

Chapter 2

Principles of Biomedical Ethics

Ethics and equity and the principles of justice do not change with the calendar.

—D. H. Lawrence

Justice consists not in being neutral between right and wrong, but in finding out the right and upholding it, wherever found, against the wrong.

—Theodore Roosevelt

Chapter Learning Objectives

At the conclusion of this chapter the reader will be able to:

1. Understand the relationships among moral value judgments, moral rules or ideals, the principles of biomedical ethics, and ethical theory
2. List and explain the principles of biomedical ethics
3. List and recognize the requirements for autonomous choice
4. Define *competency* and *decisional capacity*
5. Recognize and distinguish the various types of controlling influences that undermine voluntariness
6. Recognize and distinguish nonmaleficence and beneficence
7. Explain the rule of the double effect and recognize instances in which it does and does not apply
8. Recognize and distinguish specific and general beneficence
9. Recognize situations in which beneficence is obligatory as opposed to ideal
10. Define *paternalism* and distinguish between weak (soft) and strong (hard) paternalism
11. Recognize instances in which strong (hard) paternalism might be justified
12. State the formal principle of justice
13. List several material principles of justice
14. Explain how utilitarian, egalitarian, and libertarian views of justice differ

In the following excerpt, Joan Gibson compares ethics to science in a way that is helpful to us here and, in the process, provides a framework for the topics discussed in Section I of this text.

[A] comparison between the giving of good reasons in science, which is called “explanation,” and the giving of good reasons in ethics, which is called “moral justification,” reveals striking procedural similarities bordering on identity. . . .

Answering the question “Why?” [in science] . . . is known as explanation: the accounting for observed phenomena at levels of increased abstraction, generalization, and simplification. Moving [in the opposite direction], once the “Why?”s are answered, generates the power of prediction about future similar observations and phenomena.

And so it is with giving good reasons for individual moral judgments. . . . Answering the “Why?” moving up the [ethics pyramid] is known as moral justification. Moving down the [ethics pyramid], once the “Why?”s are answered, yields decisions about similar, future moral value judgments that must be made. Answering “Why?” . . . requires that reasons be elucidated and organized. Truth in science as well as in ethics derives not so much from discovering isolated, once-and-for-all answers, but rather from continually articulating, evaluating and revising the reasons one gives for the continually modified propositions one asserts and the consistently reevaluated judgments one makes. Extrapolating into the future (. . . making [moral] decisions) is only as sound as the integrity of prior . . . moral justifications.¹

Chapter 1 discussed the apex, as it were, of the metaphorical ethics pyramid—ethical theory. As we move down that pyramid, we will discuss ethics in an increasingly concrete or specific way—first at the level of moral principles (the focus of this chapter), then at the level of moral rules (the focus of Chapter 3), and finally at the level of moral decisions in individual cases (the focus of Chapter 4).

Different people think about or analyze problems in bioethics in different ways. Some may prefer to think through these problems in terms of the principles of biomedical ethics; others prefer the moral rules–based account of morality of Bernard Gert and associates (see Chapter 3); still others prefer the approach of casuistry (see Chapter 4). One of our purposes in this text, and in this section in particular, is to expose the reader to these various approaches.

Theory, Principles, Rules, and Moral Decisions

The focus of this chapter is on the principles of biomedical ethics, or *principlism*. Before embarking on a discussion of the principles themselves, let’s consider the following question: What are moral principles? How do they relate to moral theory, moral rules, and moral decisions?

A *principle* may be defined as “a basic truth or a *general* law or doctrine that is used as a basis of reasoning or a *guide to action* or behavior.”² Principles, like rules, are action guides, although, as the earlier excerpt should make clear, the guidance they provide is more

abstract or general than that provided by rules. Gert and colleagues have written that “principles really are action guides that summarize and encapsulate a whole [moral] *theory* and thus, in a shorthand manner, assist a moral agent in making a moral decision.”³ Thus, deciding which moral principle (or principles) to invoke as an action guide will depend on the moral theory or theories to which one subscribes.⁴

The distinction between principles and rules can perhaps further be illustrated through the use of an example drawn from the literature on the philosophy of law. Consider the problem posed by a court’s decision to deviate from precedent⁵—that is, to overrule its own prior decisions. Consider, for example, the important role that the *Roe v. Wade*⁶ decision has played in American jurisprudence and politics since 1973. Should the Supreme Court reverse itself and overturn *Roe v. Wade*? If it did so, what would that say about the lawfulness of the original 1973 decision? Of the subsequent decision? The reluctance of the Court to reverse itself, and the reasons for that reluctance, were evident in the opening lines of the Court’s opinion in *Planned Parenthood of Southeastern Pennsylvania v. Casey*,⁷ a case in which it was thought that the Court might (though it did not) overrule *Roe v. Wade*: “Liberty finds no refuge in a jurisprudence of doubt. . . . After considering . . . the rule of *stare decisis* [*stare decisis* means “to abide by, or adhere to, decided cases”],^{5(p978)} we are led to conclude this: The essential holding of *Roe v. Wade* should be retained and once again reaffirmed.”⁸

There may be another way to look at the situation. Does a court that alters the law necessarily have to go outside the law to do so?

Is it possible to argue that courts may *alter* the law while still being *bound* by the law? . . . Ronald Dworkin has developed a theory which seems to explain how that might be possible. . . . Dworkin argues that law does not consist solely of rules deliberately established in precedents and statutes. In his view, law also includes general principles which are implicit within the established black-letter provisions. Judges have the task of constructing a coherent moral theory that provides an appropriate abstract justification for the established rules and institutions. They may interpret and modify established rules in a way that brings them more closely into line with the overarching abstract justification. Thus, even when judges *modify* established legal rules they are doing so in the application of deeper legal principles.⁹

The Belmont Report

“The principles [of biomedical ethics] emerged from the work of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research,”^{3(p73)} which was created by an act of Congress in 1974. The commission was charged with “identify[ing] the basic ethical principles that should underlie the conduct of biomedical and behavioral research involving human subjects and . . . develop[ing] guidelines which

should be followed to assure that such research is conducted in accordance with those principles.”¹⁰

The commission identified three such basic principles as being “particularly relevant to the ethics of research involving human subjects: the principles of respect [for] persons, beneficence and justice.”¹¹ The commission described these principles as follows:

1. *Respect for persons.* Respect for persons incorporates at least two ethical convictions: first, that individuals should be treated as autonomous agents, and second, that persons with diminished autonomy are entitled to protection. The principle of respect for persons thus divides into two separate moral requirements: the requirement to acknowledge autonomy and the requirement to protect those with diminished autonomy.

An autonomous person is an individual capable of deliberation about personal goals and of acting under the direction of such deliberation. To respect autonomy is to give weight to autonomous persons’ considered opinions and choices while refraining from obstructing their actions unless they are clearly detrimental to others. To show lack of respect for an autonomous agent is to repudiate that person’s considered judgments, to deny an individual the freedom to act on those considered judgments, or to withhold information necessary to make a considered judgment, when there are no compelling reasons to do so.

However, not every human being is capable of self-determination. The capacity for self-determination matures during an individual’s life, and some individuals lose this capacity wholly or in part because of illness, mental disability, or circumstances that severely restrict liberty. Respect for the immature and the incapacitated may require protecting them as they mature or while they are incapacitated.

Some persons are in need of extensive protection, even to the point of excluding them from activities which may harm them; other persons require little protection beyond making sure they undertake activities freely and with awareness of possible adverse consequence. The extent of protection afforded should depend upon the risk of harm and the likelihood of benefit. The judgment that any individual lacks autonomy should be periodically reevaluated and will vary in different situations.

