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# Not just autonomy – the principles of American biomedical ethics

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## Abstract

*The Principles of Biomedical Ethics by Tom L Beauchamp and James F Childress which is now in its fourth edition has had a great influence on the development of bioethics through its exposition of a theory based on the four principles: respect for autonomy; non-maleficence; beneficence, and justice (1).*

*The theory is developed as a common-morality theory, and the present paper attempts to show how this approach, starting from American common-morality, leads to an underdevelopment of beneficence and justice, and that the methods offered for specification and balancing of principles are inadequate.*

## Introduction

It is obviously an impossible project to diagnose the state of the whole of the field of bioethics in the USA in anything less than a book-length treatment. The aim of this paper is therefore somewhat more modest, and it will only look at one specific influential school of thought within American bioethics.

The paper will proceed by offering close readings and analyses of important sections in the latest edition of the most read bioethics textbook in the USA (and probably in the world) *Principles of Biomedical Ethics*, in its fourth edition (PBE4) by Tom Beauchamp and James Childress (1).

Through this process it will become evident that the ethical system propounded by Beauchamp and Childress lacks the necessary resources satisfactorily to handle the ethically complex situations created in the interface between medicine and social justice.

Just looking at one specific approach in American bioethics could be seen as setting up a straw man, but this method is justified by the widespread use of the four principles framework in medical and nursing ethics, both academically and in practice: PBE4 is not just a small and insignificant part of American bioethics.

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## Key words

Principlism; beneficence; justice; specification; balancing.

Another problem is that the book contains 526 pages of densely printed text, and any extract of this is liable to be accused of selection bias. In the present case this is in one sense true. I only cite material which is relevant for the critique I want to put forward, but to avoid bias I have tried to provide fairly extensive quotes, and summaries of pertinent parts of the discussion which cannot be quoted at length.

In PBE4 the authors give a much longer and more in-depth account of their views on ethical theory than in the previous editions of *The Principles of Biomedical Ethics*, and this makes it possible to trace the basis of their theory in more detail than was previously possible.

*The Principles of Biomedical Ethics*, 4th ed, is a very rich book, and does reward careful study. It may well be that the widespread resistance to the four principles in the bioethics community would not have occurred if every student and end-user of the principles had been required to read the whole book. But, on the other hand, if this had been a requirement, the principles would probably never have gained the same degree of popularity among health care professionals.

## Not just autonomy?

The ethical system put forward in PBE4 is usually known as principlism. This specific version of principlism is often referred to as the 'Georgetown mantra' or 'The four principles', and its most vigorous European proponent is Raanan Gillon (2,3). The present paper is primarily concerned with the version of the four principles found in PBE4. The version put forward by Gillon is, for instance, somewhat different from the PBE4 version, and some of the argument presented here may not affect this or other non-PBE4 versions of the four principles approach.

The PBE4 version of principlism incorporates four principles as the basis for bioethical thought: respect for autonomy; non-maleficence; beneficence; and justice.

The authors go to great lengths to emphasize that this listing of the principles does not imply a ranking,

thereby trying to answer a common criticism that whereas PBE4 mentions four principles, only one or two (ie, autonomy and non-maleficence) are really important, when it comes to analysing bioethical problems.

The authors of PBE4 reject foundationalism in bioethics, and instead develop their theory as a common-morality theory: 'A common-morality theory takes its basic premises directly from the morality shared in common by the members of a society – that is, unphilosophical common sense and tradition' [(4), my emphasis].

The fact that common-morality theory necessarily uses the shared morality in a *specific society* as its basic premise, is often overlooked by both proponents and opponents of the four principles.

These basic premises derived from common morality are further analysed and re-arranged in order to reach a coherent moral theory, but it should come as no surprise that the content of this theory will be influenced by its basic premises, and therefore by the morality and culture of the society from which it originates.

