

Chapter 2

Critical Overview of Principlist Theories

In this chapter three approaches to principles are reviewed. Firstly the Four-Principle approach as described by Tom Beauchamp and James Childress.¹ Secondly Robert Veatch's theory of medical ethics² based on a contract relation and lexical ordering of principles giving priority to autonomy. Finally Engelhardt's Principle of permission,³ amending his first edition which was based on a two-principle approach of beneficence and autonomy.⁴ Clearly the authors of these three models are 'principlists' themselves and the scope here is to go beyond simple principles. One however, must start with understanding the implications of these models and perhaps why they feel that virtue may not be that necessary. Common to all three positions is the philosophical and non-clinical background of the authors. All argue from a liberal point of view and indeed view beneficence, or rather, statements like 'for the good of the patient', as paternalistic. At least, my reading of them shows that this is where they are coming from. Although Engelhardt has a medical background as well, his carrier is academic philosophy; and it is perhaps significant that of the three theories he is the one to take a warmer view to character, which led him to be more reductionist in the number of principles. He is left with the two main contentions—that of doing good, and that of justice, which aims to do good to society and the patient as well.

2.1 The 'Four-Principles' Approach

The idea of moral principles in medical ethics has been around for at least two centuries. McCullough⁵ refers to John Gregory (1724–1773) who wrote about the

¹ Beauchamp. T.L., Childress J.F., *Principles of Biomedical Ethics*, 1989.

² Veatch R., *A Theory of Biomedical Ethics*, New York: Basic Books, 1981.

³ Engelhardt H.T., Jr., *Foundations of Biomedical Ethics*, 1994.

⁴ Engelhardt H.T., Jr., *Foundations of Biomedical Ethics*, 1986.

⁵ McCullough L.B., "Bioethics in the Twenty-First Century: Why We Should Pay Attention to Eighteenth-Century Medical Ethics", in *Kenn. Inst. of Ethics J.*, Vol. 6, No. 4, pp. 329–333.

duties and qualification of a physician using David Hume's moral philosophy of the Scottish Enlightenment period.⁶ Beauchamp⁷ notes that it was the British physician Thomas Percival who furnished the first well-shaped doctrine of health care ethics which also served for the formulation of the American Medical Association's first code of ethics.⁸ He notes that Percival's beneficence-based viewpoints became the creed of the medical profession. However, Beauchamp states that "[i]n recent years...the idea has emerged—largely from writings in law and philosophy—that the proper model of the physician's moral responsibility should be understood less in terms of traditional ideals of medical benefit, and more in terms of the rights of patients, including autonomy-based rights to truthfulness, confidentiality, privacy, disclosure and consent, as well as welfare rights in claims of justice".⁹

Beauchamp and Childress argue that the principles they identify “-respect for autonomy, nonmaleficence, beneficence (including utility or proportionality), and justice, along with such derivative principles or rules of veracity, fidelity, privacy, and confidentiality—are only *prima facie* binding. None can be considered absolute”.¹⁰ The justification for the choice of these four principles is in part historical in the fact that some are deeply embedded in medical tradition, and in part because they point to an important part of morality—respect for autonomy—which has traditionally been neglected.¹¹ The difference the authors ascribe to principles (by which they refer collectively to the four principles and rules) is that they are *prima facie* binding, meaning that one is obliged to respect them unless one comes into conflict with another.¹²

In fact there have been three major interpretations of the weight of principles. They may be viewed as absolute, *prima facie*, or as relative maxims or rules of thumb.¹³ Childress quotes Paul Ramsey as viewing principles as absolute and Joseph Fletcher in his “situation ethics” as viewing principles as rules of thumb.¹⁴ This is very important in that being *prima facie* binding, “the moral agent has to justify departures from principles by showing that in the situation some other principles have more weight. However, the assignment of weight or priority depends on the situation rather than on the abstract, *a priori* ranking”.¹⁵

⁶ Ibid., p. 331.

⁷ Beauchamp. T.L., “The ‘Four-principles’ Approach”, in *Principles of Health Care Ethics*, pp. 3–12.

⁸ Ibid., p. 5.

⁹ Idem.

¹⁰ Childress J.F. “Principles-Oriented Bioethics, An Analysis and Assessment From Within”, in *A Matter of Principles?* p. 79.

¹¹ Beauchamp. T.L., op.cit., p. 4.

¹² Childress J.F., op. Cit., p. 79.

¹³ Ibid., p. 78.

¹⁴ Ibid., pp. 78–79.

¹⁵ Idem.

2.1.1 Theoretical Basis

Clouser and Gert¹⁶ still provide one of the strongest criticism of principles.¹⁷ They lament a lack of any theoretical basis which principlism, somewhat misleadingly, tends to suggest.¹⁸ The utilitarian principle of John Stuart Mill and the principle of Justice of John Rawls are summaries of comprehensive and unified theories underneath them.¹⁹ Rather, Clouser asserts that each principle functions more of a reminder that there is an ethical value the agent ought to consider. The principle does not tell the agent how to think. Receiving no guideline the agent then determines, interprets and gives his own weight to each principle. He asks where the principles come from, whether there is a priority and to what does one appeal when they conflict. "It looks as if each principle simply focuses on the key aspect of some leading theory of ethics: justice from Rawls, consequence from Mill, autonomy from Kant, and nonmaleficence from Gert. Thus they represent some historically important emphases, but without the underlying theories—and worse, without an adequate unifying theory to co-ordinate and integrate these separate, albeit essential, features of morality"²⁰ and

[i]t is a kind of relativism espoused (perhaps unwittingly) by many books (usually anthologies) of bioethics. They parade before the reader a variety of "theories" of ethics—Kantianism, deontology, utilitarianism, other forms of consequentialism, and the like—and say, in effect, choose whichever of the competing theories, maxims, principles, or rules suits you for any particular case. Just take your choice! They each have flaws—which are always pointed out—but on balance, the authors seem to be saying, they are probably all equally good!²¹

After reading through the textbook by Beauchamp and Childress one will be more fully informed and appreciative of that principle and the different theories where relevant but when dealing with an actual problem one would find oneself confused.²²

Clouser suggests common morality as a system²³ in a theory developed with Bernard Gert²⁴ which although suggesting a set of rules is not rule based but in

¹⁶ Clouser K.D., Gert B., "A Critique of Principlism", pp. 216–236.

