1. Ethical Theory and Bioethics

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The moral problems discussed in this book have emerged from professional practice in the fields of clinical medicine, biomedical research, nursing, public health, and the social and behavioral sciences. The goal of this first chapter is to provide a basis in language, norms, and theory sufficient for reading and criticizing the selections in the later chapters.

Everyone is aware that ethics in the biomedical professions has had a distinguished history. Among the most influential sources of medical and nursing ethics are its traditions: the concepts, practices, and norms that have long guided conduct in these fields. The history and precise character of these traditions may be the logical starting point in reflecting on professional ethics, but great traditions such as Hippocratic ethics often fail to provide a comprehensive, unbiased, and adequately justified ethics. Indeed, the history of medical ethics over the last two thousand years is a particularly disappointing history from the perspective of today’s concerns in bioethics about the rights of patients and research subjects.

Prior to the early 1970s, there was no firm ground in which a commitment to principles outside of Hippocratic medical ethics could take root and flourish. Particular ethical codes written for the medical, nursing, and research professions had always been written by their own members to govern their own conduct. To consult persons outside the profession was thought not only unnecessary, but dangerous. This conception has collapsed in the face of the pressures of the modern world. Such a professional morality has been judged not adequately comprehensive, coherent, or sensitive to conflicts of interest. The birth of bioethics occurred as a result of an increasing awareness that this older ethic had become obsolete.

FUNDAMENTAL PROBLEMS

THE STUDY OF MORALITY

Some Basic Concepts and Definitions. The field of ethics includes the study of social morality as well as philosophical reflection on its norms and practices. The terms ethical theory and moral philosophy refer exclusively to philosophical reflection on morality. The term morality, by contrast, refers to traditions of belief about right and wrong human conduct. Morality is a social institution with a history and a code of learnable rules. Moral standards and responsibilities predate us and are transmitted across generations. Like political constitutions and languages, morality exists before we are instructed in its relevant rules, and thus it has a transindividual status as a body of guidelines for action.

Since virtually everyone grows up with a basic understanding of the institution of morality, its norms are readily understood. All persons who are serious about living a moral life already grasp the core dimensions of morality. They know not to lie, not to steal property, to keep promises, to respect the rights of others, not to kill or cause harm to innocent persons, and the like. Individuals do not create these moral norms, and morality therefore cannot be purely a personal policy or code. The core parts of morality exist before their acceptance by individuals, who learn about moral responsibilities and moral ideals as they grow up.

Individuals also eventually learn to distinguish the general morality that holds for all persons — sometimes called the common morality (see later) — from rules that bind only members of special groups, such as physicians. We learn moral rules alongside other important social rules, which is one reason it later becomes difficult to distinguish the two. For example, we are constantly reminded in our early years that we must observe social rules of etiquette, such as saying "Please" when we want something and "Thank you" when we receive it, as well as more specific rules, such as "A judge is addressed as Judge." We are also taught rules of prudence, including
"Don’t touch a hot stove," together with rules of housekeeping, dressing, and the like.

Morality enters the picture when certain actions ought or ought not to be performed because of the considerable impact these actions can be expected to have on the interests of other people. We first learn maxims such as "Keep your promises" and "Respect the rights of others." These are elementary instructions in morality; they express what society expects of us and of everyone in terms of taking the interests of other people into account. We thus learn about moral instructions and expectations, and gradually we come to understand morality as a set of normative standards about doing good, avoiding harm, respecting others, keeping promises, and acting fairly. We also absorb standards of character and moral excellence.

The Common Morality. The set of norms that all morally serious persons share is the common morality. This morality binds all persons in all places. In recent years, the favored category to represent this universal core of morality in public discourse has been human rights, but moral obligation and moral virtue are no less vital parts of the common morality. The norms in the common morality do not deviate from what every morally serious person already knows. Every such person believes that we should not lie to others, should keep our promises, should take account of the well-being of others, and should treat them fairly. This background in morality is the raw data for theory and is why we can speak of the origins of moral principles as located in the common morality that we all already share.

A distinction is needed, however, between morality in the narrow sense and morality in the broad sense. The universal principles of the common morality comprise only a narrow range or skeleton of a well-developed body of moral standards. Morality in the narrow sense is comprised of universal principles, whereas morality in the broad (full-bodied) sense includes divergent moral norms, obligations, ideals, and attitudes that spring from particular cultures, religions, and institutions. For example, different standards of allocating resources for health care and different standards of giving to charitable causes are parts of morality in the broad sense. A pluralism of judgments and practices is the inevitable outcome of historical developments in cultures, moral disagreement and resolution, and the formulation of complex institutional and public policies.

Sometimes persons who suppose that they speak with an authoritative moral voice operate under the false belief that they have the force of the common morality (that is, universal morality) behind them. The particular moral viewpoints that such persons represent may be acceptable and even praiseworthy, but they also may not bind other persons or communities. For example, persons who believe that scarce medical resources such as transplantable organs should be distributed by lottery rather than by medical need may have very good moral reasons for their views, but they cannot claim the force of common morality for those views.

A theory of common morality does not hold that all customary moralities qualify as part of the common morality; and use of the common morality in moral reasoning need not lead to conclusions that are socially received. An important function of the general norms in the common morality is to provide a basis for the evaluation and criticism of groups or communities whose customary moral viewpoints are in some respects deficient. Critical reflection may ultimately vindicate moral judgments that at the outset were not widely shared.

Four Approaches to the Study of Ethics. Morality can be studied and developed in a variety of ways. In particular, four ways of either studying moral beliefs or doing moral philosophy appear prominently in the literature of ethics. Two of these approaches describe and analyze morality without taking moral positions, and these approaches are therefore called nonnormative. Two other approaches do involve taking moral positions and are therefore called normative. These four approaches can be grouped as follows:

A. Nonnormative approaches
   1. Descriptive ethics
   2. Metaethics

B. Normative approaches
   3. General normative ethics
   4. Practical normative ethics

It would be a mistake to regard these categories as expressing rigid, sharply differentiated approaches. They are often undertaken at the same time, and they overlap in goal and content. Nonetheless, when understood as broad polar contrasts exemplifying models of inquiry, these distinctions are important.
First among the two nonnormative fields of inquiry into morality is descriptive ethics, or the factual description and explanation of moral behavior and beliefs. Anthropologists, sociologists, and historians who study moral behavior employ this approach when they explore how moral attitudes, codes, and beliefs differ from person to person and from society to society. Their works often dwell in detail on matters such as professional codes and practices, codes of honor, and rules governing permissible killing in a society. Although philosophers do not typically engage in descriptive ethics in their work, some have combined descriptive ethics with philosophical ethics for example, by analyzing the ethical practices of Native American tribes or researching Nazi experimentation during World War II.

The second nonnormative field, metaethics, involves analysis of the meanings of central terms in ethics, such as right, obligation, good, virtue, and responsibility. The proper analysis of the term morality and the distinction between the moral and the nonmoral are typical metaethical problems. Crucial terms in bioethics, including physician-assisted suicide, informed consent, and universal access to health care, can be and should be given careful conceptual attention, and they are so treated in various chapters in this volume. (Descriptive ethics and metaethics may not be the only forms of nonnormative inquiry. In recent years there has been an active discussion of the biological bases of moral behavior and of the ways in which humans do and do not differ from animals.)

General normative ethics attempts to formulate and defend basic principles and virtues governing the moral life. Ideally, any ethical theory will provide a system of moral principles or virtues and reasons for adopting them and will defend claims about the range of their applicability. In the course of this chapter the most prominent of these theories will be examined, as will various principles of respect for autonomy, justice, and beneficence that have played a major role in some of these theories.

General normative theories are sometimes used to justify positions on particular moral problems such as abortion, euthanasia, the distribution of health care, and research involving human subjects. Usually, however, no direct move can be made from theory or principles to particular judgments, and theory and principles therefore typically only facilitate the development of policies, action guides, or judgments. In general, the attempts to delineate practical action guides are referred to as practical ethics (B.4 in the outline).

Substantially the same general ethical theories and principles apply to problems across different professional fields and in areas beyond professional ethics as well. One might appeal to principles of justice, for example, in order to illuminate and resolve issues of taxation, health care distribution, criminal punishment, and affirmative action in hiring. Similarly, principles of veracity (truthfulness) are invoked to discuss secrecy and deception in international politics, misleading advertisements in business ethics, balanced reporting in journalistic ethics, and the disclosure of the nature and extent of an illness to a patient in medical ethics.

### MORAL DILEMMAS AND DISAGREEMENTS

In the teaching of ethics, moral problems are often examined through cases — in particular, law cases, clinical cases, and public policy cases. These cases, which appear in virtually every chapter in this book, vividly display dilemmas and disagreements that require students to identify and grapple with real moral problems.

**Moral Dilemmas.** In a case presented in Chapter 3, two judges became entangled in apparent moral disagreement when confronted with a murder trial. A woman named Tarasoff had been killed by a man who previously had confided to a therapist his intention to kill her as soon as she returned home from a summer vacation. Owing to obligations of confidentiality between patient and physician, a psychologist and a consulting psychiatrist did not report the threat to the woman or to her family, though they did make one unsuccessful attempt to commit the man to a mental hospital.

One judge held that the therapist could not escape liability: "When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger." Notification of police and direct warnings to the family were mentioned as possible instances of due care. The judge argued that although medical confidentiality must generally be observed by physicians, it was overridden in this case by an obligation to the possible victim and to the "public interest in safety from violent assault."
In the minority opinion, a second judge stated his firm disagreement. He argued that a patient’s rights are violated when rules of confidentiality are not observed, that psychiatric treatment would be frustrated by nonob- servance, and that patients would subsequently lose con- fidence in psychiatrists and would fail to provide full disclosures. He also suggested that violent assaults would actually increase because mentally ill persons would be discouraged from seeking psychiatric aid.1

The Tarasoff case is an instance of a moral dilemma because strong moral reasons support the rival conclusions of the two judges. The most difficult and recalcitrant moral controversies that we encounter in this volume generally have at least some dilemmatic features. They may even involve what Guido Calabresi has called "tragic choices." Everyone who has been faced with a difficult decision—such as whether to have an abortion, to have a pet "put to sleep," or to commit a family member to a mental institution knows through deep anguish what is meant by a dilemma.

Dilemmas occur whenever good reasons for mutually exclusive alternatives can be cited; if anyone set of reasons is acted upon, events will result that are desirable in some respects but undesirable in others. Here an agent morally ought to do one thing and also morally ought to do another thing, but the agent is precluded by circumstances from doing both. Although the moral reasons behind each alternative are good reasons, neither set of reasons clearly outweighs the other. Parties on both sides of dilemmatic disagreements thus can correctly present moral reasons in support of their competing conclusions. The reasons behind each alternative are good and weighty, and neither set of reasons is obviously the best set. Most moral dilemmas therefore present a need to balance rival claims in untidy circumstances.

