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## Guest editorial: A personal view

# Health care ethics and casuistry

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In an editorial (1) Dr Gillon looks at some recent difficulties which have been raised about philosophy and the teaching of health care ethics. This matter is of sufficient importance to the readers of this journal that it is worth looking at it again, this time in an historical perspective.

One claim which is often made by those advocating the study of health care ethics is that such a study will assist in the solving of what have come to be called 'ethical dilemmas'. Since health care ethics is so widely taught for this reason the claim is worth examining. Is health care ethics in this sense possible? Is it desirable? Is it philosophy? In other words, can a case be made out for what earlier centuries called 'casuistry, or the consideration of 'nice and delicate situations in which it is hard to determine whereabouts the propriety of conduct may lie' (2).

Adam Smith is in no doubt as to where he stands on casuistry: 'The two useful parts of moral philosophy, therefore, are Ethics and Jurisprudence: casuistry ought to be rejected altogether' (3). In taking this strong line Smith was expressing the accepted view of casuistry in the second half of the eighteenth century. If he is correct in his view then a great deal of what is encouraged in present-day medical schools must be based on illusion.

His first argument against casuistry is that casuists attempt 'to no purpose, to direct by precise rules what it belongs to feeling and sentiment only to judge of' (4). Several points are involved here. One is that casuists seek for rules when it is not appropriate. But in so far as we think of medical ethics as discussed against a background of codes, then a search for precise rules might be appropriate. For example, most codes contain rules enjoining confidentiality. But can a doctor tell colleagues what patients have told him in confidence if the transmission of such information will be for their benefit? This kind of question is similar to those discussed both by the casuists of the Counter-Reformation and by those of the Protestant natural law tradition. In the same context Smith also argues that there cannot be rule-like dividing lines between closely similar cases, and that books of cases are useless because of the even greater variety of possible circumstances. These points are relevant to modern discussion in view of the dominant 'case conference'

method of teaching and discussing medical ethics. The answer to Smith here is to point out that what is taking place in such discussions is a form of what he calls 'natural jurisprudence'. It is an attempt to translate into case law, to give concrete application to, the ideals contained in codes. If natural jurisprudence is a legitimate activity, so too is this.

Smith's second group of arguments against casuistry are to the effect that it does not 'animate us to what is generous and noble' but rather teaches us 'to chicanery with our consciences' (4). Smith is certainly correct in claiming that casuistry is concerned mainly with what is required or forbidden, that is, with rules, rather than with questions of motivation. And medical ethics is predominantly concerned with similar questions. But it does not follow that to discuss such important and difficult questions is to begin to 'chicane' with our conscience. Many moral problems are of such complexity that it is not possible to pronounce immediately on them. Smith lived in a simpler age, although he perhaps underestimated the complexity of the moral problems even of his own age. As for the point that casuistry does not 'animate us to what is generous and noble', we might reply that this is not a legitimate function of ethics. Even those philosophers who allow that ethics has a normative function draw the line before this. If ethics can assist in discovering what we should do, then this is as far as it can reasonably go; to motivate is another matter entirely.

It may be, however, that Smith's point can be restated as one about awareness, rather than motivation: what in modern parlance might be called 'consciousness-raising'. It is true that the casuistry of Smith's times and earlier tended not to deal with that, but many modern writers on medical ethics are concerned with it. For example, they are sometimes concerned with raising the awareness of doctors of the indignities and impersonality of high-technology medicine. There is therefore a similarity between one aspect of modern casuistry and one aspect of what Smith means by ethics, as distinct from what he means by casuistry. Despite Smith's arguments, then, casuistry is *possible*, and medical ethics illustrates a modern form of casuistry which has similarities both to casuistry (and natural jurisprudence) in his sense and to one aspect of ethics in his sense.

Is casuistry *desirable*? It would be undesirable if it did indeed teach us to chicanery with our conscience. But this is surely not inherent in the activity. The logic of Smith's use of the term casuistry is as follows: helpful and worthwhile attempts to interpret complex doctrines, apply rules to particular cases, resolve conflicts and adapt the ideal to the real are to be applauded and called 'natural jurisprudence'; unhelpful or unsuccessful attempts at the same are to be called 'casuistry'. This criticism of Smith is a little unfair, because the casuists he criticises, as some who nowadays write on medical ethics, did attempt to find precision where it cannot be found. But this overzealous approach is not intrinsic to the casuistical process. In so far as casuistry confines itself to seeking precision where it *can* be found it can be regarded as a desirable undertaking, and the same is true of its modern counterpart, medical ethics.

