Principles of Biomedical Ethics

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uncertainty about risk, and noncompliance by patients. Moral principles and rules provide a normative structure for policy formation and evaluation, but policies are also shaped by empirical data and by information available in fields such as medicine, nursing, public health, veterinary science, economics, law, biotechnology, and psychology.

When using moral norms to formulate or criticize public policies, we cannot move with assurance from a judgment that an *act* is morally right (or wrong) to a judgment that a corresponding *law* or *policy* is morally right (or wrong). The judgment that an act is morally wrong does not necessarily lead to the judgment that the government should prohibit it or refuse to allocate funds to support it. For example, one can argue without inconsistency that sterilization and abortion are morally wrong but that the law should not prohibit them, because they are fundamentally matters of personal choice beyond the legitimate reach of government (or, alternatively, because many persons would seek dangerous and unsanitary procedures from unlicensed practitioners). Similarly, the judgment that an act is morally acceptable does not imply that the law should permit it. For example, the belief that euthanasia is morally justified for terminally ill infants who face uncontrollable pain and suffering is consistent with the belief that the government should legally prohibit such euthanasia on grounds that it would not be possible to control abuses if it were legalized.

We are not defending any of these moral judgments. We are maintaining that the connections between moral norms and judgments about policy or law are complicated and that a judgment about the morality of acts does not entail an identical judgment about law or policy. Factors such as the symbolic value of law and the costs of a program and its enforcement often must be considered.

Moral Dilemmas

Common to all forms of practical ethics is reasoning through difficult cases, some of which constitute dilemmas. This is a familiar feature of decision making in morality, law, and public policy. Consider a classic case.[16] Some years ago, judges on the California Supreme Court had to reach a decision about the legal force and limits of medical confidentiality. A man had killed a woman after confiding to a therapist his intention to do so. The therapist had attempted unsuccessfully to have the man committed but, in accordance with his duty of medical confidentiality to the patient, did not communicate the threat to the woman when the commitment attempt failed.

The majority opinion of the Court held that "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." This obligation extends to notifying the police and warning the intended victim. The

justices in the majority opinion argued that therapists generally ought to observe the rule of medical confidentiality, but that the rule must yield in this case to the "public interest in safety from violent assault." These justices recognized that rules of professional ethics have substantial public value, but they held that matters of greater importance, such as protecting persons against violent assault, can override these rules.

In a minority opinion, a judge disagreed and argued that doctors violate patients' rights if they fail to observe standard rules of confidentiality. If it were common practice to break these rules, he reasoned, the fiduciary nature of the relationship between physicians and patients would erode. The mentally ill would refrain from seeking aid or divulging critical information because of the loss of trust that is essential for effective treatment. Violent assaults would therefore increase.

This case presents straightforward moral and legal dilemmas in which both judges cite relevant reasons to support their conflicting judgments. Moral dilemmas are circumstances in which moral obligations demand or appear to demand that a person adopt each of two (or more) alternative but incompatible actions, such that the person cannot perform all the required actions. These dilemmas occur in at least two forms.[17] (1) Some evidence or argument indicates that an act is morally permissible and some evidence or argument indicates that it is morally wrong, but the evidence or strength of argument on both sides is inconclusive. Abortion, for example, is sometimes said to be a terrible dilemma for women who see the evidence in this way. (2) An agent believes that, on moral grounds, he or she is obligated to perform two or more mutually exclusive actions. In a moral dilemma of this form, one or more moral norms obligate an agent to do *x* and one or more moral norms obligate the agent to do *y,* but the agent cannot do both in the circumstance. The reasons behind alternatives *x* and *y* are weighty and neither set of reasons is overriding. If one acts on either set of reasons, one's actions will be morally acceptable in some respects and morally unacceptable in others. Some have viewed the withdrawal of life-prolonging therapies from patients in a persistent vegetative state as an instance of the second form of dilemma.

Popular literature, novels, and films often illustrate how conflicting moral principles and rules create difficult dilemmas. For example, an impoverished person who steals from a grocery store to save a family from starvation confronts such a dilemma. The only way to comply with one obligation is to contravene another obligation. Some obligation must be overridden or compromised no matter which course is chosen. From the perspective we defend in this volume, it is misleading to say that we are obligated to perform both actions in these dilemmatic circumstances. Instead, we should discharge the obligation that we judge to override what we would have been firmly obligated to perform were it not for the conflict.