One possible response to the problem of public moral dilemmas and disputes is that we do not have and are not likely ever to have a single theory or method for resolving public disagreements. In any pluralistic culture there may be many sources of moral value and consequently a plurality of moral points of view on many issues: bluffing in business deals, providing national health insurance to all citizens, involuntarily committing the mentally disturbed, civil disobedience in pursuit of justice, and so on. If this response is correct, we can understand why there seem to be intractable moral dilemmas and controversies both inside and outside professional philosophy. How-
they may also rest on purely factual disagreements. New information may have only a limited bearing on the resolution of some of these controversies, whereas in others it may have a direct and almost overpowering influence. The problem is that rarely, if ever, is all the information obtained that would be sufficient to settle factual disagreements.

2. Providing Definitional Clarity. Second, controversies have been calmed by reaching conceptual or definitional agreement over the language used by disputing parties. Controversies over the morality of euthanasia, for example, are often needlessly entangled because disputing parties use different senses of the term and have invested heavily in their particular definitions. For example, it may be that one party equates euthanasia with mercy killing and another party equates it with voluntarily elected natural death. Some even hold that euthanasia is by definition nonvoluntary mercy killing. Any resulting moral controversy over the concept euthanasia is ensnared in terminological problems, rendering it doubtful that the parties are even discussing the same problem. Fortunately, conceptual analysis does often facilitate discussion of issues, and many essays in this volume dwell at some length on conceptual analysis.

3. Adopting a Code. Third, resolution of moral problems can be facilitated if disputing parties can come to agreement on a common set of moral guidelines. If this method requires a complete shift from one starkly different moral point of view to another, disputes will virtually never be eased. Differences that divide persons at the level of their most cherished principles are deep divisions, and conversions are infrequent. Various forms of discussion and negotiation can, however, lead to the adoption of a new or changed moral framework that can serve as a common basis for discussion.

For example, a national commission appointed to study ethical issues in research involving human subjects unanimously adopted a common framework of moral principles. These principles provided a general background for deliberation about particular problems. Commissioners utilized three moral principles: respect for persons, beneficence, and justice. The principles were then used, along with other considerations, to justify a position on a wide range of moral problems that confronted the commission. This common framework of principles facilitated discussion of controversies and opened up avenues of agreement that might otherwise not have been spotted.

Virtually every professional association in medicine and nursing has a code of ethics, and the reason for the existence of these codes is to give guidance in a circumstance of uncertainty or dispute. Their rules apply to all persons in the relevant professional roles in medicine, nursing, and research and often help resolve charges of unprofessional or unethical conduct. These codes are very general and cannot be expected to cover every possible case, but agreed-upon general principles do provide an important starting point.

4. Using Examples and Counterexamples. Fourth, resolution of moral controversies can be aided by a constructive method of example and opposed counterexample. Cases or examples favorable to one point of view are brought forward, and counterexamples to these cases are thrown up against the examples and claims of the first. This form of debate occurred when the commission mentioned in the preceding section considered the level of risk that can justifiably be permitted in scientific research involving children as subjects, where no therapeutic benefit is offered to the child. On the basis of principles of acceptable risk used in their own previous deliberations, commissioners were at first inclined to accept the view that only low-risk or minimal-risk procedures could be justified in the case of children (where minimal risk refers analogically to the level of risk present in standard medical examinations of patients). Examples from the history of medicine were cited that revealed how certain significant diagnostic, therapeutic, and preventive advances in medicine would have been unlikely, or at least slowed, unless procedures that posed a higher level of risk had been employed. Counterexamples of overzealous researchers who placed children at too much risk were then thrown up against these examples, and the debate continued in this way for several months.

Eventually a majority of commissioners abandoned their original view that nontherapeutic research involving more than minimal risk was unjustified. The majority accepted the position that a higher level of risk can be justified by the benefits provided to other children, as when a group of terminally ill children become subjects of research in the hope that something will be learned about their disease that can be applied to other children. Once a consensus on this issue crystallized, resolution was achieved on the primary moral controversy about the
involvement of children as research subjects (although two commissioners never agreed).

5. Analyzing Arguments. Fifth and finally, one of the most important methods of philosophical inquiry is the exposing of inadequacies, gaps, fallacies, and unexpected consequences of an argument. If an argument rests on accepting two incoherent points of view, then pointing out the incoherence will require a change in the argument. There are many subtle ways of attacking an argument. For example, in Chapters 4-5 there are discussions of the nature of "persons" dealing with problems of the right to die and euthanasia. Some writers on these topics have not appreciated that their arguments about persons were so broad that they carried important but unnoticed implications for both infants and animals. Their arguments implicitly provided reasons they had not noticed for denying rights to infants (rights that adults have), or for granting (or denying) the same rights to fetuses that infants have, and in some cases for granting (or denying) the same rights to animals that infants have.

It may, of course, be correct to hold that infants have fewer rights than adults, or that fetuses and animals should be granted the same rights as infants. The point is that if a moral argument leads to conclusions that a proponent is not prepared to defend and did not previously anticipate, the argument will have to be changed, and this process may reduce the distance between the parties who were initially in disagreement. This style of argument may be supplemented by one or more of the other four ways of reducing moral disagreement. Much of the work published in journals takes the form of attacking arguments, using counterexamples, and proposing alternative principles.

To accept this ideal of criticism is not to assume that conflicts can always be eliminated. The moral life will always be plagued by forms of conflict and incoherence. Our pragmatic goal should be a method that helps in a circumstance of disagreement, not a method that will always eradicate problems. We need not claim that moral disagreements can always be resolved, or even that every rational person must accept the same method for approaching problems. However, if something is to be done to alleviate disagreement, a resolution is more likely to occur if the methods outlined in this section are used.

THE PROBLEM OF RELATIVISM

The fact of moral disagreement and the idea of a universal common morality raise questions about whether moral judgments can be reached impartially and hold for everyone, or instead lead to an inescapable relativism.

Cultural Relativism. Relativists have often appealed to anthropological data indicating that moral rightness and wrongness vary from place to place and that there are no absolute or universal moral standards that could apply to all persons at all times. They maintain that rightness is contingent on cultural beliefs and that the concepts of rightness and wrongness are meaningless apart from the specific contexts in which they arise. The claim is that patterns of culture can only be understood as unique wholes and that moral beliefs are closely connected in a culture.

Although it is certainly true that many cultural practices and individual beliefs vary, it does not follow that morally serious people disagree about the moral standards that were described earlier in this chapter as norms in the common morality. Two cultures may agree about these norms and yet disagree about how to apply them in particular situations or practices. The two cultures may even agree on all the basic principles of morality yet disagree about how to live by these principles in particular circumstances.

For example, if personal payments for special services are common in one culture and punishable as bribery in another, then it is undeniable that these customs are different, but it does not follow that the moral principles underlying the customs are relative. One culture may exhibit a belief that practices of grease payments produce a social good by eliminating government interference and by lowering the salaries paid to functionaries, while the people of another culture may believe that the overall social good is best promoted by eliminating all special favors. Both justifications rest on an appraisal of the overall social good, but the people of the two cultures apply this principle in disparate and apparently competing ways.

This possibility suggests that a basic or fundamental conflict between cultural values can only occur if apparent cultural disagreements about proper principles or rules occur at the level of ultimate moral principles. Otherwise, the apparent disagreements can be understood in
terms of, and perhaps be arbitrated by, appeal to deeper shared values. If a moral conflict were truly fundamental, then the conflict could not be removed even if there were perfect agreement about the facts of a case, about the concepts involved, and about background beliefs.

We need, then, to distinguish relativism of judgments from relativism of standards: Different judgments may rely upon the same general standards for their justification. Relativism of judgment is so pervasive in human social life that it would be foolish to deny it. When people differ about whether one policy for keeping hospital information confidential is more acceptable than another, they differ in their judgments, but they need not have different moral standards of confidentiality. They may hold the same moral standard on protecting confidentiality but differ over how to implement that standard.

Showing the falsity of a relativism of standards is more than we can hope to achieve here, but we can show how difficult it would be to show that it is true. Suppose, for the sake of argument, that disagreement exists at the deepest level of moral belief; that is, suppose that two cultures disagree on basic or fundamental norms. It does not follow even from a relativism of standards that there is no ultimate norm or set of norms in which everyone ought to believe. Consider an analogy to religious disagreement: From the fact that people have incompatible religious or atheistic beliefs, it does not follow that there is no single correct set of religious or atheistic propositions. Nothing more than skepticism is justified by the facts about religion that are adduced by anthropology; and, similarly, nothing more than this skepticism would be justified if fundamental conflicts of social belief were discovered in ethics.

**Normative Relativism.** Consider now a second type of relativism. Some relativists interpret "What is right at one place or time may be wrong at another" to mean that it is right in one context to act in a way that it is wrong to act in another. This thesis is normative, because it makes a value judgment; it delineates which standards or norms correctly determine right and wrong behavior. One form of this normative relativism asserts that one ought to do what one’s society determines to be right (a group or social form of normative relativism), and a second form holds that one ought to do what one personally believes is right (an individual form of normative relativism).

This normative position has sometimes crudely been translated as "Anything is right or wrong whenever some individual or some group judges that it is right or wrong." However, less crude formulations of the position can be given, and more or less plausible examples can be adduced. One can hold the view, for example, that in order to be right something must be conscientiously and not merely customarily believed. Alternatively, it might be formulated as the view that whatever is believed to be right is right if it is part of a well-formed traditional moral code of rules in a society — for example, a medical code of ethics developed by a professional society.

The evident inconsistency of this form of relativism with many of our most cherished moral beliefs is one major reason to be doubtful of it. No general theory of normative relativism is likely to convince us that a belief is acceptable merely because others believe it in a certain way, although that is exactly the commitment of this theory. At least some moral views seem relatively more enlightened, no matter how great the variability of beliefs. The idea that practices such as slavery cannot be evaluated across cultures by some common standard seems morally unacceptable, not morally enlightened. It is one thing to suggest that such beliefs might be excused, still another to suggest that they are right.

We can evaluate this second form of relativism by focusing on (1) the objectivity of morals within cultures, and (2) the stultifying consequences of a serious commitment to moral relativism. (The first focus provides an argument against individual relativism and the second provides an argument against a cultural source of relativism.)

We noted previously that morality is concerned with practices of right and wrong transmitted within cultures from one generation to another. The terms of social life are set by these practices, whose rules are pervasively acknowledged and shared in that culture. Within the culture, then, a significant measure of moral agreement (objectivity) exists, and morality cannot be modified through a person’s individual preferences.