¹⁷ Beauchamp. T.L., "The 'Four-principles' Approach", p. 8.

¹⁸ Clouser K.D., "Common Morality as an Alternative to Principlism", in *Kenn. Inst. of Ethics J.* Vol. 5, No. 3, p. 223.

¹⁹ Idem.

²⁰ Ibid., p. 224.

²¹ Idem.

²² Ibid., p. 225.

²³ Ibid., pp. 226–235.

²⁴ Gert B., *Morality: A New Justification of the Moral Rules*, New York: Oxford University Press, 1988.

which the rules are understood only as functioning within that system.²⁵ Their emphasis is thus on morality as a system.²⁶

Beauchamp contends that Clouser and Gert's 'Impartial Rule Theory' does not fare any better when comparing their principles to their rules. He admits that their rules have more specific content and direction but only because they are one tier less abstract than principles.²⁷ Moreover, elsewhere he cites that although Gert and Clouser start with particular moral judgements about which one is certain and then abstract and formulate the relevant features to help decide the unclear case, this is precisely what he and Childress have supported since the first edition of their book.²⁸ He compares a sample of rules they defend under principles with a directly related sample of basic moral rules defended by Gert and Clouser²⁹:

Beauchamp and childress	Gert and clouser
4 rules based on nonmaleficence	4 of the 10 basic rules
1. Do not kill.	1. Don't kill.
2. Do not cause pain.	2. Don't cause pain
3. Do not incapacitate	3. Don't disable
4. Do not deprive of goods	4. Don't deprive of pleasure

Their theories are similar and it is hard to find how the Impartial Rule Theory is any better.³⁰ He and Childress have always readily admitted the shortcomings of principlism and that Gert and Clouser's criticism are important problems which, however, they themselves do not solve.³¹ Beauchamp and Childress, on the other hand, have sought to arrive to moral decisions by a process of 'balancing' and 'specification'.

'Balancing' fits best with a conception of principles as prima facie binding but potentially in conflict in particular cases. The third edition of 'Principles of Biomedical Ethics' (now in its sixth edition) attempted to reduce the intuitive assignment of weights to conflicting principles in a situation by a more formal procedure for resolving conflicts among principles. Specifically, if two prima facie principles come into conflict, several conditions need to be met before one can override the other.³²

²⁵ Clouser K.D., op. cit., p. 227.

²⁶ Idem.

²⁷ Beauchamp. T.L., "Principlism and Its Alleged Competitors", in *Kenn. Inst. of Ethics J.* Vol. 5, No. 3, pp. 186–187.

²⁸ Beauchamp. T.L., "The 'Four-principles' Approach", p. 9.

²⁹ Beauchamp. T.L. op. cit., pp. 187–188.

³⁰ Beauchamp. T.L., "Principlism and Its Alleged Competitors", p. 190.

³¹ Beauchamp. T.L., "The 'Four-principles' Approach", p. 8.

³² Childress J.F. "Principles-Oriented Bioethics, An Analysis and Assessment From Within", in *A Matter of Principles?*, p. 81.

“Specification” is the attempt to give content to a principle involving specifying the cases which fall under it.³³ Childress states that although their fourth edition of ‘Principles of Biomedical Ethics’ proposes that specification be tried first (as they were helped into seeing matters more clearly by the work of “specified principlism” by Richardson and DeGrazia³⁴) he remains rather skeptical that it may serve as an exclusive model because moral conflict is inevitable within a moral universe.³⁵ But the fact that both Beauchamp³⁶ and Childress³⁷ do not take the problem of an underlying theoretical basis seriously is cause for concern. Although principlism provides the framework³⁸ it was intended to give, the substance for that framework needs more than just specification and balancing in particular cases. Although they provide useful slogans³⁹ similar to the Golden Rule they “oversimplify moral reasoning” and have “no value in determining what is the morally right way to act”. Although they have great “rhetoric value”, the attempt to reduce morality to slogans undermines the complex albeit not difficult matter at arriving to moral solutions.

Gert and Clouser expound a theory which is based on what an impartial person would respond to a given situation. Having four main components (moral rules, moral ideals, the morally relevant features of situations, and a detailed procedure of dealing with conflicts) it is not rule based but rules form only one component. Being superficially defined they find difficulty and confusion with some principles. In particular Justice “is the prime example of a principle functioning simply as a check list of moral concerns. It amounts to no more than saying that one should be concerned with matters of distribution; it recommends just or fair distribution without endorsing any particular account of justice or fairness”.⁴⁰ The principle of Justice does not make distinction between what is morally *required* and what is morally *encouraged*. John Rawls makes this error in his theory of Justice when referring to the moral duty to obey laws and the moral ideal encouraging one to make just laws (which Rawls regards as a single duty) and this is carried into the Justice used in principlism⁴¹. This failure to distinguish between what is morally required and what is morally encouraged creates significant confusion in both the principle of autonomy and the principle of beneficence. In fact the principle of autonomy as stated by Beauchamp and Childress is: *Autonomous action and*

³³ Ibid., p. 82.

³⁴ DeGrazia D. “Moving Forward in Bioethical Theory: Theories, Cases, and Specified Principlism.” In *J. of Medicine and Philosophy* 17(October); pp. 511–39.

³⁵ Childress J.F., op.cit., p. 82.

³⁶ Beauchamp. T.L., “Principlism and Its Alleged Competitors”, in *Kenn. Inst. of Ethics J.* Vol. 5, No. 3, p. 190.

³⁷ Childress J.F., op. cit., p. 75.

³⁸ Idem.

³⁹ Clouser K.D., Gert B., “Morality vs. Principlism”, p. 260

⁴⁰ Clouser K.D., Gert B., op.cit., p. 253.