In most cases of research involving human subjects, respect for persons demands that subjects enter into the research voluntarily and with adequate information. In some situations, however, application of the principle is not obvious. The involvement of prisoners as subjects of research provides an instructive example. On the one hand, it would seem that the principle of respect for persons requires that prisoners not be deprived of the opportunity to volunteer for research. On the other hand, under prison

conditions they may be subtly coerced or unduly influenced to engage in research activities for which they would not otherwise volunteer. Respect for persons would then dictate that prisoners be protected. Whether to allow prisoners to “volunteer” or to “protect” them presents a dilemma. Respecting persons, in most hard cases, is often a matter of balancing competing claims urged by the principle of respect itself.

2. *Beneficence.* Persons are treated in an ethical manner not only by respecting their decisions and protecting them from harm, but also by making efforts to secure their well-being. Such treatment falls under the principle of beneficence. The term “beneficence” is often understood to cover acts of kindness or charity that go beyond strict obligation. In this document, beneficence is understood in a stronger sense, as an obligation. Two general rules have been formulated as complementary expressions of beneficent actions in this sense: (1) do not harm and (2) maximize possible benefits and minimize possible harms.

The Hippocratic maxim “do no harm” has long been a fundamental principle of medical ethics. Claude Bernard extended it to the realm of research, saying that one should not injure one person regardless of the benefits that might come to others. However, even avoiding harm requires learning what is harmful; and, in the process of obtaining this information, persons may be exposed to risk of harm. Further, the Hippocratic Oath requires physicians to benefit their patients “according to their best judgment.” Learning what will in fact benefit may require exposing persons to risk. The problem posed by these imperatives is to decide when it is justifiable to seek certain benefits despite the risks involved, and when the benefits should be foregone because of the risks

The principle of beneficence often occupies a well-defined justifying role in many areas of research involving human subjects. An example is found in research involving children. Effective ways of treating childhood diseases and fostering healthy development are benefits that serve to justify research involving children—even when individual research subjects are not direct beneficiaries. Research also makes it possible to avoid the harm that may result from the application of previously accepted routine practices that on closer investigation turn out to be dangerous. But the role of the principle of beneficence is not always so unambiguous. A difficult ethical problem remains, for example, about research that presents more than minimal risk without immediate prospect of direct benefit to the children involved. Some have argued that such research is inadmissible, while others have pointed out that this limit would rule out much research promising great benefit to children in the future. Here again, as with all hard cases,

the different claims covered by the principle of beneficence may come into conflict and force difficult choices.

3. *Justice*. Who ought to receive the benefits of research and bear its burdens? This is a question of justice, in the sense of “fairness in distribution” or “what is deserved.” An injustice occurs when some benefit to which a person is entitled is denied without good reason or when some burden is imposed unduly. Another way of conceiving the principle of justice is that equals ought to be treated equally. However, this statement requires explanation. Who is equal and who is unequal? What considerations justify departure from equal distribution? Almost all commentators allow that distinctions based on experience, age, deprivation, competence, merit and position do sometimes constitute criteria justifying differential treatment for certain purposes. It is necessary, then, to explain in what respects people should be treated equally. There are several widely accepted formulations of just ways to distribute burdens and benefits. Each formulation mentions some relevant property on the basis of which burdens and benefits should be distributed. These formulations are (1) to each person an equal share, (2) to each person according to individual need, (3) to each person according to individual effort, (4) to each person according to societal contribution, and (5) to each person according to merit.

Questions of justice have long been associated with social practices such as punishment, taxation and political representation. Until recently these questions have not generally been associated with scientific research. However, they are foreshadowed even in the earliest reflections on the ethics of research involving human subjects. For example, during the 19th and early 20th centuries the burdens of serving as research subjects fell largely upon poor ward patients, while the benefits of improved medical care flowed primarily to private patients. Subsequently, the exploitation of unwilling prisoners as research subjects in Nazi concentration camps was condemned as a particularly flagrant injustice. In this country, in the 1940's, the Tuskegee syphilis study used disadvantaged, rural black men to study the untreated course of a disease that is by no means confined to that population. These subjects were deprived of demonstrably effective treatment in order not to interrupt the project, long after such treatment became generally available.

Against this historical background, it can be seen how conceptions of justice are relevant to research involving human subjects. For example, the selection of research subjects needs to be scrutinized in order to determine whether some classes (e.g., welfare patients, particular racial and ethnic minorities, or persons confined to institutions) are being systematically

selected simply because of their easy availability, their compromised position, or their manipulability, rather than for reasons directly related to the problem being studied. Finally, whenever research supported by public funds leads to the development of therapeutic devices and procedures, justice demands both that these not provide advantages only to those who can afford them and that such research should not unduly involve persons from groups unlikely to be among the beneficiaries of subsequent applications of the research.¹⁰

As we shall see shortly, the principlism described by Beauchamp and Childress divides Belmont's principle of beneficence into two separate principles—the principle of beneficence and the principle of nonmaleficence.

The Principles of Biomedical Ethics

“Biomedical ethics has assumed a kind of ‘principlist’ orientation over the past 30 years”;^{1(p4)} stated otherwise, the dominant approach to biomedical ethics has been the approach espoused by Beauchamp and Childress in their classic textbook, *Principles of Biomedical Ethics*.¹¹ Beauchamp and Childress “believe that principles provide the most general and comprehensive norms . . . that guide actions. The difference [between rules and principles] is that rules are more specific in content and more restricted in scope than principles.” Their approach is known as *principlism*, or the *four-principles approach* to biomedical ethics—or, more colorfully, as the Georgetown Mantra. The four principles are as follows: respect for autonomy; nonmaleficence; beneficence; and justice.

The Beauchamp and Childress text is probably the authoritative work on principlism, and it seems that most bioethical decisions are analyzed using the framework described therein. The popular text *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*¹² employs the four principles in its practical approach.

Respect for Autonomy

Personal autonomy refers to self-governance, to “self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice.”^{11(p58)} According to Beauchamp and Childress,

The principle [of respect for autonomy] can be stated as a negative obligation and as a positive obligation. As a *negative* obligation: Autonomous actions should not be subjected to controlling constraints by others. . . . As a *positive* obligation, this principle requires respectful treatment in disclosing information and fostering autonomous decision-making.”^{11(p64)}

According to Beauchamp and Childress, the principle of respect for autonomy supports a number of more specific rules, including the following:

1. Tell the truth.
2. Respect the privacy of others.
3. Protect confidential information.
4. Obtain consent for interventions with patients.
5. When asked, help others make important decisions.^{11(p65)}

In terms of the moral rules discussed in the next chapter of this book, the principle of respect for autonomy might be interpreted as another formulation of the moral rule “Do not deprive of freedom.”^{3(p78)}

In the medical context, because of the need for medical decisions to be made, the question with which we are most likely to be concerned is, Is this patient’s choice (decision) an autonomous one? The earlier excerpt provides some clues to answering that question. First, in order to be an autonomous choice, a patient’s choice must be *voluntary*. This is another way of saying that it must be free of “controlling constraints by others.” Second, a patient’s choice must be *informed*.