For example, a hospital corporation cannot develop its professional ethics in any way it wishes. No hospital chain can draw up a code that brushes aside the need for confidentiality of patient information or that permits surgeons to proceed without adequate consents from patients, and a physician cannot make up his or her individual "code" of medical ethics. If codes deviate signifi-
cantly from standard or accepted rules, they will rightly be rejected as subjective and mistaken.

Room for invention or alteration in morality is therefore restricted by the broader understanding of social morality. Beliefs cannot become *moral* standards simply because an individual so labels them. Because individual (normative) relativism claims that moral standards can be invented or labeled, the theory seems *factually* mistaken. This critique of *individual* relativism does not count against *cultural* relativism, however, because a cultural relativist could easily accept this critique. Our discussion needs to shift, then, to a second argument, which is directed at cultural forms of normative relativism.

The problem is this: In circumstances of disagreement, moral reflection is needed to resolve moral issues whether or not people accept different norms. When two parties argue about a serious, divisive, and contested moral issue — for example, conflicts of interest — most of us think that some fair and justified compromise may be reached despite the differences of belief causing the dispute. People seldom infer from the mere fact of a conflict between beliefs that there is no way to judge one view as correct or as better argued or fairer minded than the other. The more implausible the position advanced by one party, the more convinced others become that some views are mistaken or require supplementation.

People seldom conclude, then, that there is not a better and worse ethical perspective or a more reasonable form of negotiation. If cultural normative relativists deny the acceptability of these beliefs, they seem to give up too early on the possibility that moral agreement may be achieved.

**THE ACCEPTABILITY OF MORAL DIVERSITY AND MORAL DISAGREEMENT**

Even conscientious and reasonable moral agents who work diligently at moral reasoning sometimes disagree with other equally conscientious persons. They may disagree about whether disclosure to a fragile patient is appropriate, whether religious values about brain death have a central place in secular ethics, whether physician-assisted suicide should be legalized, and hundreds of other issues in bioethics. Such disagreement does not indicate moral ignorance or moral defect. We simply lack a single, entirely reliable way to resolve all disagreements.

This fact returns us to the questions about morality in the particular (or broad) sense that opened this chapter. Neither morality nor ethical theory has the resources to provide a single solution to every moral problem. Moral disagreement can emerge because of (1) factual disagreements (for example, about the level of suffering that an action will cause), (2) scope disagreements about who should be protected by a moral norm (for example, whether fetuses or animals are protected), (3) disagreements about which norms are relevant in the circumstances, (4) disagreements about appropriate specifications, (5) disagreements about the weight of the relevant norms in the circumstances, (6) disagreements about appropriate forms of balancing, (7) the presence of a genuine moral dilemma, and (8) insufficient information or evidence.

Different parties may emphasize different principles or assign different weights to principles even when they do not disagree over which principles are relevant. Such disagreement may persist even among morally serious persons who conform to all the demands that morality makes upon them. Moreover, when evidence is incomplete and different sets of evidence are available to different parties, one individual or group may be justified in reaching a conclusion that another individual or group is justified in rejecting. Even when both parties have incorrect beliefs, each party may be justified in holding those beliefs. We cannot hold persons to a higher standard in practice than to make judgments conscientiously in light of the relevant norms and the available and relevant evidence.

These facts about the moral life sometimes discourage those who must deal with practical problems, but the phenomenon of reasoned moral disagreement provides no basis for skepticism about morality or about moral thinking. Indeed, it offers a reason for taking morality seriously and using the best tools that we have to carry our moral projects as far as we can. We should not forget that we frequently obtain near complete agreement in our moral judgments and that we have the universal basis for morality considered earlier in this chapter.

When disagreements arise, a moral agent can — and often should — defend his or her decision without disparaging or reproaching others who reach different decisions. Recognition of legitimate diversity (by contrast to moral violations that call for criticism) is exceedingly important when we evaluate the actions of others. What
one person does may not be what other persons should do even when they face the same problem. Similarly, what one institution or government should do may not be what another institution or government should do. From this perspective, individuals and societies legitimately construct different requirements that comprise part of the moral life (consistent with what we have called morality in the broad sense), and we may not be able to judge one as better than another.\footnote{\textsuperscript{3}}

**MORAL JUSTIFICATION**

Typically we have no difficulty in deciding whether and how to act morally. We make moral judgments through a mix of appeals to rules, paradigm cases, role models, and the like. These moral beacons work well as long as we are not asked to deliberate about or justify our judgments. However, when we experience moral doubt or uncertainty, we are led to moral deliberation, and often from there to a need to justify our beliefs. As we deliberate, we usually consider which among the possible courses of action is morally justified — that is, which has the strongest moral reasons behind it. The reasons we finally accept express the conditions under which we believe some course of action is morally justified.

The objective of justification is to establish one’s case by presenting a sufficient set of reasons for belief and action. Not all reasons, however, are good reasons, and even good reasons are not always sufficient for justification. There is, then, a need to distinguish a reason’s relevance to a moral judgment from its final adequacy for that judgment; and also to distinguish an attempted justification from a successful justification. For example, a good reason for involuntarily committing certain mentally ill persons to institutions is that they present a clear and present danger to other persons. By contrast, a reason for commitment that is sometimes offered as a good reason, but that many people consider a bad reason (because it involves a deprivation of liberty), is that some mentally ill persons present a clear and present danger to themselves or that they require treatment for a serious mental disorder.

If someone holds that involuntary commitment on grounds of danger to self is a good reason and is solely sufficient to justify commitment, that person should be able to give some account of why this reason is good and sufficient. That is, the person should be able to give further justifying reasons for the belief that the reason offered is good and sufficient. The person might refer, for example, to the dire consequences for the mentally ill that will occur if no one intervenes. The person might also invoke certain principles about the moral importance of caring for the needs of the mentally ill. In short, the person is expected to give a set of reasons that amounts to an argued defense of his or her perspective. These appeals are usually either to a coherent group of moral principles or to consequences of actions, and they form the substantive basis of justification.

Many philosophers now defend the view that the relationship between general moral norms and particular moral judgments is bilateral (neither a unilateral “application” of general norms nor a unilateral abstraction from particular case judgments). John Rawls’s celebrated account of reflective equilibrium has been the most influential model in this literature. In developing and refining a system of ethics, he argues, it is appropriate to start with the broadest possible set of considered judgments (see later) about a subject and to erect a provisional set of principles that reflects them. Reflective equilibrium views investigation in ethics (and theory construction) as a reflective testing of moral principles, theoretical postulates, and other relevant moral beliefs to render them as coherent as possible. Starting with paradigms of what is morally right or wrong, one searches for principles that are consistent with these paradigms as well as one another. Such principles and considered judgments are taken, as Rawls puts it, “provisionally as fixed points,” but also as “liable to revision.”

**Considered judgments** is a technical term referring to judgments in which moral beliefs and capacities are most likely to be presented without a distorting bias. Examples are judgments about the wrongness of racial discrimination, religious intolerance, and predatory sexual behavior. The goal of reflective equilibrium is to match, prune, and adjust considered judgments and principles so that they form a coherent moral outlook. This model demands the best approximation to full coherence under the assumption of a never-ending search for consistency and unanticipated situations. From this perspective, ethical theories and individual moral outlooks are never complete, always stand to be informed by practical contexts, and must be tested for adequacy by their practical implications.
Although the justification of particular moral judgments is often the issue, philosophers are as also concerned with the justification of general ethical theories. Which theory, we can now ask, is the best theory? Or do all theories fail tests for considered judgments and coherence?

TYPES OF ETHICAL THEORY

Many writers in bioethics believe that we would justifiably have more confidence in our individual and communal moral judgments if only we could justify them on the basis of a comprehensive ethical theory. The ambition of such an ethical theory is to provide an adequate normative framework for processing, and hopefully resolving, moral problems.

To deal with these issues, the reader should be prepared not only to understand ethical theory but also to make some assessment of its value for bioethics. Our objective in this section is not to show how ethical theory actually can resolve problems in health care, but only to present several influential types of ethical theory. These theories should be situated under the category that we earlier called general normative ethics. We will concentrate on utilitarianism, Kantianism, virtue (or character) ethics, the ethics of care, and casuistry. Some knowledge of these theories is indispensable for reflective study in bioethics because a sizable part of the field’s literature draws on methods and conclusions found in these theories.

UTILITARIAN THEORIES

Utilitarianism is rooted in the thesis that an action or practice is right (when compared to any alternative action or practice) if it leads to the greatest possible balance of good consequences or to the least possible balance of bad consequences in the world as a whole. Utilitarians hold that there is one and only one basic principle of ethics: the principle of utility. This principle asserts that we ought always to produce the maximal balance of good consequences over bad consequences. The classical origins of this theory are found in the writings of Jeremy Bentham (1748-1832) and John Stuart Mill (1806-1873).

Utilitarians invite us to consider the larger objective or function of morality as a social institution, where morality is understood to include our shared rules of justice and other principles of the moral life. The point of the institution of morality, they insist, is to promote human welfare by minimizing harms and maximizing benefits: There would be no point in having moral codes unless they served this purpose. Utilitarians thus see moral rules as the means to the fulfillment of individual needs as well as to the achievement of broad social goals.

Mill’s Utilitarianism. In several types of ethical theory, classic works of enduring influence form the basis for development of the theory. The most influential exposition of utilitarianism is John Stuart Mill’s book Utilitarianism (1863). In this work Mill refers to the principle of utility as the Greatest Happiness Principle: “Actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness, i.e., pleasure or absence of pain.” Mill’s view seems to be that the purpose of morality is to tap natural human sympathies so as to benefit others while at the same time controlling unsympathetic attitudes that cause harm to others. The principle of utility is conceived as the best means to these basic human goals.

For Mill and other utilitarians, moral theory is grounded in a theory of the general goals of life, which they conceive as the pursuit of pleasure and the avoidance of pain. The production of pleasure and pain assumes moral and not merely personal significance when the consequences of our actions affect the pleasurable or painful states of others. Moral rules and moral and legal institutions, as they see it, must be grounded in a general theory of value, and morally good actions are alone determined by these final values.

Essential Features of Utilitarianism. Several essential features of utilitarianism may be extracted from the reasoning of Mill and other utilitarians. In particular, four conditions must be satisfied in order to qualify as a utilitarian theory.

1. The Principle of Utility: Maximize the Good. First, actors are obliged to maximize the good: We ought always to produce the greatest possible balance of value over disvalue (or the least possible balance of disvalue, if only bad results can be achieved). But what is the good or the valuable? This question takes us to the second condition.
2. A Theory of Value: The Standard of Goodness. The goodness or badness of consequences is to be measured by items that count as the primary goods or utilities. Various theories of value (or theories of the good) held by utilitarians point to (1) happiness, (2) the satisfaction of desires and aims, and (3) the attainment of such conditions or states of affairs as autonomy, understanding, various kinds of functioning, achievement, and deep personal relationships.

