

# Decision making in clinical bioethics: casuistry and moral deliberation

Elma Zoboli

## Abstract

In the ethical problems in clinics it is required to appreciate the situation through the use of organized and systematized procedures to assess the situation for decision-making, in order to decrease the typical uncertainty areas of the conflicts of values and duties found in clinics and to reach practical, wise and responsible resolutions. There are several procedures for decision making in clinical bioethics. The article presents the casuistry and deliberation. The aim is to describe the methods based on the publications of its proponents. Both procedures begin with the understanding of the clinical case and consider in the proposed resolution the circumstances and peculiarities of each situation without losing sight of the objective image of ethical duties.

**Key words:** Bioethics. Decision making. Ethics, clinical. Ethics committee. Ethical analysis.

## Resumo

### Tomada de decisão em bioética clínica: casuística e deliberação moral

Nos problemas éticos da clínica é preciso apreciar a situação com o uso de procedimentos sistematizados e organizados para a tomada de decisão, visando diminuir as áreas de incerteza características dos conflitos de valores e deveres descobertos na clínica e chegar a resoluções práticas, prudentes e responsáveis. Há vários procedimentos para a tomada de decisão em bioética clínica. O artigo apresenta a casuística e a deliberação. O objetivo é descrever os métodos a partir de publicações de seus propositores. Ambos os procedimentos têm início com a compreensão do caso clínico, considerando nas resoluções as circunstâncias e peculiaridades de cada situação sem perder de vista a imagem-objetivo dos deveres éticos.

**Palavras-chave:** Bioética. Tomada de decisões. Ética clínica. Comissão de ética. Análise ética.

## Resumen

### Toma de decisiones en bioética clínica: casuística y deliberación moral

En los problemas éticos de la clínica es necesario evaluar la situación con el uso de procedimientos sistematizados y organizados para la toma de decisión, con el fin de disminuir las áreas de incertidumbre típicas de los conflictos de valores y deberes descubiertos en la clínica y llegar a resoluciones prácticas, prudentes y responsables. Existen varios procedimientos para la toma de decisión en bioética clínica. El artículo presenta la casuística y la deliberación. El objetivo es describir los métodos desde las publicaciones de sus proponentes. Ambos procedimientos comienzan con la comprensión del caso clínico, considerando en las resoluciones las circunstancias y particularidades de cada situación, sin perder de vista la imagen objetivo de los deberes éticos.

**Palabras-clave:** Bioética. Toma de decisiones. Ética clínica. Comités de ética. Análisis ético.

---

**Professor** elma@usp.br - University of São Paulo, São Paulo/SP, Brazil.

## Correspondence

University of São Paulo, Department of Community Health Nursing. Av Dr. Eneas de Carvalho Aguiar, 419, Cerqueira César ZIP 05403-000. São Paulo/ SP, Brazil.

---

The author declares no conflict of interest.

The ability to make decisions on ethical issues is essential to professional excellence and health care quality. It is only said to be excellent the assistance that combines technical accuracy and responsibility in decision-making ethics. Ethical, as well as clinicians, judgments cannot disregard the actual conditions and specific circumstances of each context.

With regard to the clinic's ethical problems, it is not enough to appeal to intuition or common sense, as the uncertainty is a characteristic of these situations and their solutions are likely and revisable. Thus, it is best is to appreciate the particular circumstance, with the use of systematic procedures for decision-making in ethics – which will assist professionals in the through assessment of the situations, reducing areas of uncertainty and ambiguity, and enabling them to decide in a prudent and responsible manner.

There are various procedures for decision-making in clinical bioethics. In the hands of a few people they all work well, as with other people any of the following works. Usually, these people are the ones that apply the methods mechanically, without perceiving them and considering the richness and complexity of their reality<sup>1</sup>. Professionals must choose the procedure which best suits to the reality in which they act.

This article presents two procedures for decision-making in clinical bioethics: the casuistry and the deliberation. The objective is to describe both procedures based on their proponent's publications. It would be appropriate to criticize the methods, but this is not the point of the article.

