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I. INTRODUCTION

Susan Wolf recently argued that bioethics is undergoing a shift in paradigm from "principlism," which has shaped the mainstream of the field from its inception in the late 1960's, to pragmatism. She summarizes the main features of this paradigm shift as follows: "The turn toward empiricism, rejection of theoretical elegance as the measure of good bioethics and health law, and insistence instead on evaluating what meets the needs of individuals in clinical settings is a diagnostically pragmatist move."[1] By invoking the term "paradigm," Wolf appeals to the work of Thomas Kuhn, who has insightfully explained scientific revolutions with respect to dramatic changes in the theoretical paradigms that orient the various domains of science.[2] After the initial formulation of a new paradigm, the chief task for "normal science" is what Kuhn calls "paradigm articulation:" tracing its theoretical and experimental implications.[3] We endeavor in this essay to contribute to the articulation of the pragmatic paradigm for bioethics through two related investigations.

First, we examine the thought of John Dewey, the classical pragmatist. It is remarkable that Dewey's philosophy has had so little influence on the development of bioethics. The biological foundation of his thinking and his lifelong concern for integrating theory and practice by bringing scientific method to bear on moral questions make Dewey's pragmatic philosophy particularly well suited for bioethics, which operates at one of the most significant intersections of science and ethics. The development

* We dedicate this essay to John Fletcher—our mentor, colleague, and friend—whose creative work in bioethics manifests the spirit of clinical pragmatism.

1. Susan M. Wolf, *Shifting Paradigms in Bioethics and Health Law: The Rise of a New Pragmatism*, 20 AM. J. L. & MED. 395, 411 (1994).

2. *See* THOMAS S. KUHN, THE STRUCTURE OF SCIENTIFIC REVOLUTIONS (2d ed. 1970).

3. *Id.* at 23-34.

of bioethics as a discipline during the 1970's was paralleled by a renewal of philosophical interest in Dewey's thought, spurred largely by the provocative work of Richard Rorty.[4] Yet the theoretical dominance in bioethics of principlism, animated by the analytical movement in American philosophy that supplanted pragmatism, produced an intellectual environment with no room for Dewey's approach to ethics. Recent critical assaults on the abstracted theorizing of principlism and the identification of pragmatic themes, such as the importance of the empirical understanding of clinical contexts, pave the way for an examination of the fruitfulness of Dewey's philosophy as a source for reorienting bioethics.

It is particularly timely to bring Dewey's pragmatic philosophy to bear on bioethics in light of intensifying scholarly interest in Dewey over the past few years. Robert Westbrook, Steven Rockefeller, and Alan Ryan each have written significant and well-executed intellectual biographies of Dewey that approach his thought from different, but compatible, perspectives.[5] Additionally, James Campbell recently published a fine introduction to the broad range of Dewey's philosophy.[6] Bioethics scholars who wish to explore in depth the wealth of Dewey's philosophy can be aided by these, and other, guides. One aim of this essay is to encourage this exploration, which should enhance the development of both the theory and practice of bioethics.

Second, we outline some of the major implications of Dewey's pragmatic philosophy for the emerging subdiscipline of clinical ethics. Clinical ethics is concerned with analyzing and resolving moral problems that arise in the care of patients in clinical settings. In addition, clinical ethics is, or ought to be, concerned with mapping the reform of clinical practice in the light of appropriate moral ideals. This essay concentrates on two themes that have particular significance for developing a pragmatic perspective on clinical ethics. Dewey articulated a pragmatic theory of inquiry in general, and ethical inquiry in particular, that we find

4. *See generally* RICHARD RORTY, PHILOSOPHY AND THE MIRROR OF NATURE (1979 2nd prtg. 1980); RICHARD RORTY, CONSEQUENCES OF PRAGMATISM (1982 6th prtg. 1994); RICHARD RORTY, 1 OBJECTIVITY, RELATIVISM, AND TRUTH: PHILOSOPHICAL PAPERS (1991). *See also* RORTY & PRAGMATISM: THE PHILOSOPHER RESPONDS TO HIS CRITICS (Herman J. Saatkamp, Jr. ed., 1995) (providing critical evaluations of Rorty's interpretations of Dewey with replies by Rorty).

5. *See* ROBERT B. WESTBROOK, JOHN DEWEY AND AMERICAN DEMOCRACY (1991); STEVEN C. ROCKEFELLER, JOHN DEWEY: RELIGIOUS FAITH AND DEMOCRATIC HUMANISM (1991); ALAN RYAN, JOHN DEWEY AND THE HIGH TIDE OF AMERICAN LIBERALISM (1995).

6. JAMES CAMPBELL, UNDERSTANDING JOHN DEWEY: NATURE AND COOPERATIVE INTELLIGENCE 1-22 (1995).

especially well suited for guiding the analysis and resolution of moral problems in clinical practice. In addition, we see Dewey's basic social ideal of "democracy as a way of life"[7] as an orienting perspective for the reform of clinical practice, both with respect to the clinician-patient (or surrogate) dyad and the various institutional dimensions of health care. The pragmatic method of inquiry and problem-solving and the democratic model represent the two pillars of an approach to clinical ethics that we call "clinical pragmatism."[8]

This essay provides an introductory overview of selected aspects of Dewey's philosophy, emphasizing those themes that are particularly illuminating for bioethics. We then sketch the outlines of the pragmatic method of ethical inquiry and the democratic model of clinical practice. In the final section, we briefly discuss some of the major implications of clinical pragmatism for clinical ethics.

II. Sources and Key Themes of Dewey's Philosophy

John Dewey lived from 1859 to 1952, a time of great social and intellectual transformation. Dewey was the most distinguished and best known American philosopher during the first third of the twentieth century. He was perhaps the last of the grand philosophers who endeavored to make significant contributions to all the major areas of philosophy—logic, theory of knowledge, metaphysics, ethics, social philosophy, and aesthetics. A full account of the historical sources of Dewey's philosophy would span the scope of the Western philosophical tradition from the ancient Greeks to the early years of the twentieth century. For the purposes of this brief overview, we highlight three major sources: G.W.F. Hegel, Charles Darwin, and Charles Peirce.

Hegel had an enormous influence on philosophy in the latter half of the nineteenth century in the United States and Great Britain, and Dewey was an ardent Hegelian in his philosophical youth.[9] In his mature works, Dewey rejected the metaphysics of absolute idealism and Hegel's dialectical logic in favor of a thoroughgoing naturalistic philosophy of pragmatic empiricism. In accounting for the sources and nature of his philosophical enterprise, however, Dewey remarked that Hegel left "a

7. John Dewey, *Creative Democracy—The Task Before Us*, *in* John Dewey: The Political Writings 240 (Debra Morris & Ian Shapiro eds., 1993).