⁴¹ Rawls J. *A Theory of Justice* Harvard University Press, 1971, p. 115.

choices should not be constrained by others. It simply is picking out one evil, the loss of freedom, and giving it a principle all to itself.⁴² The addition of ‘autonomous’ is what causes most problems as non-autonomous choices are not included. Thus one can over-ride what are deemed to be non-autonomous choices. If one deems that a patient’s refusal is irrational, claiming therefore it is non-autonomous one may over-rule it. Conversely one may reason that although the choice is irrational, the patient is competent and therefore autonomous. Both can claim they are respecting the principle of autonomy and therefore the principle of autonomy may encourage one to act with unjustified paternalism depriving a person of freedom without adequate justification.⁴³ Clouser and Gert also note that not distinguishing between ‘protecting autonomy’ and ‘promoting autonomy’ is dangerous and makes it more difficult to solve moral problems.⁴⁴ Not protecting (i.e. violating) autonomy is breaking a moral rule and thus requires adequate justification. Not promoting autonomy is not following a moral ideal which does not require justification. Since Beauchamp and Childress say that the primary function of informed consent is to protect and promote individual autonomy, then one can not give informed consent without needing to adequately justify oneself.⁴⁵

Thus principlism’s centrepiece, ‘the principle of autonomy’, embodies a deep and dangerous level of confusion. That confusion is created by unclarity as to what counts as autonomous actions and choices and the consequent blurring of a basic moral distinction between moral rules and moral ideals. The unnecessary introduction of the metaphysical concept of autonomy inevitably results in making it more difficult to think clearly about moral problems. The goal of moral philosophy is to clarify our moral thinking, not to introduce new and unnecessary complications.

Clouser and Gert also complain about the lack of distinction between moral ideals and rules in the principle of beneficence. Beauchamp and Childress often refer to beneficence as a duty. This is not incorrect only because beneficence is a moral ideal; rather because it obscures the true meaning of duty which they (Clouser and Gert) attribute to the duty spelled out by one’s profession.⁴⁶ Thus specific duties determined by the profession are packed into a principle of “mis-conceived” general duties and this is tantamount to substituting a slogan for substance.⁴⁷

However, Beauchamp insists that in effect they are agreeing with Gert and Clouser on all substantive issues about what is morally required and that therefore they cannot be criticising their obligation of beneficence.⁴⁸ Also Gert commits himself to beneficence when acknowledging that people do have a duty to help and

⁴² Clouser K.D., Gert B., “Morality vs. Principlism” p. 254.

⁴³ *Ibid.*, pp. 254–256.

⁴⁴ *Ibid.*, pp. 256–257.

⁴⁵ *Idem.*

⁴⁶ *Ibid.*, pp. 258–259.

⁴⁷ *Ibid.*, p. 259.

⁴⁸ Beauchamp. T.L., “Principlism and Its Alleged Competitors”, p. 190.

that there are some duties that seem more general.⁴⁹ Beauchamp is in fact confident in the method of specifying⁵⁰ and especially the method of 'reflective equilibrium' developed by John Rawls for the specification of principles,⁵¹ although Childress portents to remain somewhat skeptical because of the inevitability of moral conflict. Beauchamp contends that principlism starts from paradigms of what is morally proper and morally improper and then searches for principles that are consistent with these paradigms and consistent with each other.⁵²

2.1.2 The Paradigm Case

Jonsen⁵³ looks at principlism from its origins asking first why it came out and secondly how it came out to answer the important question of what a moral principle is and how it may be invoked in the clinical decision making of a moral process. He notes that in the 70s the new-born field of bioethics was primarily a scholarly interest without a method.⁵⁴ Philosophers brought in their respective disciplines. But these had their respective problems. Thus utilitarianism conflicted with the traditional medical principle of beneficence.⁵⁵ It was during the writing of the Belmont Report that the first three principles came into being⁵⁶. This is treated further when discussing the phenomenology of principles in which their historical role is very relevant to the question 'Why these principles and not some others?'.⁵⁷ What is relevant here is that in deliberating about which principles Jonsen and Stephen Toulmin noted they were doing Casuistry—reasoning which principles by discussing cases.⁵⁸ "We noted that one task of the commission, the development of ethical principles to govern research, *was performed at the end*,⁵⁹ rather than the beginning, of the Commission's life, after it had proposed recommendations for many specific cases of research, such as that involving children, the incarcerated, and the mentally disabled".⁶⁰ Also, whilst casuistry is the art of building an argument and drawing conclusions from it by defining "topoi" (or 'topics') and

⁴⁹ Ibid., p. 189.

⁵⁰ Beauchamp. T.L., "The 'Four-principles' Approach", p. 10

⁵¹ Ibid., p. 11.

⁵² Beauchamp. T.L., op. cit., p. 11.

⁵³ Jonsen A.R., "Clinical Ethics and the Four Principles", pp. 13–30.

⁵⁴ Ibid., p. 14

⁵⁵ Idem.

⁵⁶ Jonsen A.R., op.cit., p. 14.

⁵⁷ Clouser K.D., "Common Morality as an Alternative to Principlism", p. 224.

⁵⁸ Jonsen A.R., "Casuistry: An Alternative or Compliment to Principles?", in *Kenn. Inst. of Ethics J.* Vol. 5, No. 3, p. 239.

⁵⁹ italics mine

⁶⁰ Ibid., p. 239.

then defining the features within those topics, principlism is doing just that; each principle is a topic and to arrive at a moral conclusion one must build the details of the case within each topic.⁶¹ Thus “circumstances make the case”.

Therefore whilst casuistry defined principles, it may also be used in conjunction with principles to arrive at conclusions about cases. Principlism uses ‘specification’ of each principle which Beauchamp acknowledges is doing casuistry.⁶² In my opinion it makes logical sense to deduct general principles from cases and then use those principles to interpret other cases. The problem remains one of theoretical content as one can arrive to any conclusion depending on how one interprets morality. It thus does not help much when solving a moral dilemma without having a clear idea of what we are doing and what we want to achieve (whether it is beneficence, autonomy etc.). Beauchamp in fact acknowledges that principles are “too indeterminate” and shares the fear that “they may be interpreted inflexibly”.⁶³ Jonsen does not commit himself that Casuistry is a source of principles but states that stronger claims might be made.⁶⁴ He strongly suggests it however, when referring to the process of the commission arriving to the principles in the Belmont Report.

