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Three approaches for a practical bioethics

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Abstract

This article is inspired by the need to respond to recurrent criticisms regarding the lack of operability of bioethics. It presents and characterizes three approaches that have tried to answer this criticism: principlism, casuistry and narrative. It also discusses the characterization of these approaches, especially in terms of the concepts of bioethics they defend. The article concludes by discussing the importance of carrying out a critique of such approaches, aimed at providing an alternative theory that responds to a broader concept of bioethics, as defended by the bioethics that has emerged from peripheral countries.

Keywords: Bioethics. Principle-based ethics. Bioethics-Case studies. Bioethics-Narration.

Resumo

Três apostas por uma bioética prática

Este artigo vem da necessidade de responder as recorrentes críticas feitas à bioética sobre a sua falta de operabilidade. Também apresenta e caracteriza três abordagens que tentaram respondê-las: principialismo, casuística e narrativa. Além disso, discute a caracterização dessas abordagens, especialmente no que diz respeito ao conceito de bioética que defendem, e de igual modo, finaliza indicando a importância da realização de uma crítica dessas abordagens citadas acima, com o intuito de oferecer futuramente, uma alternativa que responda a um conceito amplo de bioética como defendido pela bioética nascida em países periféricos.

Palavras-chave: Bioética. Ética baseada em princípios. Bioética-Estudos de casos. Bioética-Narração.

Resumen

Tres apuestas por una bioética práctica

Este artículo nace de la necesidad de responder a la recurrente crítica que se hace a la bioética, sobre su falta de operatividad. Presenta y caracteriza los tres enfoques que han tratado de responder esta crítica: principialismo, casuística y narrativa. Discute la caracterización hecha de esos enfoques, especialmente en lo relativo al concepto de bioética que defienden. Finaliza, señalando la importancia de emprender una crítica a los citados enfoques, en el intento de ofrecer futuramente uno alternativo que responda a un concepto de bioética amplio, como el defendido por las bioéticas nacidas en los países periféricos.

Palabras claves: Bioética. Ética basada en principios. Bioética-Estudios de casos. Bioética-Narración.

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Declara não haver conflitos de interesse.

Bioethics is about to turn 50, and although it remains in the initial process of consolidation, faces several recurring criticisms. Regardless of whether one considers the biomedical and biotechnological bioethics advocated by Beauchamp and Childress [1] or the more comprehensive global bioethics proposed by Potter [2], one of the most important criticisms remains the same: bioethics does not respond adequately to the "practical", an issue which arises from its conception as an applied ethics [3-7]. It does not do so because, apparently and increasingly, the field of reflection and contemplation is growing at the expense of a decline in action, practice and intervention.

This does not mean, however, that there has been no attempt to answer such criticism. The objective of this article is precisely to categorize this concern, by describing in *operative* terms the three practical approaches born from the same, but in an innovative manner, and not by the division described and already reported in other studies [8]. As such, the study does not adopt a descriptive, philosophical or historical perspective (already sufficiently reported in literature), but adopts a practical position, identifying the operative propositions that each approach defends, or in other words, the path that each proposes towards the making of moral decisions or actions.

The article, divided into five parts, aims to present this perspective, and in doing so take a first step towards the development of complementary approaches that respond, essentially, to visions of bioethics emerging from peripheral countries.

The four principles

Emerging from the fields of biomedicine and biotechnology in the USA, the four principles (autonomy, non-maleficence, beneficence and justice) – were created in 1979 by two Georgetown University professors, Tom Beauchamp and James Childress [1], after several scandals in that country [9]. Their main antecedent was the Belmont Report [10].

The authors argue that the methodology or operationality of this approach occurs through the translation of the principles into specific guidelines that are applicable to day-to-day situations, stating that two procedures are required for this process of translation to occur: "specification" and "weighting" [11].

Specification basically consists of a process of deliberation in which the stated principles are applied to specific cases, and involves the consideration that the principles have a *prima facie* obligation, that is, they oblige absolutely only "at first sight". This *prima facie* obligation connects with the second procedure: "weighting", which means that this absolute obligation only remains binding until there is a conflict between the four principles, and prioritizes some obligations - which were absolute "at first sight" - over others [12].

