

Principles and Other Emerging Paradigms in Bioethics

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If a history of recent biomedical ethics were written, it would encompass several disciplines, including the health professions, law, biology, the social and behavioral sciences, theology, and philosophy. Principles understood with relative ease by the members of these disciplines figured prominently in the development of biomedical ethics during the 1970's and early 1980's. Principles were used primarily to present frameworks of evaluative assumptions or general premises underlying positions and conclusions.¹ However, beginning in the mid-1980's, the paradigm of a system of principles began to be aggressively challenged. Several alternatives have since been proposed, including revivals of casuistry and virtue theory. These developments should be welcomed in bioethics because they have improved the range, precision, and quality of thought in the field. However, the various proposed alternative approaches do not replace principles if "replacement" means displacement in the way Thomas Kuhn used the language of one paradigm displacing another. The leading alternatives are thoroughly compatible with a paradigm of principles. Indeed, they are mutually supportive.

I will begin my argument to this conclusion by outlining the nature of a principle-based approach to ethics, concentrating on the book James Childress and I wrote in the mid-1970's entitled *Principles of Biomedical Ethics*. After sketching our ethical framework, Part I will point to some limitations of the model and indicate how those limitations should be handled. Finally, Part II will consider the nature and limits of three proposed alternatives to a principle-based approach.

I. PRINCIPLES AS A STARTING POINT

Principle-based ethical theories emphasize impartial moral obligations, but "principles" should not be *defined* in terms of obligations. Moral principles are simply relatively general norms of conduct that describe obligations,

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1. For example, the National Commission for the Protection of Human Subjects struggled with principles from 1974 to 1978 because of a mandate from the U.S. Congress requiring that the Commission investigate the ethics of research and explore the "basic ethical principles" of research ethics. The Commission ultimately developed an abstract schema of basic principles related to the subject areas of research ethics to which they primarily apply:

<i>Principle of</i>	<i>applies to</i>	<i>Guidelines for</i>
Respect for Persons		Informed Consent
Beneficence		Risk/Benefit Assessment
Justice		Selection of Subjects

In light of this schema, a general strategy was devised for handling problems of research ethics. See NATIONAL COMMISSION FOR THE PROTECTION OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH, THE BELMONT REPORT (No. OS 78-0012, 1978).

permissible actions, and ideals of action. A principle is a regulative guideline stating conditions of the permissibility, obligatoriness, rightness, or aspirational quality of actions falling within the scope of the principle. If principles are adequately expressed, relatively more particular moral rules and judgments are supported by, though not deduced from, the principles. For example, principles of justice provide support for particular rules and judgments regarding equal treatment, fair taxation, and just compensation.

I will not sharply distinguish between rules and principles in my arguments. Both are action guides, but rules are more specific and restricted in scope. In addition to substantive rules of truth-telling, confidentiality, privacy, fidelity, etc., *authority rules* concern who may perform and who should perform actions, including rules of surrogate authority, rules of professional authority, and rules of distributional authority that determine who should make decisions about the allocation of scarce medical resources. *Procedural rules* are also important in bioethics because they establish procedures to follow, such as procedures for determining eligibility for scarce medical resources. Principles are more abstract, leaving considerable room for judgment about individual cases and policies. This property is no imperfection in principles. We simply must take responsibility for the way we bring principles to bear in our judgments about particular cases and in the development of policies. Rules are not always available to do this work for us.

A. A Principle-Based Paradigm

Childress and I defend what has sometimes been called the four-principles paradigm of biomedical ethics. Our paradigm is that various principles worthy of acceptance in bioethics can be grouped under four general categories, viz.: (1) respect for autonomy (a principle of respect for the decision-making capacities of autonomous persons); (2) nonmaleficence (a principle of avoiding the causation of harm to others); (3) beneficence (a group of principles for providing benefits and balancing benefits against risks and costs); and (4) justice (a group of principles for fairly distributing benefits, risks, and costs).

