Second Edition

Principles of
Health Care Ethics

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Foreword: Raanan E. Gillon

It is such a delight to welcome this second and new edition of Principles of Health Care Ethics. While my own energy was inadequate to accepting the task of once again editing a hundred-author textbook, it was clear that a new edition was due and this new collection, brought together and edited by my excellent erstwhile colleague Richard Ashcroft and his associates, is in my view superb. The first edition of this book was born, in the early 1990s, of two intentions. One was to create a textbook covering most of the substantive issues in medical ethics written by a wider, more international, range of authors than the mainly American collections that already existed. The second intention was that the hundred or so authors would in their chapters all to some extent use, and or reflect upon, the Beauchamp and Childress four principles approach to medical ethics. The authors of the first edition fulfilled both intentions handsomely.

In this second edition the first intention is maintained and extended. The writers are cosmopolitan not only geographically but also in terms of perspectives and disciplines, and while the main issues of health care ethics represented in the first edition are all covered there are some fascinating additions within the new edition’s four main areas of concern.

Thus in the context of methodologies in health care ethics (HCE) there are new chapters on virtue theory, universalism and relativism, liberalism and communitarianism, deliberative bioethics, hermeneutics, empirical approaches to bioethics, the relationship of medical humanities to HCE, and a fascinating chapter on reflective equilibrium as a method in HCE. In the context of particular HCE issues there are welcome new chapters on ethics in primary care, conflicts between practitioners' personal beliefs and their care of patients, the role of conscience in health care practice, responses to violent and abusive patients, ethical issues in relation to performance enhancement in sport, ethical challenges created by contemporary emphasis on patient choice, ethical issues in relation to disability, and ethical aspects of 'medical tourism'. In the section on 'medicine in society' consideration of ethical issues in health promotion, public health and epidemiology is expanded and new chapters on ethical issues of bioterrorism, disaster relief, care of refugees and asylum seekers, and a chapter on doctors and human rights are timely additions. In the last section, on ethical issues in research and new technologies, health care research and genetics get a more intensive and contemporary treatment than in the first edition, including chapters on human cloning and stem cell research. There are also new chapters addressing xenotransplantation, vaccination to prevent addiction, psychosurgery and neuroimplantation, along with a final trio considering obligations of the pharmaceutical industry, obligations of patients, and reflections on ethics consultations and ethics committees in health care institutions.

As for my second intention in the first edition that authors should in presenting their subjects also reflect (whether positively or negatively) on the four principles approach-this, as indicated above, has been replaced by a wide range of alternative methodological approaches, and no special emphasis on the four principles. In this context let me simply state that the four principles approach got a very good airing in the first edition and in this edition their use is lucidly explained and stoutly if synoptically defended by one of their originators, Tom Beauchamp. I won't repeat my responses to objections to the approach that I offered in the first edition. Suffice it to assert that I stand by those responses and to add that during the more than twenty five years that I have supported the use of these universalisable prima facie principles in health care ethics I have not encountered either plausible objections to any one of them, nor plausible candidates for necessary additional principles that can not themselves be encompassed by one, or by some combination, of the four principles. Even the proposed additional principle of preserving and not taking human life is quite capable of justification by means of a combination of the four principles. I would suggest to readers of the new edition that they might usefully ask themselves whether any one of the individual chapters is incompatible with the four principles approach.

For my own part I continue to value the four principles approach as a way of bringing people of different faiths, different cultures, different moral and political perspectives, together in a common if basic set of prima facie moral commitments and of providing them with a common if basic moral language and a common if basic moral analytic framework. If the widespread ‘grass roots’ acceptance of these principles in international health care ethics is anything to go by they will eventually be recognised to be of international relevance and acceptability not just in health care ethics but in ethics more generally. When (yes, and if) this prediction becomes a reality I hope that Tom Beauchamp and Jim Childress will get the Nobel Peace Prize that they’ll deserve!

