Practicum

Methodologies for Clinical Ethics

JAMES F. DRANE[1]

Truly professional medical ethics requires a methodology that generates both moral discernment and consistently right judgments. In this article the author briefly reviews difficulties involved in ethical decision-making, the historical development of casuistry, and four ethical methodologies employed in clinical medicine today. These latter, which are outlined and compared, are as follows: the methodology developed by David Thomasma in the 1960s and 1970s; one created by Jonsen, Siegler, and Winslade; another developed by the author; and the Bochum Protocol authored by Hans-Martin Sass et al. of the Bochum Center for Medical Ethics in the Federal Republic of Germany.

Medical ethics is about decisions involving some element of difficulty. Existentialists remind us of the difficulty associated with the very act of deciding, given the effect choices have on the constitution of the self. Physicians and ethicists are aware of this difficulty, because each hard decision forces them to forego important possibilities and commit themselves and their resources to a certain option.

Decisions in a clinical setting can also be difficult because we may feel inclined to do something we know is morally wrong. Temptation is not something that occurs only outside the hospital. In fact, besides serving up its share of unusual temptations, the clinical setting sometimes intensifies and extends the ordinary ones as well.

Even more than in ordinary life, the clinical environment presents options and alternatives that make correct choice especially difficult. Many clinical cases are tragic—in the sense that the available alternatives seem wrong, and yet something has to be done. In many such cases the stakes are high, and the consequences are both hard to determine and difficult to accept.

One last difficulty peculiar to the clinical setting derives from the fact that each case is different and the right choice cannot be determined in advance. Therefore, in each new clinical situation a careful analysis of relevant data is essential.

CAN MEDICAL ETHICS BE ANYTHING BUT RELATIVISTIC?

The fact that modern medicine is wedded to powerful new technologies has created unprecedented new possibilities for treatment. Consequently, new moral problems abound. All these develop-

[1]Russell B. Roth Professor of Clinical Ethics, Department of Philosophy, Edinboro University of Pennsylvania, Edinboro, PA 16444, U.S.A.

ments have been occurring in a period when secularization had previously undermined an older moral order based upon commonly held religious beliefs. Thus, not only has each new medical advance created new moral options, but choices from among these must be made in a climate of pluralism.

This situation has led some to despair about ethics. Those despairing tend to claim that any agreement about right and wrong in today's moral climate is impossible, and that radical subjectivism and relativism are inevitable.

However, this view seems unnecessarily pessimistic. Even when opposing views are based on seemingly incompatible belief systems, negotiation and compromise are possible. Different belief systems can lead to identical principles, and people of good will can come to agreement about what is right, even though they may disagree about ultimate meanings or the philosophic foundations of ethics. John Stuart Mill's utilitarianism is a long way from the ethics of Jesus, and yet Mill concluded that his ethics was basically the same as Jesus' Golden Rule. "In the Golden Rule of Jesus of Nazareth we read the complete spirit of the ethics of utility. To do as one would be done to, and to love one's neighbor as oneself, constitute the ideal perfection of utilitarian morality."[2] In fact, the tendency of different theoretical foundations toward a similar list of ethical standards (truth, sanctity of life, fidelity, autonomy, beneficence, justice, equality, respect for persons, reasonableness, etc.) gives solid grounds of hope for the prospects for overcoming radical relativism.

People of good will, including committed medical professionals, can come to agreement in most clinical situations. Given an all-important commitment to doing what is right and a fairly wide agreement about guiding ethical principles, the critical process becomes one of *competent moral thinking*: moving through certain intellectual steps before arriving at a decision.

METHODOLOGY AND DISCERNMENT IN ETHICS

If love without strategy is little more than a fleeting feeling, the same is true of ethics. The passage from moral feeling to ethics is by way of a strategy for making moral evaluations. Committed professionals will not reach the same conclusion in every clinical case; but they will avoid the worst moral mistakes and come to defensible and respectful decisions more often than not, so long as they pursue an adequate evaluation process. Of course, even with broad general agreement about moral principles, applying such principles to a concrete case, or deciding which principle to apply when two or more are in conflict, is a difficult and delicate task. Therefore, while medical ethics can offer many things, one of its main tasks is to provide an appropriate moral strategy or methodology for making evaluations.