These principles, insofar as they assert obligations (but not insofar as they are used to frame ideals), should be conceived neither as so weak that they are mere rules of thumb nor as so strong that they assert absolute requirements. They are firm obligations that can be set aside only if they come into conflict with and do not override another obligation. In cases of a conflict of obligations, either obligation then has the potential to release the person from the other obligation. Often some balance between two or more norms must be found that requires some part of each obligation to be discharged, but in many cases one simply overrides the other.

This overriding of one obligation by another seems precariously flexible to some, as if moral guidelines in the end lack backbone and can be magically waived away as not *real* obligations. But in ethics, as in all disciplines that confront principled conflicts, such as law, there is no escape from the exercise

of judgment in resolving the conflicts. One function of principles is to keep judgments *principled* without removing agent *discretion*. As long as an agent does not stray beyond the demands of principles, it cannot be said that judgments are arbitrary or unprincipled, even when one principle overrides another.

I do not mean to insist that every judgment to resolve principled conflicts must itself be resolved by the principles in conflict—a manifestly false thesis. The skillful use of principles itself requires judgments, which, in turn, depend on character, moral insight, and a sense of personal responsibility and integrity. These properties of persons are neither principles nor principled. Very often sensitive, prudent, or judicious decisions are made that cannot easily be described as “principled.” However, the resolution of principled conflicts will frequently appeal to (1) one or more external principles; (2) a procedure; (3) a form of authority; (4) a balancing of principles; or (5) a specification of the principles in conflict. If a procedure or an authority is the best resource, this will be determined by principles that point to the procedure or authority so that principles will be integrally involved in each of these five forms of appeal.

In these circumstances we often need latitude to weigh alternatives in a circumstance of conflict, leaving room for negotiation and compromise. This is especially true in a situation of moral controversy. But even negotiation and compromise can follow the path of (1)-(5), and so need not be unprincipled. For example, in many difficult circumstances, two or more morally acceptable alternatives are unavoidably in conflict because both present good reasons for action. That is, both present good but not decisive or solely sufficient reasons. In the event of such a confrontation between principles, the best course is often to *further specify* the precise commitments of principles. Such action will be explained below when discussing specification.

B. Sources of Principles

The four categories of principles mentioned above are drawn from the common morality. By “the common morality” I mean the morality that all reasonable persons share and acknowledge—common sense ethics, as it is sometimes called. Its norms are based on social conventions and historical traditions rather than philosophical systems that appeal to pure reason, natural law, intuition, and the like. A substantial social consensus exists about general principles and rules in the common morality, far more consensus than exists about general norms in philosophical ethical theories. From this perspective, a paradigm of philosophical theory or method should be resisted if it cannot be made coherent with preexistent cultural understandings of what John Rawls calls our *considered judgments*. That is, those moral convictions in which we have the highest confidence and believe to have the lowest level of bias, such as principles that prohibit racial discrimination, religious intolerance, and political favoritism.

In biomedical ethics, traditional health care contexts often supply more specific moral content, typically in the form of role responsibilities. These traditions supply an understanding of obligations and virtues as they have been adapted over the centuries for professional practice. The health professional's obligations, rights, and virtues have long been framed primarily as professional commitments to shield patients from harm and provide medical care—fundamental obligations of nonmaleficence and beneficence. Professional dedication to these norms has been part of the self-understanding of physicians. For example, physicians have traditionally taken the view that disclosing certain forms of information from patient records can cause harm to patients under their care and that medical ethics obligates them to maintain confidentiality.

