to reveal information about the birth of friends' children — in order to illustrate the importance of confidentiality.

Stories with deontological trumps moved back and forward between the general and the particular, between principle and example, between generalities and detail. For example, Dr. Elwin's discussion of how he saw his relationship with his patients began with the maxim that ''the general practitioner is ultimately responsible for the patient's care'' (62). He explained that this meant that any specialist involved in the patient's care had an advisory role. Yet, he noted that there were ''special situations'' at times that might warrant a more interventionist approach for the specialist.

> 62... If you've got patients that need surgery obviously if the surgeon's doing the operation in town and so forth then he's responsible for the surgery and responsible for the post-operative care and so forth, but I think as soon as they're sort of over that then the responsibility for their care comes back to the GP...
>
> ... in terms of things like Gold Therapy or anti-cancer therapy and those sorts of things which are just way out of my area of understanding, the decisions about those — I mean, again, I still sort of have the idea, I think, in my mind, that he is providing advice but I'm sort of more, much more prepared to accept his advice because it's in an area that

I don't know a great deal about. I'm sending a patient with his rheumatoid arthritis to a fellow who suggested Gold Therapy. You might have three, four patients in the practice with rheumatoid arthritis. Maybe two of them are on Gold Therapy so you really don't have a huge amount of experience in that sort of area.

Dr. Elwin, male, 32, locum general practitioner in suburban areas

As he described these situations, Dr. Elwin moderated his original dictum to account for the out-of-the-ordinary. He still regarded himself as responsible for his patients, but in those situations in which he lacked experience, he was much more prepared to accept others' advice because he acknowledged his lack of expertise.

Consequence trumps

The second way in which the GPs used the anecdotes they related bore a family resemblance to consequentialist approaches to moral reasoning. Consequentialist theories provide a canon for judgment about whether actions are right or wrong on the balance of good and bad consequences. In a similar fashion, the moral force in a story with a consequence trump lay in the story's outcomes. Dr. Silverman provided a good example of this type of reasoning when he talked about an incident during his medical training that had influenced his views on confidentiality. In the latter part of his training a fellow student and friend had developed a peri-anal abscess when they were on a surgical rotation together.

106. . .the consultant surgeon drained it for him and it was sent to the lab, and of course [it] grew tuberculosis. . .he wasn't allowed back on the wards until he completed another year of treatment. That meant he was put back a year in his medical course purely because he caught something. What a disaster for him! And again, that's only because of the unreasonable fear, I mean, as soon as he'd started treatment he was no longer infectious. None of the people who worked closely with him for that time managed to catch it, and we were certainly a lot closer to him than any of his patients were. We were sharing rooms. We were sharing drinks. We were sharing meals. And yet none of us caught it. So I thought that was unreasonable too.

107. And did that have an impact on the way in which you now work with patients?[8]

108. . .that was a notifiable disease. It's just the way it was handled was very poor. The laboratory rang up the ward and told the staff. And so, everybody was talking about him before he was even told what was going on. I find that distinctly unreasonable, especially considering he was in a position to fully understand it. And then the subsequent discrimination which was outrageous.

Dr. Silverman, male, 32, five-person practice in a large rural town

Within this account lies the conviction that confidentiality is immensely important. It was important there because not attending to it led to 'outrageous' discrimination and a 'disaster' for Dr. Silverman's student colleague. By inference, confidentiality is always important because, if you do not attend to it, people suffer, and unfairly so.

Descriptions

Not all of the stories the GPs told had an ethical function, in the sense that they explained a moral dictum by way of examples or used the story's outcome to make a moral point. Some stories just provided a description of events, with details about time, place and person. For example, Dr. Little discussed a number of ethical issues in his interview, some of them related to economic pressures in general practice. He explained what this involved using many examples, including the following:

51. Well, [these practices that I worked in as a locum] tend to be, sort of, keeping their business up with their drug prescribing patterns or their management patterns. I guess the first time I twigged to this pattern was for a fellow that came in for a blood pressure check which was about a monthly blood pressure check and his blood pressure never had been very high and I really couldn't see why he was on much treatment anyway and such a regular follow up. And he said, "oh, and I need some more pills, Doctor." And I said, "Righto, and that's Aldomet", (I think it was that he was on), "and that's a hundred tablets and two repeats, isn't it?", and he said, "oh, can you get repeats now, Doctor?" And I thought, "Hello! They're just writing out the one amount and every time they run out the fellow has to come back and have his blood pressure measured. And just never wrote repeats." Whereas in the busy country practice I'd been used to, we were so overloaded that we'd kept people away as much as possible. . .

