

Albert R. Jonsen: one of the most important pioneers of Bioethics and Clinical Ethics. An historical portrait

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Abstract. Starting from his most significant books “The Birth of Bioethics”, “The Abuse of Casuistry”, and “Clinical Ethics”, the article aims to trace a short but exhaustive historical-scientific itinerary on the work of Albert R. Jonsen, who is considered one of the “Founding Fathers” of contemporary Bioethics and Clinical Ethics. The outlined biographical path serves as a guide to the reflection on the peculiar characteristics of the first true clinical bioethicist, really in contact with patients and health care professionals. Furthermore, the essay offers an overview on his most significant contribution in the history of bioethical thought: the definition of the Neocassistic method in Clinical Ethics.

Key words: Albert R. Jonsen, bioethics, clinical ethics, casuistry, medical ethics

Introduction

Starting from the analysis of Albert R. Jonsen’s main text “The Birth of Bioethics” (1), our work aims to outline the history of clinical ethics by focusing on the personal and professional path of one of the main authors of contemporary Bioethics.

A.R. Jonsen’s main contribution to clinical ethics is the development of a specific *method of analysis of cases* and ethical issues of biomedicine. Therefore, focusing on his work is highly important for those who are involved in Clinical Bioethics.

Moreover, this topic should be interesting for those who deal with the History of Medicine, Bioethics, and, especially, Clinical ethics “at the bedside of the patient”. In fact, a precise reference to the “practical” treatment of the ethical problems generated by contemporary techno-scientific development always emerges from Jonsen’s production.

Jonsen’s relationship with Medicine cannot be separated from a careful analysis of his academic and

personal biography. In fact, his thought has been influenced by “fatal” meetings both with prominent theologians, philosophers and jurists interested in moral issues brought by technological and scientific progress, and with doctors who are sensitive to ethical aspects connected with their daily activity.

Thanks to these meetings, he started to deal with the moral problems bounded up with Biomedicine and the concreteness of medical practice, both at a more general level, through his work with government commissions, and from a specific point of view, through the exercise, initially “pioneering”, of ethical advice - clinical real within the hospital wards.

Albert R. Jonsen is universally considered one of the “fathers” of American Bioethics and the main promoter, together with his colleague Stephen Toulmin (2), of the recovery of the *Neocassistic method* as a model of approach to ethical reasoning in the clinical field.

This work consists of a thorough examination of the theoretical path offered by the main author and

advocate of Neocastics. Through Jonsen's reference texts the research outlines the fundamental aspects of the origin and development of his model and of the consequent interpretation given to ethical issues meant as subject of investigation of Bioethics as a discipline.

The general profile of the Author wants to focus on Jonsen as *clinical bioethicist*, on his role as a pioneer and active player in the development of Bioethics. In this way, Bioethics can be regarded as a science with an autonomous status and its own fields of investigation.

Albert R. Jonsen, bioethicist in "The Birth of Bioethics"

Albert Jonsen (3) is currently co-director of the Program of Medicine and Human Values at the California Medical Center in San Francisco. He is also Emeritus Professor of Ethics and Medicine at the Faculty of Medicine at the University of Washington, where he was Director of the Department of History of Medicine and Ethics from 1987 to 1999.

His text, *The Birth of Bioethics*, begins with a short overview on his personal history. It is indeed very interesting to see which biographical and academic aspects are considered by Jonsen himself as those that led him to approach Clinical Ethics. Great contributions came both from the accurate theological-philosophical knowledge acquired over time, and by acquired over time, but also by meetings and collaborations with other scholars, who often suggested new and additional ideas for research.

At the age of 18, feeling called to the Catholic priesthood, he entered the Jesuit seminary at the Gonzaga University of Spokane, Washington, and the Santa Clara University of California (4).

After having obtained the Master's Degree in Philosophy, with a study on Aristotle, Thomas Aquinas and Maritain, he taught Philosophy at the same Jesuit College for 3 years, as he went on with his theological studies.

He was then ordained in 1962, and his superiors - Jonsen writes - accepted his request to deal with religious Ethics in an ecumenical context. Therefore, in 1967, he obtained a doctorate at the Department

of Religious Studies of the University of Yale, with a thesis on "Responsibility in contemporary religious ethics", published in 1971 (5).