Because the theory of PBE4 is developed from American common morality (and in reality only from a subset of that morality) it will mirror certain aspects of American society, and may, for this reason alone, be untransferable to other contexts and other societies.

Beauchamp and Childress do not explicitly limit the scope of application of their principles to the USA, or indicate that the approach should only be used by persons working in American health care institutions. It seems fair to assume that the authors must know that their book is widely read outside the USA, given that it is now in its fourth edition. If they themselves believed that the application of their principles should be restricted to the culture from which they are derived, or that transfer to other cultural contexts requires changes in form or content, then they could have written a few lines about how such a transfer might be accomplished.

One way to accomplish a relatively un-problematic transfer would be to build on the premise that the form of the ethical system is constant, ie, the four principles point to important parts of morality in all cultures, but that the exact content and strength of the individual principles may vary between cultures. This seems to be the approach advocated by Gillon (3), but it does not seem to be available to Beauchamp and Childress. First of all, they use more than 60 pages to specify the contents of each of the four principles, without any disclaimers that this content is only valid for the USA. Secondly, they explicitly reject the criticism put forward by Clouser and Gert that the principles are 'little more than names, checklists, or headings for values worth remembering, leaving principles without deep moral substance or capacity to guide actions' (5) by claiming that they agree that the principles need

additional content and specificity before they are of use, and that this content is supplied in the four long chapters describing the principles.

A more general problem with an account which construes the four principles as relatively contentless pointers or labels is that it can obscure important differences in moral outlook. Let us imagine that I read a paper which states: 'Based on the principle of beneficence  $x$ ,  $y$ , and  $z$  follow'. If the four principles are just pointers or labels, then I would have to know what version of the principle of beneficence the author is talking about (ie, beneficence (USA), beneficence (Denmark), or beneficence (India), etc) before I could assess the reasoning and engage in discussion. If I just assume that the author's principle of beneficence has the same content as my own, I may be seriously misled.

The American influence on the content of the principles as they are explicated in PBE4 is, for instance, exemplified in an analysis of the duties of a physician who happens to pass by the scene of an accident where people are injured. The authors wonder whether the physician has any special duty of beneficence in this situation, just because he is a physician, and reach the following conclusion: 'The physician at the scene of an accident is obligated to do more than the lawyer or student to aid the injured, in accordance with the need for the skills of the medical profession; yet a physician-stranger is not morally required to assume the same level of commitment and risk that is legally and morally required in a prior contractual relationship with a patient or hospital' (6).

It may well be true in the context of American and British common morality and law that the physician is only obligated to a limited extent, but this analysis does not travel well to many countries in continental Europe, where Good Samaritan laws have been on the statute books for at least one hundred years, and physicians have been held answerable to the full extent of their professional duties even if no prior contract was established.

### **Beneficence and justice the American way!**

The greatest influence of American common morality can be detected in the analysis of the principles of beneficence and justice. This is of the greatest importance in the present context. The cost of optimal (or even good) treatment and care for diseases like cancer or HIV/AIDS, from the time of diagnosis to the time of death, is so large that it is outside the economic possibilities of most private persons. In the end people with these diseases will therefore have to rely on the beneficence and sense of justice of their fellow citizens.

The fourth edition of *The Principles of Biomedical Ethics* defines the scope of the duty of beneficence in the following way: 'Apart from special moral

relationships such as contracts, a person X has a determinate obligation of beneficence toward a person Y if and only if each of the following conditions is satisfied (assuming X is aware of the relevant facts):

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 that X is likely to incur' (7).

The crucial clause in this analysis, and the one which most clearly reflects American common morality, is clause 4, which states that a duty of beneficence only exists if it can be discharged without incurring significant risks, costs, or burdens. We probably all agree that there is some limit to the burdens a moral agent can be expected to incur in order to help others, but it seems strange to state that the *moral duty* of beneficence is only operative if it can be discharged without significant risk. On the previous pages of PBE4 the authors discuss the suggestion by Peter Singer that: 'If it is in our power to prevent something bad from happening, without thereby sacrificing anything of comparable moral importance, we ought, morally, to do it' (8,9).