This thus leads to the questions which Jonsen poses of what *is* a principle.⁶⁵ Deriving from the latin ‘principum’ he reasons that “reasoned thought is principled thought”⁶⁶. It is what people often refer to as “in principle...”. In their simplicity and directedness principles gave moral philosophers a language to speak in.⁶⁷ G.E. Moore and William James also advocate the importance of casuistry in arriving to moral solutions.⁶⁸ Jonsen’s conclusion is that “the ultimate judgement about what should be done will flow from an interpretation of the principles in light of the circumstances and constant topics of clinical care. Principles alone do not lead to ethical decisions; decisions without principles are ethically empty”.⁶⁹ Thus while principles provide an indispensable guiding direction other features of the problem must be taken into consideration.⁷⁰

Nevertheless Jonsen admits that a nonprinciplist bioethics is possible and *necessary* (italics mine), and that principlism is an abbreviated version of moral life.⁷¹ Indeed Childress admits that he and Beauchamp become casuists when they

⁶¹ Ibid., pp. 242–243.

⁶² Beauchamp. T.L., “Principlism and Its Alleged Competitors”, p. 191.

⁶³ Idem.

⁶⁴ Jonsen A.R., “Casuistry: An Alternative or Compliment to Principles?”, p. 250.

⁶⁵ Jonsen A.R., “Clinical Ethics and the Four Principles”, p. 15.

⁶⁶ Ibid., p. 16.

⁶⁷ Jonsen A.R., Forward in *A Matter of Principles?* p. XVI.

⁶⁸ Jonsen A.R., “Casuistry: An Alternative or Compliment to Principles?”, p. 247.

⁶⁹ Jonsen A.R., “Clinical Ethics and the Four Principles”, p. 21.

⁷⁰ Ibid., p. 18.

⁷¹ Jonsen A.R., Forward in *A Matter of Principles?*, p. XVI.

examine cases.⁷² Principlism is not, in Jonsen's view, "an orthodoxy but a utilitarian abbreviation of moral philosophy and theology that served the pioneers of bioethics well and may continue to be useful",⁷³ but since "moral philosophy has rejoined the world of action and moral theology has been liberated from moralism", he advocates consideration of insights from hermeneutics, narrative and phenomenology but at the same time they too will have to meet the demands of policy formulation and practical, clinical decision processes.⁷⁴

2.1.3 The Doctor–Patient Relationship

Edmund Pellegrino argues that principles should not be abandoned but should be grounded more firmly in the phenomena of the doctor patient relationship.⁷⁵ The first problem he finds is that they are *prima facie* binding.⁷⁶ This creates the problem that when they conflict one cannot 'trump' over another since now we face the problem of one principle having more weight than the other and that moreover, there is no convincing argument or formal mechanism that would grant trumping privileges to one principle over the other.⁷⁷

Clearly, *prima facie* principles cannot be used to resolve conflicts amongst *prima facie* principles unless there is some external mechanism. This mechanism may be the circumstance of the case but in this case either the circumstances become a *prima facie* principle with moral force, or they would have to be justified by one of the *prima facie* principles themselves. In this case the problem is which one?

Pellegrino argues that autonomy has shifted the centre of gravity from the doctor more and more unto the patient.⁷⁸ The cause of this was increasing moral pluralism, a decrease in religious forces and an overall mistrust of authority and the misuse of that authority by professionals. Autonomy assures patients of participation in their treatment alternatives, the right to accept and reject any of them, and to retain control of these intimate and personal decisions. It also guarantees respect in multiculturalist societies of different moral reasoning.⁷⁹ The emphasis on autonomy has fostered contract type relationships like the consumer-type and

⁷² Childress J.F., "Principles-Oriented Bioethics, An Analysis and Assessment From Within", p. 87.

⁷³ Jonsen A.R., *op. cit.*, p. XVII.

⁷⁴ *Idem.*

⁷⁵ Pellegrino E.D., "The Four Principles and the Doctor-Patient Relationship: the Need for a Better Linkage", pp. 353–365.

⁷⁶ *ibid.*, p. 353.

⁷⁷ *Ibid.*, p. 361.

⁷⁸ *Ibid.*, p. 354.

⁷⁹ *Ibid.*, p. 355.

the negotiated contract. But the very nature of having a contract fosters mistrust in the relationship as it determines the conduct.⁸⁰ Indeed Pellegrino asserts that while these autonomy inspired models seem to protect individual rights they are in fact illusory and may even be dangerous since they are oblivious to the fact that the patient is in fact vulnerable because she is a patient; because of the power of the doctor's personality and charisma; and because there is the force of social sanction of medicine and its monopoly of medical knowledge which operates regardless of the details of the contract. Moreover, because of this signal of distrust, the doctor may withhold or restrain her inclinations to be beneficent.⁸¹ Pellegrino thus argues that autonomy must be more closely linked to beneficence and justice.

Principlism has put autonomy at loggerheads with beneficence. Pellegrino notes the emergence of this clearly in Beauchamp's book with L.B. McCullough⁸² who equate beneficence with paternalism.⁸³ Although this is treated more profoundly when dealing with the phenomenology of principles, it is of note here that the principle of autonomy can be said to have originated out of paternalism. In fact, in my opinion, it was separated from what should have been an evolving principle of beneficence. This remains the contention throughout this book. But one has to arrive to it logically.

Pellegrino also notes the conflicts between autonomy and Justice when it comes to dealing with third parties.⁸⁴ He himself proposes that autonomy cannot rule over inflicting possible harm to third parties, for example keeping the confidentiality of an HIV patient who does not wish to disclose the information to close contacts⁸⁵ yet with a *negotiated* contract model one may always make autonomy over-ride all other principles of justice.⁸⁶ The potential conflict between autonomy, beneficence and justice becomes more acute in matters of proxy decisions when the doctor has to evaluate against possible abuse by the proxy, and safeguard the welfare of the patient.