Jonsen admits in that period the interaction with his professor of Theology at Yale, James M. Gustafson, constituted his first contact with the themes concerning Bioethics. Gustafson was not only an ecumenical theologian, expert both in Protestant and Catholic Theology, but also one of the first to deal with the cultural context which was emerging along with the progress of the biomedical sciences, with particular interest to genetics and neurosciences (3-6).

In his "The Birth of Bioethics", Jonsen clearly recalls the two crucial "meetings" which led him to deal with bioethical themes. The former was with F. Patrick McKegney, director of the psychiatry department of the Yale-New Haven hospital, the latter with Englebert Dunphy, prominent surgeon at the University of San Francisco. After the presentation of the contents of his PhD thesis, Jonsen was asked by Dr McKegney: "You have read and written everything that exists on this subject, Ethics; why don't you come to the hospital now, so I will show you how ethical problems actually present themselves in concrete reality? Jonsen accepts his proposal and for two months, he followed a sort of "internship" in the hospital where Dr McKegney worked. Thanks to Dr McKegney, the theologian Jonsen had to face the first ethical practical questions concerning biomedicine. For example, if the "suicide from dialysis" can be considered a suicidal mania, a psychopathology or, given the condition of a long dependence on the aid of a life-saving support, we must consider differently the request made by some patients to "turn the machines off" and to be left to die (3).

Jonsen is thus "forced" to deal with ethical problems connected to dialysis as a life-saving technology and to study the literature on the matter (3). Furthermore, he had to experiment in practice the observation of cases, even through his actual presence. This will turn out to be a fundamental aspect of all his subsequent professional career.

The meeting with Dr. Dunphy took place in 1969, after a period spent in Paris, where Jonsen studied at Institut Catholique, and in Rome, where he attended the Gregorian University. Back to US, he

was appointed professor of Theology and Moral Philosophy at the University of San Francisco.

Dr. Dunphy invited him to get involved with the ethical problems created by kidney transplantation (7), which included the thorny question of the choice of criteria for proceeding with the allocation of organs. Dunphy asked Jonsen his opinion about the legitimacy and acceptability of the Harvard medical School proposed definition of death (8,9), in relation to the possibility of carrying out or not the kidney transplant. In fact, the University of San Francisco Medical School had constituted an ad hoc committee, to evaluate what was elaborated by the Harvard Commission, and Jonsen agreed to be member of it as a consultant. In this way, Jonsen really began to deal with Clinical Ethics.

Jonsen says:—My “internship” with Dr McKegney in the wards of the New Haven Hospital in Yale, my service as a consultant to the Committee on Brain Death at the University of San Francisco have begun my “transformation” *from an ethicist to a bioethicist* (3).

Officially, Jonsen started his career as bioethicist, with a title and a proper salary, back in spring 1972, when Dr. P. R. Lee, Chancellor of the Medical Center of the University of California in San Francisco, invites him to spend a period (which would have lasted a full year) at the new Institute of Public Health, as a “Visiting Professor” (3).

This opportunity was so significant for his training that, as Spinsanti points out (5), it marked a real turning point in Jonsen’s professional career. In fact, he had the opportunity to follow the courses of medical students, to be involved in visits, discussion of cases and even autopsies. Furthermore, he had the opportunity to listen, which turned out to be even more important

Not coincidentally, Jonsen summed up his own career as a clinical bioethicist under the programmatic motto “Watching the doctors” (10). By looking at and listening to doctors at work, Jonsen realized that a new way of doing Ethics was necessary, in comparison with the one taught in the faculties of Philosophy or Theology.

He was immediately struck by an aspect that would have played a key-role in the development of his thinking: doctors deal with *cases*, and in each case

specific circumstances have a decisive importance. Moreover, speculative and abstract approach seldom matches the way health professionals normally deal with biomedical issues. Therefore if Ethics wants to fulfil the healthcare task, it must be characterized by an academic discipline model and must deal with actual cases.

Thanks to practical experience, Jonsen also realized that ethical issues have a temporal dimension that is not so evident by considering a situation from a theoretical point of view, circumstances may change as time goes by, even significantly. Jonsen explains that when doctors say: “Let’s wait and see”, they don’t seek an excuse, postponing to avoid facing problems; they are simply recognizing that, with the passing of time, the problem can occupy in a different way.