### Casuistry

Casuistry examines the ethical problems by equating procedures based on paradigms, analogies and expert opinions on the existence and severity of moral obligations in particular situations. Obligations are set out as general, not universal or invariable, rules and maxims, as they ensure good only under the typical conditions of the agent and the situation in focus circumstances<sup>2</sup>.

Casuistry's roots come from antiquity and its largest diffusion occurred during the Christian era, especially between 1550 and 1650. This method has not arisen as a procedure to solve ethical problems. Its use started between 1000 and 1200, when urbanization provoked social, economic, political and institutional changes which had brought out new cases of conscience. Casuistry, then, had become

widely used in the joint assessment of ethical principles and details of these cases.

In 1988, Albert Jonsen and Stephen Toulmin considered the validity of the casuistry for the ethical problems discussion in the clinic, as they understood that the typical ethical analysis, both from casuistry and from the doctors, are similar in the clinical practice<sup>2</sup>. It characterizes the casuistry: arrangement of cases per paradigm and analogy; appeal to maxims; circumstances analysis; opinions qualification; accumulation of arguments and conclusion with the ethical problem resolution<sup>2</sup>.

Casuistry sorts cases into topics, by paradigm and analogy. Each topic refers to a principle. The topics begin with a key terms definition and continue with case examples, whose description includes: who, what, where, when, why, how and by what means. The first case illustrates the most obvious deviation, i.e. illustrates an extreme violation of the principle. This emblematic case is the "paradigm". The other cases, by analogy, move away from the paradigm by introducing circumstances combinations that make the affront less apparent.

In non-paradigmatic cases, conclusions are likely and not apodictic, since there is a single principle that guides the ethical problem solution. The conclusion's gradient of probability is based on the accumulation of justifications, motives and opinions that corroborates the conclusion, not the logical validity or consistency of the argument. The case analysis is ended with a solution and an advice as to the legality or permissibility to act in one way or another. In the resolutions there are alerts: *under these circumstances, given these conditions, you can fairly safely act in such way or doing this way, you will not act hastily or unadvisedly and can only be in good conscience*<sup>2</sup>.

In casuistry, the ability to recognize details and relevant characteristics of the case is what matters most to the resolution of ethical problems. The ability to recognize the action circumstances and the agent conditions weigh more than the previous domain of principles, concepts and axioms. These are referred to as they arise in the cases discussion, since in the casuistry rules and moral principles are appraised in the specific context and actual circumstances of cases – not in abstract discussions. This does not mean that professionals do not need to have common notions of ethics, standards of behavior and attitudes accepted or indicated in several different situations. They need to become familiar with the literature on ethics and to be competent in the casuistry analysis method application<sup>2</sup>.

The ethical understanding relies on the recognition of good and evil, right and wrong paradigms, as in typical cases of justice or injustice, cruelty or kindness, tell the truth or lie, whose merits and accepted attitudes are well defined. The ethical knowledge, rather than accepting universal propositions, is the ability to operate the ethical judgment with an eye for subtle and less obvious considerations that may be crucial in the implementation of rules and principles in situations. Ethical competence is the application of discernment and knowledge of the common notions of ethics in new cases.

### *Casuistry in clinics*

In the casuistry method application the clinical case discovered as an ethical issue is analyzed in terms of topics: medical indications, patient preferences, quality of life and economic factors – which is why this procedure is also known as the four boxes method.

The topics are the systematic way for the identification, analysis and resolution of ethical problems in clinics. The ethical analysis follows an orderly review of topics; that is, assessing the cases always begins by medical indications, followed by the patient preferences, quality of life, and ends with the situational aspects. This procedure allows the layout of relevant ethical facts in the case and the assessment of the need to obtain more information before the debate to solve the ethical problem.

The topic “medical indications” refers to clinical conditions and therapeutic interventions which are indicated for the patient. The first step in the ethical analysis of the case is a clear distinction of the intervention possible benefits, from the exhibition of clinical facts. The case analysis begins with the question: which are the medical indications for the case? and never by questions about the patient’s rights to refuse treatment<sup>3</sup>.