This claim is immediately rejected, and it is suggested that if we require sacrifice of people in the discharge of their duty of beneficence, we may require something which is beyond the capability of most moral agents. This seems to me to be an extremely bleak view to take of human nature. We may all agree that beneficence must be restricted both in degree and in scope, there cannot be a duty to devote all our time and resources to acting beneficently. However, if a duty of beneficence is to have any meaning, it must at least contain the notion of the possibility of sacrifice of personal interests in the discharge of the duty.

The authors then continue with a discussion of Singer's later proposal that 10 per cent of one's income given to good causes is the minimum that any reasonable ethical standard requires, and they seem to accept this, but as a maximum instead of a minimum.

In light of this, clause 4 above must therefore be interpreted as stating that a duty of beneficence only exists if it can be discharged within the yearly allocation of 10 per cent of one's income, where risks and non-monetary burdens are represented by their comparable money value. An interpretation taking this limit at face value must therefore lead to the conclusion that a society can only legitimately collect

taxes amounting to 10 per cent of the income of individual citizens in order to pay for those parts of the public social and health care programmes that cannot be legitimated by reference to their prudential value for the individual (for example, by reference to their function as an insurance substitute). And even this 10 per cent tax must be reduced if citizens are simultaneously obligated to perform other acts of beneficence.

It is also interesting to note that a strict interpretation of clause 5 would entail that it would never be morally required to put one's life at risk to save *one* other person, except within the special moral relationships mentioned in the initial *ceteris paribus* clause.

Even earlier in their exposition the authors of PBE4 distinguishes rules of beneficence from rules of non-maleficence, and present two strong claims: 'But, with rare exceptions, obligations of non-maleficence must be discharged impartially and obligations of beneficence need not be discharged impartially (10).

'Advocates of a principle of general beneficence, however, argue the far more demanding thesis that we are obligated to act impartially to promote the interests of persons beyond our limited sphere of relationships and influence' (10).

The reason for these assertions/conclusions is given in the following way: 'It is possible to act non-maleficently toward all persons, but it would be impossible to act beneficently toward all persons' (11).

### **Simply wrong**

But this is simply wrong. It is possible to act beneficently toward all persons (for example, if I made a will dividing my property into six billion equal shares, given that my property was of a sufficient size, and I had no natural heirs); and, as marxist and feminist analyses have shown, it may very well be impossible to act non-maleficently towards all because of necessarily oppressive societal structures. It may simply be impossible to live as a citizen in a modern, first-world country without harming somebody through one's action. On one, not totally ludicrous, interpretation it is, for instance, the case that every time I buy coffee in my local supermarket I act maleficently towards a large number of people in the third world. I may not be aware that that is what I am doing, but I am inflicting harm. I might claim that this harming is not intentional, but this seems a rather disingenuous excuse, given that it would only require minimal effort to make myself aware of the consequences of my act.

It could be argued that I cannot in reality act beneficently towards all, because I cannot act beneficently towards future persons. If we accept that future persons fall within the scope of the principle of beneficence that may well be true. Even if I benefit

every living person, I cannot be certain that this will also benefit future persons, and I cannot benefit future persons directly; but the same argument goes for non-maleficence. The future consequences of my present acts of non-maleficence are equally uncertain, and acting non-maleficently may in the long run create more harm than is prevented.

If future persons fall within the scope of the principle of beneficence, then they must also fall within the scope of the principle of non-maleficence, since both principles are of the same person-affecting kind. But, in that case the impossibility of acting beneficently towards all, caused by the problem of future persons, implies a similar impossibility of acting non-maleficently towards all.

The content of the principle of beneficence which emerges in PBE4 is, as we have seen, very limited, and it is not strange that critics of the PBE4 framework have claimed that beneficence disappears when compared to respect for autonomy and non-maleficence.