Of course, there is an aspect to patient autonomy that has nothing to do with any negative or positive obligations that might be owed patients by health care professionals (including physicians, physician assistants, and other allied health professionals), and so is not addressed in the previous excerpt. Some persons are simply not capable of making an autonomous choice. An example of such a person might be, for example, a neonate. The principal reason a neonate is incapable of autonomous choice (communication issues aside) is that he or she lacks *decision-making capacity*, or *competence*.¹³ Where a choice is not autonomous because of decisional incapacity (i.e., incompetence), it follows that it may not be worthy of respect and that principles other than respect for autonomy may need to be invoked as a guide to action.

In summary, then, for a patient’s choice to be an autonomous choice, the patient must make his or her choice *voluntarily* (free of controlling constraints), his or her choice must be adequately *informed*, and the patient must have *decision-making capacity* (i.e., he or she must be *competent*). Let’s turn to a brief discussion of each of these requirements.

Voluntariness

According to Beauchamp and Childress, “a person acts voluntarily to the degree that he or she wills the action without being under the control of another’s influence.”^{11(p93)} Beauchamp and Childress distinguish between influences that are controlling and those that are not. Controlling influences render acts nonautonomous because they are not voluntary. Noncontrolling influences do not vitiate the voluntariness of a person’s choice.

Beauchamp and Childress discuss three types of influence. *Coercion* “occurs if and only if one person intentionally uses a credible and severe threat of harm or force to control another. . . . Coercion voids an act of autonomy; that is, coercion renders even intentional and well-informed behavior nonautonomous.”^{11(p94)}

Persuasion, on the other hand, refers to the process whereby “a person . . . come[s] to believe in something through the merit of reasons another person advances.”^{11(p94)} Stated otherwise, persuasion is “influence by appeal to reason.”^{11(p94)} Defined this way, persuasion is clearly not a controlling influence, because ultimately the final decision remains the patient’s. Indeed, the entire informed consent process might be conceptualized as a process through which one person (the patient) comes to believe in something (that the intervention should be consented to or refused) through the merit of reasons advanced by the health care professional (HCP).

Finally, *manipulation* refers to “forms of influence that are neither persuasive nor coercive. The essence of manipulation is swaying people to do what the manipulator wants by means other than coercion or persuasion.”^{11(p95)} Beauchamp and Childress point out that, in the health care context, the principal form of manipulation is informational—that is, communicating information in a way that nonpersuasively increases the likelihood that its recipient will reach a certain conclusion. (For example, saying to a patient during the course of an informed consent discussion, “This treatment is usually successful” about a treatment that is successful 51% of the time is, strictly speaking, true, but is more likely to elicit consent from the patient than by communicating the same information by saying “This treatment fails almost half the time.”) For this reason, we believe that it makes more sense to think about manipulation as implicating the informational arm of autonomy rather than the voluntariness arm.

Information and Informed Consent

This topic is dealt with in some detail in Chapters 8 and 9. Herein, we shall confine ourselves to the topic as it relates to principlism.

Regarding the *positive* obligation inherent in the principle of respect for autonomy, what information must an HCP convey to his or her patient? Probably most of us are familiar with the mantra admonishing us to discuss with patients the material or important “risks [of], benefits [of], and alternatives [to]” the clinical intervention under consideration, with the emphasis on the concept of materiality. By implication, the disclosure should, of course, include the HCP’s recommendation.^{11(p81)}

The question that naturally follows is, When is a fact a *material* fact? Retrospectively, the issue is likely to arise in the context of medical malpractice litigation, with the question for the jury being, Did the HCP fail to disclose to the patient material information? (This is discussed in Chapters 8, 9, and 15.) Prospectively, however, the question is, How do I as an HCP decide whether a particular fact is material and whether it should be disclosed to the patient? The moral obligations imposed by the principle of respect for autonomy are likely to be more exacting than the obligations of the law. Thus, the most common legal standard of disclosure is the

“professional malpractice” standard, under which physicians are required to disclose to patients that information which would have been disclosed by the reasonable, minimally competent physician. . . . A substantial number of states use

the “material risk” or “reasonable patient” standard, which requires disclosure of risks that a reasonable patient would consider to be material in making a medical treatment decision. A small number of jurisdictions take an even more protective approach, requiring disclosure of information that a particular patient (as contrasted with a “rational” patient) would have wanted to make his or her decision.¹⁴

The latter standard is referred to as the *subjective standard*, and though it is the exception rather than the rule in the legal context, it is the “preferable *moral* standard of disclosure, because it alone acknowledges persons’ specific informational needs.”^{11(p83)}

Where adequate disclosure has been made and the patient has had an opportunity to weigh the content of the disclosure in his or her decision making, the patient’s subsequent choice may be said to be informed; alternatively, it may be said that the patient has given informed consent (or informed refusal, as the case may be). However, it is important to be aware that the term *informed consent* is sometimes used to signify something broader in scope; it is sometimes used as a synonym or alias for *autonomous choice*. Thus,

Some commentators have attempted to define informed consent by . . . dividing [it] into an *information* component and a *consent* component. The information component refers to disclosure of information and comprehension of what is disclosed. The consent component refers to both a voluntary decision and an authorization to proceed. Legal, . . . philosophical, [and] medical . . . literatures . . . favor the following elements as the components of informed consent: (1) competence, (2) disclosure, (3) understanding, (4) voluntariness, and (5) consent. . . . One gives an informed consent to an intervention if (and only if) one is competent to act, receives a thorough disclosure, comprehends the disclosure, acts voluntarily, and consents to the intervention.^{11(p79)} (Internal footnotes omitted)

Competency

As mentioned earlier, herein we employ the terms *competency* and *decisional capacity* interchangeably. As was true of informed consent, competency is discussed in detail elsewhere in this text (Chapter 7); herein, we limit ourselves to a discussion of the topic as it relates to the principle of respect for autonomy.

Competency (or *decisional capacity*) refers to one’s ability to make a particular decision. To say that someone is competent to make a particular decision is shorthand for saying that we believe he or she should be allowed to make that decision under the circumstances that prevail. Note that competency is decision specific; I may believe that my three-year-old should be allowed to choose whether he wants chocolate or vanilla ice cream, but not whether he will or will not undergo life-saving surgery.

Byron Chell has written that generally “a person is labeled competent if (1) he or she has an understanding of the situation and the consequences of the decision, and (2) the decision is based upon rational reasons.”¹⁵ Case 2-A is taken from Chell’s work.

Case 2-A

“An 86-year-old female is informed that her leg is gangrenous and that an amputation is necessary to save her life. She refuses surgery, saying ‘I am 86 and I have lived a good and full life. I do not want a further operation, nor do I want to live legless. I understand the consequence of refusing the amputation is death and I accept that consequence.’”^{15(p120)} Is this patient competent to decide to refuse the surgery?

Analysis

The issue in this case is the patient’s competency or decisional capacity. Does the patient understand her situation (i.e., that she has life-threatening gangrene)? Yes. Does she understand the consequences of her decision (i.e., that she will die without surgery)? Yes. Is her decision based on rational reasons? Most of us would probably conclude that the reasons for the refusal are rational under the situation—that having to undergo unwanted further surgery and having to live legless at the age of eighty-six might reasonably be adjudged to be a greater harm than death to an eight-six-year-old. Her refusal should be honored.