Many utilitarians agree that ultimately we ought to look to the production of *agent-neutral* or intrinsic values, those that do not vary from person to person. That is, what is good in itself, not merely what is good as a means to something else, ought to be produced. Bentham and Mill are hedonists; they believe that only pleasure or happiness (which are synonymous terms in this context) can be intrinsically good. Pluralistic utilitarian philosophers, by contrast, believe that no single goal or state constitutes the good and that many values besides happiness possess intrinsic worth — for example, the values of friendship, knowledge, love, personal achievement, culture, freedom, and liberties can all qualify.

Both the hedonistic and the pluralistic approaches have seemed to some recent philosophers relatively problematic for purposes of objectively aggregating widely different interests in order to determine where maximal value, and therefore right action, lies. Many utilitarians interpret the good as that which is *subjectively* desired or wanted. The satisfaction of desires or wants is seen as the goal of our moral actions. To maximize an individual’s utility is to maximize what he or she has chosen or would choose from the available alternatives.

3. Consequentialism. Whatever its value theory, any utilitarian theory decides which actions are right entirely by reference to the *consequences* of the actions, rather than by reference to any intrinsic moral features the actions may have, such as truthfulness or fidelity. Here the utilitarian need not demand that all future consequences or even all avoidable consequences be anticipated. A utilitarian demands only that we take account of what can reasonably be expected to produce the greatest balance of good or least balance of harm. In judging the *agent* of the action, we should assess whether the agent conscientiously attempts to produce the best utilitarian outcome.

4. Impartiality (Universalism). Finally, in the utilitarian approach all parties affected by an action must receive *impartial consideration*. Utilitarianism thus stands in sharp contrast to egoism, which proposes maximizing consequences for oneself rather than for all parties affected by an action. In seeking a blinded impartiality, utilitarianism aligns good and mature moral judgment with moral distance from the choices to be made.

*Act and Rule Utilitarianism.* Utilitarian moral philosophers are conventionally divided into several types, and it is best to think of “utilitarianism” as a label designating a family of theories that use a consequentialist principle. A significant dispute has arisen among utilitarians over whether the principle of utility is to be applied to particular acts in particular circumstances or to rules of *conduct* that determine which acts are right and wrong. For the *rule utilitarian*, actions are justified by appeal to rules such as “Don’t deceive” and “Don’t break promises.” These rules, in turn, are justified by appeal to the principle of utility. An *act utilitarian* simply justifies actions directly by appeal to the principle of utility. Act utilitarianism is thus characterized as a “direct” or “extreme” theory because the act utilitarian directly asks, “What good and evil consequences will result directly from this action in this circumstance?” — not “What good and evil consequences will result generally from this sort of action?”

Consider the following case, which occurred in the state of Kansas and which anticipates some issues about euthanasia encountered in Chapter 4. An elderly woman lay ill and dying. Her suffering came to be too much for her and her faithful husband of fifty-four years to endure, so she requested that he kill her. Stricken with grief and unable to bring himself to perform the act, the husband hired another man to kill his wife. An act utilitarian might reason that *in this case* hiring another to kill the woman was justified, although *in general* we would not permit persons to perform such actions. After all, only this woman and her husband were directly affected, and relief of her pain was the main issue. It would be unfortunate, the act utilitarian might reason, if our “rules” against killing failed to allow for selective killings in extenuating circumstances, because it is extremely difficult to generalize from case to case. The jury, as it turned out, convicted the husband of murder, and he was sentenced to twenty-five years in prison. An act utilitarian might maintain that a *rigid* application of rules inevitably leads to injustices and that rule utilitarianism cannot escape this problem of an undue rigidity of rules.
Many philosophers object vigorously to act utilitarianism, charging its exponents with basing morality on mere expediency. On act-utilitarian grounds, they say, it is desirable for a physician to kill babies with many kinds of birth defects if the death of the child would relieve the family and society of a burden and inconvenience and would lead to the greatest good for the greatest number. Many opponents of act utilitarianism have thus argued that strict rules, which cannot be set aside for the sake of convenience, must be maintained. Many of these apparently desirable rules can be justified by the principle of utility, so utilitarianism need not be abandoned if act utilitarianism is judged unworthy.

Rule utilitarians hold that rules have a central position in morality and cannot be compromised in particular situations. Compromise threatens the rules themselves. The rules’ effectiveness is judged by determining whether the observance of a given rule would maximize social utility better than would any substitute rule (or having no rule). Utilitarian rules are, in theory, firm and protective of all classes of individuals; just as human rights firmly protect all individuals regardless of social convenience and momentary need.

Nonetheless, we can ask whether rule-utilitarian theories offer anything more than act utilitarianism. Dilemmas often arise that involve conflicts among moral rules — for example, rules of confidentiality conflict with rules protecting individual welfare, as in the Tarasoff case. If there are no rules to resolve these conflicts, perhaps the rule utilitarian cannot be distinguished from the act utilitarian.

KANTIAN THEORIES

We have seen that utilitarianism conceives the moral life in terms of intrinsic value and the means to produce this value. A second type of theory departs significantly from this approach. Often called deontological (i.e., a theory that some features of actions other than or in addition to consequences make actions obligatory), this type is now increasingly called Kantian, because of its origins in the theory of Immanuel Kant (1724-1804).

Duty from Rules of Reason. Kant believed that an act is morally praiseworthy only if done neither for self-interested reasons nor as the result of a natural disposition, but rather from duty. That is, the person’s motive for acting must be a recognition of the act as resting on duty. It is not good enough, in Kant’s view, that one merely performs the morally correct action, because one could perform one’s duty for self-interested reasons having nothing to do with morality. For example, if an employer discloses a health hazard to an employee only because he or she fears a lawsuit, and not because of a belief in the importance of truth telling, then this employer acts rightly but deserves no moral credit for the action.

Kant tries to establish the ultimate basis for the validity of moral rules in pure reason, not in intuition, conscience, or utility. He thinks all considerations of utility and self-interest secondary, because the moral worth of an agent’s action depends exclusively on the moral acceptability of the rule on the basis of which the person is acting. An action has moral worth only when performed by an agent who possesses a good will, and a person has a good will only if moral duty based on a universally valid rule is the sole motive for the action. Morality, then, provides a rational framework of principles and rules that constrain and guide everyone, without regard to their personal goals and interests.

Kant’s supreme principle, the categorical imperative, also called the moral law, is expressed in several ways in his writings. His first formulation may be roughly paraphrased in this way: “Always act in such a way that you can will that everyone act in the same manner in similar situations.” Kant’s view is that wrongful practices, such as lying, theft, cheating, and failure to help someone in distress when you can easily do so, involve a kind of contradiction. Consider the example of cheating on exams. If everyone behaved as the cheater did, exams would not serve their essential function of testing mastery or relevant material, in which case there would effectively be no such thing as an exam. But cheating presupposes the background institution of taking exams, so the cheater cannot consistently will that everyone act as she does.

The categorical imperative is categorical, Kant says, because it admits of no exceptions and is absolutely binding. It is imperative because it gives instruction about how one must act. Kant clarifies this basic moral law by drawing a distinction between a categorical imperative and a hypothetical imperative. A hypothetical imperative takes the form, "If I want to achieve such and such a valued end, then I must do so and so.” These prescriptions — so reminiscent of utilitarian thinking — tell us what we must do, provided that we already have certain de-
sires, interests, or goals. An example is, "If you want to regain your health, then you must take this medication," or "If you want to improve infant mortality rates, then you must improve your hospital facilities." These imperatives are not commanded for their own sake. They are commanded as means to an end that has already been willed or accepted. Hypothetical imperatives are not moral imperatives in Kant’s philosophy because moral imperatives tell us what must be done independently of our goals or desires.

Kant emphasizes the notion of rule as universal law. Rules that determine duty are made correct by their universality, that is, the fact that they apply to everyone. This criterion of universality offers some worthwhile lessons for bioethics. Some of the clearest cases of immoral behavior involve a person’s trying to make a unique exception of himself or herself purely for personal reasons. This conduct could not be made universal, or the rules presupposed by the idea of “being an exception” would be destroyed. If carried out consistently by others, this conduct would violate the rules presupposed by the system of morality, thereby rendering the system inconsistent — that is, having inconsistent rules of operation.

Kant’s view is that wrongful practices, including invasion of privacy, theft, and manipulative suppression of information, are "contradictory"; that is, they are not consistent with the very duties they presuppose. In cases of lying, for example, the universalization of rules that allow lying would entitle everyone to lie to you, just as you would be entitled to lie to them. Such rules are inconsistent with the practice of truth telling that they presuppose. Similarly, fraud in research is inconsistent with the practice of publishing the truth. All such practices are inconsistent with a rule or practice that they presuppose.

The Requirement to Never Treat Persons as Means. A second formulation of Kant’s categorical imperative — one more frequently invoked in medical ethics — may be paraphrased in this way: “Treat every person as an end and never solely as a means.” This principle requires us to treat persons as having their own established goals. Deceiving prospective subjects in order to get them to consent to participate in nontherapeutic research is one example of a violation of this principle.

It has commonly been said that Kant is here arguing that we can never treat another as a means to our ends. This interpretation, however, misrepresents his views. He argues only that we must not treat another exclusively as a means to our own ends. When adult human research subjects are asked to volunteer, for example, they are treated as a means to a researcher’s ends. However, they are not exclusively used for others’ purposes, because they do not become mere servants or objects. Their consent justifies using them as means to the end of research.

Kant’s imperative demands only that persons in such situations be treated with the respect and moral dignity to which all persons are always entitled, including the times when they are used as means to the ends of others. To treat persons merely as means, strictly speaking, is to disregard their personhood by exploiting or otherwise using them without regard to their own thoughts, interests, and needs. It involves a failure to acknowledge that every person has a worth and dignity equal to that of every other person and that this worth and dignity cannot be compromised for utilitarian or any other reasons.

CONTEMPORARY CHALLENGES TO THE TRADITIONAL THEORIES

Thus far we have treated only two types of theory: utilitarianism and Kantianism. These theories combine a variety of moral considerations into a surprisingly systematized framework, centered around a single major principle. Much is attractive in these theories, and they have been the dominant models in ethical theory throughout much of the twentieth century. During the 1970s and much of the 1980s, utilitarian and deontological approaches exerted enormous influence on the literature and discourse of bioethics.