There is another aspect of casuistry, the desirableness of which might be questioned. Does casuistry take from us the burden of individual responsibility and hand us over to moral experts? The answer is that reference to a moral expert committee makes some sense, and need not threaten autonomy. On the other hand, there can be a tendency for doctors, to turn to 'ethicists' rather as they might turn to a biochemist, for an expert opinion. This is surely to be rejected as a legitimate procedure. The ethicist may have the legitimate function of clarifying for the doctor some of the complex moral issues with which medicine must deal. But in the end it is the doctor and the patient together who must decide. Provided they do not attempt to bypass autonomy, then, casuistry and medical ethics are desirable forms of intellectual activity.

Finally, we can raise the question of whether casuistry, granted that it is possible and can be desirable, is a branch of moral philosophy. We can ask the same of health care ethics. There is no one answer to this question because fashions change as to what is or is not a legitimate function of moral philosophy. There is, however, one objection to the view that casuistry is a legitimate branch of moral philosophy which is based on a misunderstanding. The objection is that the judgements of casuistry are directed at reaching decisions in *particular* cases, whereas moral philosophy is concerned with *types* of case. Smith himself certainly held that moral philosophy was concerned with types, for it belonged to what he called 'didactic discourse'. Didactic discourse was concerned with putting 'the arguments on both sides of the question in their true light, giving each its proper degree of influence, and has it in view to persuade no further than the arguments themselves appear convincing' (5). This type of discourse is contrasted on the one hand with rhetoric which attempts to persuade, and on the other hand with 'narrative discourse' (such as historical discourse) which is concerned with particular events or actions. Philosophy, like the sciences, is a form of didactic discourse and is directed at types of event or

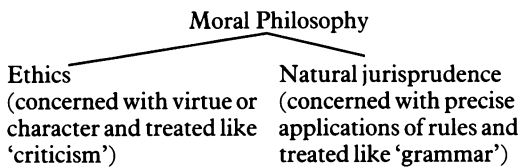
action. 'In every case, therefore, Species or Universals, and not Individuals, are the objects of Philosophy' (6). If we assume this view of philosophy, then it will follow that if casuistry is directed at reaching decisions in particular cases it cannot be a branch or moral philosophy.

This kind of objection has been discussed, perhaps surprisingly, by G E Moore. He agrees that casuistry is much more detailed and particular than ethics:

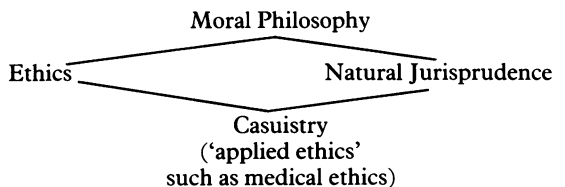
'but that means that they differ only in degree and not in kind ... Both alike deal with what is general, in the sense in which physics and chemistry deal with what is general ... Casuistry aims at discovering what actions are good, *wherever they occur*. Casuistry forms, therefore, part of the ideal of ethical science: Ethics cannot be complete without it' (7).

In so far as we accept this view of casuistry – that it attempts to produce refined rules which may help in deciding individual cases – it will fit with Smith's view of philosophy as concerned with species or types of action. Smith's own objection to the use of refined rules was rather that they tend to usurp our own decisions in particular cases. But, as we have seen, to use precise rules is not to dispense with the need for individual autonomous judgement in particular cases.

We are now in a position to sum up. Smith depicted moral philosophy as follows:



Casuistry was rejected as useless and pernicious. It can be argued however that what Smith is really rejecting is what we might call the pathology of casuistry. The valuable aspects of it can be assimilated into broad interpretations both of what he calls 'ethics' – the 'consciousness-raising' aspects of ethics – and of what he calls 'natural jurisprudence'; and this is true of that modern form of casuistry which is medical ethics. If we accept this argument then the diagram must be extended as follows:



Medical ethics can therefore be legitimately taught in medical schools either as a kind of consciousness-

about those special circumstances in which it is sometimes legitimate for doctors to mislead patients. Jackson follows Roger Higgs's view that deception is permissible only 'at either end of the scale of importance'; that is, in trivial cases, such as where a doctor might politely lie about being inconvenienced, or in extreme crises (5). I find this position unsatisfactory for two reasons.