8. Joseph J. Fins & Matthew D. Bacchetta, *Framing the Physician-Assisted Suicide and Voluntary Active Euthanasia Debate: The Role of Deontology, Consequentialism, and Clinical Pragmatism*, 43 J. Am. Geriatrics Soc'y 563, 563 (1995).

9. Rockefeller, *supra* note 5, at 19.

permanent deposit" in his thinking.[10]

Dewey's philosophy retained a Hegelian perspective on reality, as systematically interconnected and undergoing a dynamic process of development. Like Hegel, Dewey was philosophically opposed to dualistic, dichotomous thinking, that asserts or presumes sharp logical and ontological boundaries between philosophical concepts and the aspects of reality that they signify. Throughout his philosophical career, Dewey staunchly and persistently criticized the pervasive dualism characteristic of the Western philosophical tradition, including permanence and change, mind and body, reason and experience, knowledge and belief, theory and practice, and facts and values. In *Art as Experience*, Dewey formulated a methodological rule that governed his philosophy: "Wherever continuity is possible, the burden of proof rests upon those who assert opposition and dualism."[11]

In his social philosophy, Dewey espoused a communitarian version of liberalism, which was influenced by Hegel's critique of the "atomistic individualism"[12] presupposed by the classical liberal thinkers from Locke to Kant. Dewey was a champion of freedom and civil liberties, but he rejected the ideology of natural rights of individuals independent of society and historical context. Nor did Dewey see contracts between self-determining individuals as the moral glue of society. For Dewey, as for Hegel, individuality was not given as a natural fact of human life; it is created and developed through participation in social institutions.

A second seminal influence on Dewey was Charles Darwin, whose work *Origin of Species* was published in 1859, the year Dewey was born. Darwin's work, which dealt the final blow to the classical world-view in natural science, showed that the mechanistic process of natural selection could explain the marvelous adaptation of organisms to their environment without invoking Aristotelian teleologic causation in terms of purposes governing nature. In his naturalistic approach to philosophy, Dewey embraced the Darwinian revolution.[13]

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10. JOHN DEWEY, *From Absolutism to Experimentalism* (1929-30), *in* 2 THE PHILOSOPHY OF JOHN DEWEY: THE STRUCTURE OF EXPERIENCE 1-13 (John J. McDermott ed., 1973), *reprinted in* 5 JOHN DEWEY: THE LATER WORKS, 1925-1953 147, 154 (Jo Ann Boydston ed., 1981).

11. JOHN DEWEY, *Art and Experience* (1934), *in* 10 JOHN DEWEY: THE LATER WORKS, 1925-1953 34 (Jo Ann Boydston ed., 1981).

12. *See* STEVEN B. SMITH, HEGEL'S CRITIQUE OF LIBERALISM: RIGHTS IN CONTEXT 140 (1989).

13. *See* JOHN DEWEY, 1 THE PHILOSOPHY OF JOHN DEWEY: THE STRUCTURE OF EXPERIENCE 31-41 (John J. McDermott ed., 1973).

Two implications of Darwin's theory were most significant for Dewey. First, the revolutionary idea that species of living beings evolve over time undermined the metaphysical presumption that there exist fixed, permanent natural kinds. Second, the theory of evolution focused attention on the continuity between lower and higher animals, and thus supported a naturalistic conception of human life and morality. Darwin's theory offered Dewey a biological grounding for the Hegelian themes of development and continuity. Dewey based his mature philosophy on a Darwinian foundation of interaction between human organisms and their environments. He saw the distinctively human means of adaptation as the development and refinement of habits of intelligence, epitomized by experimental science.[14]

Dewey's conception of intelligence in thought and action was also influenced significantly by Charles Peirce, generally recognized as the founder of American pragmatism. It was not until Dewey emancipated his thinking from the metaphysical framework of Hegelian idealism that he came to appreciate the significance of Peirce's philosophy, particularly its implications for conceiving logic operationally as the theory of inquiry.[15] Peirce formulated pragmatism as a conception of the meaning of ideas or the definition of concepts. Stated roughly, what is meant by ascribing a property P to an object, is the effect that is observed when operations on the object are experimentally performed. Thus, to call an object hard means that it is unlikely to be scratched when brought into contact with most other substances. Conceptual meaning for Peirce is tied to experience in the context of practical, experimental action: "There is no distinction of meaning so fine as to consist in anything but a possible difference in practice."[16]

The pragmatic conception of meaning posits an integral connection between thinking, action, and experience. For both Peirce and Dewey, this integration of theory and practice is best exemplified in the experimental method of science. Dewey systematically developed the approach of pragmatic experimentalism in all aspects of his mature philosophy, including his analysis of the meaning and validation of moral judgments.[17]

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14. *See* JOHN DEWEY, HUMAN NATURE AND CONDUCT: AN INTRODUCTION TO SOCIAL PSYCHOLOGY 172 (1922).

15. *See generally* JOHN DEWEY, *Logic: The Theory of Inquiry*, *in* 12 JOHN DEWEY: THE LATER WORKS, 1925-1953 (Jo Ann Boydston ed., 1986).

16. CHARLES PEIRCE, *How to Make Our Ideas Clear*, *in* PHILOSOPHICAL WRITINGS OF PEIRCE 23-42, 30 (Justus Buchler ed., 1955).

17. *See* discussion *infra* Parts II.A, II.B.

Dewey also incorporated into his pragmatic philosophy a doctrine that Peirce called "fallibilism."[18] Peirce argued that absolute certainty can never be reached about matters of fact. He viewed fallibilism as emanating from the logic and spirit of science. The self-correcting process of scientific inquiry overthrows previously established beliefs, accepted as knowledge, and tentatively establishes new beliefs. Dewey applied Peirce's fallibilism to the domain of valuation and morality. He criticized the "quest for certainty" that dominated the classical tradition of philosophy.[19] Since moral beliefs should be considered as fallible, they have the logical status of *hypotheses*, not certain laws or self-evident truths. Dewey saw profound implications for the reconstruction of ethics and social philosophy in applying the logic of experimental inquiry to moral problems of social life.

III. DEWEY'S THEORY OF INQUIRY

The influence of Hegel, Darwin, and Peirce coalesced Dewey's mature philosophy into an effort to integrate science and ethics through the pragmatic or instrumental method of experimental inquiry. This abiding project of Dewey's career is captured in an essay on his philosophical development, aptly entitled *From Absolutism to Experimentalism.*

> I became more and more troubled by the intellectual scandal that seemed to me involved in the current (and traditional) dualism in logical standpoint and method between something called "science" on the one hand and something called "morals" on the other. I have long felt that the construction of a logic, that is a method of effective inquiry, which would apply without abrupt breach of continuity to the fields designated by both of these words, is at once our needed theoretical solvent and the supply of our greatest practical want.[20]

In his theory of inquiry, Dewey constructed a bridge between science and ethics. He understood inquiry—the use of intelligent thought to solve problems—naturalistically; it emerges from, and is continuous with, the adaptive functioning of organisms in the context of their environments. Inquiry enables human beings to suspend the ongoing process of

18. Charles Peirce, *The Scientific Attitude and Fallibilism in* THE PHILOSOPHICAL WRITINGS OF PEIRCE, *supra* note 16, at 42-60, 58.