In pursuit of an increase in world harmony it would be a great development, in my opinion, for medical ethicists to come together to promote the enormous potential moral acceptability of the four principles across all moral cultures, (including the considerable variety of moral cultures represented in this book) and then to concentrate on remaining problems. These can be (admittedly over-simply) categorised in terms of interpretation of the principles; further investigation of their scope of application (to whom or to what do we owe these four prima facie obligations?); and most difficult of all, how should we deal with conflicts between the principles when these arise, as in practice they so often do? In this last context especially, judgement plays an obviously crucial role. But just what is judgement, how is it done, how should it be done? Kant pointed out that there could be no rules for judgement between conflicting rules, on pain of an infinite regress. What then? Maybe it is in the context of judgement between conflicting moral rules, principles and values that intuition, emotion, a sense of fit, perhaps even aesthetic sensibility, do or should play an important role? Judgement, especially moral judgement, is a theme that I hope will get a thorough airing in the third edition of Principles of Health Care Ethics. Meanwhile I heartily commend the second.

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Foreword: Tony Hope

In his famous essay on Tolstoy Isaiah Berlin divided thinkers into foxes and hedgehogs. The fox knows many things; the hedgehog knows one big thing. Those who are driven to find unifying principles and ideas, like Plato, were classified by Berlin as hedgehogs. Those who, like Aristotle, prefer a less systematic approach, and like to consider each issue in its own terms, are the foxes.

The first edition of this book was a fox in hedgehog's clothing. It presented itself as unified under the 'four principles of biomedical ethics'. The editors of this second edition have thrown off the prickly outer garments and relished its foxiness. This is a book of byzantine proportions: a treasure trove for anyone with even the slightest initial interest in biomedical ethics. Indeed this book demonstrates that biomedical ethics is a microcosm of culture broadly conceived.

Principles of Health Care Ethics is unique. There is no other source-book that provides such diversity within the field. Here you can explore Eastern as well as Western approaches; examine the value of scientific studies in ethics, or of bizarre thought experiments. You can read about specific issues arising in clinical care, or gaze into a future when drugs might be widely used not only to treat disease but also to enhance health and abilities. There are twenty chapters on political and social issues and almost as many on the ethics of medical research and new technologies.

The first edition of *Principles of Health Care Ethics* was a constant companion for me, although one that was rather too frequently ‘borrowed’. This second edition is even more exciting. A book of reference; and also a book to explore.

Tony Hope
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Preface

Ranaan Gillon’s first edition of Principles of Health Care Ethics was published in 1994, and quickly became established as the leading single volume companion to the ethical issues in modern health care. In his Preface to that first edition, he defined it as having two principal purposes:

> […] to provide a collection of papers accessible to Englishspeaking health care workers internationally, introducing the wide range of issues that comprise health care ethics from a wide variety of perspectives – a variety that was more international, multidisciplinary and less predominantly American bioethical, than earlier collections. The second motive was a desire to invite each writer at least to consider in his or her contribution a common moral theme – notably that of the four prima facie principles of health care ethics and their scope of application. (Gillon (1994): xxi)

This second edition retains the first objective, but does not retain the second. Since 1994, there has been an enormous expansion in the range of topics covered in modern health care and biomedical ethics, but there has also been a shift in the philosophical centre of gravity of the field. In this preface we describe how we decided to reshape the volume in the light of current priorities in health care and biomedical ethics.

A great strength of the first edition of this volume was its commitment to a single analytical and moral framework – the so-called “Four Principles” approach created by Thomas Beauchamp and James Childress’s Principles of Biomedical Ethics, now in its fifth edition, and popularised and extended by a number of authors, most notably Raanan Gillon himself. The first edition devoted almost a third of its contents to chapters examining different philosophical, political and religious frameworks from the point of view of their convergence or divergence from the Four Principles framework. Many of these chapters retain their value as independent contributions to the scholarly and professional literature. As Raanan Gillon argues in his foreword to this second edition, the Four Principles approach could serve both as the core common ground which might serve as what Rawls termed an overlapping consensus between those who share quite different substantive moral and metaphysical views of the world, and as a process or mechanism for creating agreement among such people. Several of the chapters in the present volume develop this idea, notably the opening chapter by Thomas Beauchamp. Nevertheless we felt that the state of scholarly debate no longer supported taking this approach to organising what we intended as an overview of the field for both new students and established workers in the field.[1] This volume is therefore *Principles of Health Care Ethics* in a different sense of the word "principles": the fundamental topics and issues covered in a way which will allow people new to the field, or to specific topics within it, to grasp the essential issues.