The principle of nonmaleficence provides perhaps the best example of a traditional principle in biomedical ethics. This principle has long been associated in medicine with the injunction *primum non nocere*: "Above all [or first] do no harm," a maxim often mistakenly attributed to the Hippocratic tradition.² It has an equally prestigious position in the history of moral philosophy. John Stuart Mill, for example, praised the moral rules of nonmaleficence as "that which alone preserves peace among human beings."³ British physician Thomas Percival furnished the first developed account of health care ethics, in which he maintained that principles of nonmaleficence and beneficence fix the physician's primary obligations and triumph even over the patient's autonomy rights in a circumstance of potential harm to patients:

To a patient . . . who makes inquiries which, if faithfully answered, might prove fatal to him, it would be a gross and unfeeling wrong to reveal the truth. His right to it is suspended, and even annihilated; because, its beneficial nature being reversed, it would be deeply injurious to himself, to his family, and to the public. And he has the strongest claim, from the trust reposed in his physician, as well as from the common principles of humanity, to be guarded against whatever would be detrimental to him.⁴

Like the Hippocratics, Percival accepted as the first principle of medical ethics that the patient's best medical interest rightly determines the physician's obligations. He conceived the central virtues of the physician through models of benevolence and sympathetic tenderness, as they serve to promote the patient's welfare.

Recently, the idea has flourished in biomedical ethics that the physician's moral responsibility should be understood less in terms of traditional ideals of medical benefit and more in terms of the patients' rights of self-determination. These rights include the right to truthful disclosure, confidentiality,

2. Albert R. Jonsen, *Do No Harm: Axiom of Medical Ethics*, in *PHILOSOPHICAL AND MEDICAL ETHICS: ITS NATURE AND SIGNIFICANCE* 27-41 (Stuart F. Spicker & H. Tristram Engelhardt, Jr. eds., 1977).

3. John Stuart Mill, *Utilitarianism*, in *10 THE COLLECTED WORKS OF JOHN STUART MILL* ch. 5 (1969).

4. THOMAS PERCIVAL, *MEDICAL ETHICS; OR A CODE OF INSTITUTES AND PRECEPTS, ADAPTED TO THE PROFESSIONAL CONDUCT OF PHYSICIANS AND SURGEONS* 165-66 (1803). Percival's work served as the pattern for the American Medical Association's (AMA) first code of ethics in 1847.

privacy, and consent, as well as welfare rights rooted in claims of justice. These proposals have moved medical ethics from its traditional preoccupation with a patient-welfare model toward an autonomy model of the care of patient, while also confronting the field with a wider set of social concerns, such as the right to health care. For this reason, principles of autonomy and justice have increased in importance.

The justification for choosing the particular four groups of principles Childress and I defend is therefore partially historical (based on medical traditions of health care ethics) and partially of contemporary origin, in the context of which principles of autonomy and justice point to an important aspect of morality that was traditionally neglected in health care ethics.

C. The Need for Additional Specification of Principles

To say that principles have their origins in and find support in the common morality and in traditions of health care is not to say that their definitive appearance in an ethical theory or in a developed paradigm of biomedical ethics is identical to their appearance in the traditions from which they spring. Conceptual clarification and attempts to increase coherence give shape and substance to principles, much as judges in their opinions express and develop the commitments of legal precedents and principles of law for the cases before them.

Every ethical theory (as well as the common morality) contains regions of indeterminacy that need reduction through further development of norms in the system, augmenting them with a more specific moral content. In light of the indeterminacy found in principles and all general norms, I follow Henry Richardson in arguing that the specification of norms involves filling in details in order to overcome moral conflicts and the incompleteness of principles and rules.⁵ Specification is the progressive, substantive delineation of principles and rules, pulling them out of their abstractness and giving them a more specific and practical content. Because principles are stated at a lofty level of abstraction, little practical content can be drawn directly from the principles, and that content is still subject to competing interpretations. More precision through specification is therefore essential for regulative and decision-making contexts.