Not unlike science, medical ethics must weigh, assess, and analyze relationships shown by empirical data. But unlike many schools of philosophic ethics, the applied philosophy of medical ethics is grounded in concrete life situations where people do their living and dying. Consequently, the practicing clinical ethicist, like the scientist, must first be a fact gatherer, and then, again like the scientist, must proceed systematically to the

[2]J. S. Mill, *Utilitarianism*, Longmans, Green, London, 1987, Chapter 11, pp. 24, 25. The very same point was made by Thomas Hobbes, who is even further removed from religious foundations of ethics. *Cf.* T. Hobbes, *Leviathan*, in: Sir William Malesworth (ed.), *The English Works of Thomas Hobbes*, John Bohn, London, 1839, vols. 2 and 3, ch. 15, pp. 144–145.

analytic task at hand. Even in the initial fact-gathering stage, however, the competent clinical ethicist is aware of background assumptions and presuppositions; and so, while objectivity is a goal in medical ethics, it is an informed rather than a simple-minded objectivity, one that considers the subjective dimensions even at the early stages of observation and description.

Of course, no strategy or methodology can compensate for retarded ethical development or character flaws on the part of the decision-maker. People who are impulsive, antisocial, or narcissistic cannot distance themselves sufficiently from their own interests to make objective evaluations, let alone initiate actions for the benefit of patients. Therefore, the decision-maker in a clinical setting must have reached at least that stage of character development where response to principles and ideals is possible. This is a prime reason why physicians are expected to operate at an imprincipled level of development. Nevertheless, instances where people have attained high professional status without having attained a correspondingly high level of ethical development are legion.

An even more common obstacle to ethical discernment derives from a tendency to reach moral decisions without taking advantage of adequate methodology. When this happens, the personal capacity for discernment may be present, but clarity about how to make moral judgments is missing. Some professionals who rightly consider themselves decent and upstanding actually make decisions of great ethical importance in a willy-nilly fashion. Others, without a systematic strategy or reflective methodology, make their decisions in more pragmatic ways. Some rely on outside authority for their moral orientation; others are confident that they themselves have an intuitive grasp of what is right; and many make decisions according to group expectations. No adequate medical ethics can be based on these unreflective foundations. Truly professional medical ethics requires an ethical methodology that generates both moral discernment and consistently right judgments.

Such methodology provides an ethical decision-making framework which ensures that relevant data are considered. It also clarifies rights and responsibilities and reassures an ever-more-suspicious society that decisions important to patients and their families are made with proper deliberation. But good methodology does not ensure infallibility. The right decision will not always be made; but what can be done consistently, and this is important, is that the worst mistakes can be avoided.

It is also true that a given methodology's authority depends on the reasoned and respectful determinations derived from its use. Sometimes legal advice will be required before coming to an ethical decision, but most often the law is satisfied when persons rightfully involved in decision-making are careful and systematic about how they make decisions. This is something that a sound methodology can guarantee.

HISTORICAL METHODOLOGIES AND EMPHASIS ON THE SITUATION

Recent strategies or methodologies of clinical ethics are not entirely novel. They were antedated by procedures for arriving at defensible choices that one finds in religious ethics. Catholic moral theology, especially, was interested in such strategies for guiding the decisions of spiritual directors and for use in a confessional context. And in fact these historic methodologies have had considerable influence on the most widely used current strategies of clinical ethics.

Every model or strategy has two phases, one that directs attention to the gathering of facts and another that applies evaluative standards. A separation between the two phases is usually explicitly reflected in the model itself. The classic methodology of St. Thomas Aquinas, for example, applied standard Christian guidelines, but only after extensive attention to factual elements. Aquinas went so far as to say that human actions were evaluated as right or wrong, depending on factual or circumstantial considerations. *"Actionas humanae secundum circumstantias sunt bonae vel malae."*[3]

St. Thomas considered the circumstances, or the factual dimensions of the case, to be neither accidental nor of secondary importance. Hence the judgment, as to whether an act was right or wrong, could not derive exclusively from the structure of the act or from the intention that informed it. This is because the factual dimensions of a human action, or the peculiar and particular circumstances in which it is performed, have everything to do with its being judged right or wrong. Thus, facts and circumstances are as important as evaluative standards or principles in determining the right thing to do.

What is true of classic moral theology is also true of modern medical ethics. Medical ethics emerges from clinical contexts, and every decision is linked to a particular set of circumstances called a "case." Some forms of ethics bask in generalities and abstractions, but this is not so of either classic theologic ethics or contemporary medical ethics. Indeed, every helpful modern methodology in medical ethics gives clear prominence to the explication of medical, human, and economic factors that shift and criss-cross in every clinical case.