In the interview given to Spinsanti, Jonsen pointed out that the difference between academical Ethics expert and health professionals lies in way they manage a clinical case: each healthcare intervention the case, involves risks, requires comparative assessment of the benefits. On the other hand, the speculative thinker is not called to get involved with he single case. The Ethics expert who instead accepts to be involved in the clinic aspects has an intermediate position: he is sensitive to the management of the case and must speak the language of the clinicians alongside whom he works, but must avoid abstract discussion or long explanation of the principles, to grasp the significant particularities and characteristic circumstances that specify the present concrete case (10).

At the end of 1972, UCSF School of Medicine Dean Dr. J.R. Krevans, appointed Jonsen associate professor, entrusting him with the chair of Bioethics of the Faculty of Medicine. He taught here until 1987, when he moved to the University of Washington Department of History of Medicine and Ethics of the Faculty of Medicine.

Jonsen joined the clinical staff of the UCSF, as an expert in Ethics with the specific function of consulting (“to be a consultant”), which was a task still to be invented.

He explained that holding the position of professor of Bioethics was equivalent to being considered as “a strange, singular creature”, as he was the

first ethicists who joined the Faculty of Medicine. Furthermore, on those times Bioethics did not have an independent status, at the point that the real meaning of the term “Bioethics” was very debated, as it was still object of study (3).

This is the reason why Jonsen is considered one of the “pioneers” of the development of the Bioethics. As he himself points out “I became a bioethicist, when Bioethics was just born” (3).

Along the years he spent as a consultant ethicist, Jonsen developed the conviction that dealing with Clinical Ethics involves assuming indications of content and method requirements that make it profoundly different from that elaborated on the basis of abstract principles, even if of a high ideal profile, as happens in Catholic moral reflection.

Jonsen was also influenced by the case study methodology developed by the Business School of Harvard University, where he attended summer courses organized by Administration and Education programs, drawing the conviction that the case study method was also applicable to Clinical Ethics.

“Clinical Ethics”: the Neocasistic method of Clinical Ethics

In 1982, Jonsen published “Clinical Ethics. A practical Approach to Ethical Decisions in Clinical Medicine” (11), written in collaboration with two other leading scholars, Mark Siegler (12) and William Winslade (13).

It is important to remind that the three authors brought their own professional skills: Siegler as a doctor, Winslade as a lawyer and Jonsen as a theologian.

This work aimed to bring Ethics back into its own context, i.e. the clinical one, offering a method to consider several options in the management of similar problems, which present difficulties both from a clinical and ethical point of view.

The edition we are considering (i.e. the fifth), clearly states that the text is not only meant for clinicians and students who directly deal with the patient, but also for other professionals such as hospital administrators and lawyers, members of institutional Ethics committees, quality control officers, health

plan managers. All those, in short, whose work requires an awareness and sensitivity to the issues of clinical practice, and who have the responsibility of preserving the ethical dimension as an essential element to offer a quality health service (14).

According to the proposed method, cases have a key-role: not only border-line cases, which are of course interesting or spectacular, but also those that doctors and health professionals deal with every day in clinical practice.

For this point of view, Clinical Ethics consists in the identification, analysis and solution of moral problems that arise in the care of a patient. In fact, moral concerns cannot be separated from the medical ones. Ethical judgement is not separable from the clinical judgement, indeed, it relies on it (15).

The focus of the book is an attempt to offer a good methodology to examine clinical cases from an ethical point of view. The proposing method aims to help bring out the complex interweaving of ethical, emotional, social and economic elements offered by each case, and that must be accurately taken into account to make a good ethical-clinical decision.

Their attitude is even more explicit when they point out that their work wants to be different from other essays on the same topic. On one hand, many books on Health Ethics analyze several cases by considering classical principles such as respect for autonomy, charity, the principle of non maleficence; on the other hand, other books focus on particular and/or exceptional issues like the suspension of vital support treatments and various types of informed consent.

Jonsen clarifies that applying the neocasistic methodology to approach the moral problems emerging in cases of Clinical Ethics (16) means to conduct in a practical context, the three fundamental “steps” of the *casuistic reasoning*. This was rediscovered in his book analyzing the casuistry tout court in the history of theological-moral thought.

In case reasoning, Jonsen writes that the solutions of analyzed cases are compared with paradigms of similar cases, in which the relationship between the involved moral principles and the individual circumstances suggests the same obvious conclusions. The comparison between similar cases is called reasoning by analogy (16).