To these two procedures are added others, namely "mediation" and "negotiation", involving the permissiveness, correctness and incorrectness of moral acts, thus producing the aforementioned deliberation, which can be defined as a process in which decisions are made based on the rational plausibility of the arguments. With regards to such rationality, it is important to point out that this theory is centered on what the authors call secular human ethical rationality, or the common morality.

To explore how this operationalization – mediated by specification, weighting, mediation and negotiation, and based on rational deliberation – occurs, it is important to discuss each of the principles proposed by Beauchamp and Childress.

Autonomy

For Beauchamp and Childress [13], autonomy only occurs when there is intentionality, knowledge and the absence of external influences. It is perhaps the principle that best represents operationalization through its basic paradigm: informed and voluntary consent.

It must first be said that the authors define consent as the autonomous authorization of the individual to participate in medical intervention or research [13] and highlight the following basic components of this instrument: the initial elements (prerequisites), informative elements, and elements of consent [14].

It is also important to state that the procedures of weighting, mediation, negotiation and specification are of paramount importance in the case of autonomy and, consequently, of informed consent, especially when dealing with the autonomy of children, adolescents, psychiatric patients or humans in an unconsciousness state.

The authors also clearly define the information that should be included in informed consent. They say that it must involve facts or descriptions that patients consider important when accepting or otherwise the intervention or procedure in which they are invited to participate, as well as information related to the recommendations of the health professional, the objective of consent, its nature and limits [15].

Non-maleficence

By non-maleficence Beauchamp and Childress mean consciously refraining from harm, and explain that this principle has to do with issues related to quality of life, non-discrimination on the basis of race or gender; and the premise that morality is not only based on responsibilities, but also on harm caused by indirect damages. With non-maleficence, the authors use the same procedures as were used with autonomy, and propose three guidelines of action that, according to their understanding, allow doctors and researchers to resolve their ethical dilemmas.

The first of these guidelines is a rule regarding non-treatment, or in other words, not initiating or withdrawing treatment. The explanation for this rule lies in the premise that it is generally more difficult, as it has greater consequences, to withdraw a treatment than to initiate it, as well as in the fact that it is morally worse not to propose or not to allow the start of a treatment, than not to attempt it.

This first guideline, then, seeks to provide tools that allow the physician to: justify the information – type and quantity – that they supply to the patient; support their decisions regarding the initiation or withdrawal of treatment; and, finally, invite a patient to undergo experimental treatments of which the benefits – and the damages – are not yet known.

The second guideline involves a rule to distinguish between ordinary treatments – also described by the authors as obligatory – and extraordinary treatments – also known as optional – with the purpose of carefully determining if they are beneficial or not for the patient, taking into account the risks and benefits to which he or she will be exposed. This second guideline assists the physician, for example, in situations in which they must deal with the prolongation or otherwise of life in terminal illnesses.

Finally, the third guideline seeks to differentiate between life-sustaining techniques and purely medical techniques. The first, which authors categorize as "non-medical", includes parenteral nutrition and hydration, while the latter, considered as medical, includes life support treatments such as respirators and dialysis equipment.

Beneficence

Related to the above principle, beneficence is understood by Beauchamp and Childress as the positive obligation that all human beings must act for the benefit of others. Also relating to non-maleficence, beneficence depends entirely on autonomy, as according to the authors, an action can only be judged as beneficial when the subject of the action agrees to consider it as such.

The authors subdivide the operationalization of this principle into positive beneficence, on the one hand, and the utility principle, on the other. The idea is to clarify that, although the principle obliges action for the benefit of others, this benefit must be contextualized – which is where the utility comes in – in relation to the potential risks and contraindications that could be generated. It should be emphasized that the authors differentiate between utility and utilitarianism, clarifying that autonomy is essential and should always be respected, above cost-benefit, cost-effectiveness, or risk-benefit analysis.

Justice

The conception of the authors regarding justice is that of a distributive justice, in which scarce therapeutic resources are expected to be distributed according to a utilitarian and egalitarian logic. From a utilitarian perspective, Beauchamp and Childress defend social efficiency and the maximum benefit for the patient, while from an egalitarian perspective, the merits of each person alongside the equality of opportunities are ensured, so that one who is disadvantaged in comparison to another has an equal chance of access.

The authors have not offered a theory of operationalization for this principle, meaning that it remains only in abstract and general postulates, and escapes the procedures of specification, weighting, mediation and negotiation. Instead they suggest only chance as a way to operationalize

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justice – to which the other three principles have tried to respond.