Although Pellegrino proposes grounding principles in the phenomena of the doctor-patient relationship he does not work out a mode other than suggest that it should include insights from casuistry, moral psychology etc. However, he seems

⁸⁰ *Ibid.*, p. 356.

⁸¹ *Idem.*

⁸² Beauchamp. T.L. and McCullough L.B. *Medical Ethics: the moral responsibilities of physicians*, Prentice-Hall, Englewood Cliffs, NJ 1984.

⁸³ Pellegrino argues that Paternalism assumes that the doctor knows better what is in the patient's best interest. "Paternalism, whether benignly intended or not, cannot be beneficent in any true sense of the word. Beneficence, and its corollary, non-maleficence, require acting to advance the patient's interest, or at least not harming them. It is difficult to see how violating the patient's own Perception of his welfare can be a beneficent act. Paternalism is obviously in a polar relationship. With autonomy, but it is also diametrically opposed to beneficence and non-maleficence as well", Pellegrino E.D., *op. cit.*, p. 357.

⁸⁴ *Idem.*

⁸⁵ *Ibid.*, p. 358.

⁸⁶ *Ibid.*, p. 355.

to be suggesting that beneficence be the trump principle since it has traditionally been closest to the phenomenon of the relationship. Elsewhere with David Thomasma he argues for beneficence to be the main moral principle.⁸⁷ His disposition is however, towards a better influence of virtue-based ethics.⁸⁸ Basing his work on MacIntyre's conclusions⁸⁹ Pellegrino notes that since moral differences for humans is diverse, hoping for a virtue-based general ethics demands too much⁹⁰ but since the general good in medicine can be defined, hoping for a virtue-based ethics in medicine is not only viable but paradoxically some of the reasons arise out of the deficiencies of principles; others arise from the more limited scope of professional ethics within the larger field of bioethics.⁹¹ More importantly however, is the fact that the moral agent, who performs the act, cannot be left out of moral judgements. In order to see what is good and not merely what are the rights involved, one has to look at virtue and intentions of the person acting.⁹² He acknowledges that virtue cannot stand alone and needs to be related to other ethical theories, including principlism, into a more comprehensive moral philosophy than currently exists⁹³

Beauchamp⁹⁴ believes that he and Childress have always given the highest importance to virtues. He commends Pellegrino in proposing to relate virtue-ethics to principle-based ethics in contrast to some who seem to want to downgrade principles in favour of virtues,⁹⁵ although he seems at odds with him when Pellegrino emphasises the more foundational importance of virtue theory and refers to his account as 'virtue-based'.⁹⁶ Also, although he acknowledges that the two kinds of theories have different emphasis but are compatible⁹⁷ he overlooks how this may be done. This is true particularly in view of their main difference of thought in which principles are prima-facie binding whereas for Pellegrino and Thomasma, "beneficence remains the central moral principle of the ethics of medicine".⁹⁸

⁸⁷ Jonsen A.R., "Casuistry: An Alternative or Compliment to Principles?", p. 247.

⁸⁸ Pellegrino E.D., "Toward a Virtue-Based Normative Ethics for the Health Professions", p. 253.

⁸⁹ MacIntyre, A, *After Virtue*, 1984. , *Whose Justice? Which Rationality?*, Indiana: University of Notre Dame Press, 1988. , *Three Rival Versions of Moral Enquiry*, Indiana: University of Notre Dame Press, 1990.

⁹⁰ Pellegrino E.D., op. cit., p. 263.

⁹¹ Ibid., p. 266.

⁹² Idem.

⁹³ Ibid., p. 254.

⁹⁴ Beauchamp. T.L., "Principlism and Its Alleged Competitors", p. 194.

⁹⁵ Baier, A., *Moral Prejudices*, Cambridge: Harvard University Press, 1994

⁹⁶ Beauchamp. T.L., op. cit., p. 194.

⁹⁷ Ibid., p. 195.

⁹⁸ Pellegrino E.D., Thomasma D.C., *For the Patient's Good: The restoration of Beneficence in Health Care*, New York: Oxford University Press, 1988 pp. 7–8.

2.2 Robert Veatch's Model of Lexical Ordering

Robert Veatch proposes to resolve conflicts among principles by a method which involves both some amount of balancing and ranking of principles in a lexical order.⁹⁹ Veatch basis his thoughts on a contractual model of the doctor patient relationship in which the patient is seen as a partner.¹⁰⁰ He reviews four possible models to govern the physician-patient relationship and rejects three of them (The “Priestly model” which is basically the old paternalistic model, the “Engineering Model” which gives decision-making power to the patient and reduces the physician to the role of a technician, and the “Collegial Model” which assumes shared responsibility in decision-making and in which the patient and physician are treated on equal counts).¹⁰¹ In the remaining “contractual model”, the decision is taken according to circumstance. The physician takes responsibility for all purely technical decisions whilst the patient retains control over decisions which involve personal moral values and life-style preferences. Both are respected as free moral agents.¹⁰² Thus a patient can decide whether to opt for a surgery which the doctor feels would produce most benefit. Contractual models have been faulted for their limited features of the ideal core or essence of the physician-patient relationship.¹⁰³ It contrasts for example with Pellegrino's assertion that contract relationships are based on mistrust which can jeopardise beneficence on the part of the physician, and that in any case there is no evidence that a relationship based on mistrust is any better than a relationship based on trust, i.e. in a covenant rather than a contract.¹⁰⁴

Veatch however, is adamant on this model disagreeing with Pellegrino where he stresses the vulnerability of the Patient,¹⁰⁵ and in fact stresses that the term ‘patient’ is not a good one; people go to physicians for check-ups, child birth, immunisation, etc. and are frequently very healthy. Also in chronic diseases, although they have an illness, people are otherwise healthy.¹⁰⁶

⁹⁹ Veatch R.M., “Resolving Conflict Among Principles: Ranking, Balancing, and Specifying, in *Kenn. Inst. of Ethics J.*, Vol. 5, No. 3, pp. 199–218.