[3]T. Aquinas. *Summa Theologica (parts 1 and 2)*, Question 18, Article 3.

Medical ethics is unavoidably situational, and a workable methodology must be useful for the explication of case particulars. But being situational is not the same as being a situation ethics. Neither classic Catholic theology nor modern medical ethics are situation ethics in the sense of being radically relativistic. Objective standards and agreed-upon mainline moral determinations exist in both traditions. But in both, an act that in one situation would be considered killing and wrong, in another situation may not be considered killing and certainly not wrong.

The evaluative elements (codes, statutes, precedents, ethical principles, group or individual experiences, rational arguments, cultural norms, authority, and faith) that interact with explications of factual or clinical circumstances are all attended to in classical theology. For religious believers there are religious authorities; for secular believers there will be philosophic authorities. In this regard, it should be noted that one of the most important functions of a methodology is to keep the evaluative standards connected to the factual elements. Good methodologies help to keep medical ethics away from the danger of false generalization and rooted in real-life situations.

CASUISTRY AND CLINICAL ETHICS

A marvelous example of how a methodology organizes intelligence to arrive at defensible decisions can be seen in casuistry, a methodology that had its origins in Stoicism and Cicero and that flourished in the fifteenth and sixteenth centuries, mainly among Jesuit theologians. Casuistry is defined as "the interpretation of moral issues, using procedures of reasoning based on paradigms and analogies, leading to the formulation

of expert opinion about the existence and stringency of certain particular 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."[4] Theoretical assumptions (e.g., natural law theory) certainly were operative in casuistic thinking, as they are in modern medical ethics (e.g., deontology and utilitarianism); but the closer one gets to clinical problem-solving, the farther one gets from explicit and overt theoretical considerations.

A clinical case (from *cadere*, "to happen") is a statement about actions or affairs that makes reference to what classic theology called circumstances: Who? What? When? Where? Why? How? and By what means? In the casuistic method the circumstances (*circum*, "around," *stare*, "to stand") literally stood around the core elements, which were called "maxims" (rules or moral directives that guide moral decision-making). Maxims—in the sense of moral rules of thumb—much more than theory continue to be the major evaluative elements in clinical ethics. Examples of some common maxims include "competent patients have a right to decide"; "doctors should strive for the patient's medical good"; and "doctors should not take the life of a patient."

The usefulness of a maxim, its "cash value," resides in the assistance it can provide in making quick defensible decisions. Most often, however, more than one maxim is embedded in a case, and the clinical ethicist's task is to determine which one really rules. Furthermore, any change in the circumstances will tend to make other maxims emerge, so that careful and continuing attention must always be paid to the particulars of the case. In the past casuistry and now clinical ethics both center around cases, and circumstances are critical for each in deciding what is right or wrong.

In classic casuistry certain cases served as paradigms, illustrating which maxims prevailed in a given set of circumstances. As a case under consideration was shown similar to or different from the paradigm case, a particular decision or rule about right and wrong was thought to be more or less certainly applicable. Everything depended upon the interplay of circumstances and maxims. The same is true of medical clinical ethics. A decision about right and wrong action in a clinical case is based on circumstances and justified by a maxim or a rule. Thus casuistry, which Voltaire and others thought they had killed with cynical criticism, seems alive and well in contemporary medical ethics.

Clinical medical ethics lacks the time, interest, and inclination to be engaged in abstract consideration of theoretical ethics. Besides, abstract theory has no payoff in clinical decision-making. Casuistry, on the other hand, focuses on the circumstances of a case and prefers concrete directives (maxims). In the contemporary clinical context, like the historic situation in which casuistry developed, there is pressure to decide as well as a need to justify the decision. The casuist was faced with a confessional case or a dilemma in spiritual direction; the medical ethicist is faced with options in a medical case that must be assessed and chosen quickly. Certain topics or considerations must always be covered, and these one finds identified in the different methodologies available to guide clinical medical ethics.

[4]A. R. Jonsen and S. E. Toulmin, *The Abuse of Casuistry*, University of California Press, Berkeley, 1988, p. 257. This is a valuable reference for anyone interested in casuistry but particularly for clinical ethicists. The authors make a convincing case for the idea that modern medical ethics is casuistry.