Casuistry

Casuistry does not defend reasoning based on principles, except in cases which in some manner resort to the general principles that have been previously discussed in their particularities. Its origin is medieval and it was used by orders of Jesuits seeking a way to justify certain moral decisions [16].

According to Miller, scholars who advocate casuistry argue that it is intended to help in situations where rules become confused, and in which moral conflicts are not easily resolved, producing responses that lead to moral guilt [17].

This approach proposes to examine specific cases to extract theoretical rules which can be applied to other similar situations. For Jonsen and Toulim [18], the casuistic method can be summarized in six components: paradigms and analogies, maxims (principles, intuitions), circumstances, degrees of probability, arguments, and resolution.

Casuistry offers alternatives to so-called moral absolutisms, which is important in the reflection and decision-making of thinkers who advocate a less abstract view of the moral world. Hence, those who employ casuistry the most are those who follow the paths of utilitarianism or pragmatism.

For Kirk, reasoning that describes itself as casuistic must bring together certain attributes. Initially, the central issue must be related to the intention to solve a specific case or problem, rather than an abstract, conceptual or doctrinal dilemma [19].

It can be seen why this is the method par excellence followed by the so-called "three practical ethics" – business ethics, environmental ethics and bioethics. To clarify a little the operationalization process proposed by casuistry, we can group the necessary steps to achieve moral reasoning into stages.

First stage

The first stage involves exhaustively describing the situation to be analyzed. Casuistry emphasizes that such exhaustive description is, perhaps, the most important part of the procedure proposed, as on it will depend the appropriate choice of the paradigmatic case to be taken as a reference or, if such a case is not found, the proper identification of the situation under analysis as unprecedented – and its subsequent inclusion within the matrix of paradigmatic cases -.

Thus, the description implies a careful examination of the situation, including the identification of the central actors, the interests at stake, proposals and institutional – of social institutions such as the family, the hospital, health providers, and government, among others – and personal motives.

Second stage

The second step relates to choosing a "paradigmatic", "precedent" or "pure" case - which has already been analyzed - the characteristics of which are sufficiently similar to the situation being studied. This choice of paradigmatic cases is understood as the choice of a blueprint model or case - on which the majority agrees - from which the situation under study can be analyzed. It is assumed that a large base of paradigmatic cases guarantees suitable analysis and decision making, which is why the work of "rescuing" this type of case is central.

These cases exemplify a general ethical dictum – of general moral judgment – by which, as already mentioned, casuistry relies on abstract principles to choose, at this stage, the paradigmatic cases that will support its analysis. This is important, as those who use this approach argue that although they use cases and dwell on the particularities of each situation, they do not fall into an extreme "particularism" that lacks general principles or moral norms.

Before proceeding with the next stage, it is essential, however, to point out that those who defend casuistry clarify that at this point, when choosing the paradigmatic case, it is also possible that no "pure" cases can be adapted to the situation studied, a hypothesis against which independent analysis should be used, more based on general principles than on previous cases.

Third stage

The authors affirm that the contextualization of the situation under analysis within the paradigmatic case chosen is essential as it grants ethical certainty and justification to the casuistic analysis. Furthermore, contextualization provides appropriate frameworks to bring discursive coherence to the situations analyzed, giving ethical plausibility to the decisions that result from the use of casuistry [20].

In addition to the above, contextualization provides the opportunity to consider different practical issues, which in other approaches could not be addressed simultaneously due to being mutually exclusive or competing with or annulling each other. This is especially useful if one considers that the situations that bioethics studies are usually multifactorial, complex and conflicting.

Another useful feature of contextualization is to provide a starting point to begin deliberations, which will result in making a decision regarding the situation being analyzed. In using the paradigm, then, an attempt is made to find principles or rules that help to solve the paradigmatic case, and that can help with the situation addressed [21].

Fourth stage

This is the time to consider the elaboration of analogies that justify the decisions that will be made, taking into account the contextualization, choice and description established. We must start by saying that it is this point which, in the opinion of some authors [22], truly differentiates the theory of the four principles from casuistry and, therefore, is the core of the casuistic approach.