Methodologically, health care and biomedical ethics is far more diverse now than in 1994. We have seen the rapid growth of both empirical studies which have attended more to the differences between specific moral perspectives than to what they may have in common, and of different philosophical methodologies for analysing cases and for interpreting the ethical, legal, and social challenges posed by new health technologies and by tough decisions in health policy. We do not think that the field is in a phase of synthesis in which extracting common principles is either easy or intellectually helpful. Instead, we felt that it was important to give a sense of the diversity of intellectual approaches to ethical problems in health care. So, we chose authors for each essay who were recognised authorities on the topics they were discussing, and gave them considerable freedom as to the approach they took to presenting the topic. We

encouraged them to write as for a readership of intelligent, but not yet well informed, readers, such as we meet in our upper level undergraduate or Master’s courses. We asked each author to write new, state of the art articles, so as to give a picture of the latest thinking on each topic. In most cases, authors have set out specific arguments, taking into account contrary views, but giving their own analysis. In some cases, the articles have more of a survey article character, especially where the topic is more empirical in nature or where controversy is widespread. The editors are all philosophers, and we have favoured philosophical over legal or social science approaches to our chosen topics, but in many cases the articles do present empirical as well as theoretical, and positive as well as normative material, and some articles present a legal analysis of the topic. This diversity reflects the multidisciplinary nature of modern scholarship and research in health care ethics.

Each section opens with a brief overview of its contents by the section editor responsible for it. The first section introduces the main methodological and intellectual approaches to health care and biomedical ethics in general. This section will be of particular help to the reader who needs an orientation to the different philosophical methods in modern English-speaking philosophical health care ethics. The second section introduces the main ethical challenges in health care practice. This book is principally concerned with health care ethics, rather than biomedical ethics. Health care ethics is the study of ethical challenges in the delivery of health care. It is wider than medical ethics, which is concerned with the ethical challenges of medical care and the profession of medicine. Biomedical ethics is principally concerned with the ethical challenges of modern high technology applied to health care, rather than with the challenges of professional care. Naturally the three areas – health care ethics, medical ethics, biomedical ethics – overlap, but our emphasis is mainly on health care practice rather than policy. That noted, major growth areas in health care and biomedical ethics over the past ten years are public health ethics (concerned both with the ethics of protecting and promoting public health, and with the ethics of allocation of care between different competing needs and people) and the ethics of new technologies in health care. Section three gives an overview of public health ethics, and section four gives an overview of research ethics and ethics of new technologies in health care.

Preparing this volume for the press has been a challenge, but almost always an enjoyable one. We first invited chapters from May 2005, and received the last chapter complete from its authors in October 2006. By the time you read this, some issues may have moved on, but we hope they won't have moved on too much! From the very beginning we have had warm encouragement both from Raanan Gillon and from Lucy Sayer, our editor at John Wiley. We have had excellent practical support throughout from Lucy and from her colleague Juliet Booker. Most of all we thank our contributing authors, who have produced what we think are outstanding chapters with efficiency and grace. Time will tell whether there is a third edition, and, if so, whether it will have a more unified intellectual structure as the first edition did. Our challenge to you, as readers, is to advance the topics we have covered, and – if you find the task to your taste, to produce an intellectual synthesis. Raanan strongly believes that this is possible – we are more sceptical. But over to you!

REFERENCES

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[1] For a discussion of the current state of play regarding the Four Principles approach in health care ethics, see the special issue of the Journal of Medical Ethics published in honour of Raanan Gillon on his retirement: Journal of Medical Ethics 2003; 29(5): 265-312, and more recently Dawson and Garrard (2006)

PART I
METHODOLOGY AND PERSPECTIVES

SECTION ONE: MORAL THEORY AND HEALTH CARE ETHICS

One of the guiding thoughts for the second edition of *Principles* was to commission a collection of high quality chapters that could not only serve as a general introduction to health care ethics but also provide a resource that is sufficiently detailed for postgraduate students. Given that this section discusses the major methodologies and perspectives that are relevant to health care ethics, many of the chapters introduce moral theory at a fairly advanced level.