Although utilitarian and deontological arguments or patterns of reasoning are still common today, the theories themselves now hold a much diminished stature in the field. The reasons for the demotion of utilitarian and single-principle deontological theories concern the disadvantages of any approach that attempts to characterize the entire domain of morality with one supreme principle. Three disadvantages are especially worthy of note. First, there is a problem of authority. Despite myriad attempts by philosophers in recent centuries to justify the claim that some principle is morally authoritative — that is, correctly regarded as the supreme moral principle — no such effort at justification has persuaded a majority of philosophers or other thoughtful people that either the principle or the moral system is as authoritative as the
common morality that supplies its roots. Thus to attempt to illuminate problems in bioethics with a single-principle theory has struck many as misguided as well as presumptuous or dogmatic.

Second, even if an individual working in this field is convinced that some such theory is correct (authoritative), he or she needs to deal responsibly with the fact that many other morally serious individuals do not share this theory and give it little or no authority. Thus, problems of how to communicate and negotiate in the midst of disagreement do not favor appeals to rigid theories or inflexible principles, which can generate a gridlock of conflicting principled positions, rendering moral discussion hostile and alienating.

Third, there is the problem that a highly general principle is indeterminate in many contexts in which one might try to apply it. That is, the content of the principle itself does not always identify a unique course of action as right. It has increasingly become apparent that single-principle theories are significantly incomplete, frequently depending on independent moral considerations with the help of which the theories can serve as effective guides to action.

Much recent philosophical writing has focused on weaknesses in utilitarian and Kantian theories and on ways in which the two types of theory actually affirm some broader and less controversial conception of the moral life. Critics of utilitarian and Kantian models believe that the contrast between the two “types of theory” has been overestimated and that they do not merit the attention they have received and the lofty position they have occupied. Three accounts have been popular in bioethics as replacements for, or perhaps supplements to, utilitarian and Kantian theories. They are (1) virtue theory (which is character based), (2) the ethics of care (which is relationship based), and (3) casuistry (which is case based). These are the topics of the next three sections.

VIRTUE ETHICS

In discussing utilitarian and Kantian theories, we have looked chiefly at obligations and rights. Beyond obligations and rights, we often reflect on the agents who perform actions, have motives, and follow principles. Here we commonly make judgments about good and evil character in persons; virtue ethics gives good character a preeminent place.

Virtue ethics descends from the classical Greek tradition represented by Plato and Aristotle. Here the cultivation of virtuous traits of character is viewed as morality’s primary function. Moral virtues are understood as morally praiseworthy character traits, such as courage, compassion, sincerity, reliability, and industry. In virtue ethics, the primary concern is with what sort of person is ideal, while action is considered to have secondary importance. People are viewed as acquiring virtues much as they do skills such as carpentry, playing an instrument, or cooking. They become just by performing just actions and become temperate by performing temperate actions. Virtuous character is cultivated and made a part of the individual, much like a language or tradition.

However, an ethics of virtue is more than habitual training. One must also have a correct motivational structure. A conscientious person, for example, not only has a disposition to act conscientiously, but a morally appropriate desire to be conscientious. The person characteristically has a moral concern and reservation about acting in a way that would not be conscientious.

Imagine a Kantian who always performs his or her obligation because it is an obligation but intensely dislikes having to allow the interests of others to be of importance. Such a person does not cherish, feel congenial toward, or think fondly of others, and respects them only because obligation requires it. This person can, on a theory of moral obligation such as Kant’s (or Mill’s), perform a morally right action, have an ingrained disposition to perform that action, and act with obligation as the foremost motive. It is possible (1) to be disposed to do what is right, (2) to intend to do it, and (3) to do it while also (4) yearning to be able to avoid doing it. If the motive is improper, a vital moral ingredient is missing, and if a person characteristically lacks this motivational structure, a necessary condition of virtuous character is absent.

Consider a physician who meets his moral obligations because they are his obligations and yet has underlying motives that raise questions of character. This physician detests his job and hates having to spend time with every patient who comes through the door. He cares not about being of service to people or creating a better environment in the office. All he wants to do is make money, avoid malpractice suits, and meet his obligations. Although this man never acts immorally from the perspec-
tive of duty, something in his character is deeply defective morally. The admirable compassion and dedication guiding the lives of many health professionals is absent in this person, who merely engages in rule-following behavior.

Virtue ethics may seem only of intellectual interest, but it has practical value in that a morally good person with right desires or motives is more likely to understand what should be done, to perform required acts, and to form moral ideals than is a morally bad or indifferent person. A trusted person has an ingrained motivation and desire to do what is right and to care about whether it is done. Whenever the feelings, concerns, and attitudes of others are the morally relevant matters, rules and principles are not as likely as human warmth and sensitivity to lead a person to notice what should be done. From this perspective, virtue ethics is at least as fundamental in the moral life as principles of basic obligation.

We also often morally evaluate a person’s emotional responses — which tend to reflect one’s character — even where no particular action is called for. One might admire a social worker’s genuine sorrow at the news that another social worker’s patient committed suicide; her expression of sorrow reflects her caring and sympathy. Moreover, in practice, well-established virtues may prove at least as important as mastery of principles, rules, and other action guides. For example, it may be the case that being truthful, compassionate, perceptive, diligent, and so forth is a more reliable basis for good medical practice than knowledge of the principles and rules of bioethics.

A proponent of character ethics need not claim that analysis of the virtues subverts or discredits ethical principles, rules, or theories. It is enough to argue that ethical theory is more complete if the virtues are included and that moral motives deserve to be at center stage in a way moral principles often to be irrelevant, vacuous, or ineffectual in the moral life. A defender of principles could say that principles often to be irrelevant, vacuous, or ineffectual in the moral life. A defender of principles could say that principles of care, compassion, love, friendship, and the like. Noticeably absent are universal moral rules and impartial utilitarian calculations such as those espoused by Kant and Mill.

To understand this approach, consider the traditional theories’ criterion of impartiality in moral judgment. This criterion of detached fairness and treating similar cases similarly makes eminently good sense for courts, but does it make good sense of intimate moral relationships? The care perspective views this criterion as cutting away too much of morality in order to get to a standpoint of detached fairness. Lost in the traditional detachment of impartiality is attachment — that which we care about most and which is closest to us. In seeking blindness, we may be made blind and indifferent to the special needs of others. So, although impartiality is a moral virtue in some contexts, it may be a moral vice in others. The care perspective is especially important for roles such as parent, friend, physician, and nurse, where contextual response, attentiveness to subtle clues, and discernment are likely to be more important morally than impartial treatment.

Being cautious about abstract principles of obligation — the instruments of impartiality — is also characteristic of the ethics of care. Defenders of the ethics of care find principles often to be irrelevant, vacuous, or ineffectual in the moral life. A defender of principles could say that principles of care, compassion, and kindness structure our understanding of when it is appropriate to respond in caring, compassionate, and kind ways, but there is something hollow about this claim. It seems to best capture our moral experience to say that we rely on our emotions, our capacity for sympathy, our sense of friendship, and our knowledge of how caring people behave.

Exponents of the ethics of care have also criticized the autonomous, unified, rational beings that typify both the Kantian and the utilitarian conception of the moral self. They argue that moral decisions often require a sensitivity to the situation as well as an awareness of the beliefs, feelings, attitudes, and concerns of each of the individuals.

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involved and of the relationships of those individuals to one another.

Additional reasons exist for thinking that a morality centered on care and concern cannot be squeezed into a morality of rules. For example, it seems very difficult to express the responsibilities of a health care professional adequately through principles and rules. We can generalize about how caring physicians and nurses respond in encounters with patients, but these generalizations do not amount to principles, nor will such generalizations be subtle enough to give sound guidance for the next patient. Each situation calls for a different set of responses, and behavior that in one context is caring seems to intrude on privacy or be offensive in another context.

A morality centered on care and concern can potentially serve health care ethics in a constructive and balanced fashion, because it is close to the processes of reason and feeling exhibited in clinical contexts. Disclosures, discussions, and decision making in health care typically become a family affair, with support from a health care team. The ethics of care maintains that many human relationships in health care and research involve persons who are vulnerable, dependent, ill, and frail and that the desirable moral response is attached attentiveness to needs, not detached respect for rights. Feeling for and being immersed in the other person establish vital aspects of the moral relationship. Accordingly, this approach features responsibilities and forms of empathy that a rights-based account may ignore in the attempt to protect persons from invasion by others.

CASUISTRY

A third alternative to classic theories has been labeled casuistry. It focuses on decision making using particular cases, where the judgments reached rely on judgments reached in prior cases. Casuists are skeptical of the power of principles and theory to resolve problems in specific cases. They think that many forms of moral thinking and judgment do not involve appeals to general guidelines, but rather to narratives, paradigm cases and precedents established by previous cases.

Casuists concentrate our attention on practical decision making in particular cases and on the implications of those cases for other cases. Here we proceed by identifying the specific features of, and problems present in, the case. We may attempt to identify the relevant precedents and prior experiences we have had with related cases, attempting to determine how similar and how different the present case is from other cases. For example, if the case involves a problem of medical confidentiality, analogous cases would be considered in which breaches of confidentiality were justified or unjustified in order to see whether such a breach is justified in the present case.

Consider the way a physician thinks in making a judgment and then a recommendation to a patient. Many individual factors, including the patient’s medical history, the physician’s successes with other similar patients, paradigms of expected outcomes, and the like will play a role in formulating a judgment and recommendation to this patient, which may be very different from the recommendation made to the next patient with the same malady. The casuist views moral judgments and recommendations similarly. One can make successful moral judgments of agents, actions, and policies, casuists say, only when one has an intimate understanding of particular situations and an appreciation of treating similar cases similarly.

An analogy to case law is helpful in understanding the casuist’s point. In case law, the normative judgments made by courts of law become authoritative, and it is reasonable to hold that these judgments are primary for later judges who assess other cases — even though the particular features of each new case will be different. Matters are similar in ethics, say casuists. Normative judgments about certain cases emerge through case comparisons. A case under current consideration is placed in the context of a set of cases that shows a family resemblance, and the similarities and differences are assessed. The relative weight of competing values is presumably determined by the comparisons to analogous cases. Moral guidance is provided by an accumulated mass of influential cases, which represent a consensus in society and in institutions reached by reflection on cases. That consensus then becomes authoritative and is extended to new cases.

Cases like the Tarasoff case have been enormously influential in bioethics. Writers have used it as a form of authority for decisions in new cases. Features of their analyses have then been discussed throughout the literature of bioethics, and they become integral to the way we think and draw conclusions in the field. The leading cases become enduring and authoritative sources for reflection and decision making. Cases such as the Tuskegee syphilis
experiment case (in which a group of men were intentionally not given treatment for syphilis in order to follow the course of the disease) are constantly invoked to illustrate unjustified biomedical experimentation. Decisions reached about moral wrongs in this case serve as a form of authority for decisions in new cases. These cases profoundly influence our standards of fairness, negligence, paternalism, and the like. Just as case law (legal rules) develops incrementally from legal decisions in cases, so the moral law (moral rules) develops incrementally. From this perspective, principles are less important for moral reasoning than cases.