It does so because the argumentative strength of casuistry lies precisely in the analogies that can be created from its procedures. Additionally, the usefulness of this approach lies in the comparisons that make it possible to evaluate, or even better, guarantee the validity of such comparisons. This is of great importance, for as Calkins says all moral reasoning rests, in some sense, on analogies [23].

Continuing with the subject of analogies, it is important to say that just as paradigmatic cases provide ethical certainty and justification, analogies from paradigmatic cases to "less paradigmatic" cases transfer such justification to the latter. Analogies also ensure that the decisions taken are not decontextualized and, therefore, endow them with legitimacy. It is clear from this, once again, why analogy plays a central role in the conception of the casuistic approach. This is what Ruyter argues when recognizing that analogies are powerful tools for defending or condemning moral practices [24].

Fifth stage

The fifth stage, or decision-making regarding moral action, involves a review of the correct characterization of the situation analyzed, of the appropriate identification of the paradigmatic case to be used, and of the consistent argumentation - based on analogies - for the taking of moral action.

It can be seen in this last stage, then, that casuistry is an attempt to offer an eminently practical approach to moral reasoning which, not being exclusively based on abstract principles or rules, turns to particular cases for the resolution of moral dilemmas and of circumstances that are conflicting to those to whom they are exposed and deal, in the case of bioethics, with situations related to biomedicine and biotechnology.

It is also evident that the situations it seeks to respond to are those presented in the doctor-patient or the researcher-research participant relationships, because, like the theory of the four principles, it emerged from such areas. Casuistry is the answer of philosophers to moral problems arising in the medical field.

Narrative bioethics

Narrative bioethics is defined as "narrative ethics related to medicine", but also as "the expression of a hermeneutic approach to applied ethics, specifically in biomedicine" and as *a peculiar type of bioethics with a narrative dimension that goes beyond the usual limits of clinical bioethics, to connect with other dimensions of the medical humanities, philosophy, ethics and literature* [25].

It is seen, then, that from its very conception – by emphasizing that it is a hermeneutic approach to bioethics - narrative bioethics is aimed at action. Various scholars [26-29] have explained this, for they use narration, in a hermeneutical, deliberative, historical and dialectical way, for the understanding of - and the subsequent making of decisions about - problematic and conflictive situations that demand a specific attitude on the part of the physician.

Having established this conceptual precision, it is time, as with the other two previous approaches, to highlight the procedural particularities of narrative bioethics. To this end, what is considered the most important book on the subject will be used to adopt a practical proposal in this respect, since, as we have seen, conceptual and theoretical revisions are common, but practical approximations - such as those presented by the book - are scarce.

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The book in question is "The Fiction of Bioethics" by Tod Chambers [30], the richness of which, besides giving an operational and complex proposal of the narrative [31] absorbs multiple perspectives, as the author himself accepts. Chambers proposes the following as minimum points for the operationalization of narrative ethics - as he calls it - and therefore, for moral decision making and actions when dealing with complex situations. It should be clarified, before considering these, that the author starts from the fact that these complex situations are cases in themselves, so that the basis of the narrative approach he defends – as do other authors [25] - lies in casuistry.

First point

The first point is the identification of the interpretative stages of the narrative: recognition, formulation, interpretation and validation, through the collection of data from each medical case in the light of conventions and tools typically attributed to narration. Early on, Chambers clarifies that his starting point is cases, though viewed in a different way, and which he calls "clinical case histories". He argues that this is his starting point because these histories are today the central point of medical discourse when it comes to making moral decisions.

The author also asserts that, since the cases constitute, in themselves, a narrative genre, it is legitimate - and obligatory - to use narrative tools and conventions to enrich the casuistic analysis. When he speaks of these tools, he specifically refers to narrative conventions such as: characterization, plot, authorship, reading position, among others, which he defends as absolutely necessary to carry out a serious casuistic analysis, leading to plausible moral actions.

Chambers is especially concerned with highlighting the importance of studying the point of view of the storyteller, that is, revealing the authorship. He explains that this is important, as such authorship is of major significance in the analysis of moral dilemmas, because the reader of the case histories is immediately affected by the voice that is telling the story.