19. *See* JOHN DEWEY, *The Quest for Certainty: A Study of the Relation of Knowledge and Action* (1929), *in* 4 JOHN DEWEY: THE LATER WORKS, 1925-1953 1 (Jo Ann Boydston ed., 1981).

20. DEWEY, *supra* note 10, at 156.

responding reflexively or habitually to stimuli arising from interactions between the organism and the environment. Response is arrested in order to survey a problematic situation faced by the individual or the group, and to form a plan of action for satisfactory resolution of the problem. In other words, we can stop and think. Intelligent inquiry mediates human responses to the challenges of living. In so doing, it frees human beings from reliance on instinct and fixed routines; it enhances the power to achieve desired results.

Inquiry is contextually situated; it is activated by, and responsive to, what Dewey called a "problematic situation."[21] When things are going smoothly, in accord with well-established habits, there is no need for an intelligent organism to think. But, when faced with situations that arouse perplexity and doubt, we are prompted to stop and think about what is happening in order to plan our response. Recognition of a problem—that something is wrong—gives rise to intelligent thought. For Dewey, the scope of inquiry ranges from the common sense problem-solving of everyday life, to professional work, and to experimental and theoretical science. Thus, inquiry serves as both a practical means of adaptation and a tool for generating and validating theoretical knowledge.

Once initiated, inquiry normally proceeds by means of a number of logical steps. In *How We Think*, Dewey describes these steps as follows: "(i) a felt difficulty; (ii) its location and definition; (iii) suggestion of possible solution; (iv) development by reasoning of the bearings of the suggestion; (v) further observation and experiment leading to its acceptance or rejection."[22] For example, a patient arrives at a physician's office with a complaint of persistent pain or discomfort; something is wrong with the patient; he or she has become ill, and seeks medical attention to determine what is wrong and how it can be remedied.[23] The physician initiates clinical inquiry in an effort to understand the problematic situation posed by the patient. The physician asks questions of the patient and examines the patient's body. This effort to diagnose the problem may include performing laboratory tests, or imaging studies, to elucidate the pathophysiology underlying the patient's complaint. These diagnostic operations are guided throughout by working hypotheses, drawn from knowledge of medical science and clinical experience. The physician sys-

21. *See generally* DEWEY, *supra* note 15.

22. JOHN DEWEY, HOW WE THINK 72 (1910).

23. Dewey frequently used the example of a physician diagnosing a patient's medical problem to demonstrate the character of experimental inquiry. *See, e.g., id.* at 74. *See also* DEWEY, *supra* note 19, at 139, 165-66.

tematically tests conjectures about the medical nature of the problem, which are confirmed or ruled out in the light of the results of diagnostic procedures and the evolution of the patient's condition.

Having arrived at a diagnosis, or working speculation, about what is wrong with the patient, the process of inquiry moves to the stage of planning for the resolution of the problem. Based on the diagnostic possibilities, the physician, ideally in collaboration with the patient, determines reasonable goals for medical care and considers appropriate interventions. The deliberative process of planning depends on intelligent foresight of the probable consequences of alternative tactics for responding to the problem. The physician and patient agree to a plan of action, and the plan is put into operation. Since uncertainty about the diagnosis and the efficacy of the planned therapy always remains, the plan should be understood as an experiment that needs to be evaluated in terms of how well it works in practice and in the face of ongoing clinical developments. The process of inquiry continues until the problematic situation is satisfactorily resolved.

Although inquiry has a trajectory that can be analyzed as proceeding along functional stages, in reality it is a continuous process without discrete breaks. Earlier phases inform later developments, which in turn feed back information to clarify and refine hypotheses about the nature of the initial problem and possible future solutions. The process of inquiry is explicated graphically by Tom Burke in his book on Dewey's logic.[24] Burke likens inquiry to the "helical pattern of a corkscrew"[25] which he analyzes into two dimensions: "a linear component and a circular component."[26] The linear thrust of the corkscrew represents the teleological movement of inquiry from a problematic situation to a satisfactory resolution, following the steps illustrated above. Within this forward movement of inquiry, participants engage in continuing cycles of forming and testing hypotheses aimed at figuring out what is going on, deciding what to do, intervening experimentally, and evaluating the results. This in turn may lead to reappraisal of the problem and a new cycle of diagnosis, planning, and intervention.

Burke's analogy of the corkscrew is apt: the helical pattern fits the linear but cyclic process of inquiry. This well-designed tool symbolizes the instrumental functioning of inquiry as the logical method of intelli-

24. TOM BURKE, DEWEY'S NEW LOGIC: A REPLY TO RUSSELL (1994).
25. *Id.* at 158.
26. *Id.*

gent thought and action. Dewey's conception of inquiry, best exemplified in scientific method, integrates theory and practice. Reflective thinking, oriented in terms of established theory, develops hypotheses and designs experiments to test them. The experimental phase of scientific investigation constitutes intelligent practice guided by theory. As the result of carefully designed experimentation, theory is refined and corrected. Thinking and intervention into the world—theory and practice—interact and become mutually reinforcing in the progressive process of inquiry.

By scientific "method" Dewey did not mean an algorithmic process consisting of rules for discovering "Truth," for understanding reality, or for determining right from wrong. Rather, "method" consists of logical patterns of inquiry that promote successful problem solving. The former view treats method as the logical guide in the quest for certainty, while the latter treats method functionally and pragmatically.[27] The "method" of inquiry is not mechanical; there are no general recipes for problem solving in any domain. Careful attention to the contextual details of specific situations is required in all phases of inquiry. Imagination is needed to devise plans for interventions to resolve the problems that give rise to inquiry. Dewey often described the process of intelligent action as "creative."

IV. Dewey's Moral Philosophy

Dewey argued that the logic of inquiry, operative in the problem-solving of daily living, professions, and science, should apply also to morality. Dewey diagnosed prevailing moral thinking as mired in a classical, prescientific world-view in which absolutist and dogmatic theory is divorced from practice. Unexamined prejudice and *a priori* legislation continue to reign in the moral domain. Dewey's primary philosophical problem concerned the gap, or cultural lag, between the scientific way of knowing, which has transformed the material dimensions of modern life, and the prescientific status of morality. He endeavored to reconstruct moral thinking, and its application to social policy, in the light of his theory of experimental inquiry.