The first edition of *Principles* demonstrated the utility and applicability of the four principles approach for a broad array of issues in health care ethics. While the second edition does not attempt to do this, it does begin with and include a number of chapters discussing this approach. Beauchamp and Childress developed and refined their four principles approach in the years following the first edition of *Principles* and the first chapter of the second edition begins with an account of the mature theory by Beauchamp.

The next four chapters present important interpretations and theories of each of the principles. Stoljar and Cullity consider different theoretical accounts of autonomy and beneficence, respectively. Interest in justice theory has moved beyond simply discussing distributional justice within a nation state, and attention has turned to more international issues. Pogge's *Responsibilities for poverty-related ill health* presents his influential account of global justice. Tyler explains the relevance of the liberalism/communitarianism debate for health care ethics.

Veatch played an important role in the principles debate, and in *How many principles?*, he considers the merits of other principle-based approaches to health care ethics that use fewer or more than four principles. One important question about the application of principles to biomedical ethics is: what role do they play in practical moral reason? In Chapter 7, Jonsen gives an account of practical casuistry and how it interfaces with the use of principles in moral reason.

The next eight chapters show how a number of normative moral theories can be applied to health care ethics. Rather than simply giving an account of the different versions of utilitarianism, Häyry gives an interesting account of the way the utilitarian arguments function in bioethics. There is a tendency for introductions to ethics to mention only Kant when introducing deontology, with the consequence that some students assume that deontology implies Kantianism or absolutism. McNaughton and Rawling give an exceptionally clear account of what deontology is and contrast Kant’s version with Ross’s. O’Neill gives a concise account of Kantian ethics and its origins in Kant’s moral philosophy. Sherwin outlines a very useful taxonomy of the four major approaches to feminist bioethics. In Chapter 12, Oakley explains the nature, application and problems of virtue theory. Sheehan describes the important differences between the descriptive and metaethical versions of moral relativism.

SECTION TWO: THEOLOGICAL APPROACHES TO HEALTH CARE ETHICS

One of the most popular features of the first edition of *Principles* was the way it considered religious approaches to health care ethics, and this edition includes a section on ‘theological approaches to health care ethics’. Inevitably, it was not possible to discuss every religion that says something important about health care ethics, or even to have a chapter on each of the major religions. Nonetheless, readers who want an introduction to some of the fundamental articles of various faiths that enter into debates about health care ethics will find these chapters of value. Widdows, Rosner, Sachedina, Hughes and Coward explain what is distinctive about Christian, Jewish, Islamic, Buddhist and South Asian approaches to health care ethics (respectively). Nie offers a useful critique of the idea that there is something distinctive about Asian Bioethics.

SECTION THREE: METHODOLOGY AND HEALTH CARE ETHICS

One of the most important aspects of the development of bioethics since the first edition of *Principles* is the proliferation of methodological approaches to health care ethics. Brody offers an illuminating account of narrative ethics, and this chapter is followed by a description of the ways in which empirical methods can be incorporated into health care ethics by Sugarman, Pearlman and Taylor. Hedgcoe questions whether the emergence of empirical methods in health care ethics is merely reinventing medical sociology. Thought experiments are pervasive in philosophy and are an important rhetorical strategy in health care ethics too. Walsh gives an especially useful description of the ways in which thought experiments can contribute to argument in health care ethics.

Parker's chapter begins with the recognition that the debate about health care ethics has a political dimension and proceeds to give a typology of the deliberative democratic approaches that can be employed. Just as ethics is intertwined with politics, it is in a complicated relationship with the law, and McLean illustrates some of the ways in which law and ethics are interdependent.

Evans explains what is distinctive about the Medical Humanities, while van Willigenburg shows how Rawls's concept of Reflective Equilibrium can be applied as a method in health care ethics. Widdershoven and Abma's chapter is similar in that they also show how a philosophical concept, hermeneutics, can be employed as a method in health care ethics.