A proper understanding and analysis of ethical issues require careful presentation of the clinical case with complaints, patient status, injury’s nature, diagnosis, prognosis and therapeutic resources. The presentation purpose is to determine whether the objectives can be achieved with medical intervention. In casuistry, the medical actions objectives are: health promotion and disease prevention; relief of symptoms, pain and suffering; disease cure; premature death prevention; functional status improvement or residual functional maintenance; patient education and counseling; avoid injury to the patient during treatment<sup>3</sup>.

Many times, ethical problems elapse from the lack of clarity on the intervention objectives or the apparent incompatibility between them. Therefore, the case analysis begins by a realistic assessment of the medical indications objectives, which are clearly presented so that staff, patients and families understand the options available in the situation. Only after all intervention possibilities are clarified we move on to other topics.

The medical indications are then presented to the patient who will decide on them according to his preferences. The patients’ free and informed choice has an ethical, legal, clinical and psychological importance as their preferences are part of the clinical relationship’s core. The patient chooses based on indications and preferences. Knowing the patient’s preferences is essential for medical action, as the cooperation and satisfaction with the indicated intervention depend largely on how this meets the patient’s needs, choices and values.

It is considered the patient’s quality of life before the disease, with or without treatment, by estimating the desirable level, how to achieve it and its risks and benefits. Grievances affect peoples’ actual or potential quality of life and the fundamental objectives of medical intervention are recovering, maintaining or improving this level. It is not just a risk-benefit balance in a more immediate appreciation of the treatment’s refusal or acceptance implications; considerations about the quality of life analyze the long term consequences regarding patient’s life<sup>3</sup>.

The “quality of life” topic is the most delicate one, considering that it requires a rigorous and careful analysis and also attention not to incur distortion or prejudices. Thus, it is important to note: who does the assessment; with what criteria it is done and what type of clinical decision can be justified based on judgments about quality of life.

The external factors are the social, legal and institutional circumstances involved in the case, i.e., the context – which makes this topic also be called “contextual features”. At this topic it is necessary to be considered, among other aspects: professionals’ objectives; standards of care; community’s habits and praxis; legal rules; health policies; structure and terms of private health insurance plans; guidelines for biomedical research; training of health professionals; economic aspects; religious beliefs; educational level of the population. Contextual features influence medical care and this, in turn, affects the context, as decisions taken in each case have psychological, emotional, economic, legal, scientific,

educational or religious impact on third parties or institutions<sup>3</sup>.

The increasing mediation of clinical relationship by health insurance plans and public policies make the contextual features crucial or decisive to resolve the case. There is no general rule on the priority of contextual features, but it is taken into consideration that they cannot be prioritized over medical indications, patient references and quality of life, in that order. So that contextual features

can have decisive weight in the decision-making processes, achieving the objectives of medical intervention needs to be doubtful; patient's preferences needs to be unknown; patient's quality of life needs to be minimal; the contextual feature in question needs to be specific, clearly harmful to others and the decision needs to bring relief to this injury<sup>3</sup>. For each topic there are questions guiding the discussions and analysis of the case, as seen in Tables 1 and 2 below<sup>3</sup>:

**Table 1.** Questions about medical indications and patient preferences to analyze the case.

Medical indications	Patient preferences
1. What is the patient's medical problem? History? Medical diagnosis? Prognosis?	1. What is the patient stating about preferences for treatment?
2. Is the problem acute? Chronic? Critical? Emergent? Reversible?	2. Was the patient informed about the benefits and risks? Understood the information? Gave their consent?
3. What are the goals of treatment?	3. Is the patient mentally capable and legally competent? Is there evidence of incapacity?
4. What are the possibilities of success?	4. If competent, has the patient expressed prior preferences?
5. What are the plans in case of therapeutic failure?	5. If incapacitated, who is the appropriate surrogate? Is the surrogate using appropriate standards for decision making?
6. How can this patient be benefited by medical and nursing care?	6. Is the patient unwilling or unable to cooperate with medical treatment? If so, why?
7. How can harm be avoided?	7. In sum, is the patient's right to choose being respected to the extent possible in ethics and law?