Conflicts between moral requirements and self-interest sometimes create a *practical* dilemma, but not, strictly speaking, a *moral* dilemma. If moral reasons compete with nonmoral reasons, such as self-interest, questions about priority can still arise even though no moral dilemma is present. Examples appear in the work of anthropologist William R. Bascom, who collected hundreds of "African dilemma tales" transmitted for decades and sometimes centuries in African tribal societies. One traditional dilemma posed by the Hausa tribe of Nigeria is called *cure for impotence:*

> A friend gave a man a magical armlet that cured his impotence. Later he [the man with the armlet] saw his mother, who had been lost in a slave raid, in a gang of prisoners. He begged his friend to use his magic to release her. The friend agreed on one condition—that the armlet be returned. What shall his choice be?[18]

Difficult choice? Perhaps, but presumably not a difficult *moral* choice. The obligation to the mother is moral in character, whereas retaining the armlet is a matter of self-interest. (In this assessment, we are assuming that no moral obligation exists to a sexual partner; but in some circumstances, such an obligation would generate a moral dilemma.) A moral reason in conflict with a personal reason need not entail that the moral reason is overriding. If, for example, a physician must choose between saving his or her own life or that of a patient, in a situation of extreme scarcity of available drugs, the moral obligation to take care of the patient may not be overriding.

Some moral philosophers and theologians have argued that although many practical dilemmas involving moral reasons exist, no irresolvable moral dilemmas exist. They do not deny that agents experience moral perplexity or conflict in difficult cases. However, they claim that the purpose of a moral theory is to provide a principled procedure for resolving all deep conflicts. Some philosophers have defended this conclusion because they accept one supreme moral value as overriding all other conflicting values (moral and nonmoral) and because they regard it as incoherent to allow contradictory obligations in a properly structured moral theory. The only *ought,* they maintain, is the one generated by the supreme value.[19] We examine such theories, including both utilitarian and Kantian theories, in Chapter 9.

In contrast to the account of moral obligation offered by these theories, we maintain throughout this book that various moral principles, rules, and rights can and do conflict in the moral life. These conflicts sometimes produce irresolvable moral dilemmas. When forced to a choice, we may "resolve" the situation by choosing one option over another, but we still may believe that neither option is morally preferable. A physician with a limited supply of medicine may have to choose to save the life of one patient rather than another and still find his or her moral dilemma irresolvable. Explicit acknowledgment of such dilemmas helps deflate unwarranted expectations about what moral principles and theories can

do. Although we often find ways of reasoning about what we should do, we may not be able to reach a reasoned resolution in many instances. In some cases the dilemma only becomes more difficult and remains unresolved even after the most careful reflection.

A Framework of Moral Norms

The moral norms that are central for biomedical ethics derive from the common morality, though they certainly do not exhaust the common morality. These norms are treated individually in Chapters 4 through 7 in Part II of this book. Most classical ethical theories accept these norms in some form, and traditional medical codes presuppose at least some of them.

Principles

The set of pivotal moral principles defended in this book functions as an analytical framework of general norms derived from the common morality that form a suitable starting point for biomedical ethics.[20] These principles are general guidelines for the formulation of more specific rules. In Chapters 4 through 7 we defend four clusters of moral principles: (1) *respect for autonomy* (a norm of respecting and supporting autonomous decisions), (2) *nonmaleficence* (a norm of avoiding the causation of harm), (3) *beneficence* (a group of norms pertaining to relieving, lessening, or preventing harm and providing benefits and balancing benefits against risks and costs), and (4) *justice* (a group of norms for fairly distributing benefits, risks, and costs).

Nonmaleficence and beneficence have played a central role in the history of medical ethics. By contrast, respect for autonomy and justice were neglected in traditional medical ethics and have risen to prominence only recently. In 1803, British physician Thomas Percival published *Medical Ethics,* the first comprehensive account of medical ethics in the long history of the subject. This book served as the prototype for the American Medical Association's first code of ethics in 1847. Percival argued, using somewhat different language, that nonmaleficence and beneficence fix the physician's primary obligations and triumph over the patient's preferences and decision-making rights in circumstances of conflict.[21] Percival greatly understated the importance of principles of respect for autonomy and distributive justice for physician conduct. However, in fairness to him, these considerations are now prominent in discussions of ethics in medicine in a way they were not when he wrote at the turn of the nineteenth century.