There was no moral system at work in Dewey's ethical thought. He did not view the task of moral philosophy as developing a theory that formu-

27. *See* Richard Rorty, *Pragmatism Without Method*, *in* 1 Objectivity, Relativism, and Truth: Philosophical Papers 63-77 (1991) (Rorty's critique of the scientific method and his endorsement of "pragmatism without method" appears to be directed to this rationalistic conception of method.).

lates and justifies basic or supreme principles of morality. Instead, Dewey's moral philosophy encompassed two related components: (1) a naturalistic theory of valuation, including the validation of moral judgments, based on his logic of inquiry; and (2) a pragmatic conception of moral principles as hypothetical tools or guides in the process of ethical inquiry.

A. Moral Valuation

Dewey's empirical and naturalistic theory of valuation has affinities with the major thinkers in the utilitarian tradition including David Hume, Jeremy Bentham, and John Stuart Mill. Dewey, however, criticized his naturalistic predecessors for treating valuation, the source of moral knowledge, as deriving from the passive satisfaction of desire. This position parallels Dewey's critique of the classical empiricism espoused by these thinkers, who understood perception, the source of empirical knowledge, as the passive processing of sense-data.[28] According to Dewey, we gain knowledge of fact and value experimentally, by intelligent intervention in the world. Dewey argued that the empirical theory of values advanced by these thinkers needs to be reconstructed in conformity with the logic of experimental inquiry.

The difference between Mill and Dewey on the theory of valuation is instructive. Dewey agreed with Mill that values must be understood experientially in terms of the satisfaction of desires. In a famous passage of his work, *Utilitarianism,* Mill declared that the grounds for judging that an object is desirable are similar to the grounds for judging that an object is visible: "The only proof capable of being given that an object is visible is that people actually see it . . . . In like manner, I apprehend, the sole evidence it is possible to produce that anything is desirable is that people do actually desire it."[29] Dewey criticized Mill for failing to make clear that "desirable" means what *ought* to be desired; whereas the visible concerns what is *capable* of being seen. Dewey posed the problem of valuation in the following question: How can we make the transition logically from *de facto* desiring to *de jure* judgments of what is desirable? Dewey attempted his most systematic answer to this problem in a chapter of *The Quest for Certainty* entitled "The Construction of Good."[30]

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28. JOHN DEWEY, *Changed Conceptions of Experience and Reason, in* RECONSTRUCTION IN PHILOSOPHY 77, 84 (1948).

29. JOHN STUART MILL, UTILITARIANISM 32 (1971).

30. *See* DEWEY, *supra* note 19.

The title of this chapter is significant. The good, or value, for Dewey is not simply to be passively experienced. Knowledge of value must be constructed in the process of inquiry, which Dewey calls "valuation," just as knowledge of nature is constructed by scientific investigation. "The fact that something is desired only raises the question of its desirability; it does not settle it."[31] Valuation is governed by the logic of inquiry. What satisfies our desires becomes a value only so far as it subsequently is found to be *satisfactory* as the result of methodical inquiry. For example, to many people smoking cigarettes is satisfying. Medical science, however, has demonstrated that it contributes to morbidity and mortality. Therefore, although cigarette smoking may be desired and satisfying, it is not *desirable* or *satisfactory*. Indeed, the alteration of habits by many Americans, in the wake of scientific investigation and dissemination of information concerning the ill effects of smoking, illustrates the power of inquiry as instrumental in transforming the conditions of living.

Valuation, like factual knowledge, involves a claim that is verified or falsified in the future as the result of inquiry. This status of making a claim about future satisfactions makes value judgments sources of reliable guidance and regulation of conduct. The desirable is *to be* desired; it is satisfactory because, and insofar as, it proves satisfying. Reflective judgment, based on the method of experimental inquiry, links the desired and satisfying to the desirable and the satisfactory. Dewey did not equate value judgments and factual judgments; however, consistent with his philosophical opposition to dualistic thinking, he did not understand the distinction between facts and values as forming a strict logical or ontological dichotomy. Experimental inquiry bridges the gap between fact and value.

The evaluation of medical treatments in clinical trials exemplifies Dewey's theory of valuation. The fact that a drug or procedure is accepted by clinicians as effective for the treatment of patients with a certain condition does not count as adequate proof of its medical value. The perceived efficacy may be due to the placebo effect of a medical intervention, expected to be therapeutic, rather than its distinctive characteristics of the treatment. Randomized clinical trials are considered the "gold standard" of medical valuation; they seek to demonstrate that an experimental treatment, that is desired and thought to be effective, will prove clinically satisfactory and thus be desirable. A treatment becomes validated in the context of carefully controlled experimentation that com-

31. *Id.* at 208.

pares the results of administering the treatment to a suitable placebo, or an already validated standard treatment, to randomly selected groups of patients. Although the opportunities for scientifically rigorous valuation in human affairs are limited, an indefinitely broad field of operation for the logic of pragmatic valuation based on empirical observation remains. This valuation involves framing value hypotheses, planning experimental interventions, and testing how they work in practice.

Dewey argued that the type of thinking characteristic of science is applicable in ethics as a method of determining and validating moral judgments and resolving moral problems. Our claim that an object is good is tested by intelligently directed conduct. Values are determined, or constructed, by a process of inquiry yielding reliable, but not certain, results. Peirce's fallibilism applies to the domain of values and moral judgments, as well as to the world of facts. Our current valuations should be seen as provisional and open to revision in the light of future experience.

Dewey's emphasis on applying the scientific method of experimental inquiry to the resolution of moral problems may give the impression that his approach to ethics is one of impersonal calculation of consequences, without any role for emotions in moral valuation and deliberation. This is far from the truth. Emotional responses often indicate whether something is morally improper. Thus, they function as indications that a problematic situation warranting ethical inquiry exists. Like Hume, Dewey considered the emotive disposition of sympathy as a necessary condition of the moral life. Dewey observed that: "It is sympathy which saves consideration of consequences from degenerating into mere calculation, by rendering vivid the interests of others."[32] Dewey rejected the dichotomy between cognition and emotion, that has characterized mainstream ethical theory since the time of Kant: "*Emotional* reactions form the chief materials of our knowledge of ourselves and others."[33] In the pragmatic approach to ethical inquiry, emotions offer a rich source of moral insight that needs to be combined with empirical observation and logical reasoning in order to anticipate and evaluate the consequences of action and to plan creative solutions to moral problems.[34]

32. JOHN DEWEY, THEORY OF THE MORAL LIFE 130 (1980).

33. *Id.* at 129.

34. JOHN DEWEY, *Theory of Valuation* (1939), *in* 13 JOHN DEWEY: THE LATER WORKS 1938-1939 249 (Jo Ann Boydston ed., 1991).