**Table 2.** Questions about quality of life and contextual features to consider in the case

Qualidade de vida	Aspectos conjunturais
1. What are the prospects, with or without treatment, for a return to normal life?	1. Are there family issues that might influence treatment decisions?
2. Are there biases that might prejudice the provider's evaluation of the patient's quality of life?	2. Are there provider (physicians and nurses) issues that might influence treatment decisions?
3. What physical, mental and social deficits is the patient likely to experience if treatment succeeds?	3. Are there financial and economic factors?
4. Is the patient's present or future condition such that his or her continued life might be judged undesirable?	4. Are there religious or cultural factors?
5. How does the patient argue about renouncing treatment? Is there any plan and rationale to forgo treatment?	5. Are there limits on medical confidentiality?
6. Are there plans for comfort and palliative care?	6. Are there problems of resources' allocation?
	7. How does the law affect treatment decisions?
	8. Is clinical research or treatment involved?
	9. Is there any conflict of interest on the part of the providers or the institution?

After traveling through the four boxes of topics, there are other questions to be answered: *which is the ethical issue in the case, where is the conflict?; Is the case similar to others already found?; What is known about cases similar to this?; Are there clear precedents on the case?; Is it a paradigmatic case?; To what extent does this case approaches or differ*

*from the paradigmatic case?; Is the paradigmatic case's detachment or proximity important for the ethical analysis?; To what extent does the resolution of other cases depend on this one?*<sup>3</sup>. The casuistry analysis' path allows identifying the case's ethical problem and makes it possible to reach a practical solution in decision making.

## Deliberation

Deliberation of ethical problems is the consideration of values and duties involved in concrete facts in order to handle the situation of moral conflict, in a reasonable and cautious way, through discussions and decisions made using interpersonal dialogue. It aims to achieve prudent solutions and not only the ideal or right decision or the one maximizing results. This is because the deliberation rationality is not idealistic, pragmatic or utilitarian, but critical-hermeneutic<sup>1,4</sup>. This paper presents the proposal of Diego Garcia for deliberation in clinical bioethics.

### Moral deliberation

Deliberation is a systematized and contextualized itinerary to analyze ethical problems aiming to find concrete solutions among prudent alternatives. This analysis is not abstract, but it considers the circumstances of the act and its foreseeable consequences. The deliberation's goal is the courses of action which are prudent. In clinical bioethics, prudence is expressed in the ability to value what is involved in the case, with a view to reasonable decisions.

In deliberation, it is not a matter of dealing with ethical questions as a 'dilemma', confronting pro and con arguments to reach the course most likely to be correct. To reduce ethics to probability calculations is incompatible with deliberation<sup>5</sup>. In deliberation, professionals think together, share their perceptions; i.e. they bring into dialogue different moral senses. Different perspectives of reality are important to improve moral sense, as this is collective and not only individual<sup>6</sup>. The deliberative procedure is a resource to help sorting the discussions around ethical problems, through sequential steps<sup>6</sup>.

In clinical bioethics, an 'ethical issue' is a case in which values and also mandatory duties compete, and professionals don't know how to act. The ethical issue is discovered in the case as a conflict of values. There are clinical cases that bring no difficulties for professionals as the decision to make is clear. But there are other conflictive and contradictory cases, i.e. cases which are seen by the professional as ethical problems. When such a situation happens, it means he has a "direction paralysis"; he does not know what to do or how to act and needs aid, therefore something is "hammering" his moral conscience<sup>6</sup>.

The ethical issues hold moral outputs, courses of action; i.e., possible solutions to the case. These are always more than two – that is why we talk about ethical problems and not dilemmas. The possible outputs form a range, in whose extremes there are solutions which perform one of the values in conflict and annihilate the other. In the space between the opposite extremes there are located prudent outputs, embodying conflicting values to the maximum, or injuring them as little as possible<sup>6</sup>.