That these four clusters of moral principles are central to biomedical ethics is a conclusion the authors of this work have reached by examining *considered moral judgments* and *the way moral beliefs cohere,* two notions discussed in Chapter 10. The selection of these four principles, rather than some other

clusters of principles, does not receive an argued defense in Chapters 1 through 3. However, in Chapters 4 through 7, we defend the vital role of each principle in biomedical ethics.

Rules

Our larger framework in this book encompasses several types of norms: principles, rules, rights, and virtues. Principles are more general and comprehensive norms than rules, but we draw only a loose distinction between rules and principles. Both are norms of obligation, but rules are more specific in content and more restricted in scope. Principles do not function as precise guides in each circumstance in the way that more detailed rules and judgments do. Finally, principles and rules of obligation have correlative rights, and virtues often have corresponding principles and rules (see Chapter 9).

We defend several types of rules, of which the most important categories are substantive rules, authority rules, and procedural rules.

Substantive rules. Rules of truth telling, confidentiality, privacy, forgoing treatment, informed consent, and rationing health care provide more specific guides to action than do abstract principles. An example of a rule that sharpens the requirements of the principle of respect for autonomy in certain contexts is "Follow an incompetent patient's advance directive whenever it is clear and relevant." To indicate how this rule *specifies* the principle of respect for autonomy, we may state it more fully as "Respect the autonomy of incompetent patients by following all clear and relevant formulations in their advance directives." This formulation shows how the initial norm of respect for autonomy endures even while becoming specified. (See the section "Specification" later in this chapter.)

Authority rules. We also defend rules of decisional authority—that is, rules regarding who may and should make decisions and perform actions. For example, *rules of surrogate authority* determine who should serve as surrogate agents when making decisions for incompetent persons; *rules of professional authority* determine who in professional ranks should make decisions to override or to accept a patient's decisions; and *rules of distributional authority* determine who should make decisions about allocating scarce medical resources.

Authority rules do not delineate substantive standards or criteria for making decisions. However, authority rules and substantive rules can interact. For instance, authority rules are justified, in part, by how well particular authorities can be expected to respect and comply with substantive rules and principles.

Procedural rules. We also defend rules that establish procedures to be followed. Procedures for determining eligibility for organ transplantation and procedures for reporting grievances to higher authorities are typical examples. We often

resort to procedural rules when we run out of substantive rules and when authority rules are incomplete or inconclusive. For example, if substantive or authority rules are inadequate to determine which patients should receive scarce medical resources, we resort to procedural rules such as queuing and lottery.[22]

Conflicting Moral Norms

Prima Facie Obligations and Rights

Principles, rules, obligations, and rights are not rigid or absolute standards that allow no compromise. Although "a person of principle" is sometimes regarded as strict and unyielding, principles must be balanced and specified so they can function in particular circumstances. It is no objection to moral norms that, in some circumstances, they can be justifiably overridden by other norms with which they conflict. All general moral norms are justifiably overridden in some circumstances. For example, we might justifiably not tell the truth to prevent someone from killing another person; and we might justifiably disclose confidential information about a person to protect the rights of another person.

Actions that harm individuals, cause basic needs to go unmet, or limit liberties are often said to be wrong *prima facie* (i.e., wrongness is upheld unless the act is justifiable because of norms that are more stringent in the circumstances) or wrong *pro tanto* (i.e., wrong to a certain extent or wrong unless there is a compelling justification)—which is to say that the action is wrong in the absence of other moral considerations that supply a compelling justification.[23] Compelling justifications are sometimes available. For example, in circumstances of a severe swine flu pandemic, the forced confinement of persons through isolation and quarantine orders might be justified. Here a justifiable infringement of liberty rights occurs.

W. D. Ross defended a distinction that we accept in principle between *prima facie* and *actual* obligations. A *prima facie* obligation must be fulfilled unless it conflicts with an equal or stronger obligation. Likewise, a *prima facie* right, we maintain (here extending Ross), must prevail unless it conflicts with an equal or stronger right (or conflicts with some other morally compelling alternative). Obligations and rights always constrain us unless a competing moral obligation or right can be shown to be overriding in a particular circumstance. As Ross puts it, "the greatest balance" of right over wrong must be found. Agents can determine their *actual* obligations in such situations by examining the respective weights of competing prima facie obligations. What agents ought to do is, in the end, determined by what they ought to do all things considered.[24]

As an example, imagine that a psychiatrist has confidential medical information about a patient who also happens to be an employee in the hospital where the psychiatrist practices. The employee is seeking advancement in a stress-filled position, but the psychiatrist has good reason to believe that this advancement

would be devastating for both the employee and the hospital. The psychiatrist has several prima facie duties in these circumstances, including those of confidentiality, nonmaleficence, beneficence, and respect for autonomy. Should the psychiatrist break confidence in this circumstance to meet these other duties? Could the psychiatrist make "confidential" disclosures to a hospital administrator and not to the personnel office? Addressing such questions through a process of moral deliberation and justification is required to establish an agent's actual duty in the face of these conflicting prima facie duties.