B. The Pragmatic Conception of Principles

Dewey developed a pragmatic conception of moral principles as a guide for moral deliberation in the process of ethical inquiry. As a species of practical deliberation, moral deliberation takes place in the context of inquiries responsive to problematic situations. Ethical inquiry is instrumental to the mutual adaptation of human agents in social environments; it is directed to problem solving in social contexts in which associated agents are concerned about evaluating conduct as good or right. Within inquiry, moral rules and principles function logically as *hypotheses*, as presumptive guides to conduct in the situation.[35] Principles play an important role both in the diagnostic and intervention planning stages of inquiry. They shed light on what is occurring morally in a problematic situation, aid in suggesting possible courses of conduct, and operate as constraining factors in deciding what is best to do. From this perspective, rules and principles are not absolutely decisive or final; they have the logical status of working hypotheses for the satisfactory resolution of morally problematic situations. In the process of ethical inquiry and efforts to resolve moral problems, we clarify, test, and revise our moral rules and principles.

According to Dewey, "life is a moving affair in which old moral truth ceases to apply."[36] Thus, principles should no longer be seen as fixed and immutable. Instead, they should be understood as hypothetical guides constructed for regulating conduct in various situations which need to be reconstructed when the conditions regulating conduct change significantly. To take an example from bioethics, the moral rule that physicians have a duty to preserve life has been modified now that techniques of life-sustaining treatment can prolong the process of dying or maintain life in states of intolerably poor quality. Based on developments in the law and morality, it is considered ethically permissible to forego such treatment, and thus hasten death, if the burdens are considered to outweigh the benefits from the patient's perspective.[37]

Dewey criticized the traditional insistence on fixed moral laws as a version of the quest for certainty. It shields morality from criticism and reform. Just as the modern scientific view of laws of nature, is that they have the status of hypotheses to be confirmed, modified, or refuted by

35. JOHN DEWEY, HUMAN NATURE AND CONDUCT: AN INTRODUCTION TO SOCIAL PSYCHOLOGY 238, 239 (1944).

36. *Id.*

37. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 196-206, 211-219 (4th ed., 1994).

experimental inquiry, so moral principles ought to be regarded as hypothetical. "A moral law, like a law in physics, is not something to swear by and stick to at all hazards; it is a formula of the way to respond when specified conditions present themselves. Its soundness and pertinence are tested by what happens when it is acted upon."[38] When experimental inquiry is endorsed and practiced in the moral life, belief in fixed moral laws will be surrendered. It is critical to stress that Dewey did not suggest that in applying scientific method to ethics, we need to wipe the moral slate clean. Moral rules and principles embedded in our social institutions have survived the test of enduring experience in human adaptive conduct. Reconstruction of morality builds on a foundation of prior construction. Traditional moral rules and principles continue to function as resources for ethical inquiry to the extent that they provide satisfactory guidance in resolving morally problematic situations.

Dewey's pragmatic conception of principles conflicts with the mainstream of moral philosophy from Immanuel Kant to the present. Kant argued that to be moral is to do one's duty for duty's sake. Moral rules are absolutely binding; they have the status of strict laws which we are bound to respect. They are categorical rather than hypothetical. Kant contends that this conception of absolutely binding moral rules is given in the common moral consciousness.[39] Does it make sense to think of moral rules as hypotheses? Consider the ten moral rules propounded and defended by Bernard Gert in his book *Morality*.[40] Are rules such as "Don't lie," "Don't kill," "Don't cheat," and "Keep your promises," hypothetical guides, or are they moral laws binding conduct? Furthermore, if one takes a stand on principle, stakes one's character, or perhaps one's life, on a matter of principle, how can such a stand be taken on a mere hypothesis or tool?

This objection from traditional morality we do not regard as posing a serious problem for Dewey's moral philosophy. For Dewey, principles function as hypotheses *in the process of inquiry*. It is necessary to distinguish between situations in which there is no doubt about what ought to be done morally, and morally uncertain situations that call for inquiry to

38. JOHN DEWEY, *The Quest for Certainty: A Study of the Relation of Knowledge and Action* (1929), *in* 4 JOHN DEWEY: THE LATER WORKS, 1925-1953 222 (Jo Ann Boydston ed., 1981).

39. IMMANUEL KANT, GROUNDWORK OF THE METAPHYSICS OF MORALS (H.J. Paton trans., 1964).

40. BERNARD GERT, MORALITY: A NEW JUSTIFICATION OF THE MORAL RULES (1988).

determine what should be done. When it is known, or claimed to be known, what should be done, then the rule or principle that directs and justifies conduct is not entertained as a hypothesis. Rather, it stipulates what should be definitely done. Principles function as hypothetical guides in ethical inquiry when the point of inquiring is to judge what is right and good to do in a particular problematic situation. For example, when the course of action chosen might stake one cherished principle against another. In the face of problematic situations, it cannot be presumed in advance that a given moral rule or principle should guide conduct. The directive force of the rule, or principle, that makes it applicable and determinative for the situation under investigation is the very question at issue. The nature of the situation needs to be surveyed; all the relevant moral considerations bearing on it should be brought to light and evaluated. The inquiry should focus on the probable consequences of following a given rule or principle in the situation. The relevance and scope of a rule or principle, and its weight in comparison with competing moral considerations, must critically be assessed. Once it has been decided that a rule or principle should govern conduct in a problematic situation, then that decision is binding.

Dewey's moral philosophy is opposed to the idea that ethical theory can or ought to take the form of a rigorous decision procedure—a method for deducing correct moral judgments applicable to moral problems. As indicated above, the relevance and weight of moral considerations to resolving a problem of conduct cannot be determined in advance of inquiry. The moral life involves choosing the better course of action in complex, particular situations. Fixed rules do not provide reliable and satisfactory guidance. At any given time morality, like science, is not final, but subject to development. The quest for certainty in ethics produces or reinforces dogmatism, absolutism, antipathy to social reform, and lack of due concern for the possibly adverse consequences of adhering to fixed moral laws. Dewey argued that we need a continuous process of ethical inquiry, involving critical thinking, empirical research, and experimentation, to discover and reconstruct the moral knowledge instrumental to solving the moral problems of modern life.

V. Democracy as a Way of Life

Dewey's social philosophy and theory of education center around the fundamental ideal of democracy. Dewey focused on democracy as a broad, inclusive moral ideal—as a pluralistic way of life, not just as a

mechanism of government.[41] Institutions and social relations should be characterized by cooperation, discussion, consultation, and participation. "The keynote of democracy as a way of life may be expressed . . . as the necessity for the participation of every mature human being in formation of the values that regulate the living of men together."[42] For Dewey, democracy is an ideal for social life. He invokes the traditional ideals of liberty, equality, and fraternity as constitutive of, and mutually implicated in, democracy as a way of associated life:

> Fraternity is another name for the consciously appreciated goods which accrue from an association in which all share, and which give direction to the conduct of each. Liberty is that secure release and fulfillment of personal potentialities which take place only in rich and manifold association with others: the power to be an individualized self making a distinctive contribution and enjoying in its own way the fruits of association. Equality denotes the unhampered share which each individual member of the community has in the consequences of associated action.[43]

Commitment to the ideal of democracy as a way of life means that the burden of proof is on those who wish to defend undemocratic, authoritarian institutions and social relations involving adults. In group activities, such as the military, a ship at sea, team sports, that require precise coordination and discipline, a hierarchy of power and subordination is necessary and appropriate. Also, democracy may not be appropriate for institutions and social relations involving young children and cognitively impaired adults who are not in a position to exercise responsible self-direction and participate as moral agents in decision making.