For example, when a patient refuses blood transfusion on religious grounds, the team immediately realizes the two extreme outputs: 'go on with the transfusion by force, in order to prevent the patient's death' and 'respect his decision and let him die'. These extreme outputs are not prudent, because they annihilate a value to save another. On one hand there are the values 'health' and 'life', which health care professionals usually choose. At the other pole of the conflict, there is the value: 'respect the patient's will'. To choose to save the values 'life' and 'health', proceeding with the transfusion by force (even though behind the patient's back), ends up totally prejudicing the value 'respect the patient's will'. The choice to 'respect the patient's will', by not performing the transfusion, ends up prejudicing the values 'life' and 'health', which tends to be quite distressing for professionals. Between these extreme solutions there are intermediate courses of action, which embodies those conflicting values to the maximum, or injures them as little as possible (life, health and respect the patient's will). Among the intermediate courses, there will be prudent solutions, or optimum courses. These can be more than one, equally prudent<sup>6</sup>.

### Facts, values and duties in deliberation

The chain reaction of facts, values and duties involved in ethical issues has led to moral judgments. Ethics involves these three aspects of reality: the facts which are guided by cognitive logic; the valuation as result of estimation; and the duties, which are the moral obligation to implement the values in the situation.

Fact is any and all data of perception; something objective, incisive, authoritative, observable by anyone. The descriptive judgments correspond to the facts, or judgments of fact, that is, the reproduction of the noticeable data which was observed in reality, for example: 'the femur is fractured' or 'this is a rainy morning'. The value judgments express the estimation over perception, for example: 'such action is unfair'; 'what you have done to the

patient is inhumane'; 'the morning is beautiful'. Facts are perceived and values estimated. The moral judgment begins with the judgments of fact, as they allow deepening the knowledge of reality. However, facts are just one of the scopes of deliberation. It is deliberated on facts, values and duties<sup>7</sup>.

Value is assigned to all that is perceived, necessarily. There are no pure facts, as they always carry along the values. These are not hard data of perception and cannot be seen or touched. Facts and values are distinct, but related, scopes of reality. Actions are within the scope of facts; values are the motivations and justifications for actions. These, then, anchor on facts and suffer social, historical and cultural influences. That is, the values are, at the same time, individually intuited and socially constructed<sup>4</sup>. Values correspond to judgments of value, which rely on the judgments of fact<sup>7</sup>.

Because values have individually intuited components, there is a risk of subjectivism. However, it is not just about personal preferences, as some of these are socially and politically dubious. And yet, there are values that must be assumed by everyone so that reality becomes more appropriate to an experience which is compatible with human dignity: freedom, solidarity and beauty<sup>8</sup>.

Duties are the formal aspect of moral obligation. Duties' contents come from values. The duty admits two levels: the 'ideal duty' or 'should' and the 'feasible duty' or 'must'. On the ethical equating, there are considered the ideal and categorical propositions from the scope of 'should' and the possible and hypothetical propositions from the 'must' level. The moral obligation is to realize 'should' starting with 'must'. In deliberation, it is considered the scope of 'should', which is the moment of ideality, the image-objective, in order to reach the 'must' level; that is, the one that is possible to achieve from the values in conflict<sup>4</sup>. Prudent decisions, taken with 'moral responsibility', provide the linkage between 'should' and 'must'<sup>7</sup>.

When duties come into conflict and professionals do not know how to act in order to materialize the values in their clinical practice, if they just look into the 'ideal world' they will not be able to get to the 'shall' possible in each case. Deliberation makes this route easier. The deliberative procedure of Diego Garcia has been proposed for bioethics committees, but can also be used in multiprofessional teams meetings, individual decisions or in the mediation of ethical conflicts between patients, family and professionals. In this paper, we use the application in bioethics committees as a guide to describe the procedure.

### *The deliberative procedure*

The deliberative process' itinerary includes: deliberation on the facts (presentation of the case and clarification of facts); deliberation on the values (identification of case's ethical issues; indication of fundamental ethical problem and identification of values in conflict); deliberation on the duties (identification of extreme, intermediate and optimal courses of action); deliberation on the responsibilities (submission of the optimal course to consistency tests of time, advertising and legality)<sup>4</sup>.