The principle of justice fares equally badly. Very early on in the book we read: 'For example, if the theory proposed such high requirements for personal autonomy ... or such lofty standards of social justice ... that, realistically, no person could be autonomous and no society be just, the proposed theory would be deeply defective' (12).

### A just society

It is interesting to note in this context that on most accounts of justice it is actually the case that it will be very difficult or realistically impossible to create and maintain a just society. It seems impossible to claim that any presently existing society is just in a strict sense, and no realistic plans have been put forward to rectify this lamentable state of affairs. But on the PBE4 account we can probably instead simply choose to abandon our ideas about justice, since they are obviously too strict and stringent.

Whether this conclusion follows in a way which is damaging to the PBE4 account of justice depends on the meaning of the clause 'realistically could'. The fourth edition of the *Principles of Biomedical Ethics* uses a notion of 'realistic possibility' or 'practicality' to distinguish between obligatory and supererogatory acts, and in the assessment of ethical theories. The exact meaning of this notion is never made explicit, but it is, for instance, used to cast doubt on utilitarianism as a viable moral theory because of its stringent moral demands, and it is claimed that utilitarians cannot maintain the crucial distinction between the obligatory and the supererogatory. This is a fairly commonplace objection, and could be made even if the PBE4 notion of practicality put the dividing line between the obligatory and the supererogatory so that the area of obligation became very large. The PBE4 discussion of supererogation at the end of the book does, however, support a

reading which points towards the area of obligation as being rather restricted. The closest possible approximation to the PBE4 idea of 'realistically could' one can get to is therefore something like 'within the reach of the average person'.

According to this conception of realistic possibility, it seems that the authors of PBE4 must place the quest for a just society within the realm of the supererogatory, and outside of the obligatory, because the chance of reaching a just society is small (or non-existent), and the effort required great. But it is difficult to see how the fulfilment of a putative obligation to work towards a just society could ever be supererogatory. If I know that the society in which I live is unjust, then I must have an obligation to try to rectify this state of affairs, even though that obligation might well be unfulfillable.

In their chapter on the principle of justice the authors discuss Michael Walzer's contention that within the sphere of health care there is a distinctive logic that 'Care should be proportionate to illness and not to wealth' (13,14), and that this distinctive logic forms part of common morality. The fourth edition of the *Principles of Biomedical Ethics* rejects this contention: 'It is doubtful that equal access to health care finds stronger support throughout the American tradition than free-market principles or beliefs in the right to a decent basic minimum of health care' (15).

From this, probably correct, interpretation of the American moral tradition PBE4 can only draw the conclusion that an egalitarian health care system is not morally mandated, but only some form of two-tier or multi-tier system with a decent minimum of health care for everybody: 'The first tier would *presumably* cover *at least* public health measures and preventive care, primary care, acute care, and special social services for those with disabilities' (16) [my emphasis].

'... , the decent-minimum proposal has proved difficult to explicate and implement. It raises problems of whether society can fairly, consistently, and unambiguously devise a public policy that recognizes a right to care for primary needs without creating a right to exotic and expensive forms of treatment, such as liver transplants costing over \$200,000 for what many deem to be marginal benefits in quality-adjusted life-years' (17).

It is only with great hesitancy that I invite the reader to ponder how many people would evaluate the costs and benefits in using \$50,000 each year for a number of years on the care and treatment of a drug-addict with HIV-infection and multi-resistant tuberculosis.

If the content of common morality is to any extent dependent on the number of members of the community who hold a certain point of view, I will safely predict that this treatment scenario falls outside what American (and European) common morality countenances.

And even if we reject clearly prejudicial components in common morality, it seems that the present

cost-benefit ratio of AIDS care or care for persons with untreatable cancers may put it beyond the decent-minimum commitment in the communal first tier.