Dr. Little, male, 48, senior doctor in community casualty service, considerable rural experience

Dr. Little was not using this anecdote to illustrate a rule-of-thumb (a deontological trump) or to make

[8] Text in italics are the interviewer/author's words.

a moral point based on the outcome of the story (a teleological trump). Rather, he was conveying what it was like to be a general practitioner. In a most effective manner, he was showing me what it was like to be him. This is another important, but different, role for story-telling — to tell others what it is like to be us.

Story-telling as homespun casuistry

What do these GPs' stories offer by way of evidence for or against Jonsen and Toulmin's assertion that ordinary people reason casuistically? There are at least four parallels between the methodology of casuistry, as articulated by Jonsen and Toulmin, and the ways in which these GPs used stories in their moral reasoning. The first, and most obvious, similarity is that the GPs' stories embraced casuistry's emphasis on particular individuals and situations. The GPs' interest in detail illustrated, as casuistry does, how important it is to deal with *specific* problems rather than to speak in generalities about the moral issue of which this case might be an example.

The way in which the GPs used their stories also shared with casuistry its case comparison method. In the simplest examples, the GPs merely moved from case to case, finding similarities and differences. In more complex examples, the experience was described as a 'case' might be, with details about "who, what, when, where, how and by what means" (Jonsen & Toulmin, 1988).

Third, in many anecdotes, the maxim or rule-of-thumb such as a casuist would use to define the case's 'type' was explicitly mentioned by the GPs (Jonsen, 1991). For example, Dr. Kingsford had begun his interview by describing an ethical issue he had dealt with concerning conflict between a young woman and her father. He summarised his position in this situation as:

> 16. My own role, I think, is to try and defuse the situation between the two. I think there's nothing to be gained. I think you've got to honest about it if you think, what you think, that's why I was honest when I gave my statement to the police, what I thought had happened...

From this point on the interview revolved mainly around Dr. Kingsford's notions about 'being honest' and what that entailed. He used a number of cases to fill out the meaning and practice of honesty. For example, he recognised that there are limitations to how honest you can be:

> 52...But often you don't know. For instance, I will never tell someone "you've got two months to life", or "you've six months to live"...

Dr. Kingsford's comment here was a form of specification of his maxim. He transformed 'being honest' into 'being honest judiciously'. Yet, despite its intuitive appeal, the specification only really acquired force when Dr. Kingsford offered an example of the implications of being 'brutally honest':

> ...I've got a patient in hospital now with cancer of the lung that's virtually been told by someone at the [main metropolitan] Hospital, two and a half years ago that she only had a few months to live. Well she's just come into hospital now, having spent most of the time at home and she will be going home from hospital again and she's still going on quite satisfactorily. She's on MS Contin for pain, and she's needed a lot of counselling because she gets very frightened. But it all boils back to the fact the she was told she had a few months to live, but not to bother to make another appointment in fact. That was one of the things, she said, "oh, why didn't they ask me to come back for another appointment?", at the Hospital because they didn't expect her to live, you see. But now two and a half years down the track she's still going on quite satisfactorily. It's just a very, very slow growing cancer. And I don't think any doctor can accurately say that you've got so much time to live, because, in fact, I get very annoyed when people come and say, "oh, I've been to a specialist, and he said I've got six months to live." You can never say that in medicine. It's very foolhardy to do that.
>
> Dr. Kingsford, male, 57, married, partner in three-person rural practice

In this example Dr. Kingsford labelled his story — as about 'honesty' — in much the same way as a casuist would use a case's type to establish the base from which one moves to compare the case with other cases. The label provided the link he needed to draw comparisons with other events.