Second point

The second is the analysis of the "level of detachment" that the author and the reader of the text have regarding the case that is being narrated. At this point, Chambers invites us to analyze what he calls the subjects of "authorship" or "readership" - also called "narrateeship" – as he considers the style of writing - and its consequent readability - to be crucial in the development and understanding of a medical case. At this point, it is a question of observing how the medical case is being described in terms of authorship, such as whether the third person voice is being used to narrate, or if the reader is directly appealed to in the analysis of a bioethical dilemma.

It is useful to note that Chambers gives different names to the different kinds of authorship - naming them, for example, as "biological", "academic", "philosophical", "casuistic", "implied" - in order to illustrate the specific characteristics that each one implies. In the case of the philosophical, mediated by the third person, there is a dramatization of the situation narrated, while in the case of "casuistic", the diametrically opposed effect occurs: there is a de-dramatization of the events narrated.

Finally on this point, according to the author, reflection on the level of distancing between author and reader is central to the discipline of medical ethics as it allows us to understand the association between the author and the different levels of the narration. This translates into the suggestion that by reflecting on the kind of authorship presented, one might better understand the moral judgment that lies behind the reported situations and, therefore, have a better prior analysis for future decision making.

Third point

The third point consists of the discussion of the chronotope, in other words, the place and time in which the narrated events occur. It implies the observation of time and place as an indivisible unit and the producer of moral actions and decisions. Turning to the words of renowned author Mikhail Bakhtin, Chambers emphasizes the importance of analyzing the management of time and place in the histories presented in medical cases. In this sense, the author highlights the need to identify the complex - or, on the contrary, reductionist - character of the world presented within those histories, in spatial and temporal terms.

Over time, however, Chambers introduces an interesting concept that has to do not only

with the description of the time in which the case is presented, but with the aspects of acceleration and deceleration of the narrative. In this respect, the author identifies at least four types of time, which differ in the way in which they are used to tell a story: ellipsis, when there is no mention of time in the history; summary, when time in history is contracted, giving the impression that all events have occurred almost simultaneously; scene, when time is marked sequentially – the best example of which is seen in stories that include dialogues; and stretch, when the time is dynamic, in a process that is not necessarily sequential.

Fourth point

The fourth point is connected to the examination of the opening and the closing of the histories, in order to understand the impact these have on the data presented. In total relation to the previous point, Chambers proposes reflecting not only on the description and use of time in cases related in bioethics, but also on what he calls temporal "disruptions", that is, the beginning and end of the stories being told. The importance of these disruptions is so great that the author compares them to the existence of different narrative genres, because according to his understanding, they let us glimpse a certain worldview.

Continuing with this line of thinking, Chambers argues that the type of beginning of a story can make the reader expect, with a greater or lower degree of anxiety, a transgression during the narrative, or anticipate the occurrence of a particular event. He exemplifies this point with police novels or works of terror, and argues that the beginnings and closures of medical cases that analyze bioethics typically lead the reader to expect a transgression to occur.

To complement this idea, Chambers asserts that bioethics case histories share a well-defined type of beginning and end. Regarding the former, Chambers argues that it is usually two sentences in which the positions of the doctor and the patient regarding the dilemma they are facing and the expectations they both have are made relatively clear. In terms of the latter, the author highlights three characteristics: the ending generally features a question or a call to action, and is directed at the reader.

Fifth point

The fifth, and last, point discussed by the author is related to the study of cases from the perspective of feminist theory, which includes both the analysis of gender as a constitutive part of the history, and a reflection on the differences between female and male writing styles.

Based on the question of whether it is possible to discuss a gender-related manner of telling stories, Chambers points out that it is important to reflect on the masculine and feminine roles present in the stories, as they bring with them implicit cultural codes that necessarily impact on the moral actions and the decision making that the narrative induces, as described in the previous stages.

Considering gender, according to the author, is equivalent to unveiling the true character, origin and purpose of the codes described and, therefore, of the attitudes, actions and decisions that have been naturalized by the force of customs, power or time. In other words, Chambers argues that a gender-mediated reading of the cases reported in the bioethical narrative may lead to a more critical view of the data discussed in the first stage of this section.

There is, however, a fundamental point that Chambers emphasizes, and which is repeated here, after having been touched on in the third point: the importance of social justice in the methodology of narrative bioethics. For the author, the reflection of the role of gender in the narrated history also opens the door to an encounter with social justice, which has been forgotten in the area of bioethics. The next part of this article will develop the argument related to social justice in narrative bioethics.