A common theme which emerges in the treatment of beneficence and justice in PBE4 is a reluctance to endow these principles with much substantive content. There are many rejections of other authors who put forward too demanding and stringent conceptions of either principle, and through the gradual grinding down by removing the demanding components of the duty of beneficence and the principle of justice we end up with a totally watered-down conception without any substance or moral bite.

### Specification and balancing

Another serious problem with the moral framework put forward in PBE4 is its lack of explicit decision rules. According to PBE4 good moral theories and principles should have ‘output power’, they should give ‘creative and practical solutions’, and be ‘adaptive to novelty’ (18). The principlism in PBE4 fulfils all these criteria, but unfortunately at the expense of any clear guidance as to how we are to reach answers to moral questions. The theory may have a lot of output power, but what is produced is produced via, but not by, the theory.

What do I mean by this?

According to PBE4 moral judgment can be aided by reflecting on the four principles, and by applying them to the case at hand through the processes of specification and balancing. Specification and balancing are not parts of the generic four principles approach (which would then be a six principles approach), but they are integral parts of the model for justification in morality which is developed in PBE4, and the total PBE4 model cannot be assessed just by looking at the four principles. Without specification and balancing the four principles are morally inert.

Specification takes place when we explicate the exact content of a given principle, norm, or rule. When we, for instance, specify the rule, ‘Doctors should put their patients’ interests first’ we see that it does not imply that they should falsify information on insurance forms (19). Specification involves one principle and can resolve some moral conflicts, whereas moral problems involving more than one principle also requires balancing between these principles (see below). Unfortunately no procedural rules are put forward to guide the process of specification, apart from the rules of justification and coherence regulative for all rational discourse.

When it comes to balancing we get some more specific guidance. The fourth edition of the *Principles of Biomedical Ethics* accepts the distinction between *prima facie* and actual obligations as proposed by W D Ross, but the authors further argue for a set of conditions that must be met to

justify infringing one *prima facie* norm in order to adhere to another:

- ‘1. Better reasons can be offered to act on the overriding norm than on the infringed norm. ...
2. The moral objective justifying the infringement has a realistic prospect of achievement.
3. No morally preferable alternative actions can be substituted.
4. The form of infringement selected is the least possible, commensurate with achieving the primary goal of the action.
5. The agent seeks to minimize the negative effects of the infringement’ (20).

The authors note that some of these conditions appear to be tautological, and it is difficult not to agree with them. If one applies the ‘not test’ by trying to assert the opposite of the five conditions it is obvious that they are not only nearly tautological but also totally uncontroversial. It would indeed be strange to override a *prima facie* obligation if ‘Only worse reasons can be offered to act on the overriding norm than on the infringed norm’!

But can the five conditions help us, if we don’t have any further conditions delimiting the field of considerations that can validly be introduced in the balancing?

Not very much, because they are almost purely formal. We are given no criteria with which we can decide whether something is a relevant *moral* consideration.

Strangely enough the authors of PBE4 seem to see this as a strength in their theory: ‘As with specification, the process of balancing cannot be rigidly dictated by some formulaic “method” in ethical theory. The model of balancing will satisfy neither those who seek clear-cut, specific guidance about what one ought to do in particular cases nor those who believe in a lexical or serial ranking of principles with automatic overriding conditions’ (21).

I will leave aside the question of lexical ranking, but a balancing model, which is a central component in a moral theory put forward for use in the health care context, must be able to give ‘clear-cut, specific guidance about what one ought to do in particular cases’ in a reasonably large number of cases, otherwise it is at greater risk of becoming a rhetorical justification of intuitions or prejudices.

It is evident that a lack of definitive moral decidability will greatly expand the output power of a moral theory, at least in terms of the number of answers produced, and that this lack will also enhance the ability to give ‘creative and practical solutions’ (although they will not be definitive), and the ability to be ‘adaptive to novelty’. Unfortunately the answers produced will be underdetermined by the content of the theory, and the final choice between available answers will have to be made on the basis of considerations outside of the PBE4

framework. We can only hope that these decisive considerations will be moral considerations.