CONTEMPORARY U.S. METHODOLOGIES[5]

Shortly after contemporary medical ethics emerged into public awareness in the late 1960s and 1970s, David Thomasma developed a clinical ethics program at the University of Tennessee in Memphis. Thomasma's program was immersed in the clinical setting, and the methodology he developed for ethical decision-making paralleled the methodology used by doctors to make medical decisions. Briefly, he distilled the moral reasoning process about cases into six steps which clinicians were trained to follow. These steps have been slightly altered by him over the years, but in essence they are as follows:[6]

1. Describe the medical facts of the case.
2. Describe the values (goals, interests) of all parties involved in the case: physicians, patients, house staff, hospital, society.
3. Determine the principal value clash.
4. Determine possible courses of action which could protect as many of the values in the case as possible.
5. Choose a course of action.
6. Defend this course of action.

Thomasma defended his methodology and the need for clinicians to learn ethical reasoning procedures in a book he wrote in 1981 with Edmund Pellegrino.[7]

In 1982 Albert Jonsen, Mark Siegler, and William Winslade published a small volume on medical ethics written specifically for doctors and aimed toward the facilitation of clinical decision-making.[8] They transformed Thomasma's six steps into four areas of concern, into which they packed many complex considerations. Recognizing that doctors are used to making medical decisions that follow a certain methodology but are uncomfortable with ethical decisions, the authors discussed the reasons for physician discomforts and then worked to overcome them through a systematic approach to ethical problems. Their method was designed to provide a checklist for physicians that would ensure all relevant considerations were taken into account: What facts are most relevant to the case? How should the facts be organized to develop critical considerations? and How should the various ethical considerations be weighed? The four areas of concern that they described are as follows:

1. *Medical indications (the physician's domain):* Diagnosis, prognosis, therapeutic alternatives, clinical strategy based on risks and benefits of various courses of management, and particular characteristics of the patient.
2. *Patient preferences (patient decision-making based on medical indicators):* How to handle a conflict between medical indicators and patient preferences; competency considerations; overriding a patient's refusal; what to do when a patient is incompetent and dying.

[5]The methodologies presented in this article are shortened versions or outlines of the originals.

[6]D. Thomasma, Training in medical ethics: An ethical workup, *Forum on Medicine* 1(12):36, 1978. The workup cited is an update of the 1978 version that Thomasma uses at Loyola University's Stritch School of Medicine.

[7]E. Pellegrino and D. Thomasma, *A Philosophical Basis of Medical Ethics*, Oxford University Press, New York, 1981.

[8]A. Jonsen, M. Siegler, and W. Winslade, *Clinical Ethics*, Macmillan, New York, 1982. Mark Siegler later wrote a separate article on methodology (M. Siegler, Decision-making strategy for clinical-ethical problems in medicine, *Arch Intern Med* 142:2,178–2,179, 1982).

3. *Quality of life consideration (when patients cannot decide for themselves):* When a patient is unable to make his or her decisions, a surrogate must decide whether treatment creates more benefit or more burden (Is the surgery, radiation, medical regime, etc. worth it?). A value is placed on features of human experience (consciousness, capacity for relationship, pain, function). Such quality of life evaluations occur only when patients are unable to make judgments, their preferences are unknown, and the medical goals are limited (e.g., in cases involving terminal illness, permanently unconscious patients, handicapped neonates, or an order not to apply cardiopulmonary resuscitation).
4. *External factors (effects of decisions upon others):* Clinical decisions commonly have impacts extending beyond the doctor/patient/surrogate triad; they affect the patient's family, limited resources, limited finances, medical teaching needs, and the safety and well-being of society. These factors are weighed last and are not given great weight in routine decisions.

The decision-maker using this methodology is not only guided in his or her considerations of basic subjects, but is advised when to introduce each consideration and how much weight to assign it. The four general areas of concern are relatively simple, but within each category many different elements and levels of ethical reflection are included.

An ethical workup designed by the author of this article[9] attempts to separate out the different elements and levels of discourse, as well as to show how decision-makers logically proceed from one to the other. Like the former model, it has four main parts:

Expository phase: Guiding the identification of relevant factual material.

1. *Medical factors:* Diagnosis, prognosis, therapeutic options, realistic medical goals, treatment effectiveness, uncertainties associated with scientific understanding in medical practice.
2. *Ethical factors:* Who is the patient and what does he or she want? What are the interests, wishes, feelings, intuitions, and preferences of the patient, physicians, staff, hospital administrators, society?
3. *Socioeconomic factors:* Costs borne by patient, family, hospital, HMO, insurance company, national government, or local community.

Rational phase: Guide to reasoning about the relevant data.