At first sight, casuistry seems strongly opposed to the frameworks of principles in traditional duty-based theory. However, closer inspection of casuistry shows that its primary concern (like the ethics of care) is with an excessive reliance in recent philosophy on impartial, universal action guides. Two casuists, Albert Jonsen and Stephen Toulmin, write that "good casuistry... applies general principles to particular cases with discernment." As a history of similar cases and similar judgments mounts, we become more confident in our general judgments. A "locus of moral certitude" arises in the judgments, and the stable elements crystallize into tentative principles. As confidence in these generalizations increases, they are accepted less tentatively and moral knowledge develops.7

Today’s casuists have resourcefully reminded us of the importance of analogical reasoning, paradigm cases, and practical judgment. Bioethics, like ethical theory, has sometimes unduly minimized this avenue to moral knowledge. Casuists also have rightly pointed out that generalizations are often best learned, accommodated, and implemented by using cases, case discussion, and case methods. These insights can be utilized by connecting them to an appropriate set of concepts, principles, and theories that control the judgments we make about cases.

Nonetheless, this form of reasoning can be misleading. Casuists sometimes write as if cases lead to moral paradigms, analogies, or judgments entirely by their facts alone (or perhaps by appeal only to the salient features of the cases). This premise is suspect. No matter how many facts are stacked up, we will still need some value premises in order to reach a moral conclusion. The properties that we observe to be of moral importance in cases are picked out by the values that we have already accepted as being morally important. In short, the paradigm cases of the casuists are value laden.

The best way to understand this idea of paradigm cases is as a combination of (1) facts that can be generalized to other cases — for example, "The patient refused the recommended treatment" — and (2) settled values — for example, "Competent patients have a right to refuse treatment." In a principle-based system, these settled values are called principles, rules, rights claims, and the like; and they are analytically distinguished from the facts of particular cases. In casuistical appeals to cases, rather than keeping values distinct from facts, the two are bound together in the paradigm case; the central values are generalizable, however, and must be preserved from one case to the next.

ETHICAL PRINCIPLES

Various basic principles are accepted in classic ethical theories and also seem to be presupposed in traditional codes of ethics. There is an "overlapping consensus" about the validity of these principles. But what is a principle, and which ones overlap the different theories?

A principle is a fundamental standard of conduct from which many other moral standards and judgments draw support for their defense and standing. For example, universal moral rights and basic professional duties can be delineated on the basis of moral principles. Ideally, a set of general principles will serve as an analytical framework of basic principles that expresses the general values underlying rules in the common morality and guidelines in professional ethics.

Three general moral principles have proved to be serviceable as a framework of principles for bioethics: respect for autonomy, beneficence, and justice. These three principles should not be construed as jointly forming a complete moral system or theory, but they can provide the beginnings of a framework through which we can reason about problems in bioethics. Each is treated in a separate section here.

One caution is in order about the nature and use of such principles. Moral thinking and judgment must take account of many considerations besides ethical principles and rules, and principles do not contain sufficient content to determine judgments in a great many cases. Often the most prudent course is to search for more information about cases and policies rather than trying to decide prematurely on the basis of either principles or some general theoretical commitments. More information some-
times will resolve problems and in other cases will help fix the principles that are most important in the circumstances.

Principles provide a starting point for moral judgment and policy evaluation, but — as we saw in the previous section and will see in the section on public policy — more content is needed than that supplied by principles alone. They are tested and reliable starting points, but they rarely are sufficient for moral thinking.

RESPECT FOR AUTONOMY

One principle at the center of modern bioethics is respect for autonomy. It 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 thus means freedom from external constraint and the presence of critical mental capacities such as understanding, intending, and voluntary decision-making capacity.

To respect an autonomous agent is to recognize with due appreciation that person’s capacities and perspective, 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: Autonomy of action should not be subjected to control by others. The principle provides the basis for the right to make decisions, which in turn takes the form of specific autonomy related rights.

For example, in the debate over whether autonomous, informed patients have the right to refuse self-regarding, life-sustaining medical interventions; the principle of respect for autonomy suggests a morally appropriate response. But the principle covers even simple exchanges in the medical world, such as listening carefully to patients’ questions, answering the questions in the detail that respectfulness would demand, and not treating patients in a patronizing fashion.

Respect for autonomy has historically been connected to the idea that persons possess an intrinsic value independent of special circumstances that confer value. As expressed in Kantian ethics, autonomous persons are ends in themselves, determining their own destiny, and are not to be treated merely as means to the ends of others. Thus, the burden of moral justification rests on those who would restrict or prevent a person’s exercise of autonomy.

To respect the autonomy of self-determining agents is to recognize them as entitled to determine their own destiny, with due regard to their considered evaluations and view of the world. They must be accorded the moral right to have their own opinions and to act upon them (as long as those actions produce no moral violation). Thus, in evaluating the self-regarding actions of others, we are obligated to respect those people as persons with the same right to their judgments as we possess to our own, and they in turn are obligated to treat us in the same way.

Medical and nursing codes have begun in recent years to include rules that are explicitly based on this principle. For example, the first principle of the American Nurses’ Association Code reads as follows:

The fundamental principle of nursing practice is respect for the inherent dignity and worth of every client. Nurses are morally obligated to respect human existence and the individuality of all persons who are the recipients of nursing actions…. Truth telling and the process of reaching informed choice underlie the exercise of self-determination, which is basic to respect for persons. Clients should be as fully involved as possible in the planning and implementation of their own health care.

The controversial problems with the noble-sounding 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 such other moral principles as beneficence and justice. Among the best known problems of conflict are found in cases of overriding refusals of treatment by patients, as in Jehovah’s Witnesses’ refusals of blood transfusions.

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 an individual’s choices endanger the public health, potentially harm another party, or in-
volve a scarce resource for which a patient cannot pay, it may be justifiable to restrict exercises of autonomy. If restriction is in order, the justification will rest on some competing moral principle such as beneficence or justice. This issue of both specifying and balancing the demands made by conflicting moral principles can now be seen to apply to each of these principles.

BENEFICENCE

The welfare of patients is the goal of health care. This welfare objective is medicine’s context and justification: Clinical therapies are aimed at the promotion of health by cure or prevention of disease. This value has long been treated as a foundational value — and sometimes as the foundational value — in medical and nursing ethics. Among the most quoted principles in the history of codes of medical ethics is the maxim primum non nocere: "Above all, do no harm." Although the origins of this abstract principle are obscure and its implications often unclear, it has appeared in many medical writings and codes, and it was present in nursing codes as early as Florence Nightingale’s Pledge for Nurses. Many current medical and nursing codes assert that the health professional’s "primary commitment" is to protect the patient from harm and to promote the patient’s welfare.

Other duties in medicine, nursing, public health, and research are expressed in terms of a more positive obligation to come to the assistance of those in need of treatment or in danger of injury. In the International Code of Nursing Ethics, for example, it is said that "[T]he nurse shares with other citizens the responsibility for initiating and supporting action to meet the health and social needs of the public." Various sections of the Principles of Medical Ethics of the American Medical Association express a virtually identical point of view.

The range of duties requiring abstention from harm and positive assistance may be conveniently clustered under the single heading of beneficence. This term has a broad set of meanings, including the doing of good and the active promotion of good, kindness, and charity. But in the present context the principle of beneficence has a narrower meaning: It requires us to abstain from injuring others and to help others further their important and legitimate interests, largely by preventing or removing possible harms. Presumably such acts are required when they can be performed with minimal risk to the actors; one is not under an obligation of beneficence in all circumstances of risk.

According to William Frankena, the principle of beneficence can be expressed as including the following four elements: (1) one ought not to inflict evil or harm (a principle of nonmaleficence). (2) One ought to prevent evil or harm. (3) One ought to remove evil or harm. (4) One ought to do or promote good." Frankena suggests that the fourth element may not be an obligation at all (being an act of benevolence that is over and above obligation) and contends that these elements appear in a hierarchical arrangement so that the first takes precedence over the second, the second over the third, and the third over the fourth.

There are philosophical reasons for separating passive nonmaleficence (as expressed in element 1) and active beneficence (as expressed in elements 2-4). Ordinary moral thinking often suggests that certain duties not to injure others are more compelling than duties to benefit them. For example, we do not consider it justifiable to kill a dying patient in order to use the patient’s organs to save two others. Similarly, the obligation not to injure a patient by abandonment seems to many 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 this hierarchical ordering rule, it is not firmly sanctioned by either morality or ethical theory. The obligation expressed in element 1 may not always outweigh those expressed in elements 2-4. For example, the harm inflicted in element 1 may be negligible or trivial, whereas the harm to be prevented in element 2 may be substantial: 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 they themselves conflict when one must either avoid harm or bring aid. In such cases, one needs a decision procedure for choosing one alternative rather than another. But if the weights of the two principles can vary, as they can, there can be no mechanical decision rule asserting that one obligation must always outweigh the other.

One of the most vexing problems in ethical theory is the extent to which the principle of beneficence 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. Any analy-
sis of beneficence, in the broad sense just delineated, would potentially demand severe sacrifice and extreme generosity in the moral life — for example, giving a kidney for transplantation or donating bone marrow. As a result, some philosophers have argued that this form of beneficent action is virtuous and a moral ideal, but not an obligation. We are not required by the general canons of morality to promote the good of persons, even if we are in a position to do so and the action is morally justified.

Several proposals have been offered in moral philosophy to resolve this problem by showing that beneficence is a principle of obligation, but these theoretical ventures are extraneous to our concerns here. The scope or range of acts required by the obligation of beneficence is an undecided issue, and perhaps an undecidable one. Fortunately, we do not need a resolution in the present context. That we are morally obligated on some occasions to assist others — at least in professional roles such as nursing, medicine, and research — is hardly a matter of moral controversy. Beneficent acts are demanded by the roles involved in fiduciary relationships between health care professionals and patients, lawyers and clients, researchers and subjects (at least in therapeutic research), bankers and customers, and so on.

We can treat the basic roles and concepts that give substance to the principle of beneficence in medicine as follows: The positive benefits that the physician and nurse are obligated to seek all involve the alleviation of disease and injury, if there is a reasonable hope of cure. The harms to be prevented, removed, or minimized are the pain, suffering, and disability of injury and disease. In addition, the physician and nurse are enjoined from doing harm if interventions inflict unnecessary pain and suffering on patients.