A fourth similarity with casuistry lay in the way the GPs moved back and forth between different anecdotes and between different ways of reasoning about those anecdotes. Dr. Elwin did this as he developed his discussion of the general practitioner–patient relationship, shifting from a general statement to specific instances to special situations and then back to a modified maxim. Dr. Silverman's discussion of honesty was also an example of this. For instance, one of his anecdotes began with the maxim:

> 62....I feel very strongly that people should know what's happening. I don't believe that any treatment or investigation of the patient should be done without people knowing why...

When asked why, he responded with an anecdote about his friend who died of bowel cancer and used it to illustrate his rule-of-thumb (using the story as a deontological trump).

> 64. A friend of mine died early last year of bowel cancer. He was initially sent for a Barium enema, without really knowing what was going on. He complained, of bleeding — he knew he had piles, but his doctor sent him for a Barium enema without telling him why. He just said, "oh I think we ought to do this, just to make sure there's nothing else going on". That was it...

From here, Dr. Silverman moved on to the anger and disillusionment his friend had felt about not being informed of the reasons for tests (using the story as a consequence trump).

> 64...And when the result came back that there was an obvious tumour there, he was extremely upset and angry because he hadn't been told. He felt that he should have at least been told that was a possibility, and that was what was being checked for. The other reason he was angry was because, in addition to this diagnostic test that was being done, he was also sent for faecal occult bloods and he found out later that you sort of, well you already know you've got bleeding piles and when you know that you're in a risk group that should be checked diagnostically, a screening test isn't appropriate, and he, of course, he paid for that. And he was very angry about that, too. He felt that the doctor was dishonest with him, and that undermines the relationship without a good trusting doctor/patient relationship you're not going to be able to achieve other things later...

His next move was to use the anecdote as a springboard to make some general comments about trust in general practice, and the need to:

> 64...build up a relationship. If you start off by deceiving somebody, or you undermine their confidence in you in any way, then they've two choices, they can change doctor, which breaks up the continuity of care and decreases the quality of care generally, usually. Or, they will question everything you do, which means that the consultations will take a lot longer to achieve the same ends. Or, they just won't do it, which can have disastrous consequences.
>
> Dr. Silverman, male, 32, five-person practice in large rural town

Dr. Silverman shifted easily between the particular — a friend's illness — and the general — the doctor–patient relationship — and between deontological reasoning and teleological reasoning.

Although the GPs' use of stories shared with casuistry four characteristics — of particularity, case description, maxims, and eclectic movement between cases and forms of reasoning — the GPs did not embrace formal casuistry's methods wholeheartedly. In particular, they parted company with casuists in their use of paradigm cases. As noted above, one of the most important tools in formal casuistry is the paradigm or analogy, used in a way that illuminates the unclear by comparison with the clear. Formal casuists move in their thinking from clear and obvious cases to problematic ones. The GPs' stories, however, were not 'paradigm' cases, as Jonsen and Toulmin have explicated them, in at least two senses.

First, in the GPs' moral reasoning, cases were not always selected for comparison because they were clear or because they provided examples of moral certainty, at least beyond the experience of the teller. Consequently, they lacked the moral force that the paradigm case has for the casuist. The clearest examples of anecdotes that lacked this paradigmatic role are found in those stories that functioned primarily as descriptions. Casuists continually place their cases in the context of other cases, usually by searching for and applying relevant maxims. The descriptive story did none of this because it had no maxim to offer; rather, it provided details about time, place and person — the 'circumstances' of the case — without identifying the maxims needed to give the case its moral identity.

Second, and more importantly, when the GPs did articulate maxims, their stories were very unlike the paradigm cases envisaged and debated by casuists. Paradigm cases for the casuist are generally public cases around which there is a body of debate and discussion. The casuist has access in these cases to the consensus that emerges about 'the right thing to do', and therefore a base from which they can reason. The GPs' cases, paradigm or otherwise, were private, for the most part shared only with me and perhaps a few close colleagues. Eight of the 13 GPs had commented during their interviews that they did at times seek advice or discuss issues with their medical colleagues. Yet, it is a huge step from a quiet conversation with a colleague to explore ideas and search for alternative solutions to the public debate that is required for the development of consensus around a paradigm case. In addition, two of the GPs said clearly (and regretfully) that they did not discuss ethical issues with their colleagues at all.