Is democracy as a way of life relevant to thinking about the moral dimension of the relationship between physician, and the competent, adult patient? Dewey lived before the advent of the bioethics movement, with its critique of medical paternalism. Yet Dewey's analysis of the problems posed by social relationships involving control and subordination applies aptly to the traditional model of the physician-patient relationship:

> The very fact of exclusion from participation is a subtle form of suppression. It gives individuals no opportunity to reflect and decide upon what is good for them. Others who are supposed to

41. *See* JOHN DEWEY, *Creative Democracy—The Task Before Us*, *in* JOHN DEWEY: THE POLITICAL WRITINGS 240 (Debra Morris & Ian Shapiro eds., 1993).

42. JOHN DEWEY, *Democracy and Educational Administration*, *in* JOHN DEWEY, PROBLEMS OF MEN 57, 58 (1946).

43. JOHN DEWEY, THE PUBLIC AND ITS PROBLEMS 150 (1954).

> be wiser and who in any case have more power decide the question for them and also decide the methods and means by which subjects may arrive at the enjoyment of what is good for them. This form of coercion and suppression is more subtle and more effective than is overt intimidation and restraint. When it is habitual and embodied in social institutions, it seems the normal and natural state of affairs.[44]

Traditional medical paternalism and more subtle forms of physician dominance and patient compliance, operating in contemporary clinical practice, make it seem normal and natural for patients to adopt passive, subordinate roles in relationships with physicians. But commitment to democracy as a way of life calls this into question. Is the patient so incapacitated by illness as to be incapable of participating in planning for medical care? Are patients so ignorant or lacking in intelligence that they are unable, with the help of physician communication, to understand their medical condition and assess the risks and probable benefits of alternative courses of treatment? Is trustful submission necessary for healing?

We contend that the model of shared decision-making developed by Jay Katz, endorsed by the President's Commission, and recently reconstructed by Howard Brody in a focus on power in medicine and the role of primary care, agrees with Dewey's ideal of democracy as a way of life.[45] This democratic model contrasts with both traditional medical paternalism, in which the physician rules the clinical realm, and the autonomy model of consumer sovereignty, in which the physician is an expert technician available to inform and to do the bidding of the patient. Current practice reflects an unstable hybrid of the traditional and autonomy models that is fraught with inherent tensions. Medical paternalism violates the principle of respect for the patient as a person. Consumer sovereignty in medicine, governed by autonomy as the preeminent principle, is incompatible with a therapeutic relationship and does not do justice to the professional integrity of physicians. Instead of allocating decision-making sovereignty to the physician or the patient, the democratic model prescribes a shared process of discussion, negotiation, compromise, and consensus. In contested cases it may become necessary to determine who

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44. DEWEY, *supra* note 41, at 58-59.

45. JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 85 (1984); *See* 1 PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. AND BIOMED. AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS (1982); HOWARD BRODY, THE HEALER'S POWER x-xi (1992).

decides; however, this is required only when collaboration breaks down without the prospect of repair. Within the democratic model, the focus is on how the parties to the clinical encounter can work together to arrive at a mutually satisfactory plan for the care of the patient.

Any workable model of the physician-patient relationship must accommodate the obvious and inherent inequalities in the roles of physician and patient. The patient is sick, vulnerable, and in need of help; the physician is a professional who professes the knowledge, skill, dedication, and trustworthiness to help the patient recover health, preserve life, and relieve suffering. In spite of these inequalities in existential situation, knowledge, power, and authority, the ideal of democracy as a way of life is relevant to medicine. Democracy rejects authoritarian hierarchy, operating by command or control, and obedience or submission. It does not reject authority of expertise or presuppose full equality and mutuality. Just as Dewey advocated democratization of education without undermining the authority and guidance of teachers, so the democratic model of medicine does not prescribe elimination of inequalities in knowledge and role in the physician-patient relationship.

The bioethics movement, with its successful challenge to the traditional paternalism of physicians, has contributed to the democratization of medicine. It now seems quaint to speak of "doctors' orders." Yet the still prevalent language of physician *management* and patient *compliance* suggests lingering elements of a relationship of dominance and submission, rather than a fully realized collaborative partnership in healing and promoting health. Democratization of the clinician-patient relationship requires a much deeper transformation than adherence to the legal doctrine of informed consent and recognition of the patient's right to refuse treatment. Democracy in the clinic means that clinicians should strive to facilitate positive participation by educating patients about their conditions, inviting conversation aimed at a shared process of setting goals, and deliberating about alternative approaches to treatment and care. Clinicians must share power with patients and family members by subordinating the technical aspects of medicine, over which they maintain control, to the ethical aspects of determining, through dialogue and negotiation, what is good for patients.

VI. Implications for Method in Clinical Ethics

The dominant paradigm of bioethics, known as "principlism," has generally adopted the stance of applied ethics: the application of general

principles, articulated by ethical theory, to moral problems in health care. By focusing ethical reflection on determining and justifying what is the right thing to do in the face of isolated moral quandaries in medical care, this approach has tended to detach moral judgment from the context of clinical practice—the ongoing process of interaction centered on the care of the patient. Abstract ethical analysis concentrating on general principles often does not offer useful guidance to clinicians struggling with concrete problems in the care of patients that pose moral issues.

Principles of Biomedical Ethics,[46] now in its fourth edition, is the leading text in the field of bioethics, offering an excellent resource for teachers of bioethics by providing careful analyses of moral concepts relevant to health care and by exhibiting in detail the significance of basic moral principles. However, it fails to supply a workable method for clinicians and clinical ethicists to analyze and resolve moral problems in the care of patients. Instead, the text provides an elaborate theory of justification for the application of general principles that is removed from the process of clinical decision making. In the third edition of their text, Beauchamp and Childress state: "We believe one of the major defects in contemporary theory in biomedical ethics is its distance from clinical practice . . . . But this defect cannot be corrected here."[47] Although they omit this statement from the fourth edition, the problem remains.