1. *Medical ethical categories:* Terms like informed consent, refusal of treatment, confidentiality, experimentation, and euthanasia create a general taxonomy for organizing data and referral to available literature. The language of medical ethics provides the tools for thinking about cases.
2. *Principles and maxims:* Beneficence, autonomy, respect, truth, fidelity, sanctity of life, and justice are widely accepted guides for reflection. More concrete guides come in the form of specific rules: Do not prolong death; always relieve suffering; respect competent patients' wishes.
3. *Legal decisions and professional codes:*

[9] J. F. Drane, Ethical workup guides clinical decision-making, *Health Progress* 69(11):64–67, 1988.

Paradigm legal cases guide reflection about other cases (for example, a Quinlan-type case). Professional codes, updated by proclamations of professional organizations, also guide reflection.

Volitional phase: Moving from facts and reflection to decision-making.

1. *Ordering the goods:* When more than one good value or interest is realizable, all must be listed according to a scale of priorities. For example, competent patient preferences have priority over physician or family preferences; in an epidemic, societal goods take preference over individual goods.
2. *Ordering principles:* When principles come into conflict, they are ordered according to personal beliefs and professional commitments. For physicians, beneficence (caring for a patient, curing, saving life, relieving pain) takes priority. Other principles are respected but are never preferred to beneficence.
3. *Making a decision:* Professional people decide, with as much prudence and sensitivity as their personality development permits. Special care is required whenever a decision will result in a patient's death.

Public phase: Preparing for public scrutiny and defense of decisions:

1. Making assumptions explicit, becoming aware of subjective factors and underlying beliefs.
2. Correlating reasons and feelings, striving for consistency in using principles, maxims, and rules.
3. Organizing arguments for public discourse. In a pluralistic society an acceptable ethic is supported by convincing reasons.

The methodologies of Thomasma, Siegler, and Drane all touch the same basic points. They differ in the explicitness with which key elements are reflected in the outline. However, none of the three would disagree about any element included in the others' models. Each model attempts to provide a procedural system that can be used by clinical decision-makers no matter what their theoretical beliefs (utilitarian or deontologist, religious or secular).[10] The methodologies differ, then, in choice of terms, ordering of topics, prominence of themes, and temporal sequences.

A EUROPEAN/LATIN AMERICAN METHODOLOGY

Hans-Martin Sass, former Director of the Bochum Center for Medical Ethics in West Germany, is the author of the Bochum Protocol. José A. Mainetti, Director of the Institute of Medical Humanities at the University of La Plata, Argentina, strongly endorses this methodology as an alternative to "made in USA" approaches to bioethics,[11] which Mainetti feels reflect a North American culture, society, and medicine that is technologized, secular, and pluralistic. (Recently, however, Mainetti has seen North American medical ethics moving toward European and Latin American styles.)

In this view medical traditions in Eu-

[10] H. Brody, *Ethical Decisions in Medicine (second ed.)*, Little Brown, Boston, 1981. In this book the author provides an outline of different methodologies, depending on one's theoretical belief (utilitarian, deontologist, etc.).

[11] H. M. Sass, H. Viefhues, and J. A. Mainetti, *Protocolo de Bochum para la práctica ético-médica (second ed.)*, Zentrum für Medizinische Ethik, Bochum, 1988.

rope and Latin America are more humanistic, and their medical ethics are not so tied to deontological and utilitarian theories. Because they are less formalistic, theory-driven, and rule-dominated, according to Mainetti and Lebener, they can help renew medical practice.

Because European medical ethics is more sensitive to virtue considerations and less dominated by principles, it needs its own methodology—one that avoids even the appearance of an engineering strategy applied by technical experts—to bring about socially acceptable solutions. Mainetti finds such a method in Hans-Martin Sass' Bochum Protocol, which, like two of the other models we have seen, has four phases, each of which is divided into subsections. This model consists largely of questions:

Identification of scientific/medical findings: What treatment would be best in light of the scientific medical facts?

1. *General reflections:* Diagnosis, prognosis, treatment alternatives, treatment benefits or results, prognosis without treatment?
2. *Special reflections:* How do treatment options with their benefits and burdens apply to this particular patient?
3. *Physician's task:* Are clinical conditions such as to provide adequate treatment? Is the doctor competent? Is medical knowledge clear? Is medical ignorance recognized?

Identification of ethical/medical findings: What treatment would be best in light of ethical/medical factors?