If the patient refused surgery, insisting that she did not have gangrene, we could argue that she was incompetent because she lacked an understanding of the situation. If instead, while conceding that she had gangrene, she nevertheless refused surgery, insisting that the gangrene would be cured by a course of antibiotics, we could argue that she was incompetent because she lacked an understanding of the consequences of her decision. “If she were to say, ‘I understand the [situation and the] consequences but I refuse the operation because the moon is full,’ it is not likely she would be considered competent. . . . Her decision does not rationally or reasonably follow from her premise. . . . She would be labeled incompetent.”^{15(p120)}

The Problem of Religious Beliefs

Consider a different case now, that of a Jehovah’s Witness who refuses a lifesaving blood transfusion. Recall that “a person is labeled competent if (1) he or she has an understanding of the situation and the consequences of the decision, and (2) the decision is based upon rational reasons.”¹⁵ The application of part 1 of this test is relatively straightforward, even in cases involving religious beliefs. We ask whether the patient understands the situation and the consequences of the decision. If the patient understands that he has a life-threatening bleed and is likely to die without the transfusion, he will have passed the first part of the test of competency. If instead he insists that he will be cured by Jehovah without the need for a blood transfusion, that belief might be treated as a religious delusion and the patient adjudged to be incompetent.¹⁶

However, what about part 2 of the test for competency? Even the Jehovah’s Witness who understands that he has a life-threatening bleed and is likely to die without the transfusion, when asked to give reasons for his refusal, is likely to give religious reasons—such as fear of eternal damnation.¹⁷ The problem, of course, is that religious beliefs, based as

they are upon that which cannot be proved, cannot be said to be rational. In the words of Sam Harris in his provocative book *The End of Faith*,

Is a person really free to believe a proposition for which he has no evidence? No . . . We have names for people who have beliefs for which there is no rational justification. When their beliefs are extremely common we call them “religious”; otherwise, they are likely to be called “mad,” “psychotic,” or “delusional.”¹⁸

Of course, we do not, as a rule, deem patients to be incompetent merely because the reasons for their refusal are religious.¹⁹ Chell explains that if the reason for a patient’s refusal is a religious one, the patient will not be deemed incompetent on that basis so long as the religious beliefs are “held by a sufficient number of persons for a sufficient period of time or [are] sufficiently similar to other orthodox beliefs such that we do not label the beliefs crazy or nonreligious.”^{15(p123)}

When might a religious belief be considered crazy or nonreligious? Consider, as an example, a patient who claimed to belong to the Church of the Fonz²⁰ and refused potentially lifesaving treatment because of his interpretation of the teachings of the “sacred texts” of his religion, old *Happy Days* episodes. It is likely that such a patient would be deemed to be incompetent.

Competency and Respect for Autonomy

Deciding whether a patient is competent is an important and unavoidable decision. The choice is unavoidable because the default position is that the patient’s choice will be implemented absent some objection on the part of the HCP (the law, after all presumes that all persons are competent absent evidence to the contrary). The choice is important because, in making it, we walk a fine line between Scylla and Charybdis—that is, between the Scylla of erroneously adjudging an autonomous choice to be nonautonomous (and thus wrongfully failing to acknowledge the patient’s autonomy) and the Charybdis of erroneously adjudging a nonautonomous choice to be autonomous (and thus wrongfully failing to protect from harm a patient unable to protect himself or herself).

Ultimately, a number of factors will influence an HCP’s determination as to whether a particular patient is competent or not. Not surprisingly, one of them is the HCP’s degree of certainty that the patient is competent. The more certain I am that a patient has decisional capacity, the more likely I am to honor his or her decision, whether I agree with it or not. A second factor concerns the HCP’s medical certainty regarding the facts of the situation and the patient’s prognosis. Whether or not I decide to honor the decision of a patient of arguable competency to refuse a lifesaving intervention will depend at least in part on how certain I am that the intervention is in fact lifesaving. Perhaps the patient might survive even without the intervention. To the extent that I as an HCP am uncertain about my prognostication, I will be more likely to err on the side of deciding that the patient’s wishes should be honored. A third factor concerns the HCP’s assessment of the severity of the situation and the potential outcome of the patient’s decision. A patient

with a lower extremity venous stasis ulcer who refuses to wear a compressive dressing runs the risk that her wound may not heal or that wound healing will be delayed; a patient with clinical and computed tomographic evidence of acute appendicitis who refuses appendectomy runs the risk of death. It should be clear that, when the decisional capacity of these two patients is in question and all other things are equal, an HCP would be more likely to honor the treatment refusal of the former than the latter.

Case 2-B “When Is Odysseus to Be Believed?”

A fifty-eight-year-old woman with chronic obstructive pulmonary disease (COPD) had, over a period of years, repeatedly expressed a desire not to be endotracheally intubated and mechanically ventilated “unless such an intervention were to be purely temporary.”^{21(p54)} The patient was brought to the hospital in terminal respiratory failure, and it was the opinion of the medical staff—including a consulting pulmonologist—that if she were placed on a ventilator there was almost no chance of her ever being weaned. When her physician asked her whether she wanted to be intubated, she expressed a wish to be placed on a ventilator “even if she would never again be able to be weaned from it.” The physicians caring for her decided that her request to be intubated did not represent an autonomous choice because it was made under the “internal coercion of panic, fear, anoxia [and] hypercarbia,” and because it was entirely inconsistent with her repeatedly and emphatically stated prior wishes. The patient was sedated and allowed to die. Do you agree with the decision not to intubate her?

Analysis

As mentioned previously, this case can be analyzed at a number of levels. Because this chapter deals with the principles of biomedical ethics, our analysis will proceed from that level.

The question to be answered is whether the patient should have been intubated. To answer this question, the first issue that needs to be addressed is whether this patient’s death-bed consent to intubation was *autonomous*. (Assume that the patient’s choice to refuse even life-sustaining treatment, if autonomous, should be respected.) Recall that a choice is autonomous if it is voluntary, informed, and made by an agent with decisional capacity (a competent agent).

In this case it is the decisional capacity or competency of the patient and the voluntariness of her choice that are in question. Thus, there are two questions that must be answered: (1) Did she have decisional capacity or competency? And (2) was her choice voluntary?

First, did she have decisional capacity or competency? Recall that a patient is competent if (1) she has an understanding of the situation and the consequences of her decision, and (2) her decision is based on rational reasons. We are told that she was “slightly ‘fuzzy’—albeit grossly oriented,” and that the physicians responsible for her care were concerned about her anoxia and hypercarbia. Regarding her anoxia and hypercarbia, was she anoxic and/or hypercarbic enough to be rendered incompetent? We simply do not seem to have enough information to be able to answer this question. Luckily, under the law there is a rebuttable presumption that

(continues)

Case 2-B “When Is Odysseus to Be Believed?” (*continued*)

patients are competent—that is, the burden of persuasion rests with those who would argue that a person lacks decisional capacity or competency. Because of this presumption, we would argue that absent probative evidence to the contrary, the patient was competent to consent to intubation and mechanical ventilation.