Discussion

The three approaches for developing a practical bioethics emerged from central countries, and correspond to a vision of bioethics that defines the field as exclusively related to medicine and biotechnology. All three also identify the importance of making bioethics a concrete instrument for confronting dilemmas and moral conflicts. In this sense, aware of the existence of robust and abundant theoretical development, they are more concerned with providing the discipline with steps, stages and techniques to be implemented.

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In the midst of these steps, stages and techniques, the tools offered by the narrative have been especially relevant, as they have allowed ideas, such as principles, and exercises, such as case studies, to be better interpreted, by proposing a process of reflection and interpretation of the same. In this sense, the narrative has offered a hermeneutic and interpretative look [32] at approaches that on many occasions did not question or think about themselves, allowing better informed and contextualized decision making in the clinical environment [33].

It is important at this point to add that the narrative begins from the recognition of the importance of casuistry, which is part of its construction. This is evident when the proponents of the narrative explicitly accept that the exercise of narration is born from the understanding of medical cases as stories and when narrative elements are used by them to enrich those stories. It is clear, therefore, that more than a paradigmatic rupture, these thinkers propose to build on what has been constructed, taking not only the cases as narratives, but the principles as support for the analyzes and moral judgments.

This construction on what has already been constructed is relevant, as it shows that the hermeneutic component that the narrative involves necessarily enriches the moral reasoning exercise that principialism and casuistry have proposed to do for decades. José Roque Junges [34], a Brazilian bioethicist, perceives that bioethics may have two strands, arguing that casuistry and principialism are two complementary faces of bioethics, and suggesting that hermeneutics is a necessary complement to avoiding ethical and cultural conventions or economic and political conservatism in issues related to health.

Notwithstanding the above, it is possible to see a subtle openness to other themes, moving from principialism, to casuistry and to narrative. Narrative, especially, opens up possibilities not found in the other approaches to include the gender perspective and the defense of social justice and implement specific steps to operationalize bioethics. In this sense, the idea of bioethics that the narrative hopes to put into practice could be open to themes other than the merely biomedical and biotechnological.

The relationship between narrative, ethics, gender and social justice is not unprecedented, and there is already important literature on the subject. It is important to remember that this nascent relationship in bioethics, the fruit of narrative bioethics, has a consolidated antecedent, of which an important exponent is Martha Nussbaum, a recognized American philosopher who shows clearly how narrative can serve to address moral conflicts relating to the inequality and poverty present in the world, essentially through what she describes as the moral imagination and the moral narration [35].

Nussbaum has emphasized in several of her works [36] that narrative elements, sometimes generated by the Socratic method, can enrich moral judgment, producing in actors who make decisions emotions such as empathy and compassion. According to the author, these elements can lead to richer moral decisions, taking into consideration the different nuances that stories – in contrast to simple cases or reports - include, among others: settings, times, characters, traditions, feelings, values and principles.

A few more words should be devoted to the way in which, according to Nussbaum, it is possible to make moral decision-makers enrich their discussion and moral reasoning. In this regard, this author proposes the inclusion of literary texts [37], such as novels and poems, both during the academic study and training of these decision makers, as well as in discussions about the decision to be made. Nussbaum says that literature has the power to make human beings imagine realities opposite to their own and, in doing so, to become more sensitive to the situations of pain, fear or sadness that another human being may be going through [38].

This author shows, for example, in one of her most important works, how the narration of a life history marked by poverty, inequality and injustice can lead to the creation of an economic theory that produces moral decisions that create public policies that are more inclusive and fairer in health, economic and social issues. Nussbaum even observes that this is one of the few viable ways to counteract the economic perspective that globalization defends, with its subsequent neoliberal policies generating misery, inequality and death [39].

This is relevant because it shows that the narrative has the potential, indeed, to be a vehicle that introduces social, health and environmental issues to bioethics, which is historically associated only with biomedical and biotechnological issues. And, furthermore, that this narrative responds equally well

to the need to enrich analysis and moral reasoning in both epistemological and methodological terms.

Following this line of thinking, it may be that this narrative bioethics is the approach that best dialogues with the bioethics that emerged outside central countries, the majority of which lack, for the most part, practical developments that support their theoretical foundation. It could be that a narrative approach is the opportunity for these bioethics – which include Latin American bioethics [37,38] - to be made operational and definitive, complementing their already well-defended epistemological bases.