¹⁰⁰ Veatch R.M., “Models for Medicine in a Revolutionary Age.” In *Hastings Cent Rep.* 2 No. 3 (1972), pp. 5–7. , *A Theory of Medical Ethics*, 1981. , *The Patient-Physician Relation*, 1991.

¹⁰¹ Brody H., “The Physician/Patient Relationship.”, in *Medical Ethics*, ed. Veatch R.M., Jones and Bartlett Publishers, 1989, p. 70.

¹⁰² Idem.

¹⁰³ Ibid., p.71.

¹⁰⁴ Pellegrino E.D., “The Four Principles and the Doctor-Patient Relationship.: the Need for a Better Linkage”, p. 356.

¹⁰⁵ Idem.

¹⁰⁶ Veatch R.M., *The Patient-Physician Relation*, p. 2.

In his “mixed strategy” approach for resolving conflicts among principles¹⁰⁷ Veatch classifies beneficence and nonmaleficence as utility Consequence-Maximising Principles insofar as these two principles try to bring out the maximum good consequence.¹⁰⁸ Autonomy and Justice he calls Nonconsequentialist Principles since they do not focus on maximising consequences.¹⁰⁹ A limited amount of balancing has to occur here between the two principles in each category. Finally one lexically ranks the nonconsequentialist over the consequentialist thereby ranking autonomous decisions above the outcome of balancing beneficence with nonmaleficence. In this respect he uses a limited amount of balancing which he considers to be the weakness of the four principle approach used by Beauchamp and Childress.¹¹⁰ The reasons for this are that historically balancing is connected to intuitionism as it can be argued that balancing theory is nothing more than an elaborate rationale for letting preconceived prejudices rise to the surface in which one principle is always made more weighty than another. He also notes that with balancing alone, one may consider that the overall good to society or the individual outweighs the autonomy of the individual. Again, why this is so is probably a result of his own argument that the balance is found in nothing but preconceived prejudices. If the society one lives in does not conform to my moral understanding, why should it trump over one's own autonomy. As an example one could take previous communism which trumped over religious freedom of individuals.

Veatch himself contends that there should be occasions where, when justice and autonomy enter into conflict, justice takes priority.¹¹¹ “The real question is when autonomy must give way”, prophesizing this as the critical moral project for the future of biomedical ethics.¹¹²

There is however, an inherent fault with Veatch's model. Veatch divides the consequence maximising principles into ‘Individual’ and ‘Social’, i.e. those brought forward by the ‘Hippocratic utility’ of the doctor towards the patient and those of ‘social utility’ which considers the benefits and harms on all parties concerned brought about by the action.¹¹³ Yet he states that he has, “no doubt that some social consequences not only deserve consideration, they even deserve to be overriding. The problem is determining which social consequences”.¹¹⁴ This means effectively that he is willing to admit that there are instances in which the consequence maximising principles will be lexically ranked over the

¹⁰⁷ Veatch R.M., “Resolving Conflict Among Principles: Ranking, Balancing, and Specifying”, pp. 199–218.

¹⁰⁸ *Ibid.*, p. 201.

¹⁰⁹ *Ibid.*, p. 202.

¹¹⁰ *Ibid.*, p. 209.

¹¹¹ Veatch R.M., “Which Grounds for Overriding Autonomy Are Legitimate?” in *Hastings Cent. Rep.* Vol. 26 No. 6, p. 43.

¹¹² *Ibid.*, p. 42.

¹¹³ Veatch R.M., *op. cit.*, p. 210 & p. 212.

¹¹⁴ Veatch R.M., *op. cit.*, p. 43.

nonconsequentialist ones. This goes against his model which strongly affirms the converse. Whilst one has to concede that in general he would not allow social consequences to overrule autonomy, it is of course these problem cases that create the dilemma, which models are supposed to solve.

Veatch suggests finding a method which would sharply distinguish the “mere aggregate” social consequences, “which can never by themselves overcome autonomy”, from other specific concerns such as the promotion of justice.¹¹⁵ But since social utility is after all a balance between social good and social bad, then justice does not always remain a nonconsequentialist principle.

A second fault with the ‘lexical ordering’ model is that it does not cater for situations in which beneficence can override autonomy without being paternalistic but for the simple sake of beneficence—the good of the patient, and, more importantly without destroying the physician-patient relationship. Such is the case when the patient asks for a treatment which is futile. This could be simply the prescription of an antibiotic to asking for medication which is still controversial which the patient would have heard about. Another example would be when a patient requests something that is deemed immoral on the part of the physician. The physician can appeal to justice but in reality one is making consequentialist arguments. Another situation is in dealing with a proxy deciding on, say, a terminally ill patient, and who the physician has reason to suspect as having a conflict of interest.¹¹⁶

This in fact points to a weakness of the ‘contractual’ physician patient relationship. Whilst this partnership is supposed to respect the physician as a moral being and not simply as an equal,¹¹⁷ it does not say what the physician can do in such cases. In this respect, Pellegrino notes that, “In practical terms this will mean that, institutionally and ethically, mechanisms be devised to permit doctors as well as patients to withdraw from their relationship.... The doctor cannot withdraw without first making provisions for transfer to another doctor, because to do so would constitute abandonment, in itself a serious breach of ethical obligation”.¹¹⁸ This can be problematic however, in cases of abortion and assisted suicide. The Catholic Catechism, for example, would consider such action as being an accomplice.¹¹⁹ Clearly if a patient puts trust in a physician, the definition of this trust must include the physician as a moral being and therefore his acceptance for what he is and believes in, which may include not participating in acts which the physician deems immoral.

¹¹⁵ Idem.

¹¹⁶ Pellegrino E.D., “The Four Principles and the Doctor–Patient Relationship.: the Need for a Better Linkage”, p. 359.

¹¹⁷ Veatch R.M., *The Patient-Physician Relation*, p. 4.