These matters are more complicated than Ross suggests, particularly when rights come into conflict. We often need to develop a structured moral system or set of guidelines in which (1) some rights in a certain class of rights have a fixed priority over others in another class and (2) it is extremely difficult for morally compelling social objectives to outweigh basic rights.

No moral theory or professional code of ethics has successfully presented a system of moral rules free of conflicts and exceptions, but this fact should not generate either skepticism or alarm. Ross's distinction between prima facie and actual obligations conforms closely to our experience as moral agents and provides indispensable categories for biomedical ethics. Almost daily we confront situations that force us to choose among conflicting values in our personal lives. For example, a person's financial situation might require that he or she choose between buying books and buying a train ticket to see friends. Not having the books will be an inconvenience and a loss, whereas not visiting home will disappoint the friends. Such a choice does not come effortlessly, but we are usually able to think through the alternatives, deliberate, and reach a conclusion. The moral life presents similar problems of choice.

Moral Regret and Residual Obligation

An agent who determines that an act is the best act to perform under circumstances of a conflict of obligations may still not be able to discharge all aspects of moral obligation by performing that act. Even the morally best action in the circumstances may still be regrettable and may leave a moral residue, also referred to as a moral trace.[25] Regret and residue over what is not done can arise even if the right action is clear and uncontested.

This point is about continuing obligation, not merely about feelings of regret and residue. Moral residue results because an overridden prima facie obligation does not simply go away when overridden. Often we have residual obligations because the obligations we were unable to discharge create new obligations. We may feel deep regret and a sting of conscience, but we also realize that we have a duty to bring closure to the situation.[26] We can sometimes make up for our inability to fulfill an obligation in one or more of several ways. For example, we may be able to notify persons in advance that we will not be able to keep a

promise; we may be able to apologize in a way that heals a relationship; we may be able to change circumstances so that the conflict does not occur again; or we may be able to provide adequate compensation.

Specifying Principles and Rules

The four clusters of principles we present in this book do not constitute a general ethical theory. They provide only a framework of norms with which to get started in biomedical ethics. These principles must be specified in order to achieve more concrete guidance. Specification is a process of reducing the indeterminacy of abstract norms and generating rules with action-guiding content.[27] For example, without further specification, "do no harm" is too bare a starting point for thinking through problems such as whether it is permissible to hasten the death of a terminally ill patient.

Specification is not a process of producing or defending general norms such as those in the common morality; it assumes that the relevant norms are available. Specifying the norms with which one starts—whether those in the common morality or norms previously specified to some extent—is accomplished by narrowing the scope of the norms, not by explaining what the general norms mean. We narrow the scope, as Henry Richardson puts it, by "spelling out where, when, why, how, by what means, to whom, or by whom the action is to be done or avoided."[28] For example, the norm that we are obligated to "respect the autonomy of persons" cannot, unless specified, handle complicated problems in clinical medicine and research involving human subjects. A definition of "respect for autonomy" (e.g., as "allowing competent persons to exercise their liberty rights") clarifies one's meaning in using the norm, but it does not narrow the scope of the general norm or render it more specific in guiding actions.

Specification adds content. For example, as noted previously, one possible specification of "respect the autonomy of persons" is "respect the autonomy of competent patients by following their advance directives when they become incompetent." This specification will work well in some medical contexts, but it will confront limits in others, where additional specification will be needed. Progressive specification can continue indefinitely, but to qualify all along the way as a specification some transparent connection must be maintained to the initial general norm that gives moral authority to the resulting string of specifications. This process is a prime way in which general principles become practical instruments for moral reasoning; and the process also helps explain why the four-principles approach to biomedical ethics is not merely an abstract theory.[29]

An example of specification arises when psychiatrists conduct forensic evaluations of patients in a legal context. Psychiatrists cannot always obtain an informed consent and, in those circumstances, they risk violating their obligations to respect autonomy. However, obtaining informed consent is a central

imperative of medical ethics. A specification aimed at handling this problem is "Respect the autonomy of persons who are the subjects of forensic evaluations, where consent is not legally required, by disclosing to the evaluee the nature and purpose of the evaluation." We do not claim that this formulation is the best specification, but it approximates the provision recommended in the "Ethical Guidelines for the Practice of Forensic Psychiatry" of the American Academy of Psychiatry and the Law.[30] This specification attempts to guide forensic psychiatrists in discharging their diverse moral obligations.