In this regard, it is worth recalling that the origin of the narrative in bioethics is Latin American, specifically through the work of Mainetti [40-43] in Argentina in the 1980s. This South American physician, a disciple of Paul Ricoeur – the father of hermeneutics – was a pioneer in introducing literary elements to bioethical analysis, emphasizing the importance of enriching a purely clinical moral analysis with the tools that literature and hermeneutics provide, among them, creativity, imagination and sensitivity. Certainly, this finding can be of great help in the development of a narrative practice for bioethics from peripheral countries whose interests are more connected with social than strictly medical and biotechnology issues.

Final considerations

It is important to note that, as described above, the three approaches analyzed here – the theory of the four principles, casuistry and narrative bioethics - have important similarities and even represent a "continuum". Thus, the innovative narrative approach or that proposed by narrative ethics is evidently based on the study of cases, on the recognition of the importance that this study has and, therefore, on casuistry. This, in turn, and as several of the authors who defend it seek to clarify, is closely related to the respect and acceptance of the validity of principles, and therefore, with principles such as those defended by the theory of the four principles.

From the previous observation, the narrative approach must be effectively operationalized, proposing concrete ways that will, in fact, lead to the sensitization and generation of emotions proposed by the authors. In other words, narrative bioethics must provide not only the important space for a reading (and re-reading) of the principles and cases reported by bioethics for decades, but also the tools that produce the aforementioned sensitization. In this respect, the use of literature, by means of novels and poems, to name just a few literary genres, will be essential. However, other artistic languages capable of generating emotions, such as the empathy and compassion emphasized by authors who defend the narrative in ethics, should not be excluded.

It is also important to note that all the approaches analyzed respond to a conception of bioethics in the medical and biotechnological area. However, in the narrative approach there could be an opening for the inclusion of other issues, such as those defended by bioethics that did not emerge within the central countries - such as Latin American bioethics - which, in general, lack practical operational developments. Thus, a next step will be to critically review these three procedural approaches in order to propose, in the future, a practical perspective that applies to the broad vision of bioethics defended by Potter and taken up by the bioethics of peripheral countries.

This point is fundamental as it means the implementation of the practical approach that has been sought by these non-central bioethics. In other words, what is proposed here is that narrative bioethics can offer answers to the recurrent criticism that peripheral bioethics do not have enough methodological and procedural elements to develop their premises and conceptual bases. In this sense, the intriguing progress made by Martha Nussbaum, in relating ethics, decisions and moral reasoning, social causes, inequity, injustice, narrative and imagination, is central, as it demonstrates that it is possible to use narrative from a procedural point of view to produce better informed and more profound moral decisions. This is the hope, and also the challenge for future studies.