The fundamental reference is to the so-called paradigmatic cases, which provide initial presumptive or probable indications. By analyzing similarities and differences with the case under examination, and in the absence of exceptional circumstances, the probable indications acquire conclusive value for the exercise of moral judgment, which takes place by analogy.

Jonsen argues (16) that the reasoning by *analogy* is clearly different from the typical deductive method of the Bioethics of Principles, which proceeds rigidly from the premises to its logical conclusions. Moreover, Jonsen explains that the analogical elements are not concepts, but the features of the actually considered situation.

Given this basic theoretical “premise”, in Clinical Ethics Jonsen, Siegler and Winslade presented the neocassistic method applied to Clinical Ethics as consisting, essentially, of three phases in succession:

1. Exposure of the clinical case;
2. Commentary on the case;
3. Moral advice or recommendation.

The exposition of the case must report all the information of the patient’s clinical history, starting the main symptoms present, the recent and the remote pathological history, the family and social history, the results of the objective tests carried out, the laboratory data that led to the diagnosis and allowed to formulate an adequate treatment plan. Besides, the examination of the existential, psychological, emotional, socio-cultural conditions of the patient and his or her family are meaningful elements in order to outline clinical path. Of course, the patient’s choices should be shared as much as possible.

The second moment is that of the “moral” commentary.

The commentary is based on four categories, four criteria the authors suggest to analyze for each clinical case, especially if it raises some ethical dilemma. In fact, as Jonsen writes, they constitute the load-bearing structure and essential characteristics of the relationship between doctor and patient. Furthermore, they are the key elements of the cases that constitute the “content” of Clinical Ethics (14).

They are:

1. Medical indications;
2. The patient’s preferences;

3. Quality of life;
4. Contextual aspects, such as the social, economic, legal and administrative context.

Medical indications: are all information about the diagnosis, prognosis and treatment of the medical problem of the patient. They must be the object of ethical discussion, as they must be considered for their possibility of benefiting the patient and respecting his preferences.

Patient preferences are value judgements expressed by the patient regarding the assessment of the risk/benefits of any medical treatment, They are based on the patient’s background regarding personal, religious and moral beliefs.

Quality of life: this criterion refers to the current living conditions of the patient. It concerns both the quality of the current condition and his or her existential condition, i.e. the ethical judgment of the individual about the quality of his or her real psychophysical state.

The contextual aspects are the set of interpersonal relationships, institutional, financial and social situations that can influence positively or negatively the care of the patient. In the same way, the context in which the patient is placed is influenced by the decisions taken by or on the patient. In fact, any decisions that may have a psychological, emotional, financial, legal, scientific, educational or religious impact on others. These aspects must always be examined and evaluated because they could be of crucial importance for the profiling and resolution of the ethical problem emerging from the case (14).

The Authors state that although individual cases may differ from each other, these criteria are always relevant, help to organize the data. At the same time, they draw attention to ethical principles that are appropriate to the specific case, thus “represent a systematic method to identify and analyze ethical problems that occur in clinical medicine”.

The four criteria would allow the clinician to understand the connection between ethical principles and the circumstances of the individual clinical case. When it is analyzed, “the different circumstances are placed in all four categories and affect the meaning and relevance of the ethical principles involved” (14).

By examining the four criteria together, clini-

cians can verify how the principles and circumstances, as a whole, define the ethical problem of a specific case and what resolution they suggest. Therefore, the formulation of a good ethical-clinical judgment consists in assessing how ethical principles should be interpreted in the actual situation that occurs in daily practice.

Gracia (15) also points out that these criteria have an explicit reference link with the Belmont Report Principles, as the medical criteria are usually based on the principle of charity, on the patient's preferences over autonomy, on the quality of life over welfare, on the contextual aspects on the principle of justice or social equity.

Jonsen, Siegler and Winslade clearly state that the four criteria can be considered "road signs", which guide the clinician through the complexity of real cases. Thanks to them, healthcare personnel can assess how much a real ethical case falls within the more general understanding of similar situations, and then create an appropriate opinion on it (14).

The four criteria can also be helpful during meeting among operators, patients and families at the time of hospitalization.

The essay is then divided into four chapters, each of which explores a criterion through the definition of the main related bioethical concepts that may affect it. The volume then illustrates typical cases in which the specific criterion plays a decisive role and, finally, critically examines the arguments commonly offered to solve the problem.