Another example of specification involves the oft-cited rule "Doctors should put their patients' interests first." In some countries patients can receive the best treatment available only if their physicians falsify information on insurance forms. The rule of patient priority does not imply that a physician should act illegally by lying or distorting the description of a patient's problem on an insurance form. Rules against deception, on the one hand, and for patient priority, on the other, are not categorical imperatives. When they conflict, we need some form of specification in order to know what we can and cannot do.

A survey of practicing physicians' attitudes toward deception illustrates how some physicians reconcile their dual commitment to patients and to nondeception. Dennis H. Novack and several colleagues used a questionnaire to obtain physicians' responses to difficult ethical problems that potentially could be resolved by deception. In one scenario, a physician recommends an annual screening mammography for a fifty-two-year-old woman who protests that her insurance company will not cover the test. The insurance company would cover the costs if the physician stated the reason as "rule out cancer" rather than "screening mammography," but the insurance company understands "rule out cancer" to apply only if there is a breast mass or other objective clinical evidence of the possibility of cancer, neither of which was present in this case. Almost 70% of the physicians responding to this survey indicated that they would state that they were seeking to "rule out cancer," and 85% of this group (85% of the 70%) insisted that their act would not involve "deception."[31]

These physicians' decisions are crude attempts to specify the rule that "Doctors should put their patients' interests first." Some doctors seem to think that it is properly specified as follows: "Doctors should put their patients' interests first by withholding information from or misleading someone who has no *right* to that information, including an insurance company that, through unjust policies of coverage, forfeits its right to accurate information." In addition, most physicians in the study apparently did not operate with the definition of deception favored by the researchers, which is "to deceive is to make another believe what is not true, to mislead." Some physicians apparently believed that "deception" occurs when one person unjustifiably misleads another, and that it was justifiable to mislead the insurance company in these circumstances. It appears

that these physicians would not agree on how to specify rules against deception or rules assigning priority to patients' interests.

All moral rules are, in principle, subject to specification. They all will need some additional content, because, as Richardson puts it, "the complexity of the moral phenomena always outruns our ability to capture them in general norms."[32] Many already specified rules will need further specification to handle new circumstances of conflict. These conclusions are connected to our earlier discussion of particular moralities. Different persons and groups will offer conflicting specifications, potentially creating multiple particular moralities. In any problematic case, competing specifications are likely to be offered by reasonable and fair-minded parties, all of whom are committed to the common morality. Nothing in the model of specification suggests that we can avoid all circumstances of conflicting judgments.

To say that a problem or conflict is resolved or dissolved by specification is to say that norms have been made sufficiently determinate in content that, when cases fall under them, we know what ought to be done. Obviously some proposed specifications will not provide the most adequate or justified resolution. When competing specifications emerge, we should seek to discover which is superior. Proposed specifications should be based on deliberative processes of reasoning, as we discuss them in Chapter 10. In this way, we can connect specification as a method with a model of justification that will support some specifications and not others.

Finally, some specified norms are virtually absolute and need no further specification. Examples include prohibitions of cruelty that involves the unnecessary infliction of pain and suffering.[33] More interesting are norms that are intentionally formulated with the goal of including all legitimate exceptions. An example is, "Always obtain oral or written informed consent for medical interventions with competent patients, *except* in emergencies, in forensic examinations, in low-risk situations, or when patients have waived their right to adequate information." This norm needs further interpretation, including an analysis of what constitutes an informed consent, an emergency, a waiver, a forensic examination, and a low risk. However, this rule would be absolute if it were correct that all legitimate exceptions had successfully been incorporated in its formulation. If such rules exist, they are rare. In light of the range of possibilities for contingent conflicts among rules, even the firmest and most detailed rules are likely to encounter exceptive cases.

Weighing and Balancing

Principles, rules, obligations, and rights often must be balanced. Is balancing different from specification, and, if so, how?

The process of weighing and balancing. Balancing is the process of finding reasons to support beliefs about which moral norms should prevail. Balancing is concerned with the relative weights and strengths of different moral norms, whereas specification is concerned primarily with their scope (i.e., range). Accordingly, balancing consists of deliberation and judgment about these weights and strengths. Balancing seems particularly well suited for reaching judgments in *particular* cases, whereas specification seems especially useful for developing more specific *policies* from already accepted general norms.