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Referências

1. Beauchamp T, Childress J. Principles of biomedical ethics. Nova York: Oxford University Press; 1979.
2. Potter VR. Bioethics: the science of survival. Perspect Biol Med Univ Wisconsin. 1970;14:127-53.
3. Kottow M. Bioética: una disciplina en riesgo. Rev Redbioética/Unesco. 2010;1(1):159-73.
4. Maclean A. The elimination of morality: reflections on utilitarianism and bioethics. Londres: Routledge; 1993. p. 219.
5. Illich I. The immorality of bioethics. Deans Lecture Manuscript, State College, 7. Sep. 1997.
6. Koch T. Bioethics: the failure of a bad idea. The Huffington Post [Internet]. 11 nov 2012 [acesso 18 out 2015]. Disponível: http://bit.ly/2sVMhRf
7. Koch T. Thieves of virtue: when bioethics stole medicine. Cambridge: MIT Press; 2012.
8. Davies R, Ives J, Dunn M. A systematic review of empirical bioethics methodologies. BMC Med Ethics. 2015;16:15. DOI: 10.1186/s12910-015-0010-3
9. Brant AM. Racism and research: the case of the Tuskegee Syphilis study. Hastings Cent Rep. 1978;8(6):21-9.
10. United States. The Belmont report: ethical principles and guidelines for the protection of human subjects of research. Bethesda: US Department of Health, Education and Welfare; 1978.
11. Thompson J. Los principios de ética biomédica. Precop SCP Ascofame CCAP. 2008;5(4):15-34.
12. Siurana JC. Los principios de la bioética y el surgimiento de una bioética intercultural. Verit Valparaíso. 2010;22:121-57.
13. Beauchamp T, Childress J. Principles of biomedical ethics. 5ª ed. New York: Oxford University Press; 2001. p. 454.
14. Eyal N. Informed consent. In: The Stanford encyclopedia of philosophy [Internet]. 2012 [acesso 18 out 2015]. Disponível: http://stanford.io/2sqf53j
15. Beauchamp T, Childress J. Principles of biomedical ethics. 4ª ed. Nova York: Oxford University Press; 1994.
16. Fernández A. La casuística: un ensayo histórico-metodológico en busca de los antecedentes del estudio de caso. Arbor. 2002;171(675):489-511.
17. Miller R. Casuistry and modern ethics: a poetics of practical reasoning. Chicago: University of Chicago Press; 1996.
18. Jonsen A, Toulmin S. The abuse of casuistry: a history of moral reasoning. Berkeley: University of California; 1988.
19. Kirk K. Consciente and its problems: an introduction to casuistry. Louisville: Westminster John Knox Press; 1999.
20. Bell D. Casuistry: towards a more complete approach. [tese]. University of Illinois at Urbana-Champaign; 2007.
21. Jonsen J. Causistry. In: Sugarman J, Sulmasy D, editores. Methods in medical ethics. Washington: Georgetown University Press; 2001.
22. Kuczewski M. Casuistry and Its communitarian critics. Kennedy Inst Ethics J. 1994;4(2):99-116.
23. Cudney P. What really separates casuistry from principlism in biomedical ethics. Theor Med Bioeth. 2014;35(3):205-29.
24. Calkins M. Developing a virtue-imbued casuistry for business ethics. Londres: Springer; 2014.
25. Domingo T, Feito L. Bioética narrativa. Madrid: Escolar y Mayo; 2013. p. 52.
26. Cole T, Carlin N, Carson R. Medical humanities: an introduction. Nova York: Cambridge University Press; 2015.
27. Hawkins A. Literature, philosophy and medical ethics: let the dialogue go on. Journal Med Philos. 1996;21(3):341-54.
28. Terry J, Williams P. Literature and bioethics: the tension in goals and styles. Lit Med. 1988;7:1-21.
29. Hawkins A. Ephiphanic knowledge and medicine. Cambridge Q Healthc Ethics. 2005;14(1):40-6.
30. Chambers T. The fiction of bioethics: cases as literary texts. Nova York: Routledge; 1999.
31. Chambers T. The fiction of bioethics: a precis. Am J Bioeth. 2001;1(1):40-3.
32. Rosas C. El paciente como "texto" según Ricoeur: implicaciones en bioética. Rev. bioét. (Impr.). 2014;22(2):234-40.
33. Manchola C, Brazão E, Pulschen A, Santos M. Cuidados paliativos, espiritualidade e bioética narrativa em unidade de saúde especializada. Rev. bioét. (Impr.). 2016;24(1):165-75.
34. Junges JR. Bioética como casuística e como hermenêutica. Revista Bras Bioética. 2005;1(1):28-44
35. Nussbaum M. Love's knowledge. Nova York: Oxford University Press; 1990.
36. Nussbaum M. The fragility of goodness. Cambridge: Cambridge University Press; 1986.
37. Nussbaum M. Cultivating humanity. Cambridge: Harvard University Press; 1997.
38. Nussbaum M. Political emotions: why love matters for justice. Cambridge: Belknap Press of Harvard University Press; 2013.
39. Nussbaum M. Creating capabilities: the human development approach. Cambridge: The Belkap Press of Harvard University Press; 2011.
40. Mainetti J. Bioética ficta. La Plata: Quirón; 1993.
41. Mainetti J. Bioética narrativa. In: Tealdi J, editor. Diccionario latinoamericano de bioética. Bogotá: Unesco/Universidad Nacional de Colombia; 2008.

42. Mainetti J, Pérez M. Los discursos de la bioética en América Latina. In: Pessini L, Barchifontaine C, Lolas F, editores. Perspectivas de la bioética en Iberoamérica. Chile: OPS; 2007.
43. Mancholá-Castillo C. Por una bioética distinta: narrativa y latinoamericana. Revista Redbioética/ Unesco. 2014;2(10):70-80.

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