1. *Patient health and well-being:* What burdens (physical or spiritual) are associated with each therapeutic alternative?
2. *Patient self-determination:* What are the patient's values, attitudes, and level of understanding? Can the patient's participation and decision-making be respected, or will it be set aside in favor of a surrogate's decision?
3. *Medical responsibility:* Can conflicts between doctor, patient, staff, and family be mediated without undermining trust, confidentiality, or truth? How much clarity, certainty, or doubt exists about the appropriateness of ethical categories and their interrelationships?

Case management: What decision is best, in light of all the above considerations?

1. What are the most acceptable options given the medical ethical findings? Is further consultation or patient transfer required?
2. What are the concrete obligations of the physician, patient, staff, and family in light of the treatment chosen?
3. Are there arguments against the decision? Was the decision discussed with the patient? Was the patient's consent received?

Additional questions regarding ethical evaluation:

1. In cases requiring prolonged treatment: Regarding routine review of medical treatment and ethical appraisal, Is the treatment plan flexible? Are palliative measures considered when prognosis is dismal? Is consideration of the patient's expressed and presumed wishes assured?
2. When social factors are present: Regarding family, emotional, professional, and economic complications,

Can the complications be borne by the patient, family, and community? Is the patient's social integration, happiness, and personality development being promoted? How are these social factors to be evaluated vis-à-vis the medical/scientific and medical/ethical considerations?

3. In therapeutic and nontherapeutic experimentation: How does the experiment affect the medical/ethical considerations? If disclosure to the patient is incomplete or is not understood, can the experiment be justified? If the patient has not consented, can it be justified? Was patient selection fair? Can the patient withdraw at any time?

SIMILARITIES AND DIFFERENCES

Similarities between the European/Latin American and the U.S. methodologies are many, but the former does show several distinguishing characteristics. Although the principles turn out to be the same, less prominence is given to autonomy in the Bochum Protocol. The section on patient self-determination, for example, is written from a physician's perspective. The protocol asks what the doctor knows about the patient's value system, attitudes, and understanding. This approach leads to the question "To what extent can the patient be taken into consideration or to what extent can he (she) be completely set aside?"[12] Such phrasing would be inconceivable in a United States methodology, where the cultural emphasis on patient autonomy is strong. Similarly, the Bochum Protocol makes treatment decisions primarily the doctor's responsibility (the physician is asked to consider discussing issues with patients and then to decide whether or not to follow patient preferences). And a comparable difference regarding patient autonomy is seen in the section on experimentation. (The protocol asks questions about justifying research when the patient is not informed or has not consented to participate. In the United States any such medical behavior would be ethically and legally indefensible.)

In general, the Bochum Protocol is as formalistic and technical as the North American models but displays certain elements not found in the latter. For instance, more explicit reference is made to epistemologic issues ("What important factors is the doctor ignorant of?" "Are the medical concepts sufficiently clear?"). Taking medical ignorance and lack of clarity into consideration is not quite the North American style. Young doctors, in fact, work hard during medical training to develop an impression of certainty and self-confidence (some would say infallibility).

CONCLUDING REMARKS

The four methodologies just described move from the relatively simple to the relatively complex. Thomasma's model provides the simplest outline of critical issues. Siegler lists only four topics but includes many more complex considerations under each. Drane unpacks some of the complex issues and organizes them according to an epistemologically progressive schema. The Bochum Protocol incorporates clinical, ethical, and epistemologic issues and, in addition, covers different clinical settings.

An evaluation of the different models would require a testing of their effectiveness and usefulness to practitioners:

[12]H. M. Sass, H. Viefhues, and J. A. Mainetti, *Protocolo de Bochum para la práctica ético-médica (second ed.)*, Zentrum für Medizinische Ethik, Bochum, 1988.

How well are the crucial elements kept before the decision-maker? Is the decision-maker sensitized to critical problem areas? Are potentially unrecognized issues signaled? Is the model pragmatic and clinically workable?

Personally, I see advantages and disadvantages in each model and suspect that practitioners will decide for themselves which one works best and how the most workable model can be improved.

The fact that there are different approaches to ethical decision-making in different regions is readily understandable. European medicine is more humanistic, in the sense that medical training continues to include philosophy of medicine, history of medicine, medical anthropology, and now medical ethics. It is easier with such a background to consider a less technical and more philosophically sophisticated decision-making approach. North American doctors and medicine, on the other hand, are more clinically focused and less appreciative of philosophic issues in medical practice. Their strengths lie more along pragmatic lines. Ideally, however, the best methodology would be both clinically practical and philosophically sophisticated. If cooperation between North American, European, and Latin American ethicists moves forward, then both goals might come closer to realization.