Conclusions

This paper began with a discussion of the work of Jonsen and Toulmin, and I offered a critique of the empirical evidence they provide to support their

assertion that every-day moral reasoning is casuistic. One might conclude from Jonsen and Toulmin's views about their own moral reasoning that they appear to use their own experience of 'doing ethics' to show that casuistry does match real life moral decision-making. I noted also, however, the scepticism of social science critics concerning the strength of the relationship between the moral theories of bioethicists and the moral reasoning of lay people.

What does the empirical research described in this paper have to offer this debate? First, it suggests that there is a role for casuistry in every-day moral reasoning. The research reported in this qualitative study of moral reasoning in general practice implies that aspects of every-day moral reasoning are casuistic in nature, at least partially and incompletely. The stories the GPs told and the moral purposes to which they put those stories — their consequence and deontological trumps — point to a way of doing ethics that is similar to casuistry.

Second, the research indicates that the resemblance with casuistry is not perfect. While there are parallels between the methodology of casuistry and the ways in which the GPs used anecdotes, those parallels are weakened by the absence in the GPs' moral reasoning of clear paradigm cases.

Taken together, these two points suggest an answer to the question posed in the introduction: 'What is the evidence for contemporary casuistry's claim that every-day moral reasoning is casuistic in nature?' Casuistic reasoning is indeed relevant to ordinary moral reasoning, but the role that it plays is perhaps more inchoate and muted than Jonsen and Toulmin would have us believe.

To what extent it is possible to generalise from the details of the research reported in this paper to other settings and to related matters? The conclusions I draw are, in some ways, rather unexceptional. I am not arguing that all people are casuists, even though I think it likely that a deal of moral reasoning shares something in common with this approach much of the time. My more modest conclusion is that we can regard the homespun casuistic reasoning described here as indicative of the role moral theory can play in every-day moral reasoning. If this is the case, moral theory does matter in the moral deliberation of ordinary people.

If moral theory matters, then bioethics is on solid ground when it takes theoretical endeavours seriously. This has clear implications for much bioethical activity, including the description and analysis of cases, the delineation and analysis of core concepts, how empirical work in ethics is defined and conducted, how codes of ethics are constructed, and the nature of ethics education for practitioners. The rush to provide a meaningful framework for bioethical activity should not be accompanied by the assertion that moral theory is somehow now irrelevant to moral decision-making. The research reported in this paper injects a cautionary note if we are tempted to throw the ethical theory baby out with the bath water of moral abstractness.

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References

Anspach, R. (1993). *Deciding who lives: Fateful choices in the intensive care nursery*. Berkeley: University of California Press.

Arras, J. D. (1991). Getting down to cases: The revival of casuistry in bioethics. *Journal of Medicine and Philosophy*, *16*, 29–51.

Beauchamp, T. L. (1995). Principlism and its alleged competitors. *Kennedy Institute of Ethics Journal*, *5*, 181–198.

Bernard, H. R. (1988). *Research methods in cultural anthropology*. Beverley Hills, CA: Sage.

Bosk, C. L. (1979). *Forgive and remember*. Chicago: University of Chicago Press.

Braunack-Mayer, A. J. (1998). General practitioners doing ethics: An empirical perspective on bioethical methods. Ph.D. Thesis, University of Adelaide, South Australia.

Brown, L. M., Tappan, M. B., Gilligan, C., Miller, B. A., & Argyris, D. E. (1989). Reading for self and moral voice: A method for interpreting narratives of real-life moral conflict and choice. In M. J. Packer, & R. B. Addison (Eds.), *Entering the circle: Hermeneutic investigation in psychology* (pp. 141–164). Albany: State University of New York Press.

Chambliss, D. F. (1996). *Beyond caring: Hospitals, nurses, and the social organization of ethics*. Chicago: University of Chicago Press.

Childress, J. (1994). Principles-oriented bioethics — an analysis and assessment from within. In E. R. DuBose, R. Hamel, & L. J. O'Connell (Eds.), *A matter of principles? Ferment in US bioethics* (pp. 72–98). Pennsylvania: Trinity Press International.