A major consequence of the principlism paradigm is that ethical and clinical thinking are divorced. For example, the opening paragraph of a recent article on the care of terminally ill patients reflects this separation of the ethical and the clinical:

> How should the clinician respond when terminally ill patients express distress over a prolonged death or inquire about accelerating death? How should we answer patients and family members who ask or even demand that death be hastened? In the medical literature, euthanasia and assisted suicide are primarily treated as ethical issues, but ethical principles offer limited guidance for the clinical tasks of caring for these patients. Moreover, we find that when requests for euthanasia and assisted suicides are framed primarily as ethical matters, key clinical issues in the evaluation of such patients may be missed.[48]

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46. *See generally* BEAUCHAMP & CHILDRESS, *supra* note 37.

47. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 21 (3d ed. 1989).

48. Susan D. Block & J. Andrew Billings, *Patient Requests to Hasten Death*, 159 ARCHIVES INTERNAL MED. 2039, 2039 (1994).

The separation of clinical and ethical thinking constitutes a central challenge for the discipline of clinical ethics, which stands for integrating ethics into clinical practice. To bridge the gap between ethical and clinical thinking, the prevailing approaches of both bioethics and clinical problem-solving need to be reconstructed. Ethical analysis must be responsive to the concrete contexts of clinical reality, within which moral problems in the care of patients arise and are resolved. Clinical thinking must include ethical reflection, and clinical practice must be open to reform in the light of ethical critique.

In recent years, casuistry, a case-based method of moral reasoning, has reemerged as an alternative to the abstract, theory-driven application of principles.[49] The emphasis on concrete details of cases, analogical reasoning, appeal to paradigm cases, and the moral discernment that guides particular judgments is salutary for bioethics. There is no fundamental incompatibility, however, between principlism and casuistry, and when deployed in practice, these approaches tend to converge.[50] On one hand, because cases do not speak morally for themselves, casuists must invoke general moral norms in interpreting and analyzing cases.[51] On the other hand, the application of a theory of general bioethical principles to specific cases calls for a process of *specification* and *balancing* that involves attentiveness to circumstances and context.[52] The convergence between principlism and casuistry is perhaps best illustrated in Baruch Brody's *Life and Death Decision Making*, which applies a pluralistic theory consisting of a diverse variety of general "ethical appeals" to forty challenging cases.[53]

At a deeper level, principlism and casuistry share a common model of moral problem solving, which we call the "judgment model." In the judgment model, the facts of a case are given, and a moral dilemma or quandary is posed. After the ethical issues at stake in the case are identified, the task for ethical thinking is to invoke general principles, or to reason by analogy and appeal to paradigm cases. In either approach, the aim is to reach and justify a judgment about what is the right or wrong thing to

49. ALBERT R. JONSEN & STEPHEN TOULMIN, THE ABUSE OF CASUISTRY: A HISTORY OF MORAL REASONING (1988).

50. Tom L. Beauchamp, *Principlism and its Alleged Competitors*, 5 KENNEDY INST. ETHICS J. 181, 191 (1995).

51. *See* John D. Arras, *Getting Down to Cases: The Revival of Casuistry in Bioethics*, 16 J. MED. & PHIL. 29-51 (1991).

52. *See* BEAUCHAMP & CHILDRESS, *supra* note 47 (arguing that specifying and balancing principles are both required in order to achieve resolution of moral problems).

53. *See generally* BARUCH A. BRODY, LIFE AND DEATH DECISION MAKING (1988).

do in the situation. The focus in the judgment model is on making and defending an ethically correct decision about the moral dilemma from a detached perspective of ethical judgment.

In contrast, clinical pragmatism, inspired by Dewey's philosophy, adopts a "process model" of moral problem solving. In this model, the facts of the case unfold and are assessed in a dynamic process of inquiry aimed at providing a satisfactory resolution to a morally problematic situation involving the care of a specific patient. The task is to develop and negotiate an intelligent and ethically appropriate plan of action for the engaged participants. The process model of moral problem solving is inherently dynamic; it concerns interactions between clinicians and patients (or surrogates) in a relational process with a trajectory extending into the future. Moral valuation is combined with clinical assessment and problem solving. Accordingly, moral judgments are oriented and adapted to the ongoing project of planning for the care of patients. This model attends to the interpersonal process of moral problem solving, as well as to the substantive decisions about the proper action to take.

Understanding this method of ethical inquiry as clinical and scientific, does not indicate that the definition and resolution of moral problems are merely matters of technical expertise. Satisfactory moral problem solving in the care of patients requires empathic understanding, dialogue, and negotiation between professionals and lay persons. Similarly, by adopting a process model of moral problem solving, clinical pragmatism does not endorse, as normative, prevailing patterns of clinical practice. The Deweyan ideal of democracy as a way of life operates as a guide to ethical critique and reform of clinical practice.

Following Dewey's theory of inquiry, moral problem solving in clinical practice proceeds by a number of logically connected steps. To demonstrate and evaluate this method requires detailed examination of cases that pose moral problems.[54] We confine our attention here to a schematic outline of the method of clinical pragmatism.

Case analysis begins with assessing the patient's situation: i.e., determining what is going on morally. The ethically relevant considerations at

54. *See, e.g.*, Joseph J. Fins et al., Clinical Pragmatism: A Method of Moral Problem Solving for Clinical Practice (case analysis submitted for publication, on file with author) (providing a detailed case analysis using the method of clinical pragmatism); Fins & Bacchetta, *supra* note 8 (providing a foundation upon which the authors build their approach); John C. Fletcher et al., *A Case Method in Planning for the Care of Patients*, *in* INTRODUCTION TO CLINICAL ETHICS 19-34 (John C. Fletcher et al. eds., 1995) (providing additional foundation upon which the authors built their approach).

stake in the evolution of the case must be identified and critically evaluated. The assessment includes the following: relevant medical facts; the life situation of the patient; the patient's capacity to make health care decisions; the beliefs, values, preferences, and needs of the patient; the impact of the care of the patient on family members and others intimately concerned with the patient; institutional arrangements that may be obstructing shared decision making; the perspectives of involved clinicians; and relevant moral, legal, and institutional norms.

The next step in problem solving is to determine the appropriate goals of medical care, taking account of the existential and clinical dimensions of the situation under inquiry. Many moral problems in the care of patients arise from a truncated process of setting goals. For example, in the hospital setting, clinicians may presume that the appropriate goal is to intervene aggressively to seek a cure, or to prolong life. Focusing on particular organ systems rather than the patient as a whole, and operating in conformity with the often implicit imperative to treat whatever is treatable, clinicians may concentrate inquiry on the technical aspects of medical decision making without paying due attention to the goals of treatment and care.[55] Alternatively, clinicians who seek to limit aggressive intervention for patients who are terminally ill and incapacitated may press family members to agree to a plan of forgoing resuscitation in the event of a cardiac arrest before the surrogate decision makers have been prepared adequately for the imminent death of the patient. To the extent possible and desired, patients or surrogate decision makers should collaborate in the task of setting and negotiating goals. This requires a climate of open, patient, and empathic communication to facilitate adequate understanding of the patient's condition, and to prepare the patient or surrogate for meaningful participation in the medical decision-making process.