The last 10 chapters in Part one are similar in that they all explain moral concepts, distinctions or doctrines that are central to health care ethics. Chapter 29 is by Childress, and he makes a number of very useful distinctions between the different forms of paternalism. The concept of a 'medical need' can play an important role in prioritisation, and Culyer distinguishes and evaluates the theoretical possibilities. Rights theory is important and often not explained with the clarity with which Wilson has written Chapter 31. 'Exploitation' has always been an important moral concept for health care ethics, but now that it is becoming accepted as a key principle for research ethics, a clear understanding of it is essential. Chapter 32 is by Wertheimer and shows how his theory of exploitation (arguably the most influential and successful account developed thus far) can be applied to health care ethics. The remaining chapters explain important concepts such as Competence to Consent (Jonas), The Doctrine of Double Effect (Uniacke), Ordinary and Extraordinary Means (John), Acts and Omissions (Takala), Personhood and Moral Status (Newson), and Commodification (Wilkinson).

John R. McMillan

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The ‘Four Principles’ Approach to Health Care Ethics

TOM L. BEAUCHAMP

My objective is to explain the so-called four principles approach and to explain the philosophical and practical roles these principles play. I start with a brief history and then turn to the four principles framework, its practicality, and philosophical problems of making the framework specific.

THE ORIGINS OF PRINCIPLES IN HEALTH CARE ETHICS

Prior to the early 1970s, there was no firm ground in which a commitment to principles or even ethical theory could take root in biomedical ethics. This is not to say that physicians and researchers had no principled commitments to patients and research subjects. They did, but moral principles, practices and virtues were rarely discussed. The health care ethics outlook in Europe and America was largely that of maximizing medical benefits and minimizing risks of harm and disease. The Hippocratic tradition had neglected many problems of truthfulness, privacy, justice, communal responsibility, the vulnerability of research subjects and the like (Jonsen, 1998; Pellegrino & Thomasma, 1993). Views about ethics had been largely confined to the perspectives of those in the professions of medicine, public health and nursing. No sustained work combined concerns in ethical theory and the health care fields.

Principles that could be understood with relative ease by the members of various disciplines figured prominently in the development of biomedical ethics during the 1970s and early 1980s. Principles were used primarily to present frameworks of evaluative assumptions so that they could be used, and readily understood, by people with many different forms of professional training. The distilled morality found in principles gave people a shared and serviceable group of general norms for analysing many types of moral problems. In some respects, it could even be claimed that principles gave the embryonic field of bioethics a shared 'method' for attacking its problems, and this gave some minimal coherence and uniformity to bioethics.

There were two primary sources of the early interest in principles in biomedical ethics. The first was the *Belmont Report* (and related documents) of the National Commission for the Protection of Human Subjects (Childress et al., 2005; National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1978), and the second was the book entitled *Principles of Biomedical Ethics*, which I co-authored with James F. Childress. I here confine discussion to the latter.

Childress and I began our search for the principles of biomedical ethics in 1975. In early 1976 we drafted the main ideas for the book, although only later would the title *Principles of Biomedical Ethics* be placed on it (Beauchamp & Childress, 1979). Our goal was to develop a set of principles suitable for biomedical ethics. Substantively, our proposal was that traditional preoccupation of health care with a beneficence-based model of health care ethics be shifted in the direction of an autonomy model, while also incorporating a wider set of social concerns, particularly those focused on social justice. The principles are understood as the standards of conduct on which many other moral claims and judgements depend. A principle, then, is an essential norm in a system of moral thought, forming the basis of moral reasoning. More specific rules for health care ethics can be formulated *by reference to* these four principles, but neither rules nor practical judgements can be straightforwardly *deduced* from the principles.

THE FRAMEWORK OF PRINCIPLES

The principles in our framework have always been grouped under four general categories: (1) respect for autonomy (a principle requiring respect for the decision-making capacities of autonomous persons); (2) nonmaleficence (a principle requiring not causing harm to others); (3) beneficence (a group of principles requiring that we prevent harm, provide benefits and balance benefits against risks and costs); (4) justice (a group of principles requiring appropriate distribution of benefits, risks and costs fairly). I will concentrate now on an explication of each of the principles and how they are to be understood collectively as a framework of principles.