The four clinical cases used in the text as main examples are patients who have been given the fictitious names of Mr. Cure, Mrs. Care, Mrs. Comfort and Mr. Cope (11). Of course, the names have been chosen to suggest some typical aspects of their health condition. In this way, the reader can find the additional variables that allow to consider the elements that are introduced to express a possible ethical assessment of the problems arisen by the considered situation. For example, the case of Mrs. Care allows the authors both to ethically analyze the problem of care for the final patient and to define when a medical intervention can be considered futile in medicine. In this case, the Authors point out that the woman is in the condition of being close to the end. The "physi-

ological futility", compared to her clinical condition, would be a sufficient ethical reason for the doctor to propose the suspension of all interventions, except those that provide some relief to the patient.

Just to better explain, if we consider the Italian debate, the proposed solution could be regarded as too extreme. Nevertheless, we should focus on the adopted methodology, which provides the most exhaustive presentation of the typical case and which can thus offer a broader reading of the several ethical issues that a specific case can introduce.

Finally, the third methodological "step" is the real moral advice. Gracia (15) states that is the most problematic aspect, because advising on the importance of facts, opinions and circumstances from the ethical point of view is very demanding.

According to the Authors, ethical priority should be ideally given to the preferences of the patient, followed by medical indications. If, for any reason, the patient's preferences are unknown (e.g. in the case of the vegetative state) and medical indications are not so clear, it would be necessary to resort to the other two criteria and even to change the order of priority. However, the text also aims to "set out the way in which this order can be altered in particular cases, so that the factors that we have placed at the bottom (quality of life, contextual factors) are of the greatest importance" (15).

Through the use of the proposed method, it is thus possible to determine evaluative judgements, clarifying whether a fact should be considered relevant, important or decisive.

Relevant simply means that a consideration plays a role in the deliberation of an ethical problem: therefore, it should not be discarded as "inadmissible evidence" (...)

If a consideration is relevant, it may have varying degrees of importance. Its greater or lesser importance can sometimes be assessed intuitively. If not, it will be necessary a careful analysis of the reasons for or against. (...) After a careful analysis of its implications and of other values, an important consideration can be finally considered decisive when the scale decides in favour of a particular choice.

A consideration is said decisive when, after having analyzed all the other relevant and important

considerations, it turns out to be of greater importance.

Of course, what is to be considered decisive is debatable, but we believe that in many clinical situations a wider consensus can be achieved through the careful analysis of relevant and important considerations (15).

The Authors are thus able to clarify the meaning of descriptive terms by defining the concept of “permission” and “mandatory” in relation to practical actions that may or may not be implemented in clinical reality.

An action is allowed when, after a sufficient analysis, it is not possible to find decisive considerations. The alternatives of choice will be offered by the important considerations, in which case the choice of the person cannot be forced towards one or the other of the alternatives. When there is a decisive condition in favour of the alternative, we consider that this alternative is compulsory. Therefore, we seem to be allowed to detach a person in a permanent vegetative state from the respirator. And it is compulsory, in our opinion, to respect the refusal of treatment (except for very concrete circumstances) of a patient who is competent or capable of understanding and wanting (15).

The same curator of the Italian edition of the text, A.G. Spagnolo, points out that “you can not help but appreciate the methodological aspect, more than the content of the specific decisions, which is the main merit of the work. Even wisdom and common sense emerge from the majority of the proposed conclusions, which do not come from pre-established ideologies, but from the actual analysis of the case, where the direct and empathetic involvement of the Authors always emerges” (14).

Spagnolo hopes that the clinicians read the whole essay in order to acquire a good understanding of the method, before adopting it for the management of their clinical cases. He adds that, as far as Italian Bioethics is concerned, the text is both a useful aid for Bioethics teaching in the Faculty of Medicine and Surgery and to Health Professions and as a methodological tool for ethics committees and for ethical advisors who will deal with ethical advice in clinical practice (17-9).

Conclusion

In short, our analysis aim to prove that A. R. Jonsen’s contribution has been fundamental to point out the need clinical bioethicists in health care structures. In fact, bioethicists can complement and support the task of healthcare personnel, thanks not only to philosophical skills and to the knowledge of a solid *methodology* but also to the attention to the variability of real cases. This would allow a high standard patient care, which is not only desirable, but possible.

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