Deliberating about how to resolve the problem centers on arriving at a clinically and ethically appropriate plan. Alternative courses of action are considered and assessed in the light of their anticipated consequences. Both clinical and ethical considerations are integrated in this process of deliberation. Appeals to clinical judgments, of what is medically indicated, and to moral judgments, that invoke principles, operate in tandem as hypothetical directives that guide the process of problem solving, not

55. HOWARD BRODY, THE HEALER'S POWER, 150-53 (1992).

as trumps that dictate decisions.[56] Deliberation leads to a decision about what to do, understood as an experimental intervention aimed at achieving a satisfactory resolution of the problem. The plan is implemented, results are evaluated, and modifications made as needed.

Clinical pragmatism understands moral problem solving as proceeding according to the same method of inquiry as clinical problem solving. The focus of clinical inquiry is widened to include ethical reflection, analysis, and deliberation in order to solve moral problems in the care of patients. Clinical pragmatism also reconstructs ethical thinking in the process of integrating it with clinical problem solving. In this process model, moral judgment, like clinical judgment, centers on the details of concrete problematic situations in the context of planning for the care of patients. The resources of ordinary morality and ethical theory—moral intuitions and sentiments, principles, rules of obligation, rights, and virtues—are treated hypothetically as tools to guide problem solving. By integrating ethical and clinical thinking, the method of clinical pragmatism is serviceable to clinicians and ethicists.

There are some affinities and significant differences between clinical pragmatism and the approach taken in *Clinical Ethics*, a text which makes an admirable effort to integrate ethics into clinical practice.[57] It is meant to be useful to clinicians at the bedside, as indicated by the subtitle, "A Practical Approach to Ethical Decisions in Clinical Medicine." Unfortunately, it serves more in providing physicians with handy answers intended to be authoritative for resolving ethical dilemmas rather than formulating or illustrating a method of ethical problem solving. The four orienting topics of this approach, indications for medical intervention, preferences of patients, quality of life, and socioeconomic factors, are indispensable for ethical inquiry in clinical medicine. Nonetheless, by separating the text into chapters organized around each of these topics, the authors do not clarify how these and other ethical considerations work together in the concrete process of inquiry and problem solving. In addition, the authors' "practical approach" addresses moral problems within prevailing standards of clinical practice. Although this approach recognizes the principle of respect for patients as persons, the text's model of the physician-patient relationship retains features of physician dominance and patient management. The physician is responsible for treatment

56. Franklin G. Miller, *The Concept of Medically Indicated Treatment*, 18 J. MED. & PHIL. 91, 95, 98 (1993).

57. *See* ALBERT R. JONSEN ET AL., CLINICAL ETHICS: A PRACTICAL APPROACH TO ETHICAL DECISIONS IN CLINICAL MEDICINE (2d ed. 1986).

planning and decision making, subject to the acceptance or veto of the competent patient. *Clinical Ethics* concentrates on the responsibility of physicians for providing ethically appropriate care of patients and resolving moral problems that arise in clinical practice. The roles of nurses, social workers, and other clinical professionals are not addressed. Reform of clinical practice in the light of a democratic ideal of participation, dialogue, and negotiation is not articulated as a goal in this approach to clinical ethics.

In introducing clinical pragmatism, via an overview of the thought of John Dewey, we have concentrated on the pragmatic method of inquiry and the democratic model of relationships in health care. These two components should be understood as working together. Ethical inquiry, because it concerns shared problems in social contexts, is a cooperative, communal activity. The good constructed by means of inquiry is an interpersonal or social good. The values of those concerned with shared problems need to be accounted for and appraised in inquiry. Construction of a shared, common good—a good that a number of concerned individuals associated together join in constructing—links ethical inquiry with democracy as an ideal. The democratic model provides the ideal context within which inquiry and planning for the ethically appropriate and good care of patients takes place. Therefore, inquiry concerning what is good for patients should, to the extent possible and desired, be done *with* the participation of patients. A process of communicative interaction and negotiation characterizes both the pragmatic method of inquiry and the democratic model. In the democratic model, clinicians and patients collaborate through shared inquiry and problem-solving and ongoing dialogue to construct good clinical practice.

Clinical pragmatism also has implications for relationships between health care providers. In particular, the way in which physicians, nurses, and other health professionals interact merits examination and reconstruction in the light of both the pragmatic method of inquiry and the ideal of democracy as a way of life. A focal point of analysis and reform is the collaboration between physicians and their clinical colleagues in ethical deliberations concerning planning for the care of patients and in implementing and evaluating clinical interventions. Clinical pragmatism presents a perspective on clinical ethics applicable to all clinicians, with respect to both professional activities and interprofessional cooperation.

VII. CONCLUSION

Clinical pragmatism aims to integrate clinical and ethical thinking by means of an approach to moral problem solving drawn from a Deweyan conception of scientific method. Rather than a method for bioethics experts asked to render judgments on perplexing moral quandaries, clinical pragmatism is a method for engaging practitioners, patients, surrogates, and ethicists in the task of promoting and implementing good clinical practice. In other words, clinical pragmatism adopts a *process* model of moral problem solving, instead of the *judgment* model characteristic of principlism and casuistry. Clinical pragmatism guides moral problem solving within the dynamic interactive processes of relationships among clinicians, and between clinicians and patients. It offers an ethical approach to assessing, negotiating, and implementing decisions connected with the context of ongoing planning for the care of patients. Furthermore, clinical pragmatism is oriented in terms of a democratic ideal. It urges both the integration of ethical and clinical problem solving, and the reform of clinical practice in the light of the ideal of democracy as a way of life.

In other essays we intend to illustrate concretely the merits of the pragmatic method of inquiry for resolving moral problems in the care of patients and to flesh out the democratic model. Following Dewey's commitment to integrating theory and practice and social reconstruction, we plan to address strategies for implementating the method and the model. Dewey saw education as a major instrument of social reform. We will examine how clinical pragmatism can be taught to medical and nursing students and to clinicians with the aim of integrating ethics into clinical practice. In addition, the relationship of clinical pragmatism to other types of ethical theory, including utilitarianism, situation ethics, casuistry, and "principle-based common morality theory,"[58] deserves detailed examination. Accordingly, we have issued a significant promissory note, which we hope to redeem, with suitable pragmatic "cash value" in the future.

58. *See generally* BEAUCHAMP & CHILDRESS, *supra* note 37, at 100 (establishing "principle-based, common-morality theories" as the label used to describe the authors' approach to ethical theory and comparing principle based theories to other theories).