The metaphor of larger and smaller weights moving a scale up and down has often been invoked to depict the balancing process, but this metaphor obscures what happens in balancing. Justified acts of balancing are supported by good reasons. They need not rest merely on intuition or feeling, although intuitive balancing is one form of balancing. Suppose a physician encounters an emergency case that would require her to extend an already long day, making her unable to keep a promise to take her son to the local library. She then engages in a process of deliberation that leads her to consider how urgently her son needs to get to the library, whether they could go to the library later, whether another physician could handle the emergency case, and so on. If she determines to stay deep into the night with the patient, she has judged this obligation to be overriding because she has found a good and sufficient reason for her action. The reason might be that a life hangs in the balance and she alone may have the knowledge to deal adequately with the circumstances. Canceling her evening with her son, distressing as it may be, could be justified by the significance of her reasons for doing what she does.

One way of analyzing the process of balancing merges it with specification. In our example, the physician's reasons can be generalized to similar cases: "If a patient's life hangs in the balance and the attending physician alone has the knowledge to deal adequately with the full array of the circumstances, then the physician's conflicting domestic obligations must yield." Even if we do not always state the way we balance considerations in the form of a specification, might not all deliberative judgments be made to conform to this model? If so, then deliberative balancing *is* nothing but deliberative specification.

The goal of merging specification and balancing is appealing, but it is not well-suited to handle all situations in which balancing occurs. Specification requires that a moral agent extend norms by both narrowing their scope and generalizing to relevantly similar circumstances. Thus, "respect the autonomy of competent patients when they become incompetent by following their advance directives" is a rule suited for all incompetent patients with advance directives. However, the responses of caring moral agents, such as physicians and nurses, are often highly specific to the needs of *this* patient or *this* family in *this* circumstance. Numerous considerations must be weighed and balanced, and any generalizations that could be formed might not hold even in closely related cases.

Generalizations conceived as policies might even be dangerous. For example, cases in which risk of harm and burden are involved for a patient are often circumstances unlikely to be decided by expressing, by rule, how much risk is allowable or how heavy the burden can be to secure a certain stated benefit. After levels of risk and burden are determined, these considerations must be balanced with the likelihood of the success of a procedure, the uncertainties involved, whether an adequately informed consent can be obtained, whether the family has a role to play, and the like. In this way, balancing allows for a due consideration of all the factors, including norms, bearing on a complex circumstance.

Consider the following discussion with a young woman who has just been told that she is HIV-infected, as recorded by physician Timothy Quill and nurse Penelope Townsend:[34]

> PATIENT: Please don't tell me that. Oh my God. Oh my children. Oh Lord have mercy. Oh God, why did He do this to me?...
> DR. QUILL: First thing we have to do is learn as much as we can about it, because right now you are okay.
> PATIENT: I don't even have a future. Everything I know is that you gonna die anytime. What is there to do? What if I'm a walking time bomb? People will be scared to even touch me or say anything to me.
> DR. QUILL: No, that's not so.
> PATIENT: Yes they will, 'cause I feel that way...
> DR. QUILL: There is a future for you...
> PATIENT: Okay, alright. I'm so scared. I don't want to die. I don't want to die, Dr. Quill, not yet. I know I got to die, but I don't want to die.
> DR. QUILL: We've got to think about a couple of things.

Quill and Townsend work to calm down and reassure this patient, while engaging sympathetically with her feelings and conveying the presence of knowledgeable medical authorities. Their emotional investment in the patient's feelings is joined with a detached evaluation of the patient. Too much compassion and emotional investment may doom the task at hand; too much detachment will be cold and may destroy the patient's trust and hope. A balance in the sense of a right mixture between engagement and detachment must be found.

Quill and Townsend could try to specify norms of respect and beneficence to indicate how caring physicians and nurses should respond to patients who are desperately upset. However, such a specification will ring hollow and will not be sufficiently subtle to provide practical guidance for this patient, let alone for all desperately upset patients. Each encounter calls for a response not adequately captured by general rules and their specifications. Behavior that is a caring response to one desperate patient will intrude on privacy or irritate the next desperate patient. A physician may, for example, find it appropriate to touch or caress a patient X, while appreciating that such behavior would be entirely inappropriate for another patient Y in a similar circumstance. How physicians

and nurses balance different moral considerations often involves sympathetic insight, humane responsiveness, and the practical wisdom of discerning a particular patient's circumstance and needs.[35] Balancing often is a more complex set of activities than those involved in a straightforward case of balancing two conflicting principles or rules. Considerations of trust, compassion, objective assessment, caring responsiveness, reassurance, and the like are all being balanced. To act compassionately may be to undercut objective assessment. Not all of the norms at work can reasonably be said to be specifications, nor need there be a final specification.

