It is now widely held that applied ethics is not simply a matter of using some version of a standard ethical theory. One cannot simply apply utilitarianism or deontology to a real-life situation. Partly this is due to the fact that these theories are complex and have many fine-tuned versions, and partly this is due to the fact that real-life cases do not present themselves as simple puzzles to be solved. Cases involve questions of timing, style and feelings. These are noticeably absent from the way many traditional philosophers have suggested solving ethical problems. Going from case to case, not using general principles as if they were immutable, indeed developing rules of thumb in ethics is called the casuistical approach. Sometimes, the word casuistical is used to mean quibbling unnecessarily. This is a pejorative sense of the word and is not how it is meant here. As you will see in the cases below, being a casuist is no more than doing a good job of deciding what the right thing is.

Here are two cases worked out in the manner of casuistry. If you would like to read more on this topic, see A. Jonsen, and S. Toulmin, _The Abuse of Casuistry_, Berkeley: University of California Press, 1988. Jonsen and Toulmin argue that the case method so often used in medical ethics is nothing more than casuistry at its best.

**Case 1**

A family physician was asked by the middle-aged daughter of an elderly man to talk him into leaving his apartment for a nursing home on the grounds that the old man almost burned down the apartment complex when he forgot about a pot on the stove. (The father and his daughter were both patients of the physician—a true family physician.)

The man’s story was quite different. First, he scorched the pan and that’s all. Second, all his friends live at, or near, his apartment complex. If he moved, he would lose their companionship, since neither he nor they had ready access to cars or public transportation. Moreover, in a nursing home, smoking his beloved cigars would be prohibited.
The physician in this case is in a bind. She may want to help her younger patient to feel that her father is safe. The physician may also want to please the younger patient rather than lose business. On the other hand, she is responsible not just for the relative safety of the elderly father, but also for his sense of his own well-being. The physician cannot readily appeal to facts because they are in dispute. The physician can only trust her judgment as to the total competence of the father. But, of course, she is just a family physician. She is not a trained psychiatrist with a specialty in geriatrics. Should she call in such a specialist to determine the competence of the father? Who will pay? If such a referral is not covered by insurance will the daughter pay, knowing that the advice might be to leave him alone, he is fine? Will the father be willing to pay knowing that the opinion might be that he is not competent enough to be living alone? Will the father even put up with such an interview, feeling as he does, “under siege”? The best the physician can do in this situation is get the two together to talk. The physician can be a kind of moderator, but not a decision-maker and definitely in this case not an enforcer.

Notice how this simple case of a burned pot turned into so much more than the categorical imperative or the Principle of Utility. Just look at the latter. Do that action that will create the greatest good for the greatest number. Which good (independence for the father, relief for the daughter, happy patients for the physician) for whom (the father, the daughter, the physician, the other members in the apartment complex)? How should these be ranked and by whom? Of course, they could be ranked by each person involved. But would that really yield the best answer?

**Case 2**

Baby L is a two-year-old girl. She was born about four weeks premature and in great distress. At birth, she exhibited poor neurological functioning and required resuscitation and mechanical ventilation. Although her breathing improved to the point where the mechanical ventilation was no longer needed, her neurological condition worsened. She often choked when fed and suffered numerous seizures. She was responsive only to pain.

Baby L spent fourteen months in neonatal and infant intensive care. She was released in the care of her mother and twenty-four-hour nursing. Two weeks later, Baby L was readmitted because of pneumonia. A course of antibiotics cleared the pneumonia and Baby L was released. However, the pneumonia proved to be recurrent and basically resistant to treatment.
Baby L was readmitted at twenty-three months for severe pneumonia and shock. She needed mechanical ventilation and began showing signs of cardiac failure. She had four cardiac arrests—from each of which she was resuscitated.

The baby’s mother insisted that everything be done for her baby. The nursing staff felt that the baby’s condition was hopeless. A consulting pediatric neurologist agreed. She pointed out that the baby could not survive for any length of time (no matter what the level of support) and that the medical interventions were causing the baby pain.

The staff (nurses and physicians) wanted Baby L to be allowed to die. The mother refused to allow it, continuing in her demand that her baby be saved at all costs. The Ethics Committee was convened.

(Adapted from the *New England Journal of Medicine*, April 5, 1990.)

Here it is obvious that no appeal to some simple ethical principle will convince the mother. She might well believe that the baby’s suffering now will be rewarded later by a long and normal life or by an afterlife of blessed eternity. It is also obvious that the staff want the baby left alone in order to alleviate her suffering. There is no easy middle ground either. Transferring the baby to another facility where the staff felt comfortable keeping the baby alive seems only fair to the present staff—so long as the two facilities are equal in competence. Whose interests are paramount here? Mother and baby certainly are paramount, but, again, the staff should not be overlooked because their attitudes affect how they do their work in general. That is, if they are dispirited, other patients might suffer. If it is true that the baby cannot live long, then suffering should be kept to a minimum, unless of course one thinks that suffering is good—if not for the infant, then perhaps for the mother.

Of course, there are no guarantees. The baby might live and might have a decent life. Doctors have been wrong before. Perhaps this is what the mother is thinking. Suppose that she says this to the ethics committee. Is it for them to tell her no, in this case there is almost no chance of an incorrect prognosis? Here one has moved to the ethics of the ethics committee. Is it important that the mother be happy with the recommendation of the ethics committee? They are just recommendations and the mother can still insist that everything be done. Would this count as a futile request, one that doctors may ignore? In general, if a patient asks for treatment that has no reasonable expectation of yielding an improved (or return to baseline) quality of life, then the request is considered futile and may be ignored. But it is one thing
to ignore the request of a terminally ill ninety-year-old who hopes against hope for an extra good day of life, ignoring the pleas of a mother on behalf of her baby.

**Case 3**

Three years ago, one of your patients, an eighty-year-old man, had to have a leg amputated due to diabetes. Now, the man’s daughter brings him to your office. The elderly man’s other leg is gangrenous beyond any medical treatment. It must be amputated or he will die. The man tells you that he let the condition worsen because he wanted to die. He certainly prefers death to losing the other leg and becoming what he considers to be a total invalid. The man refuses to consent to any treatment especially surgery. His daughter wants him to have the surgery. The elderly man is stubborn but clearly competent.

**Case 4**

A woman is in the last stages of labor. She was admitted through the emergency room. No one at the hospital knows her. She says that she has never had any prenatal care, that she has one two-year-old child at home, but refuses to give an address. Her labor has stopped and there is fear that the fetus will be in distress. The doctor on call would like to do a cesarean section since he fears for the fetus’s life. The doctor explains to the woman that in his opinion she ought to have a cesarean. She refuses to have the surgery. A hospital psychiatrist examines her and finds that she is competent.

Now you try to work through cases 3 and 4. First try a typical deontological approach—what would Kant say? Then try a typical utilitarian analysis. Notice that case 4 is complicated by the life of the fetus. How would a Kantian count a fetus as against the autonomy of an adult? Is there some way to judge the future pleasures of the woman, doctors, staff and child so that they can be ranked for a Jeremy Bentham-like approach?