Those engaged in both medical practice and research know that risks of harm presented by interventions must be weighed against possible benefits for patients, subjects, and the public. The physician who professes to “do no harm” is not pledging never to cause harm but rather to strive to create a positive balance of goods over inflicted harms. This is recognized in the Nuremberg Code, which enjoins: "The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment."

Every civilized society is a cooperative venture structured by moral, legal, and cultural principles that define the terms of social cooperation. Beneficence and respect for autonomy are principles in this fabric of social order, but justice has been the subject of more treatises on the terms of social cooperation than any other principle. A person 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 term distributive justice refers to fair, equitable, and appropriate distribution in society determined by justified norms of distribution that structure part of the terms of social cooperation. 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; Medicare checks and grants to do research are distributed benefits.

Recent literature on distributive justice has tended to focus on considerations of fair economic distribution, especially unjust distributions in the form of inequalities of income between different classes of persons and unfair tax burdens on certain classes. But many problems of distributive justice exist besides issues about income and wealth, including the issues raised in prominent contemporary debates over health care distribution, as discussed in Chapter 2.

There is no single principle of justice. Somewhat like principles under the heading of beneficence, there are several principles of justice, each requiring specification in particular contexts. But common to almost all theories of justice is a minimal, beginning principle: 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 is referred to as the formal principle of justice, or sometimes as the formal principle of equality — formal because it states no particular respects in which people ought to be treated. It merely asserts that whatever respects are under consideration, 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 therefore lacks substance as a specific guide to conduct. Equality must here be understood as “equality in
the relevant respects.” 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.

The following is a sample list of major candidates for the position of valid material principles of distributive justice (though longer lists have been proposed): (1) To each person an equal share. (2) To each person according to individual need. (3) To each person according to acquisition in a free market. (4) To each person according to individual effort. (5) To each person according to societal contribution. (6) To each person according to merit. There is no obvious barrier to acceptance of more than one of these principles, and some theories of justice accept all six as valid. Most societies use several principles in the belief that different rules are appropriate to different situations.

Because the formal and material principles leave space for differences in the interpretation of how justice applies to particular situations, philosophers have developed diverse theories of justice that provide material principles, specify the principles, and defend the choice of principles. These theories attempt to be more specific than the formal principle by elaborating how people are to be compared and what it means to give people their due. Egalitarian theories of justice emphasize equal access to primary goods; libertarian theories emphasize rights to social and economic liberty; and utilitarian theories emphasize a mixed use of such criteria so that public and private utility are maximized.

The utilitarian theory follows the main lines of the explanation of utilitarianism given earlier, and thus economic justice is viewed as one among a number of problems concerning how to maximize value. The ideal economic distribution, utilitarians argue, is any arrangement that would have this maximizing effect.

Egalitarianism holds that distributions of burdens and benefits in a society are just to the extent they are equal, and deviations from equality in distribution are unjust. Most egalitarian accounts of justice are guardedly formulated, so that only some basic equalities among individuals take priority over their differences. In recent years an egaliitarian theory discussed earlier in the section on Kantian theories has enjoyed wide currency: John Rawls's *A Theory of Justice*. This book has as its central contention that we should distribute all economic goods and services equally except in those cases in which an unequal distribution would actually work to everyone's advantage, or at least would benefit the worst off in society.

Sharply opposed to egalitarianism is the libertarian theory of justice. What makes libertarian theories libertarian is the priority afforded to distinctive processes, procedures, or mechanisms for ensuring that liberty rights are recognized in economic practice — typically the rules and procedures governing social liberty and economic acquisition and exchange in free market systems. Because free choice is the pivotal goal, libertarians place a premium on the principle of respect for autonomy. In some libertarian systems, this principle is the sole basic moral principle, and there thus are no other principles of justice. We will see in Chapter 2 that many philosophers believe that this approach is fundamentally wrong because economic value is generated through an essentially communal process that our health policies must reflect if justice is to be done.

Libertarian theorists, however, explicitly reject the conclusion that egalitarian patterns of distribution represent a normative ideal. People may be equal in a host of morally significant respects (for example, entitled to equal treatment under the law and equally valued as ends in themselves), but the libertarian contends that it would be a basic violation of justice to regard people as deserving of equal economic returns. In particular, people are seen as having a fundamental right to own and dispense with the products of their labor as they choose, even if the exercise of this right leads to large inequalities of wealth in society. Equality and utility principles, from this libertarian perspective, sacrifice basic liberty rights to the larger public interest by coercively extracting financial resources through taxation.

These three theories of justice all capture some of our intuitive convictions about justice, and each exhibits strengths as a theory of justice. Perhaps, then, there are several equally valid, or at least equally defensible, theories of justice and just taxation. This problem will be studied further in Chapter 2.

The Prima Facie Nature of Principles. W. D. Ross, a prominent twentieth-century British philosopher, developed a theory intended to assist us in resolving problems of a conflict between principles. Ross’s views are based on an account of what he calls prima facie duties, which he contrasts with actual duties. A prima facie duty is a duty
that is always to be acted upon unless it conflicts on a particular occasion with an equal or stronger duty. A prima facie duty, then, is always right and binding, all other things being equal; it is conditional on not being overridden or outweighed by competing moral demands. One’s actual duty, by contrast, is determined by an examination of the respective weights of competing prima facie duties.

Ross argues that several valid principles, all of which can conflict, express moral duties (that is, obligations). These principles do not, Ross argues, derive from either the principle of utility or Kant’s categorical imperative. For example, our promises create duties of fidelity, wrongful actions create duties of reparation, and the generous gifts of our friends create duties of gratitude. Ross defends several additional duties, such as duties of self-improvement, nonmaleficence, beneficence, and justice. Unlike Kant’s system and the utilitarian system, Ross’s list of duties is not based on any overarching principle. He defends it simply as a reflection of our ordinary moral conventions and beliefs.

The idea that moral principles are absolute values that cannot be overridden has had a long, but troubled, history. It seems beyond serious dispute that all moral norms can be justifiably overridden in some circumstances. For example, we might withhold the truth in order to prevent someone from killing another person; and we might disclose confidential information about one person in order to protect the rights of another person. Principles, duties, and rights are not absolute or unconditional merely because they are universal. Both utilitarians and Kantians have defended their basic rule (the principle of utility or the categorical imperative) as absolute, but this claim to absoluteness is dubious. For Ross’s reasons, among others, many moral philosophers have with increasing frequency come to regard principles, duties, and rights not as unbending standards but rather as strong prima facie moral demands that may be validly overridden in circumstances of competition with other moral claims.

Although no philosopher or professional code has successfully presented a system of moral rules that is free of conflicts and exceptions, this fact is no cause for either skepticism or alarm. Prima facie duties reflect the complexity of the moral life, in which a hierarchy of rules and principles is impossible. The problem of how to weight different moral principles remains unresolved, as does the best set of moral principles to form the framework of bioethics. Nonetheless, the general categories of prima facie principles discussed here have proven serviceable as a basic starting point and source for reflection on cases and problems. The main difficulty with these principles is that in most difficult contexts they must be specified.

The Specification of Principles. Practical moral problems often cannot, as we noticed earlier, be resolved by appeal to highly general principles. Practical problems typically require that we make our general norms suitably specific.” Universal norms are mere starting points that almost always must be transformed into a more specific and relevant form in order to create policies, bring controversial cases to closure, resolve conflicts, and the like. The implementation of the principles must take account of feasibility, efficiency, cultural pluralism, political procedures, uncertainty about risk, noncompliance by patients, moral dilemmas, and the like. In short, the principles must be specified for a context.

Specification is not a process of producing general norms; it assumes that they are already available. It is the process of making these norms concrete so that they can meaningfully guide conduct. This process requires reducing the indeterminateness of the general norms to give them increased action-guiding capacity while retaining the moral commitments in the original norm. Filling out the commitments of the norms with which one starts is accomplished by narrowing the scope of the norms, not merely by explaining what the general norms mean. For example, without further specification the principle respect the autonomy of competent persons is too spare to handle complicated problems of what to say or ask for in clinical medicine and research involving human subjects.

A mere definition of respect for autonomy (as, say, “allowing competent persons to exercise their liberty rights”) might clarify one’s meaning, but would not narrow the general norm or render it more specific. Specification is a different kind of spelling out than analysis of meaning. It adds content. For example, one possible specification of respect the autonomy of competent persons is “respect the autonomy of competent patients after they become incompetent by following their advance directives.”

After this specification, when one subsequently encounters difficult cases of vague advance directives and must decide whether to observe them, one could further specify as follows: “Respect the autonomy of competent
patients (after they become incompetent) by following their advance directives if and only if the directives are clear and relevant." As other problems and conflicts of norms emerge, the process of specification must continue. That is, already specified rules, guidelines, policies, and codes must be further specified to handle new or more complex circumstances. Such progressive specification is the way we do and should handle problems that arise in devising internal standards of medical morality.

A specification, by definition, must retain the initial norm while adding content to it. In the case of progressive specification, there must remain a transparent connection to the initial norm that gives moral authority to the string of norms that develop over time. Of course, there is always the possibility that more than one line of specification will issue from one or more initial norms. That is, different persons may offer different specifications. In this process of specification, overconfidence in one’s specifications can lead to a dogmatic certainty of the sort found in the authoritative pronouncements of professional medical associations. Moral disagreement in the course of formulating specifications is inevitable and may not be eliminated by even the most conscientious specifications. In any given problematic or dilemmatic case, several competing specifications are virtually certain to be offered by reasonable parties. Alternative specifications are no more a matter of regret than are other contexts in which reflective persons offer alternative solutions to practical problems.

**LAW AND POLICY**

Moral principles are often already embedded in public morality, public policies, and institutional practices, but if these values are already in place, how can moral reflection on philosophical theory assist us in the complicated task of forming and criticizing institutional policies, public policies, and laws?

**ETHICS AND PUBLIC AFFAIRS**

Institutional and public policies are almost always motivated by and incorporate moral considerations. Policies such as those that fund health care for the indigent and those that protect subjects of biomedical research are examples. Moral analysis is part of good policy formation, not merely a method for evaluating already formed policy. A policy, in the relevant sense, is comprised of a set of normative, enforceable guidelines that govern a particular area of conduct and that have been accepted by an official body, such as an institutional board of trustees, an agency of government, or a legislature. The policies of corporations, hospitals, trade groups, and professional societies are private rather than public, but the discussion that follows is directed at all forms of policy.