First, I believe there are cases which are neither trivial nor critical where we are prepared to tolerate benevolent deception from doctors in order to help patients through some temporary distress, so long as the truth is made known as soon as possible. For example, if a badly injured patient in casualty anxiously asks: 'Will I make that job interview on Monday?', it is hard to blame the doctor if she answers: 'Maybe, hang on in there', because this is not a good time to break the news that the chances are nil. Deception might also be permitted in certain cases where a patient's full knowledge of his or her condition might seriously inhibit recovery; for example, in cases where patients (children perhaps) will be unduly or irrationally frightened by an accurate description of their predicament. In both cases, however, such well-intentioned help becomes illegitimate as soon as it threatens the patient's dignity or autonomy.

Second, and more importantly, I am very suspicious of the claim that deception is more likely to be legitimate in a crisis. Surely, it is precisely in such cases that doctors are under a special obligation to be truthful. This is particularly so in terminal cases where a strategy of benevolent deception may deny patients the opportunity, albeit the tragic opportunity, to come to terms with their own mortality, to reflect on the character of their life in the light of their imminent death, and to take proper leave of friends and family.

The position I have outlined discusses the morality of deception in terms of the right to autonomy, and the right to be treated with dignity. Such rights may be seen as 'deontological constraints' upon our actions, specifying things we should not do regardless of the consequences. As such, the kinds of obligations these constraints place upon us cannot be explained within the kind of consequentialist framework Jackson finds attractive. Indeed, it may be impossible to justify such constraints in a way that does not appeal to some

further moral concept which might itself be challenged. There is perhaps no story we can tell in non-moral terms (for example, in terms of consequences, functions, or the demands of rationality and consistency), that will silence the moral sceptic. What can be said to someone who asks why he should treat other people with dignity, except perhaps that to do otherwise is to fail to recognise their humanity? And if the next question is: 'Why should I care about their humanity?', there simply is nothing to say. But this does not show that a belief in the value of human dignity is unjustified; it is just that from the perspective of someone who genuinely cannot see why he should care about the humanity of others, nothing *could* count as a reason to respect human dignity. Thus, if someone does not recognise the value of such deontological constraints, no argument will bring him round. However, recognise these constraints we must, not only if we are to appreciate the true wrongness of lying or deception in medical contexts, but also if the discipline of medical ethics is to make a genuine contribution to the moral integrity of medical practice (6).

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## References and notes

- (1) Jackson J. Telling the truth. *Journal of medical ethics* 1991; 17: 5–9.
- (2) See reference (1): 6.
- (3) See reference (1): 8.
- (4) In his *Fundamentals of ethics*, Oxford: Oxford University Press, 1983, ch 4, John Finnis develops a similar point into an attack on the entire species of consequentialist positions.
- (5) Higgs R. On telling patients the truth. In: Lockwood M, ed. *Moral dilemmas in modern medicine*. Oxford: Oxford University Press, 1985.
- (6) A version of this paper was read in reply to Jennifer Jackson at a Queen's University philosophy colloquium in October 1990. I am indebted to Ms Jackson and to my colleagues at Queen's for their responses then. I am also grateful to Alistair MacLeod for his comments on the manuscript.

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raising discipline ('How would you like it if someone kept the truth from you?') or as a matter of applying rules and principles to difficult cases (8).

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## References

- (1) Gillon R. Philosophy and the teaching of health care ethics. *Journal of medical ethics* 1991; 17: 171–172, 198.

- (2) Smith A. *The theory of moral sentiments*. Oxford: Oxford University Press, 1976: VII, iv, 17.
- (3) See reference (2): VII, iv, 34.
- (4) See reference (2): VII, iv, 33.
- (5) Smith A. *Lectures on rhetoric and belles lettres*. Oxford: Oxford University Press, 1983: 149.
- (6) Smith A. *Essays on philosophical subjects*. Oxford: Oxford University Press, 1980: 119.
- (7) Moore G E. *Principia ethica*. Cambridge: Cambridge University Press, 1903: 4–5.
- (8) Elliott C. Solving the doctor's dilemma? *New scientist* 1992 Jan 11: 42–44.