RESPECT FOR AUTONOMY

Respect for autonomy is rooted in the liberal moral and political tradition of the importance of individual freedom and choice. In moral philosophy personal autonomy refers to personal self-governance: personal rule of the self by adequate understanding while remaining free from controlling interferences by others and from personal limitations that prevent choice. ‘Autonomy’ means freedom from external constraint and the presence of critical mental capacities such as understanding, intending and voluntary decisionmaking capacity (Childress, 1990; Engelherdt, 1996; Katz, 1984; Kukla, 2005). The autonomous individual acts freely in accordance with a self-chosen plan, analogous to the way an independent government manages its territories and sets its policies. A person of diminished autonomy, by contrast, is in some respect controlled by others or incapable of deliberating or acting on the basis of his or her desires and plans.

To respect an autonomous agent is to recognize with due appreciation that person’s capacities and perspectives, including his or her right to hold certain views, to make certain choices, and to take certain actions based on personal values and beliefs. The moral demand that we respect the autonomy of persons can be expressed as a *principle* of respect for autonomy, which should be stated as involving both a negative obligation and 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 both respectful treatment in disclosing information and actions that foster autonomous decision making.

Many autonomous actions could not occur without others’ material cooperation in making options available. Respect for autonomy obligates professionals in health care and research involving human subjects to disclose information, to probe for and ensure understanding and voluntariness, and to foster adequate decision making. True respect requires more than mere noninterference in others’ personal affairs. It includes, at least in some contexts, building up or maintaining others’ capacities for autonomous choice while helping to allay fears and other conditions that destroy or disrupt their autonomous actions. Respect, on this account, involves acknowledging the value and decision-making rights of persons and enabling them to act autonomously, whereas disrespect for autonomy involves attitudes and actions that ignore, insult, demean or are inattentive to others’ rights of autonomy.

Many issues in professional ethics concern failures to respect a person’s autonomy, ranging from manipulative underdisclosure of pertinent information to nonrecognition of a refusal of medical interventions. For example, in the debate over whether autonomous, informed patients have the right to refuse medical interventions, the principle of respect for autonomy suggests that an autonomous decision to refuse interventions must be respected. Although it was not until the late 1970s that serious attention was given to rights to refuse for patients, this is no reason for thinking that respect for autonomy as now understood is a newly added principle in our moral perspective. It simply means that the implications of this principle were not widely appreciated until recently (Faden & Beauchamp, 1986).

Controversial problems with the principle of respect for autonomy, as with all moral principles, arise when we must interpret its significance for particular contexts and determine precise limits on its application and how to handle situations when it conflicts with other moral principles. Many controversies involve questions about the conditions under which a person’s right to autonomous expression demands actions by others, and also questions about the restrictions society may rightfully place on choices by patients or subjects when these choices conflict with other values. If restriction of the patient’s autonomy is in order, the justification will always rest on some competing moral principles such as beneficence or justice.

NONMALEFICENCE

Physicians have long avowed that they are obligated to avoid doing harm to their patients. Among the most quoted principles in the history of codes of health care ethics is the maxim *primum non nocere:* ‘Above all, do no harm’. British physician Thomas Percival furnished the first developed modern account of health care ethics, in which he maintained that a principle of nonmaleficence fixes the physician’s primary obligations and triumphs even over the principle of respect for the patient’s autonomy in a circumstance of potential harm to patients:

> To a patient… who makes inquiries which, if faithfully answered, might prove fatal to him, it would be a gross and unfeeling wrong to reveal the truth. His right to it is suspended, and even annihilated; because… it would be deeply injurious to himself, to his family, and to the public. And he has the strongest claim, from the trust reposed in his physician, as well as from the common principles of humanity, to be guarded against whatever would be detrimental to him (Percival, 1847).

Many basic rules in the common morality are the requirements to avoid causing a harm. They include rules such as do not kill, do not cause pain, do not disable, do not deprive of pleasure, do not cheat and do not break promises (Gert, 2005). Similar, but more specific prohibitions are found across the literature of biomedical ethics, each grounded in the principle that intentionally or negligently caused harm is a fundamental moral wrong.

Numerous problems of nonmaleficence are found in health care ethics today – some involving blatant abuses of persons and others involving subtle and unresolved questions. Blatant examples of failures to act nonmaleficently are found in the use of physicians to classify political dissidents as mentally ill, thereafter treating them with harmful drugs and incarcerating them with insane and violent persons (Bloch & Reddaway, 1984). More subtle examples are found in the use of medications for the treatment of aggressive and destructive patients. These common treatment modalities are helpful to many patients, but they can be harmful to others.