Crabtree, B. J., & Miller, W. L. (1991). A qualitative approach to primary care research: The long interview. *Family Medicine*, *23*, 145–151.

Denzin, N. K. (1970). *The research act*. Chicago: Aldine Publishing Co.

DeVries, R., & Subedi, J. (Eds.). (1998). *Bioethics and society. Constructing the ethical enterprise*. Englewood Cliffs, NJ: Prentice-Hall.

Dey, I. (1993). *Qualitative data analysis: A user-friendly guide for social scientists*. London: Routledge.

DuBose, E. R., Hamel, R., & O'Connell, L. J. (Eds.). (1994). *A matter of principles? Ferment in US bioethics*. Pennsylvania: Trinity Press International.

Elliott, C. (1992). Where ethics comes from and what to do about it. *Hastings Center Report*, *22*, 28–35.

Elliot, C. (1992). Solving the doctor's dilemma. *Bioethics News*, *11*(4), 19–23.

Fox, R. C. (1979). *Essays in medical sociology: Journeys into the field*. New York: Wiley.

Gilchrist, V. J. (1992). Key informant interviews. In B. F. Crabtree, & W. L. Miller (Eds.), *Doing qualitative research* (pp. 70–89). Beverley Hills, CA: Sage.

Green, R. M., Gert, B., & Clouser, K. D. (1993). The method of public morality versus the method of principlism. *Journal of Medicine and Philosophy*, *18*, 477–489.

Hoffmaster, B. (1992). Can ethnography save the life of medical ethics?. *Social Science and Medicine*, *35*, 1421–1431.

Hunter, K. M. (1986). "There was this one guy..." The uses of anecdote in medicine. *Perspectives in Biology and Medicine*, *29*, 619–630.

Hunter, K. M. (1996). Narrative, literature, and the clinical exercise of practical reason. *The Journal of Medicine and Philosophy*, *21*, 303–320.

Jennings, B. (1990). Ethics and ethnography in neonatal intensive care. In G. Weisz (Ed.), *Social science perspectives on medical ethics* (pp. 261–272). Boston: Kluwer Academic Publishers.

Jonsen, A. R. (1986). Casuistry and clinical ethics. *Theoretical Medicine*, *7*, 65–74.

Jonsen, A. R. (1991). Casuistry as methodology in clinical ethics. *Theoretical Medicine*, *12*, 295–307.

Jonsen, A. R. (1995). Casuistry. In W. T. Reich (Ed.), *Encyclopedia of bioethics* (2nd ed) (pp. 344–350). New York: Simon and Schuster Macmillan.

Jonsen, A. R. (1995). Casuistry: An alternative or complement to principles?. *Kennedy Institute of Ethics Journal*, *5*, 237–251.

Jonsen, A. R., Siegler, M., & Winslade, W. (1992). *Clinical ethics: A practical approach to ethical decisions in clinical medicine*. New York: Macmillan.

Jonsen, A. R., & Toulmin, S. E. (1988). *The abuse of casuistry. A history of moral reasoning*. Berkeley: University of California Press.

Kopelman, L. M. (1994). Case method and casuistry: The problem of bias. *Theoretical Medicine*, *15*, 21–37.

Lauritzen, P. (1996). Ethics and experience: The case of the curious response. *Hastings Center Report*, *26*, 6–15.

McCracken, G. (1988). *The long interview*. Beverley Hills, CA: Sage.

National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research. (1978). *Ethical guidelines for the protection of human subjects of research*. DHEW Publication No. (OS) 78-00. Department of Health, Education, and Welfare, Washington.

Richards, T., & Richards, L. (1991). The NUDIST qualitative data analysis system. *Qualitative Sociology*, *14*, 307–324.

Siegler, M., Pellegrino, E. D., & Singer, P. A. (1990). Clinical medical ethics. *The Journal of Clinical Ethics*, *1*, 5–9.

Toulmin, S. (1981). The tyranny of principles. *Hastings Center Report*, *11*, 31–39.

Wildes, K. W. (1993). The priesthood of bioethics and the return of casuistry. *Journal of Medicine and Philosophy*, *18*, 33–49.