¹¹⁸ Pellegrino E.D., op. cit., p. 359.

¹¹⁹ Giacchi E., “Amerai il prossimo tuo come te stesso”, *Parte Terza: La Vita in Cristo*, Sezione seconda: I dieci Comandamenti, Capitolo secondo: Articolo 5: Il quinto Comandamento, nn 2272.

Veatch's principle argument therefore is to give autonomy the highest importance amongst the principles. Although he acknowledges that there may be cases where justice can and should prevail, the model of lexical ordering and the relationship based on a contract does not answer these questions. He refers to this as a challenge to bioethics in the future.¹²⁰ "Autonomous individuals are self-legislating, but that means legislating only for themselves. If this is the case, autonomy's triumph is truly temporary. The real challenge in medical ethics is deciding which version of community should dominate when our ethic turns social".¹²¹

2.3 The Principle of Permission

Engelhardt also puts a different emphasis on principles, giving autonomy priority as a "side constraint".¹²² Whilst at first assigning priority to two principles, autonomy and beneficence,¹²³ his later treatment of 'Foundations' argued for a single principle of 'permission'.¹²⁴ This is described as a negotiated contract model in which the notion of a universally applicable set of principles beyond autonomy is irrelevant: "doctor and patient may pursue any course they wish, provided it is mutually agreed upon. That which is agreed upon is no concern of third parties. It might include active euthanasia, assisted suicide or an advance directive that calls for the involuntary or non-voluntary euthanasia."¹²⁵

Engelhardt¹²⁶ recognises the impossibility of discovering *the* secular, canonical, concrete ethics. He attempts instead to secure a content-less secular ethics without establishing the moral worth or moral desirability of any of the particular choices. The fact is recognised that persons within a particular moral community will not be appreciated by moral strangers as having a claim on them unless the latter convert to the particular view of the former.¹²⁷ Indeed Engelhardt laments the fact that people "should join a religion"; but outside this we are in a sense doomed to living in a society which can have no state regulating morality.¹²⁸ The morality that binds moral strangers thus has to be by default libertarian,¹²⁹ not because of

¹²⁰ Veatch R.M., "Which Grounds for Overriding Autonomy Are Legitimate?", p. 43.

¹²¹ Veatch R.M., *The Patient-Physician Relation*, p. 161.

¹²² Childress J.F. "Principles-Oriented Bioethics, An Analysis and Assessment From Within", p. 77.

¹²³ Engelhardt H.T., Jr., *Foundations of Biomedical Ethics*, 1994.

¹²⁴ Engelhardt H.T., Jr., *Foundations of Biomedical Ethics*, 1986.

¹²⁵ Pellegrino E.D., "The Four Principles and the Doctor-Patient Relationship.: the Need for a Better Linkage", p. 359.

¹²⁶ Engelhardt, H.T., op., cit., p. vii.

¹²⁷ Idem.

¹²⁸ Ibid., p. xi.

¹²⁹ Ibid., p. x.

any value attributed to freedom but because in the light of the failure of the enlightenment project and the modern moral project, this is the only way they can meet.¹³⁰ Thus conceived the principle of autonomy is re-named as the principle of permission.¹³¹ Elsewhere, with Kevin Wildes, he argues that if one rejects the principle of autonomy so construed, and if not all hear or acknowledge the voice of God in the same way, and moreover, if secular society cannot provide a content-full morality on which to go on, one cannot complain through secular reasoning.¹³² Those who accept the principle have to find a moral basis. Engelhardt argues that if one refuses to participate, one simply has discovered a limit to the area of agreement. It is through this, Engelhardt says, that true equality is appreciated; by having the right not to participate in any particular community.¹³³

In summary therefore, since there are as many theories of fairness and content-full understanding of distributive justice as there are major religions in the world, and since the definition of what is good may vary between individuals, justice and beneficence have to be defined and agreed upon within a permissive relationship.¹³⁴ This is particularly true, within this vision, for the principle of beneficence since morality involves willing the good of others and since there is no canonical, content-full definition of good outside particular moral narratives.¹³⁵

Thus middle level principles are very ambiguous, they argue, when it comes to defining what they are.¹³⁶ When one argues the case for procurement of organs from third world countries, for example, opponents will say that this is exploitation of people vulnerable to poverty. In fact all four principles can be invoked in opposition. But those in favour will argue that it is they who forbid such sales who are in fact exploiting the poor to satisfy their own moral sentiments which are not shared by many inhabitants of the developing world.¹³⁷ “In that there is no possibility in general secular terms of resolving the disputes regarding the moral probity of the sale of human organs or of commercial surrogacy, choices in this area fall by default beyond general secular moral authority.¹³⁸ The same conclusions are unavoidable in the case of health care social welfare because there is no canonical secular understanding of distributive justice.¹³⁹ Thus principles are

¹³⁰ Engelhardt H.T., Wildes K.W., “The Four Principles of Health Care Ethics and Post-modernity: why a libertarian interpretation is unavoidable”, in *Principles of Health Care Ethics*, p. 136.

¹³¹ Engelhardt H.T., op. cit., p. x.

¹³² Engelhardt H.T., Wildes K.W., op. cit., p. 137.

¹³³ Engelhardt H.T., op., cit., p. 70.

¹³⁴ Engelhardt H.T., Wildes K.W., op. cit., p. 138.

¹³⁵ Ibid., p. 137.

¹³⁶ Ibid., p. 143.

¹³⁷ Ibid., pp. 144–145.

¹³⁸ Ibid., p. 145.