#### *Deliberation on the facts*

##### • **Presentation of the case**

The professional who has identified the case as an ethical problem and do not know what to do about it, submits the case to the bioethics committee. He then tells the clinical history, with emphasis on the ethical aspects and data regarding the patient's social, family, cultural, educational and religious conditions, as well as others he deems important to understand the situation.

This stage resembles clinical sessions. However, the focus here is the ethical problem. The clinical history facts are explored at length, as they are the support of the values in conflict in the case. The clinical history is the ethical problem material support to be analyzed, and must be known and understood in order to reduce the areas of uncertainty in the deliberation.

##### • **Clarification of the case's facts**

After presenting the case, members of the bioethics committee shall clarify points that were unclear or not included, through questions to the professional who has referred the case. For the success of the deliberative procedure, it is essential to understand the case. Flaws in its understanding may be carried to other stages of the deliberation and compromise the prudence of decision. The better the understanding of the case is, the easier it will be to recognize available resources to propose feasible courses of action.

#### *Deliberation on the values*

##### • **Identification of ethical issues**

Members of the bioethics committee shall make a list of the moral problems they have perceived in the case. As these are difficulties and doubts, the best way to enunciate the ethical problems is through questions. In order to facilitate the identification of the values in conflict in the problems, questions must have precise, clear, and unambiguous language.

Binary questions must be avoided: *'Must the doctor respect the patient's decision to refuse the transfusion?'; 'Is it lawful to respect the patient's decision to refuse the transfusion?'* or *'Is it ethical that professionals respect the will of the patient who refuses the transfusion?'*. Do not use legal questions or from legal nature: *'Is it legal not to transfuse a patient who needs the procedure but refuses it?'* or *'Is it legal to respect the patient's will, even if this might lead to his death?'*. The best thing to do is to formulate open questions: *'How far does the responsibility of a doctor facing a patient who doesn't want to receive a transfusion go?'*

To provide greater clarity to questions, do not use polysemous terms such as autonomy, beneficence, non-maleficence, fairness, integrity. The 'question-problem' must be formulated according to the reality of the case and must not be 'generic', 'standardized'. Not all formulated questions express 'real' ethical problems, that is, there are some which do not contain conflicts of values. But to reduce the risk of excluding the 'real ethical problems', it is not appropriate to make a very small list. In parallel, extensive lists tend to repeat.

- **Indication of the fundamental ethical problem**

It is impossible to analyze all the ethical issues identified in the case. This is the reason why one issue is elected to be the deliberation target. This is the 'fundamental ethical problem'. It is usually the professional who has presented the case to the bioethics committee who elects the fundamental ethical problem, as he was the one who had recognized the clinical case as an ethical issue.

- **Identification of values in conflict**

To address this question it is first necessary to determine whether the question chosen as the 'fundamental moral problem' is, in fact, a conflict of values. If so, the procedure continues with the identification of the values in conflict. Otherwise, you must return to the list in order to indicate another fundamental ethical problem.

A conflict of values poorly defined compromises the deliberative process' sequence, as the essence of the case is lost. This fact implies that the language in the identification of values in conflict must be clear and precise, requiring increased attention since the values are expressed in abstract terms, and prone to inaccuracies with which we are not yet accustomed. To enunciate values in conflict, one must transpose the concrete language of problems to more abstract terms, without prejudicing accuracy.

Not to disperse the discussion, you may want to choose two or at most four values for deliberation.

### *Deliberation on the duties*

- **Identification of extreme courses of action**

What is defined as 'course of action' refers to each solution alternatives to the case. Values in conflict are arranged in two opposite poles. Each end corresponds to an extreme 'course of action' that accomplishes only one of the values in conflict and consequently destroys the other. The extreme courses are reckless and shall be avoided. Avoiding extremes is not easy, as the human mind 'naturally' reclines to the poles when it envisions only two ways to solve ethical problems.

- **Identification of intermediate courses of action**

Moral outputs that lie between the extremes poles are the 'intermediate courses of action'. They leave from the extremes toward the center, the 'happy medium', a privileged space of prudence to perform the two values in conflict.