The theory in PBE4 therefore, not surprisingly, fulfils all the PBE4 criteria for a good moral theory, but the cost which has been paid is very high.

## Conclusion

The problem with the principlism of PBE4 is thus not only the explicitly American nature of the model, with its subsequent underdevelopment of the positive obligations incorporated in beneficence and justice, but also that we are presented with a structure for moral reasoning which cannot give any definite answers to moral problems, or perhaps more accurately can produce almost any answer we want.

This problem is freely acknowledged by the authors, but they fail to see that it shifts the ground beneath their elaborate theoretical structure. They write: 'The attempt to work out the implications of general theories for specific forms of conduct and moral judgment will be called *practical ethics* here... . The term *practical* refers to the use of ethical theory and methods of analysis to examine moral problems, practices, and policies in several areas, including the professions and public policy. Often no straightforward movement from theory or principles to particular principles is possible in these contexts, although general reasons, principles, and even ideals can play some role in evaluating conduct and establishing policies' (22) [italics in original].

'We have not attempted a general ethical theory and do not claim that our principles mimic, are analogous to, or substitute for the foundational principles in leading classical theories such as utilitarianism (with its principle of utility) and Kantianism (with its categorical imperative) ... . As we have acknowledged, even the core principles of our account are so scant that they cannot provide an adequate basis for deducing most of what we can justifiably claim to know in the moral life' (23).

But what use do we have in the practical health care setting for an account where even the proponents claim that '... even the core principles of our account are so scant that they cannot provide an adequate basis for deducing most of what we can *justifiably claim to know in the moral life*' (23) [my emphasis]?

One answer could be, that even if the four principles approach cannot provide definitive answers it can provide an initial mapping of the moral domain in individual problem cases, it can facilitate the identification of the morally relevant facts, and it can thereby create the basis for an adequate discussion of such cases.

This suggestion raises two questions: a. does the PBE4 framework map the whole moral domain, and b. does the PBE4 framework contain sufficient guidance about the moral relevance of specific considerations?

There is no doubt that large parts of the moral domain can be accommodated within the four principles approach, but the inclusion in PBE4 of a chapter on 'Virtues and ideals in professional life' enumerating four(!) focal virtues, suggests that even the inventors of the four principles approach believe that there is more to morality than principles. Using only the four principles as an analytic tool, may therefore leave out other important moral considerations.

Within the PBE4 framework, the only guidance about the moral relevance of specific considerations is found in the chapters explicating the content of the four principles. I have argued above that much of this content is only applicable within an American context, and that it cannot be transferred in any straightforward manner to other cultural contexts. Even if this is only partly true it leaves the non-American user of the PBE4 approach with limited or no guidance as to the moral relevance of specific considerations falling within one of the four broad principles. Any use of the PBE4 approach as an analytic tool outside America can therefore only proceed, if the content of the four principles is worked out for the specific cultural context in which the framework is applied.

The two considerations mentioned here indicate that although the PBE4 approach may have value as a tool for elucidating specific moral problems, this value is predicated on a re-working of the content of the four principles for each new cultural context, and on an explicit recognition that the four principles must be supplemented by further moral considerations.

## Acknowledgements

This paper was written in pursuance of the project for the European Commission Biomedical and Health Research Programme: *AIDS: Ethics, Justice and European Policy*. The author gratefully acknowledges the stimulus and support provided by the commission. A preliminary version of this paper was read at a seminar at Ersta Institute of Health Care Ethics, Stockholm. I thank all the participants for their comments. I also thank the editor and two anonymous referees for their helpful comments and suggestions.

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- (18) See reference (1): 26.
- (19) See reference (1): 29.
- (20) See reference (1): 34.
- (21) See reference (1): 36.
- (22) See reference (1): 4.
- (23) See reference (1): 106–107.
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## News and notes

### Endowed chair in medical ethics

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