Second, was her choice to refuse mechanical ventilation voluntary? As stated earlier, “a person acts voluntarily to the degree that he or she wills the action without being under the control of another’s influence.” Clearly this patient was not under the control of any other person’s influence. Beauchamp and Childress state, however, that conditions such as debilitating disease (among others) can diminish or void voluntariness.²² In this case, the physicians responsible for her care expressed concern regarding the “internal coercion of panic [and] fear.”²³ Were the patient’s panic and fear great enough to void voluntariness? We would argue that the same policy considerations that undergird the presumption of competency should undergird a presumption of voluntariness. Who is to say that, faced with the real and immediate specter of one’s death, one does not possess a certain insight or clarity lacking in the rest of us? Why should we believe that fear of death precludes the ability to choose autonomously? We believe that her (later) choice to consent to intubation and mechanical ventilation should have been honored and that she should have been intubated.²⁴

Nonmaleficence

The Hippocratic imperative to physicians, “Bring benefit and do no harm,” expresses the principles of nonmaleficence (“do no harm”) and beneficence (“bring benefit”).^{12(p18)}

The *principle of nonmaleficence* refers to the duty to refrain from causing harm. It underlies the medical maxim *Primum non nocere*: “Above all [or first] do no harm.”^{11(p113)} The principle of nonmaleficence says, “One ought not to inflict evil or harm,”^{11(p116)} where a harm is defined as an adverse effect on one’s interests. According to Beauchamp and Childress, the principle of nonmaleficence supports a number of more specific moral rules, including the following:

1. Do not kill.
2. Do not cause pain or suffering.
3. Do not incapacitate.
4. Do not cause offense.
5. Do not deprive others of the goods of life.^{11(p117)}

In terms of the moral rules you will learn about in the next chapter, Gert has suggested that the principle of nonmaleficence is

most reasonably interpreted as . . . summarizing . . . the moral rules “Don’t kill,” “Don’t cause pain,” . . . “Don’t disable,” . . . and probably the rule “Don’t deprive of pleasure” as well. Even the rule “Don’t deprive of freedom” can be included in

the principle of nonmaleficence, but principlism seems to prefer to include it under the principle of autonomy.^{3(p76)}

Harmful acts are generally *prima facie*²⁵ wrong, but will not but considered wrong if the harm is justifiable. Harm is justifiable if there is a “just, lawful excuse or reason for the [prima facie harmful] act or [omission].”^{5(p599)} For example, killing is *prima facie* prohibited under the principle of nonmaleficence, but killing in self-defense, although clearly harmful of another, is not wrongful. Likewise, “[s]aving a person’s life by a blood transfusion clearly justifies the inflicted harm of venipuncture on the blood donor.”²⁶

The Rule of the Double Effect

Case 2-C demonstrates the application of the principle of nonmaleficence and introduces the derivative *rule of the double effect (RDE)*.

Case 2-C

A patient with a long smoking history is hospitalized with advanced COPD and lung cancer metastatic to bone.²⁷ Consider the following scenarios and questions:

1. The patient’s wife requests that the physician increase the rate of the morphine infusion to a point adequate to control the patient’s pain, irrespective of any effect it might have on his respiratory rate. Should the physician acquiesce?
2. The patient’s wife requests that the inevitable be hastened and that sufficient morphine be administered to end the patient’s life and hence his suffering. Should the physician acquiesce?

Analysis

The principle of nonmaleficence imposes a *prima facie* prohibition on the infliction of harm or risk thereof on this patient, and increasing the amount of morphine the patient is receiving will expose the patient to an increased risk of respiratory depression and death. On the other hand, inadequate or suboptimal dosing of this patient’s morphine will harm the patient as well by causing pain and suffering. What, therefore, should be done? The answer lies in the RDE, which recognizes that there is a morally relevant difference between the intended effects of an action and its unintended though foreseen effects. Under the RDE, when an action has two inextricably linked foreseen effects (one ethically permissible and the other ethically questionable), the permissible effect may be pursued (even though the questionable or harmful one will follow) provided that all of the following conditions are met.

1. *The nature of the act.* The act must be good, or at least morally neutral (independent of its consequences).
2. *The agent’s intention.* The agent intends only the good effect. The bad effect can be foreseen, tolerated and permitted, but it must not be intended.

(continues)

Case 2-C (*continued*)

3. *The distinction between means and effects.* The bad effect must not be a means to the good effect. If the good effect were the direct causal result of the bad effect, the agent would intend the bad effect in pursuit of the good effect.
4. *Proportionality between the good effect and the bad effect.* The good effect must outweigh the bad effect. That is, the bad effect is permissible only if a proportionate reason compensates for permitting the foreseen bad effect.^{11(p129)}

In this case, morphine indeed has two inextricably linked effects—one ethically permissible (analgesia) and the other ethically problematic (respiratory depression). The act in question (intravenous administration of a pharmaceutical) is arguably at least a morally neutral act, satisfying condition 1. Condition 2 is satisfied in scenario 1 if the physician titrates the morphine drip only as high as is needed to achieve adequate analgesia. Likewise, condition 3 is satisfied in scenario 1 because respiratory depression is not the means to analgesia. Finally, condition 4 is satisfied in scenario 1 because most people would agree that achieving adequate pain control at the end of life of a terminal cancer patient is worth any foreseeable shortening of the patient's life that might occur as a result of narcotic administration. Therefore, in scenario 1 the RDE applies and the physician's acquiescence does not violate the principle of nonmaleficence.

In scenario 2, on the other hand, condition 2 is not satisfied because the physician intends the bad effect (respiratory depression). Likewise, in scenario 2 the bad effect (respiratory depression) becomes the means to the good effect (analgesia). Thus, a physician who acquiesced under scenario 2 would be violating the principle of nonmaleficence.

Beneficence

The *principle of beneficence* “asserts the duty to help others further their important and legitimate interests.”²⁸ Under the principle of beneficence,

1. One ought to prevent evil or harm.
2. One ought to remove evil or harm.
3. One ought to do or promote good.^{11(p115)}

According to Beauchamp and Childress, the principle of beneficence supports a number of more specific rules, including the following:

1. Protect and defend the rights of others.
2. Prevent harm from occurring to others.
3. Remove conditions that will cause harm to others.
4. Help persons with disabilities.
5. Rescue persons in danger.^{11(p167)}

Unlike the negative prohibitions of nonmaleficence, beneficence exhorts those to whom it applies to act affirmatively. In other words, one can obey the dictates of *nonmaleficence* by merely refraining from acting; not so in the case of *beneficence*.

Beauchamp and Childress distinguish between specific beneficence and general beneficence. *Specific beneficence* is obligatory beneficence. It refers to those positive obligations (i.e., duties to act) we owe to others to further their important and legitimate interests. We owe a duty of specific beneficence to those others with whom we are in some special relationship. (We shall consider such relationships again in Chapter 15.) Thus, we owe a duty of specific beneficence, for example, to our children, and, as HCPs, to our patients. As HCPs, we are obligated not merely to refrain from harming our patients (under the principle of nonmaleficence), but to act in their best medical interests.

General beneficence “is directed beyond those special relationships to all persons.”^{11(p169)} For the most part, general beneficence is ideal beneficence—that is, although moral ideals encourage us to act affirmatively so as to help others with whom we do not find ourselves in a special relationship, we are not obliged to do so by the moral rules (see Chapter 3). I say “for the most part” because Beauchamp and Childress argue that, even apart from special relationships, a person X owes an obligatory duty of beneficence toward a person Y if each of the following conditions is true:

1. Y is at risk of significant loss of or damage to life or health or some other major interest.
2. X’s action is needed (singly or in concert with others) to prevent this loss or damage.
3. X’s action (singly or in concert with others) has a high probability of preventing it.
4. X’s action would not present significant risks, costs or burdens to X.
5. The benefit that Y can be expected to gain outweighs any harms, costs, or burdens to X that is likely to occur.^{11(p171)}

Case 2-D

A seventy-nine-year-old female patient (Mrs. Y) was admitted to the hospital with an acute, non-Q-wave myocardial infarction.²⁹ On cardiac catheterization, she was found to have a tapering stenosis of the left anterior descending (LAD) coronary artery, a sixty percent obstruction proximally increasing to a ninety percent obstruction distally. The right and circumflex systems were found to be diffusely but mildly diseased. Her ejection fraction was about forty percent. The patient was evaluated at a medical-surgical conference, and because the nature of the LAD lesion rendered percutaneous transluminal coronary angioplasty (PTCA) difficult, coronary artery bypass grafting (CABG) was considered. Ultimately, however, the recommendation was for medical therapy.