A provocative question about nonmaleficence and physician ethics has been raised by Paul S. Appelbaum in an investigation of ‘the problem of doing harm’ through testimony in criminal contexts and civil litigation – for example, by omitting information in the context of a trial, after which a more severe punishment is delivered to the person than likely would have been delivered. Appelbaum presents the generic problem as one of nonmaleficence:

> If physicians are committed to doing good and avoiding harm, how can they participate in legal proceedings from which harm may result? If, on the other hand, physicians in court abandon medicine’s traditional ethical principles, how do they justify that deviation? And if the obligations to do good and avoid harm no longer govern physicians in the legal setting, what alternative principles come into play? … Are physicians in general bound by the principles of beneficence and nonmaleficence? (Appelbaum, 1990)

BENEFICENCE

The physician who professes to ‘do no harm’ is not usually interpreted as pledging never to cause harm, but rather to strive to create a positive balance of goods over inflicted harms. Those engaged in medical practice, research and public health know that risks of harm presented by interventions must often be weighed against possible benefits for patients, subjects and the public. Here we see the importance of beneficence as a principle beyond the scope of nonmaleficence.

In ordinary English the term *beneficence* connotes acts of mercy, kindness, charity, love and humanity. In its most general meaning, it includes all forms of action intended to benefit other persons. In health care ethics beneficence commonly refers to an action done to benefit others, whereas benevolence refers to the character trait or virtue of being disposed to act for the benefit of others. The principle of beneficence refers to a moral obligation to act for the benefit of others. No demand is more important when taking care of patients: the welfare of patients is medicine’s context and justification. ‘Beneficence’ has long been treated as a foundational value – and sometimes as the foundational value (Pellegrino, 1994; Pellegrino & Thomasma, 1988) – in health care ethics.

The principle of beneficence requires us to help others further their important and legitimate interests, often by preventing or removing possible harms. This principle includes rules such as ‘maximize possible benefits and minimize possible harms’ and ‘balance benefits against risks’. Many duties in medicine, nursing, public health and research are expressed in terms of a positive obligation to come to the assistance of those in need of treatment or in danger of injury. The harms to be prevented, removed or minimized are the pain, suffering and disability of injury and disease. The range of benefits that might be considered relevant is broad. It could even include helping patients find appropriate forms of financial assistance and helping them gain access to health care or research protocols. Sometimes the benefit is for the patient, at other times for society.

Some writers in health care ethics suggest that certain duties such as not to injure others are more compelling than duties to benefit them. They point out that we do not consider it justifiable to kill a dying patient in order to use the patient’s organs to save two others, even though benefits would be maximized, all things considered. The obligation not to injure a patient by abandonment has been said to be stronger than the obligation to prevent injury to a patient who has been abandoned by another (under the assumption that both are moral duties). Despite the attractiveness of these notions that there is a hierarchical ordering rule, Childress and I reject such hierarchies on grounds that obligations of beneficence do, under many circumstances, outweigh those of nonmaleficence. A harm inflicted by not avoiding causing it may be negligible or trivial, whereas the harm that beneficence requires we prevent may be substantial. For example, saving a person's life by a blood transfusion clearly justifies the inflicted harm of venipuncture on the blood donor. One of the motivations for separating nonmaleficence from beneficence is that these principles themselves come into conflict. As the weights of the two principles can vary, there can be no mechanical decision rule asserting that one obligation must always outweigh the other.

Perhaps the major theoretical problem about beneficence is whether the principle generates general moral duties that are incumbent on *everyone* – not because of a professional role, but because morality itself makes a general demand of beneficence. Many analyses of beneficence in ethical theory (most notably utilitarianism, Kagan, 1989; Miller, 2004; Singer, 1993; 1999) seem to demand severe sacrifice and extreme generosity in the moral life – for example, giving a kidney for transplantation or donating bone marrow to a stranger. Consequently, some moral philosophers have argued that such beneficent action is virtuous and a moral ideal, but not an obligation, and therefore that there is no principle of beneficence of the sort proclaimed in the four principles approach.