- **Identification of the optimal course of action**

Among the 'intermediate courses' the 'optimal course' is elected, that is, the one which embodies conflicting values to the maximum, or injures them as little as possible. The choice of the 'optimal course' requires a delicate and thoughtful exercise to compare the options. This step of the deliberative procedure is the moral moment itself. The 'optimal course' will be the most prudent and responsible alternative to solve the ethical problem.

### *Deliberation on the responsibilities*

- **Application of consistency tests**

Once the 'optimal course' has been chosen, you must submit it to a proof of consistency through evidences of *legality* ('is the decision legal?'); *advertising* ('would I be willing to publicly defend the decision made?'); and *temporality* ('would I make the same decision if I had more time to decide?'). These criteria aim to testify the 'optimal course of action' prudence and responsibility.

The test of time is a mental exercise applied in order to verify whether the decision is not being hasty, impulsive or excessively driven by emotions. The proof of legality reminds that there are moral decisions that are illegal. The proof of advertising aims to determine whether the decision enjoys public, responsible and fair argument. The most prudent decision goes through the three tests.

• **Final decision**

This step is up to the professional who has referred the case to the bioethics committee. The committee indicates prudent paths to solve the ethical problem, but the people involved in the case are the ones who put them into practice after taking their decision to follow or not the deliberation result.

**Final Considerations**

Given the moral pluralism, deliberation becomes an important clinical bioethics tool. Health

professionals need to develop habits, skills and deliberative competences to enhance health care quality.

Both procedures presented in this article, casuistry and determination, begin with the clinical case understanding. They are procedures that provide concrete decisions, indicating a feasible course of action to solve the ethical problem in focus. Both consider the circumstances and peculiarities of the situation without losing sight of the objective image of ethical duties. They are systematized ways to organize the discussion on values in conflict and duties found in the clinic and to reduce areas of uncertainty in the ethical decision making process.

**References**

1. Guillén DG. La deliberación moral: el papel de las metodologías en ética clínica. Madrid: Universidad Complutense; 2009.
2. Jonsen AR, Toulmin SE. The abuse of casuistry: a history of moral reasoning. Bekerley: University of California Press; 1988.
3. Jonsen AR, Siegler M, Winslade WJ. Ética clínica. 4ª ed. Lisboa: McGraw-Hill; 1999.
4. Zoboli ELCP. Deliberação: leque de possibilidades para compreender os conflitos de valores na prática clínica da atenção básica [tese]. São Paulo: USP; 2010.
5. Gracia D. Moral deliberation: the role of methodologies in clinical ethics. Med Health Care Philos. 2001;4(3):223-32.
6. Pose C. Lo bueno y lo mejor: introducción a la bioética médica. Madrid: Editorial Triacastela; 2009.
7. Pose C, Gracia D. Introducción a la bioética: origen, fundamentación y metodo [material didáctico]. Madrid: Universidad Complutense; 2006.
8. Ortis AC. El mundo de los valores: ética mínima e educación. Bogotá: Editorial el Buho; 2007.
1. Guillén DG. La deliberación moral: el papel de las metodologías en ética clínica. Madrid: Universidad Complutense; 2009.
2. Jonsen AR, Toulmin SE. The abuse of casuistry: a history of moral reasoning. Bekerley: University of California Press; 1988.
3. Jonsen AR, Siegler M, Winslade WJ. Ética clínica. 4ª ed. Lisboa: McGraw-Hill; 1999.
4. Zoboli ELCP. Deliberação: leque de possibilidades para compreender os conflitos de valores na prática clínica da atenção básica [tese]. São Paulo: USP; 2010.
5. Gracia D. Moral deliberation: the role of methodologies in clinical ethics. Med Health Care Philos. 2001;4(3):223-32.
6. Pose C. Lo bueno y lo mejor: introducción a la bioética médica. Madrid: Editorial Triacastela; 2009.
7. Pose C, Gracia D. Introducción a la bioética: origen, fundamentación y metodo [material didáctico]. Madrid: Universidad Complutense; 2006.
8. Ortis AC. El mundo de los valores: ética mínima e educación. Bogotá: Editorial el Buho; 2007.