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Case 2-D (continued)

Two days after being discharged from the hospital on medical therapy, the patient was brought to the hospital in cardiac arrest and pulmonary edema. She was resuscitated and found to have suffered no permanent neurologic sequelae, and she was stabilized through the use of an intra-aortic balloon pump (IABP). Myocardial infarction was ruled out. Over the following days, numerous efforts to remove the IABP were unsuccessful; the patient's coronary artery perfusion was dependent on the IABP. Her physicians believed that her only chance for survival was revascularization. Because the facility at which she was hospitalized did not offer cardiac surgery or angioplasty, her physicians contacted cardiothoracic surgeons at a number of regional facilities; all of them refused to accept the patient in transfer because her surgical mortality was felt to be unacceptably high, and it was believed that her (likely) death would adversely affect their mortality statistics, which were being published in the state in which they practiced. By day 9 of hospitalization, her condition had deteriorated further and, believing at this point that it was riskier for the patient to undergo CABG than PTCA, her physicians contacted interventional cardiologists at a number of regional facilities. All refused to accept the patient because she was so high risk. On day 21 of hospitalization, the patient expired. Was the refusal of the subspecialists to accept Mrs. Y in transfer a violation of the principle of beneficence?

Analysis

The issue is whether the subspecialists violated the principle of beneficence. Recall from the previous discussion that there are two categories of beneficence—specific and general. Specific beneficence is the obligatory beneficence that we owe to those others with whom we are in a special relationship. Were any of the subspecialists who were asked to accept Mrs. Y in transfer in a special relationship with her? Probably not. There is no indication in the facts provided that any of them were in a preexisting doctor–patient relationship with her. What about the fact that they were asked by the physicians caring for her to accept her in transfer? Does that create a special relationship? Because, traditionally, physicians have been free to determine which patients they will and will not see, the answer is probably no. (A special relationship might exist if, for example, there was a law in place prohibiting subspecialists from refusing transfers such as the one in question. Alternatively, a special relationship might be found to exist if the referring physicians and the subspecialists were all on the medical staff at the institution where the patient was hospitalized, and there was in place a call schedule for subspecialists.) Therefore, the subspecialists arguably owe no duty of specific beneficence to Mrs. Y.

Do the subspecialists owe an obligatory duty of beneficence to Mrs. Y under the principle of general beneficence? Recall that a person X owes an obligatory duty of beneficence toward a person Y if (1) Y is at risk of significant loss of or damage to life or health or some other major interest; (2) X's action is needed (singly or in concert with others) to prevent this loss or damage; (3) X's action (singly or in concert with others) has a high probability of preventing this loss or damage; (4) X's action would not present significant risks, costs, or burdens to X; and (5) the benefit that Y can be expected to gain outweighs any harms, costs, or burdens to X that are likely to occur. Because strong arguments can be made that each of these conditions apply to the case under discussion, we believe a very strong argument can be made that the subspecialists' refusal constituted a violation of the principle of beneficence—specifically of an obligatory (as opposed to ideal) duty of general beneficence.

Paternalism

Stated simply, *medical paternalism* consists in the judgment that the principle of beneficence trumps the principle of autonomy. Probably most of us have heard the term *paternalism* bandied about pejoratively, though that was not always the case. Historically, beneficence was thought to express the primary obligation of physicians and HCPs; only more recently has the principle of respect for autonomy gained ascendancy.

Beauchamp and Childress define paternalism as “the intentional overriding of one person’s known preferences . . . by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person whose preferences . . . are overridden.”^{11(p178)} Further, they distinguish between weak (soft) and strong (hard) paternalism.

In weak paternalism, an agent intervenes on grounds of beneficence . . . only to prevent *substantially [nonautonomous] conduct*. . . [Such conduct] include[s] cases of consent or refusal that is not adequately informed, severe depression that precludes rational deliberation, and addiction that prevents free choice and action.

...

Strong paternalism, by contrast, involves interventions intended to benefit a person, despite the fact that the person’s risky choices . . . are informed, voluntary and autonomous.^{11(p181)}

Whether weak paternalism is even a *prima facie* wrong in need of a defense is arguable,^{11(p181)} because if a person’s choice is not autonomous, it need not be respected. Strong paternalism is, on the other hand, more controversial. According to Beauchamp and Childress,

Normally, strong paternalism is appropriate and justified in health care only if the following conditions are satisfied:

1. A patient is at risk of a serious, preventable harm.
2. The paternalistic action will probably prevent the harm.
3. The projected benefits to the patient of the paternalistic action outweigh its risks to the patient.
4. The least autonomy-restrictive alternative that will secure the benefits and reduce the risks is adopted.^{11(p186)}

Justice

The *principle of justice* underlies concerns about how social benefits and burdens should be distributed. For example, is it fair that two patients, otherwise similarly situated, are treated disparately by the health care system because one is affluent and the other is indigent? Between two otherwise similarly situated patients in need of a liver transplant,

who should receive the one organ that is available—the recovering alcoholic who has been sober for one year or the patient dying of biliary atresia?³⁰

The *principle of formal justice* is common to all theories of justice, and is traditionally attributed to Aristotle. It holds that justice requires that equals be treated equally, and unequals be treated unequally, but in proportion to their relevant inequalities. The question that naturally arises is, When is an inequality a relevant inequality? The various answers to this question constitute the *material principles of distributive justice*. Thus,

Philosophers . . . have proposed each of the following principles as a valid material principle of distributive justice. . . .

1. To each person an equal share
2. To each person according to need
3. To each person according to effort
4. To each person according to contribution
5. To each person according to merit
6. To each person according to free-market exchanges^{11(p228)}

The material principle of justice that one applies will depend on the theory of justice to which one subscribes.

Utilitarian Theories of Justice

Under utilitarian theories (see Chapter 1), “justice is merely the name for the . . . obligation created by the principle of utility,”^{11(p231)} under which we should “strive to produce as much overall happiness as possible.”³¹ Thus, for utilitarians a just distribution of benefits and burdens would be one that produces the most overall happiness. For the utilitarian, “all rules of justice, including equality, can bow to the demands: ‘each person maintains that equality is the dictate of justice, except where he thinks that expediency requires inequality.’ Whatever does the greatest overall good will be ‘just’ [internal footnotes omitted].”³²

Egalitarian Theories of Justice: Rawls

“*Egalitarian* theories of justice hold that persons should receive an equal distribution of certain goods. . . . *Qualified egalitarianism* requires only some basic equalities among individuals and permits inequalities that redound to the benefit of the least advantaged [italics added].”^{11(p233)} John Rawls’s “justice as fairness,” as described in his work *A Theory of Justice*, is probably the foremost modern version of such a qualified egalitarianism. Rawls argues that the principles of justice are those principles that would be chosen by persons behind a metaphorical “veil of ignorance”—that is, persons who “would not know their own race, sex, degree of wealth, or natural abilities.”³³ According to Rawls, those principles of justice to which persons would agree would be as follows:

First: each person is to have an equal right to the most extensive basic liberty compatible with a similar liberty for others.