In many clinical contexts it may be hopelessly complicated to engage in specification. For example, in cases of balancing harms of treatment against the benefits of treatment for incompetent patients, the cases are often so exceptional that it is perilous to generalize a conclusion that would reach out to other cases. These problems may be further complicated by disagreements among family members about what constitutes a benefit, poor decisions and indecision by a marginally competent patient, limitations of time and resources, and the like.[36]

We do not suggest that balancing is a matter of spontaneous, unreflective intuition without reasons. We are proposing a model of moral judgment that focuses on how balancing and judgment occur through practical astuteness, discriminating intelligence, and sympathetic responsiveness that are not reducible to the specification of norms. The capacity to balance many moral considerations is connected to what we discuss in Chapter 2 as capacities of moral character. Capacities in the form of virtues of compassion, attentiveness, discernment, caring, and kindness are integral to the way wise moral agents balance diverse, sometimes competing, moral considerations.

Practicability supplies another reason why the model of specification needs supplementation by the model of balancing. Progressive specification covering all areas of the moral life would eventually mushroom into a body of norms so bulky that the normative system would become unwieldy. A scheme of comprehensive specification would constitute a package of potentially hundreds, thousands, or millions of rules, each suited to a narrow range of conduct. In the ideal of specification, every type of action in a circumstance of the contingent conflict of norms would be covered by a rule, but the formulation of rules for every circumstance of contingent conflict would be a body of rules too cumbersome to be effective. The greater the number of rules and the more complex each rule, the less likely it is that the moral system will be functional and useful for guiding decisions.

Conditions that constrain balancing. To allay concerns that the model of balancing is too intuitive or too open-ended and lacks a commitment to firm principles and rigorous reasoning, we propose six conditions that should help reduce intuition, partiality, and arbitrariness. These conditions must be met to justify infringing one prima facie norm in order to adhere to another.

1. Good reasons can be offered to act on the overriding norm rather than on the infringed norm.
2. The moral objective justifying the infringement has a realistic prospect of achievement.
3. No morally preferable alternative actions are available.[37]
4. The lowest level of infringement, commensurate with achieving the primary goal of the action, has been selected.
5. All negative effects of the infringement have been minimized.
6. All affected parties have been treated impartially.

Although some of these conditions are obvious and noncontroversial, some are often overlooked in moral deliberation and would lead to different conclusions were they observed. For example, some proposals to use life-extending technologies, despite the objections of patients or their surrogates, violate condition 2 by endorsing actions in which no realistic prospect exists of achieving the goals of a proposed intervention. Typically, these proposals are made when health professionals regard the intervention as legally required, but in some cases the standard invoked is merely a traditional or deeply entrenched perspective.

Condition 3 is more commonly violated. Actions are regularly performed in some settings without serious consideration of alternative actions that might be performed. As a result, agents fail to identify a morally preferable alternative. For example, in animal care and use committees a common conflict involves the obligation to approve a good scientific protocol and the obligation to protect animals against unnecessary suffering. A protocol is often approved if it proposes a standard form of anesthesia. However, standard forms of anesthesia are not always the best way to protect the animal, and further inquiry is needed to determine the best anesthetic for the particular interventions proposed. In our schema of conditions, it is unjustifiable to approve the protocol or to conduct the experiment without this additional inquiry, which affects conditions 4 and 5 as well as 3.

Finally, consider this example: The principle of respect for autonomy and principles of beneficence (which require acts intended to prevent harm to others) sometimes come into contingent conflict in responding to situations that arise in the treatment of HIV/AIDS patients. Respect for autonomy sets a prima facie barrier to invasions of privacy and the mandatory testing of people at risk of HIV infection, yet their actions may put others at risk under conditions in which society has a prima facie obligation to act to prevent harm to those at risk. To justify overriding respect for autonomy, one must show that mandatory testing that invades the privacy of certain individuals is necessary to prevent harm to others and has a reasonable prospect of preventing such harm. If it meets these conditions, mandatory testing still must pass the least-infringement test (condition 4), and health workers must seek to reduce negative effects, such as the consequences that individuals fear from testing (condition 5).[38]

In our judgment, these six constraining conditions are morally demanding, at least in some circumstances. When conjoined with requirements of coherence that we propose in Chapter 10, these conditions provide a strong measure of protection against purely intuitive, subjective, or partial balancing judgments. We could try to introduce further criteria or safeguards, such as "rights override nonrights" and "liberty principles override nonliberty principles," but these rules are certain to fail in circumstances in which rights claims and liberty interests are relatively minor.