I agree, of course, that the line between what is required and what is not required by the principle is difficult to draw, and that drawing a precise line independent of context is impossible. I do not agree, however, with the radical view that there are no obligations of beneficence – neither general nor specific obligations. I return to this problem of weighing, judging and specifying below in a discussion of the notion of *prima facie* duties.

JUSTICE

Every civilized society is a cooperative venture structured by moral, legal and cultural principles of justice that define the terms of cooperation. A person in any such society has been treated justly if treated according to what is fair, due or owed. For example, if equal political rights are due all citizens, then justice is done when those rights are accorded. The more restricted notion of *distributive justice* refers to fair, equitable and appropriate distribution in society. Usually this term refers to the distribution of primary social goods such as economic goods and fundamental political rights, but burdens are also within its scope. Paying for forms of national health insurance is a distributed burden; medical-welfare checks and grants to do research are distributed benefits.

There is no single principle of justice in the four principles approach. Somewhat like principles under the heading of beneficence, there are several principles, each requiring specification in particular contexts. But common to almost all theories of justice – and accepted in the four principles approach – is the minimal (formal) principle that like cases should be treated alike, or, to use the language of equality, equals ought to be treated equally and unequals unequally. This elementary principle, or formal principle of justice, states no particular respects in which people ought to be treated. It merely asserts that whatever respects are relevant, if persons are equal in those respects, they should be treated alike. Thus, the formal principle of justice does not tell us how to determine equality or proportion in these matters, and it lacks substance as a specific guide to conduct.

Many controversies about justice arise over what should be considered the relevant characteristics for equal treatment. Principles that specify these relevant characteristics are often said to be ‘material’ because they identify relevant properties for distribution. Childress and I take account of the fact that philosophers have also developed diverse theories of justice that provide sometimes conflicting material principles. We try to show that there are some merits in egalitarian theories, libertarian theories and utilitarian theories, and we defend a mixed use of principles in these theories. We think that these three theories of justice all capture some of our intuitive convictions about justice and that they can all be tapped as resources that will help to produce a coherent conception of justice.

However, many issues of justice in health care ethics are not easily framed in the context of traditional principles and abstract moral theories (Buchanan, 1997; Buchanan et al., 2000; Daniels, 1985; 2006; Powers & Faden, 2006). For example, some basic issues in health care ethics in the last three decades centre on special levels of protection and aid for vulnerable and disadvantaged parties in health care systems. These issues cut across clinical ethics, public health ethics and research ethics. The four principles approach tries to deal with several of these issues, without producing a grand theory for resolving all issues of justice. For example, we address issues in research ethics about whether research is permissible with groups who have been repeatedly used as research subjects, though the advantages of research are calculated to benefit all in society. We argue that as medical research is a social enterprise for the public good, it must be accomplished in a broadly inclusive and participatory way, and we try to specify the commitments of such generalizations. Thus, we incorporate principles of justice but do not produce a general theory of justice.

THE FRAMEWORK OF FOUR PRINCIPLES AND THE EVOLUTION OF THE THEORY

The choice of our four types of moral principle as the framework for moral decision-making in bioethics derives in part from professional roles and traditions. As noted earlier, health professionals' obligations and virtues have for centuries (as found in codes and learned writings on ethics) been framed by professional commitments to provide medical care and to protect patients from disease, injury and system failure. Our principles build on this tradition, but they also significantly depart from it by including parts of morality that traditionally have been neglected in health care ethics, especially through the principles of respect for autonomy and justice. All four types of principles are needed to provide a comprehensive framework for biomedical ethics, but this general framework is abstract and spare until it has been further specified – that is, interpreted and adapted for particular circumstances.

Principles of Biomedical Ethics has evolved appreciably since the first edition in its understanding of abstractness and the demands of particular circumstances. This is not because the principles have changed, but because over the years Childress and I have altered some of our views about the grounding of the principles and about their practical significance. Two major changes deserve special attention. The first is our development of the idea that the four principles are already embedded in public morality – a universal common morality – and are presupposed in the formulation of public and institutional policies. The second is our adoption of Henry Richardson's account of the