Second: social and economic inequalities are to be arranged so that they are both (a) reasonably expected to be to everyone's advantage, and (b) attached to positions and offices open to all.^{33(p450)}

The first principle applies, for example, to the distribution of political liberty and rights such as those protected in the American Bill of Rights. The second principle applies, for example, to the distribution of income and wealth; what the second principle means is that social and economic goods "are to be distributed equally unless an unequal distribution of any, or all, of these values is to everyone's advantage."^{33(p451)}

Libertarian Theories of Justice: Nozick

Unlike the theories of justice just discussed, libertarian theories do not focus on maximizing utility or on achieving an equal distribution of goods; rather, libertarian conceptions of justice tend to emphasize the importance of "the unfettered operation of fair procedures."^{11(p232)} Robert Nozick developed a libertarian theory of justice—the so-called *entitlement theory*—in his work *Anarchy, State, and Utopia*. Therein, he distinguishes between *historical* principles of justice and *unhistorical* (or end-result) principles of justice (such as utilitarian justice or egalitarian justice), arguing that the justice of any particular distribution of a good among a number of individuals depends not upon how much of the good each individual has, but upon how that distribution came about. Under Nozick's theory,

A distribution is just if it arises from another just distribution by legitimate means. The legitimate means of moving from one distribution to another are specified by the principle of justice in transfer. The legitimate first "moves" are specified by the principle of justice in acquisition. Whatever arises from a just situation by just steps is itself just.³⁴

There are three principles of justice under Nozick's theory of justice: (1) the *principle of justice in acquisition*, which deals with the appropriation by persons of previously unheld things; (2) the *principle of justice in transfer*, which deals with the appropriation by persons of holdings from other persons; and (3) the *principle of rectification*, which, as the name suggests, deals with what may be done in order to rectify past injustices that have shaped present holdings.^{34(pp150–153)}

The following excerpt illustrates how a person's past actions can influence his or her present entitlements.

Ordinary prudence . . . require(s) that a (driver) be prepared to stop short . . . if by doing so he can avoid death or injury to another person. Let it be conceded also that a person need not in general take an action sacrificing his own life in order to avert a grave risk to another. Now let us imagine the case where A loads his truck with heavy steel pipe in such a way that if he stops short [the pipe] will

shift forward and is very likely to crush him. . . . A, thus laden, sees B drive out of a side road into his path. If A stops short he will avoid hitting and perhaps killing B, but he will also risk being killed by the pipe stacked in his truck. It would seem that A had the right to impose no more than a certain level of risk on others in venturing out on the highway. If he stays within that level and . . . something goes wrong . . . he is not at fault . . . [and] need not sacrifice his life to avoid taking the life of another person who is involved in the encounter. But since [A] ventured out bearing this particularly heavy and dangerous burden he forfeits that right. This argument makes the rightfulness of A's conduct depend on choices made on some distinct, earlier occasion. We can see this if we contrast A's situation with that of C, a hitchhiker who is a passenger [in] A's truck. C is not constrained to risk his life to save B. If A in a fit of cowardice had leapt from the cab leaving C at the controls, we feel that C would be justified in not stopping short. Yet at the moment of the crucial option—to stop or not to stop—the choice of risks presented to A or to C would be exactly the same. This must show that A's prior action in loading the truck in some way obligated him to drive so as to avert danger to persons in B's position, even at the risk of his own life.³⁵

This example may help explain our intuition that “it is fairer to give a child dying of biliary atresia an opportunity for a *first* normal liver than it is to give a patient with ARESLD [alcohol-related end-stage liver disease] who was born with a normal liver a *second* one.”^{30(p1297)}

Absolutely Scarce Resources

As a rule, in medicine we believe that the “health care system should respond based on the actual medical needs of patients” (i.e., that the operative material principle of justice is need) and that “whenever possible all in need should be treated.”³⁶ When all in need cannot be treated, however, then what? If we are dealing with an absolutely scarce resource (such as organs for transplantation), how do we decide who shall receive it when it cannot simply be divided equally between all in need? Generally, some type of selection system must be employed. Such systems include the *chronological system* (“first come, first served”), the *lottery system* (self-explanatory), the *waiting list system* (which differs from the chronological system in that medical criteria are taken into account), and *criteria systems*. Criteria employed in criteria systems include, for example, medical criteria (e.g., how good an HLA “match” exists between the organ donor and the organ recipient) and age (e.g., all other things being equal, it makes more sense to transplant an organ into a child whose life expectancy is, say, seventy years, than into an adult whose life expectancy is twenty-five years).³⁷

Critique of Principlism

Although principlism has been the dominant approach to bioethics over the past several decades, Gert and colleagues have criticized it on a number of grounds.³⁸ We shall examine just a few of those criticisms here.

First, they have argued that, except for the principle of nonmaleficence (see below), the principles of biomedical ethics are flawed because they are not true action guides. Rather, Gert and associates argue, they

function as checklists, naming issues worth remembering when one is considering a biomedical moral issue. “Consider this . . . consider that . . . remember to look for . . .” is what they tell the agent; they do not embody an articulated, established, and unified moral system capable of providing useful guidance.^{3(p75)}

Beauchamp and Childress concede that their “four clusters of principles do not constitute a general moral theory. They provide only a framework for identifying and reflecting on moral problems.”^{11(p15)}

Second, principlism has been criticized as failing to distinguish between what is morally required (by the moral rules) and what is morally encouraged (by the moral ideals). For example, the principle of respect for autonomy does not distinguish between “Tell the truth” (a moral rule) and “When asked, help others make important decisions” (a moral ideal).^{3(p81)}

Third, principlism has been criticized as failing to provide an “agreed-upon method for resolving . . . conflicts” between the principles when in fact they conflict with each other.^{3(p87)}

Chapter Summary

Principles, like rules, are action guides, although the guidance they provide is more abstract or general. The principles of biomedical ethics emerged from the 1974 Belmont Report. The principles, as subsequently described by Beauchamp and Childress, include respect for autonomy; nonmaleficence; beneficence; and justice. Under the principle of respect for autonomy, a patient’s choice is autonomous if (1) the choice is voluntary (i.e., it is free of controlling constraints by others), (2) the patient is adequately informed, and (3) the patient possesses decision-making capacity or competence. The principle of nonmaleficence refers to the duty to refrain from causing harm. The principle of beneficence asserts the duty to help others and encompasses both specific (obligatory) and general (ideal, and sometimes obligatory) beneficence. Medical paternalism consists in the judgment that the principle of beneficence trumps the principle of autonomy. The principle of formal justice holds that justice requires that equals be treated equally, and unequals be treated unequally, but in proportion to their relevant inequalities. The material principles of distributive justice purport to answer the question, When is an inequality a relevant inequality? Principles that have been proposed as valid material principles of distributive justice include the following: to each person an equal share; to each person according to need; to each person according to effort; to each person according to contribution; to each person according to merit; and to each person according to free-market exchanges.

Review Questions

1. How do the principles of biomedical ethics relate to ethical theory? To the moral rules?
2. List four principles of biomedical ethics.
3. What does the principle of respect for autonomy demand of us?
4. What elements must be present in order for a choice to be autonomous? Why does it matter whether a choice is autonomous?
5. How does one decide whether a patient possesses decisional capacity?
6. How does one decide whether a patient's choice is a voluntary choice?
7. What does the principle of nonmaleficence demand of us?
8. What is the rule of the double effect? What elements must be present in order for it to apply?
9. What does the principle of beneficence demand of us?
10. What is the difference between specific and general beneficence? Between obligatory and ideal beneficence?
11. What is paternalism? Is it ever justified? When?
12. What does the formal principle of justice require?
13. What are the material principles of justice under utilitarian, egalitarian, and libertarian views of justice?