Moral Diversity and Moral Disagreement

Conscientious and reasonable moral agents understandably disagree over moral priorities in circumstances of a contingent conflict of norms. Morally conscientious persons may disagree, for example, about whether disclosure of a life-threatening condition to a fragile patient is appropriate, whether religious values about brain death have a place in secular biomedical ethics, whether teenagers should be permitted to refuse life-sustaining treatments, and hundreds of other issues. Such disagreement does not indicate moral ignorance or moral defect. We simply lack a single, entirely reliable way to resolve many disagreements, despite methods of specifying and balancing.

Moral disagreement can emerge because of (1) factual disagreements (e.g., about the level of suffering that an action will cause), (2) disagreements resulting from insufficient information or evidence, (3) disagreements about which norms are applicable or relevant in the circumstances, (4) disagreements about the relative weights or rankings of the relevant norms, (5) disagreements about appropriate forms of specification or balancing, (6) the presence of a genuine moral dilemma, (7) scope disagreements about who should be protected by a moral norm (e.g., whether embryos, fetuses, and sentient animals are protected; see Chapter 3), and (8) conceptual disagreements about a crucial moral notion (such as whether removal of nutrition and hydration at a family's request constitutes *killing*).

Different parties may emphasize different principles or assign different weights to principles even when they agree on which principles are relevant. Such disagreement may persist among morally committed persons who recognize all the demands that morality makes on them. If evidence is incomplete and different items 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 its beliefs. We cannot hold persons to a higher practical standard than to make judgments conscientiously in light of the relevant norms and relevant evidence.

When moral disagreements arise, a moral agent can—and usually 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 warrant criticism and perhaps even punishment, is vital when we evaluate the actions of others. One person's conscientious assessment of his or her obligations may differ from another's when they confront the same moral problem. Both evaluations may be appropriately grounded in the common morality. Similarly, what one institution or government determines it should do may differ from what another institution or government determines it should do. In such cases, we can assess one position as morally preferable to another only if we can show that the position rests on a more coherent set of specifications and interpretations of the common morality.[39]

Conclusion

In this chapter we have outlined what is sometimes called the *four-principles approach* to biomedical ethics,[40] now commonly designated *principlism.*[41] The four clusters of principles that we propose as a moral framework derive from the common morality, but when specifying and balancing these principles in later chapters we will also call upon historical experience in formulating professional obligations and virtues in health care, public health, biomedical research, and health policy. We will criticize many assumptions in traditional medical ethics, current medical codes, and other parts of contemporary bioethics, but we are also deeply indebted to the insights and commitments found in these moral viewpoints. Our goal in later chapters is to develop, specify, and balance the normative content of the four clusters of principles, and there we often seek to render our views consistent with professional traditions, practices, and codes.

Principlism, then, is not a mere list and analysis of four abstract principles. It is a theory about how principles link to and guide practice. We will be showing how these principles are connected to an array of transactions, practices, understandings, and forms of respect in health care settings, research institutions, and public health policies.

NOTES

1. See Albert R. Jonsen, *The Birth of Bioethics* (New York: Oxford University Press, 1998), pp. 3ff; Jonsen, *A Short History of Medical Ethics* (New York: Oxford University Press, 2000); and Edmund D. Pellegrino and David C. Thomasma, *The Virtues in Medical Practice* (New York: Oxford University Press, 1993), pp. 184–89.

2. These distinctions should be used with caution. Metaethics frequently takes a turn toward the normative. Likewise, normative ethics relies on metaethics. Just as no sharp distinction should be drawn between practical ethics and general normative ethics, so no clear line should be drawn to distinguish normative ethics and metaethics.

3. Although there is only one universal common morality, there is more than one theory of the common morality. For a diverse group of recent theories, see Alan Donagan, *The Theory of Morality* (Chicago: University of Chicago Press, 1977); Bernard Gert, *Common Morality: Deciding What to Do*