¹³⁹ Idem.

simply ‘chapter headings’ under which one clusters various considerations of each one.¹⁴⁰

James Lindemann Nelson¹⁴¹ concedes that Engelhardt remains faithful to the methodology of modern philosophy and that he will not accept that achieving coherence among principles together with our conceptions and morals of the world will be enough to warrant any judgements.¹⁴² Also it is not coincidental that Engelhardt supports such a view, himself being an Orthodox Catholic believing that God reveals himself only to some. It is only with God’s revelation that one can come to understand morality the Christian way. Outside any particular religious view we are in a sense doomed to this principle of permission.¹⁴³ Engelhardt sincerely laments the poverty of the implications of ‘permission’.¹⁴⁴ “The book acknowledges that, when individuals attempt to resolve controversies and do not hear God (or do not hear him clearly) and cannot find sound rational arguments to resolve their moral controversies, they are left with the device of peaceably agreeing how and how far they will collaborate”.¹⁴⁵

Although Nelson recognises Engelhardt’s arguments to be forceful (in that whatever normative justification you favour, it will always presuppose the very thing it is trying to justify), he does find fault with giving oneself a reason why one should adhere to such an agreement being proposed.¹⁴⁶ If it turned out that what we agree with within the relationship does not serve my interest, why should one adhere to the agreement? In the sense, why should one be ‘moral’ in observing this agreement in the view that the agreement gives ‘moral authority’? “What is there in what Engelhardt has said which would provide me with anything that I could rationally count as a moral reason—a secular, public kind of moral reason—for sticking to the agreement?”.¹⁴⁷ One could, say, argue for the sake of peace, but even Engelhardt agrees that ‘this view of ethics and bioethics is not grounded in a concern for peaceableness’.¹⁴⁸ If there is no common morality, some people may opt for not wanting peace.¹⁴⁹ Another possibility could be that it is within one’s interests to act peacefully if one is to secure a way without force to reach agreements. But Nelson points out that this leaves me thinking only strategically rather than morally; the only way one can claim to have made a moral act is by adhering to my agreements. This is rather a restricted and qualified view of

¹⁴⁰ Ibid., p. 146.

¹⁴¹ Nelson J.L., “Everything Includes Itself in Power: Power and Coherence in Engelhardt’s Foundations of Bioethics”, in *Reading Engelhardt*, Kluwer Academic Publications 1997, pp. 17–18.

¹⁴² Ibid., p. 18.

¹⁴³ Ibid., p. 16.

¹⁴⁴ Ibid., p. 17.

¹⁴⁵ Engelhardt H.T., op. cit., p. x.

¹⁴⁶ Nelson J.L., op. cit., p. 21.

¹⁴⁷ Ibid., pp. 21–22.

¹⁴⁸ Engelhardt H.T., op. cit., p. 70.

¹⁴⁹ Nelson J.L., op. cit., p. 22.

morality. Apart from strategic considerations therefore, if one is advantaged in the relationship there is no reason why one should care about the other. It seems impossible how permissions and agreements, as such, count as moral reasons for action.¹⁵⁰

The only way one can see the principle of permission working is when moral strangers meet within a relationship and agree upon it only when their respective moralities have points on which they agree. Therefore, we will both be doing, on that particular occasion something which we both deem to be moral. If one then wishes for something else which the person in this relationship will not agree on moral terms, one simply goes to another (albeit, moral stranger) with whom at least some overlap in view exist on this second thing. This way people do not give each other permission to do anything against our moral beliefs *within* a relationship; but give permission to leave the relationship for another one should it suit us to do so. Rather than permission this would be tolerance to each other's views. On that particular point with which we are agreeing we will not be moral strangers.

The only way which one can permit something, with which one morally does not agree, to happen within the contract would be to allow oneself to do something immoral. This would turn one into an immoral agent however, and may even give reason to the other person not to refuse trust in the first place. If the only morality available to allow one to participate with moral strangers serves as a trump to one's own moral values then there clearly is a *reductio ad absurdum* in the view of relationships for how can one conceive oneself to have done something moral when by the very act one commits an immorality? How is the person to trust me not to break this moral agreement when I have given proof of my willingness to waiver morality?

In speaking about Kant, Engelhardt criticises how he “smuggled” content into his moral conclusions,¹⁵¹ putting respect for persons, beneficence and the will as part of secular morality. But at least one person, Stanley Hauerwas,¹⁵² has doubts whether Engelhardt can show that the principle of permission is the “core” of the morality of the mutual respect¹⁵³ as such an “account seems too close to Kant for someone who has disavowed the Kantian deduction.”

Although Engelhardt sees liberal democracies morally neutral by default¹⁵⁴ and moreover, committed to being morally neutral, Hauerwas challenges whether one such democracy even exist, for governments always have particular sets of

¹⁵⁰ This argument in itself points to the phenomenology of the doctor-patient relationship: based on beneficence; for there can be no other reason, other than for strategic gain, why a doctor should enter into such a relationship. This view is recalled in the section of the phenomenology of the Physician-patient relationship.

¹⁵¹ Engelhardt H.T., Jr., *Foundations of Biomedical Ethics*, New York: Oxford University Press, 1986, pp. 105–108.

¹⁵² Hauerwas S., “Not All Peace is Peace: Why Christians Cannot Make Peace with Engelhardt's Peace”, in *Reading Engelhardt*, p. 39.

¹⁵³ Engelhardt H.T., Jr., *Foundations of Biomedical Ethics*, p. 117.

¹⁵⁴ *Ibid.*, p. 120.

interests.¹⁵⁵ Engelhardt's may thus be only a thought experiment, but even so the "peace" offered is too coercive.¹⁵⁶ Moreover, why should people care for others simply because they fall ill? And why should society pay for people who waste their time caring for the sick? In reasoning this way Hauerwas thinks Engelhardt to be basing his thoughts on his own Christian beliefs.¹⁵⁷ If there is an alternative, Hauerwas says it is in *being* an alternative and that that is what Christian hospitality towards the ill is all about.¹⁵⁸

Clearly all these theories lament a common external morality or Justice. In shifting from the phenomenology of medicine they do not resolve dilemmas. Rather they confuse them and try to justify anything libertarian. What follows is a phenomenological look at each principle to attempt its insertion in a physician-patient phenomenology-based model. This will hopefully give us a new insight into the evolving nature of the doctor-patient relationship.

¹⁵⁵ Hauerwas S., op. cit., p. 40.

¹⁵⁶ Idem.

¹⁵⁷ Ibid., p. 41.

¹⁵⁸ Ibid., p. 42.