Endnotes

1. Gibson J. Thinking about the "ethics" in bioethics. In: Furrow BR, Greaney TL, Johnson SH, Jost TS, Schwartz RL, eds. *Bioethics: Health Care Law and Ethics*. 5th ed. St. Paul, MN: Thomson, 2001:1–5.
2. *Oxford American Dictionary*. Heald College ed. New York: Avon, 1980:710; italics added.
3. Gert B, Culver CM, Clouser KD. *Bioethics: A Return to Fundamentals*. New York: Oxford University Press, 1997:71–92, p. 75; italics added.
4. In Chapter 1, we learned about a number of ethical theories, as we were introduced to the thinking of Descartes, Aristotle, Aquinas, Kant, and Mill. The theory of *common morality* was not discussed therein, but will be developed in Chapter 3.
5. "Prior cases which are close in facts or legal principles to the case under consideration are called precedents." *Black's Law Dictionary*. Abridged 6th ed. St. Paul, MN: West Publishing, 1991:814.
6. *Roe v. Wade*, 410 U.S. 113 (1973).
7. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992).
8. Justices Scalia, Thomas, and White, along with Chief Justice Rehnquist, dissented in part. In his dissent, Justice Scalia wrote:

The authors of the joint opinion, of course, do not squarely contend that *Roe v. Wade* was . . . correct . . . ; merely that it must be followed, because of *stare decisis*. But in their exhaustive dis-

cussion of all the factors that go into the determination of when *stare decisis* should be observed and when disregarded, they never mention “how wrong was the decision on its face?” Surely, if “[t]he Court’s power lies . . . in its legitimacy, a product of substance and perception,” the “substance” part of the equation demands that plain error be acknowledged and eliminated. *Roe* was plainly wrong—even on the Court’s methodology of “reasoned judgment,” and even more so (of course) if the proper criteria of text and tradition are applied. (Internal citations omitted)

9. Simmonds NE. Philosophy of law. In: Bunnin N, Tsui-James EP, eds. *The Blackwell Companion to Philosophy*. Oxford, England: Blackwell Publishers, 1996:396.
10. The Belmont Report: ethical principles and guidelines for the protection of human subjects of research. Available at: <http://ohsr.od.nih.gov/guidelines/belmont.html>. Accessed June 11, 2008.
11. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 5th ed. Oxford: Oxford University Press, 2001.
12. Jonsen AR, Siegler M, Winslade WJ. *Clinical Ethics*. 6th ed. New York: McGraw-Hill, 2006.
13. Some distinguish competency from decisional capacity. Thus, strictly speaking, *incompetency* refers to a formal judicial finding that a person cannot make legally effective decisions regarding his or her own affairs. *Decisional capacity*, on the other hand, refers to a person’s ability to make a particular decision and is not dependent on any formal judicial finding. Herein we shall use the two terms interchangeably in the latter sense.
14. Hall MA, Bobinski MA, Orentlicher D. *Health Care Law and Ethics*. 7th ed. Austin, TX: Aspen Publishers, 2006:203–204.
15. Chell B. Competency: what it is, what it isn’t, and why it matters. In: Monagle JF, Thomasma DC, eds. *Health Care Ethics: Critical Issues for the 21st Century*. Sudbury, MA: Jones and Bartlett, 2004:117–127.
16. In *In re Milton*, 505 N.E. 2d 255 (Ohio 1987), treatment was allowed despite the patient’s religious refusal. The court disregarded the patient’s belief that her evangelist husband would heal her as a “religious delusion,” characterizing her decision as a nonchoice.
17. Dixon JL. Blood: whose choice and whose conscience? Available at: http://www.watchtower.org/e/hb/index.htm?article=article_07.htm Accessed June 10, 2008. Reprinted there by permission of the *New York State Journal of Medicine*, 1988;88:463–464, copyright by the Medical Society of the State of New York.
18. Harris S. *The End of Faith: Religion, Terror, and the Future of Reason*. New York: W. W. Norton & Company, 2004.
19. Thus, the First Amendment holds that “Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.” State governments are similarly constrained by the Fourteenth Amendment, which makes the First Amendment applicable to them.
20. “The Father, the Son, and the Holy Fonz.” Available at: http://en.wikipedia.org/wiki/The_Father,_the_Son,_and_the_Holy_Fonz. “The Father, the Son, and the Holy Fonz” was the eighteenth episode of the fourth season of *Family Guy*.
21. Loewy E. Changing one’s mind: when is Odysseus to be believed? *J Gen Intern Med* 1988;3:54–58. See also Paola F. Changing one’s mind [letter]. *J Gen Intern Med* 1988;3:416.
22. In the criminal law context, a controlling influence exerted by person A on person B is sometimes referred to as *duress*, and under certain circumstances will cause the law to excuse the

- (otherwise criminal) conduct of B; a controlling influence exerted by nonhuman events or circumstances on person B is sometimes referred to as *necessity*. Necessity does not excuse B's conduct, but may be used to argue that what he or she did was justified. See Emanuel S. *Criminal Law*. 2nd ed. Larchmont, NY: Emanuel Law Outlines, 1987:91–101.
23. Recall room 101 in Orwell's *1984*, where Winston Smith finds "the worst thing in the world"—rats—and under the coercion of fear and panic betrays his lover Julia. See Orwell G. *1984*. New York: Signet Classics, 1949.
 24. This case illustrates another important point. One should not ask a question unless one is willing to act on the answer one gets. If the patient's request to be intubated was not going to be heeded, why ask?
 25. *Prima facie* means "at first sight; . . . a fact presumed to be true unless disproved by some evidence to the contrary." See *Black's Law Dictionary* (abridged 6th ed.), 825.
 26. Beauchamp TL, Walters L, Kahn JP, Mastroianni AC. Ethical theory in bioethics. In: Beauchamp TL, Walters L, Kahn JP, Mastroianni AC, eds. *Contemporary Issues in Bioethics*. 7th ed. Belmont, CA: Thomson, 2008:1–34.
 27. Adapted from a case in *Clinical Ethics* (6th ed.), pp. 129–130.
 28. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 2nd ed. New York: Oxford University Press, 1983.
 29. Paola FA, Freeman I. The skilled specialist's ethical duty to treat. *J Clin Ethics* 1994;5(1):16–18.
 30. Moss AH, Siegler M. Should alcoholics compete equally for liver transplantation? *JAMA* 1991;265:1295–1298.
 31. Mill JS. Utilitarianism. In: Sher G, ed. *Moral Philosophy*. San Diego: Harcourt, Brace, Jovanovich, 1987:369–383, p. 369.
 32. Lebacqz K. *Six Theories of Justice*. Minneapolis: Augsburg Publishing House, 1987:21.
 33. Rawls J. A theory of justice. In: Sher G, ed. *Moral Philosophy*. New York: Harcourt, Brace, Jovanovich, 1987:453–472, p. 457.
 34. Nozick R. *Anarchy, State, and Utopia*. New York: Basic Books, 1974:151.
 35. Fried C. Imposing risks upon others. In: Sher G, ed. *Moral Philosophy*. San Diego: Harcourt Brace Jovanovich, 1987:705.
 36. Kilner JF. *Who Lives? Who Dies? Ethical Criteria in Patient Selection*. New Haven, CT: Yale University Press, 1992.
 37. Leenen HJJ. Selection of patients: an insoluble dilemma. *Med Law* 1988;7:233–245.
 38. It should be kept in mind, however, than many of their criticisms of principlism were leveled at its earlier versions, as formulated in earlier editions of the Beauchamp and Childress text *Principles of Biomedical Ethics*. Principlism has evolved over the years.