Many articles in this volume are concerned with the use of ethical theory for the formulation of public affairs. Joel Feinberg has made a suggestive comment about one way in which the problems raised in these essays might be viewed from an ideal vantage point:

> It is convenient to think of these problems as questions for some hypothetical and abstract political body. An answer to the question of when liberty should be limited or how wealth ideally should be distributed, for example, could be used to guide not only moralists, but also legislators and judges toward reasonable decisions in particular cases where interests, rules, or the liberties of different parties appear to conflict…. We must think of an ideal legislator as somewhat abstracted from the full legislative context, in that he is free to appeal directly to the public interest unenumbered by the need to please voters, to make “deals” with colleagues, or any other merely “political” considerations…. The principles of the ideal legislator… are still of the first practical importance, since they provide a target for our aspirations and a standard for judging our successes and failures.

However, policy formation and criticism usually involve complex interactions between moral values and cultural and political values. A policy will be shaped by empirical data and information in relevant fields such as medicine, economics, law, and the like. By taking into consideration factors such as efficiency and clientele acceptance, we interpret principles so that they provide a practical strategy for real-world problems that incorporate the demands of political procedures, legal constraints, uncertainty about risk, and the like. For example, in this book we will consider policies pertaining to physician-assisted suicide, ethics committees in hospitals, public allocations for health care, regulation of risk in the workplace, protection of animal and human subjects of research, legislative definitions of death, liability for failures of disclosure and confidentiality, policies to control developments in genetics, the control of epidemics, and a
host of other moral problems of institutional and public policy.

A specific example of ethics at work in the formulation of policy is found in the work of the previously mentioned National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, which was established by a federal law. Its mandate was to develop ethical guidelines for the conduct of research involving human subjects and to make recommendations to the Department of Health and Human Services (DHHS). To discharge its duties, the commission studied the nature and extent of various forms of research, its purposes, the ethical issues surrounding the research, present federal regulations, and the views of representatives of professional societies and federal agencies. The commission engaged in extensive deliberations on these subjects in public, a process in which moral reasoning played as central a role as the information and methods supplied from other fields.

Subsequent government regulations regarding research issued by the relevant agency (DHHS) were developed on the basis of work provided by the commission. These public laws show the imprint of the commission in virtually every clause. The regulations cannot be regarded as exclusively ethical in orientation, but much distinctive ethical material is found in the commission documents, and ethical analysis provided the framework for its deliberations and recommendations. The commission also issued one exclusively philosophical volume, which sets forth the moral framework that underlies the various policy recommendations it made. It is among the best examples of the use of moral frameworks for actual (not merely theoretical or programmatic) policy development and of a philosophical publication issued through a government-sponsored body.

Several U.S. federal branches, agencies, and courts regularly use ethical premises in the development of their health policies, rules, or decisions. These include the Centers for Disease Control (CDC), the National Institutes of Health (NIH), the Agency for Health Care Policy and Research (AHCPR), and the U.S. Supreme Court. Ethical analysis also often plays a prominent role in policy formation in bioethics. Examples include the widely examined work of the Oregon legislature on rationing in health care, the New York Task Force on Life and the Law, the New Jersey Bioethics Commission, and so on. Their reports and legislative actions raise vital questions explored at various points in this book about the proper relation between government and professional groups in formulating standards of practice.

**MORALITY AND LAW**

The "morality" of many actions that have a public impact is commonly gauged by whether the law prohibits that form of conduct. Law is the public’s agent for translating morality into explicit social guidelines and practices and for determining punishments for offenses. Both case law (judge-made law expressed in court decisions) and statutory law (federal and state statutes and their accompanying administrative regulations) set standards for science, medicine, and health care, and these sources have deeply influenced bioethics.

In these forms law has placed many issues before the public. Case law, in particular, has established influential precedents that provide material for reflection on both legal and moral questions. Prominent examples include judicial decisions about informed consent and terminating life-sustaining treatment. The line of court decisions since the Karen Ann Quinlan case in the mid-1970s, for example, constitutes an important body of material for moral reflection. Most of the chapters in this book contain selections from case law, and selections in the chapters frequently mention actual or proposed statutory law.

Moral evaluation is, nonetheless, very different from legal evaluation. Issues of legal liability, costs to the system, practicability within the litigation process, and questions of compensation demand that legal requirements be different from moral requirements. The law is not the repository of our moral standards and values, even when the law is directly concerned with moral problems. A law-abiding person is not necessarily morally sensitive or virtuous, and from the fact that an act is legally acceptable it does not follow that this act is morally acceptable.

The judgment that an act is morally acceptable also does not imply that the law should permit it. For example, the moral position that various forms of euthanasia are morally justified is consistent with the thesis that the government should legally prohibit these acts, on grounds that it would not be possible to control potential abuses.

Bioethics in the United States is currently involved in a complex and mutually stimulating relationship with law. The law often appeals to moral duties and rights,
places sanctions on violators, and in general strengthens the social importance of moral beliefs. Morality and law share concerns over matters of basic social importance and often acknowledge the same principles, obligations, and criteria of evidence. Nevertheless, the law rightly backs away from attempting to legislate against everything that is morally wrong.

LEGAL AND MORAL RIGHTS

Much of the modern ethical discussion that we encounter throughout this volume turns on ideas about rights, and many public policy issues concern rights or attempts to secure rights. Our political tradition itself has developed from a conception of human rights. However, until the seventeenth and eighteenth centuries problems of social and political philosophy were rarely discussed in terms of rights. New political views were introduced at this point in history, including the notion of universal natural (or human) rights. Rights quickly came to be understood as powerful assertions of claims that demand respect and status.

Substantial differences exist between moral rights and legal rights, because legal systems do not formally require reference to moral systems for their understanding or grounding, nor do moral systems formally require reference to legal systems. One may have a legal right to do something patently immoral or have a moral right without any corresponding legal guarantee. Legal rights are derived from political constitutions, legislative enactments, case law, and the executive orders of the highest state official. Moral rights, by contrast, exist independently of, and form a basis for, criticizing or justifying legal rights.

Philosophers have often drawn a distinction between positive and negative rights. A right to well-being — generally the right to receive goods and services — is a positive right, and a right to liberty — generally a right not to be interfered with — is a negative right. The right to liberty is a negative right because no one has to do anything to honor it. Presumably all that must be done to honor negative rights is to leave people alone. The same is not true of positive rights. To honor those rights, someone has to provide something. For example, if a person has a human right to well-being and is starving, then someone has an obligation to provide that person with food. This important distinction between positive and negative rights is analyzed in Chapter 2 under the subject of the right to health care.

Because general negative rights are rights of noninterference, their direct connection to individual self-determination is apparent. Because general positive rights require that all members of the community yield some of their resources to advance the welfare of others by providing social goods and services, there is a natural connection in theories that emphasize positive rights to a sense of the commons that limits the scope of individualism. The broader the scope of positive rights in a theory, the more likely that theory is to emphasize a scheme of social justice that confers positive rights to redistributions of resources.

Accordingly, a moral system composed of a powerful set of general negative obligations and rights is antithetical to a moral system composed of a powerful set of general positive obligations and rights, just as a strong individualism is opposed to a strong communitarianism. Many of the conflicts that we encounter throughout this book spring from these basic differences over the existence and scope of negative and positive rights and obligations, especially regarding the number, types, and weight of positive rights and obligations.

LAW, AUTHORITY, AND AUTONOMY

As important as autonomy rights are, no autonomy right is strong enough to entail a right to unrestricted exercises of autonomy. Acceptable liberty must be distinguished from unacceptable, but how are we to do so?

Liberty-Limiting Principles. Various principles have been advanced in the attempt to establish valid grounds for the limitation of autonomy. The following four "liberty-limiting principles" have all been defended.

1. The Harm Principle: A person’s liberty is justifiably restricted to prevent harm to others caused by that person.
2. The Principle of Paternalism: A person’s liberty is justifiably restricted to prevent harm to self caused by that person.
3. The Principle of Legal Moralism: A person’s liberty is justifiably restricted to prevent that person’s immoral behavior.
4. The Offense Principle: A person's liberty is justifiably restricted to prevent offense to others caused by that person.

Each of these four principles represents an attempt to balance liberty and other values. The harm principle is universally accepted as a valid liberty-limiting principle, but the other three principles are highly controversial. Only one of these controversial principles is pertinent to the controversies that arise in this volume: paternalism. Here the central problem is whether this form of justification for a restriction of liberty may ever validly be invoked, and, if so, how the principle is to be formulated.

Paternalism. The word *paternalism* refers to treating individuals in the way that a parent treats his or her child. Paternalism is the intentional limitation of the autonomy of one person by another, where the person who limits autonomy appeals exclusively to grounds of benefit for the person whose autonomy is limited. The essence of paternalism is an overriding of a person’s autonomy on grounds of providing that person with a benefit in medicine, a medical benefit.

Examples in medicine include involuntary commitment to institutions for treatment, intervention to stop "rational" suicides, resuscitating patients who have asked not to be resuscitated, withholding medical information that patients have requested, compulsory care, denial of an innovative therapy to patients who wish to try it, and some government efforts to promote health. Other health-related examples include laws requiring motorcyclists to wear helmets and motorists to wear seat belts and the regulations of governmental agencies such as the Food and Drug Administration that prevent people from purchasing possibly harmful or inefficacious drugs and chemicals. In all cases the motivation is the beneficent promotion of individuals health and welfare.

Paternalism has been under attack in recent years, especially by defenders of the autonomy rights of patients. The latter hold that physicians and government officials intervene too often and assume too much paternalistic control over patients’ choices. Philosophers and lawyers have generally supported the view that the autonomy of patients is the decisive factor in the patient-physician relationship and that interventions can be valid only when patients are in some measure unable to make voluntary choices or to perform autonomous actions. The point is that patients can be so ill that their judgments or voluntary abilities are significantly affected or are incapable of grasping important information about their case, thus being in no position to reach carefully reasoned decisions about their medical treatment or their purchase of drugs. Beyond this form of intervention, many have argued, paternalism is not warranted.

However, paternalism also has defenders, even under some conditions in which autonomous choice is overridden. Any careful proponent of a principle of paternalism will specify precisely which goods and needs deserve paternalistic protection and the conditions under which intervention is warranted. Some writers have argued that one is justified in interfering with a person’s autonomy only if the interference protects the person against his or her own actions where those actions are extremely and unreasonably risky (for example, refusing a life-saving therapy in non terminal situations) or are potentially dangerous and irreversible in effect (as some drugs are). According to this position, paternalism is justified if and only if the harms prevented from occurring to the person are greater than the harms or indignities (if any) caused by interference with his or her liberty and if it can be universally justified, under relevantly similar circumstances, always to treat persons in this way.

This moderate formulation of paternalism still leaves many critics resolutely opposed to all possible uses of this principle. Their arguments against paternalism turn on some defense of the importance of the principle of respect for autonomy. We will many times encounter such appeals in this volume, especially as applied to rightful state intervention in order to benefit patients or subjects without their authorization.

NOTES