Principles are not so much *applied* as they are *explicated and made suitable* for specific tasks, typically by developing policies. Judgment and decision-making are essential for this interpretive process. For this reason, philosophers like John Mackie rightly argue that ethics is "invented." Mackie does not mean that individuals create personal moral policies, but that "intersubjective standards" are built up over time through communal agreements and decision-making. What is morally demanded, enforced, and condemned is less a matter

5. Henry S. Richardson, *Specifying Norms as a Way to Resolve Concrete Ethical Problems*, 19 PHIL. PUB. AFF. 279 (1990).

of what we discover in already available basic principles and more a matter of what we decide by reference to and in development of those principles.

As a simple example of specification and "invention" in this sense, consider conflicts of obligation that emerge from the dual roles of research scientist and clinical practitioner. As an investigator, the physician has an obligation to generate scientific knowledge that will benefit *future* patients. As a clinical practitioner, the physician has obligations of care that require acting in the best interests of present patients. The very notion of physician-as-scientist suggests two roles that pull in different directions, each role having its own specifiable set of obligations.⁶ How, then, do we make these various obligations more precise, specific, and coherent when they come into conflict?

One possibility is to segregate the roles so that they cannot conflict, for example, specifying that physicians with clinical responsibilities cannot use their own patients when discharging research responsibilities. This formulation is an "invention" specifying that a physician's obligations of beneficence to patients must not be confounded or compromised by research obligations. This specification will solve some problems about the dual role, but it will leave others unresolved and in need of additional inventiveness and specification. Suppose, for example, that it is in everyone's best interest in some circumstances for a set of physicians to assume both roles despite the conflicts of interest that will occur for these physicians. We might then specify that "physicians can simultaneously accept clinical and research obligations for the same patients only if a full disclosure is made to the patients of the dual role and of any conflicts of interest present in the dual role." This specification attempts to make the obligations jointly acceptable by adding disclosure obligations that did not previously exist.

Such specifications will involve at times a balancing of principles, at times an appending of additional obligations, and at other times a development of one or more principles by making them more precise for purposes of policy. In all of these ways, we become more specific and practical while retaining fidelity to our original principle(s). This strategy has the advantage of allowing us to unpack our evaluative commitments and to expand them as well, presumably achieving a more workable and a more coherent body of contextually relevant norms. Of course, many already specified norms will need further specification as new or unanticipated circumstances arise. All moral norms are potentially subject to this process of further inventive revision and specification. Progressive specification usually *should* occur in practical settings, gradually reducing circumstances of conflict and insufficiency of content.⁷

There are, of course, tangled problems about the best method for achieving specification and about how to *justify* a proposed specification; specification, however, not merely a bare appeal to principles and rules, is clearly needed.

6. Benjamin Freedman, *Equipose and the Ethics of Clinical Research*, 317 NEW ENG. J. MED. 141 (1987).

7. Richardson, *supra* note 5, at 294.

The analytic model for reaching specification and justification in health care ethics that Childress and I have used involves a dialectical balancing of principles against other moral considerations in an attempt to achieve general coherence and a mutual support among the accepted norms. A now widely accepted method of this general description that can be used for the specification of principles is called "reflective equilibrium." This method views the acceptance of principles as properly beginning with considered judgments, but then as requiring a matching, pruning, and developing of considered judgments and principles in an attempt to make them coherent. Starting with paradigms of what is morally proper or morally improper, we then search for specifications of principles that are consistent with these paradigms and consistent with each other.⁸

A specified principle, then, is acceptable in a system of norms if it heightens the mutual support of other norms in the system that have themselves survived in reflective equilibrium. This understanding of the principles paradigm assumes that no canonical content exists for bioethics. There is no scripture, no authoritative interpretation of anything analogous to scripture, and no authoritative interpretation of that large mass of judgments, rules, standards of virtue, and the like that we often collectively sum up by use of words such as "morality" or "bioethics." A principle-based account also disavows models of a single ultimate principle of ethics and of absolute rules. The principles approach supports a method of inventive content expansion into more specific norms, not a system layered by priorities among rules or among categories of ethics. From this perspective, principles are the background framework, but also are the point at which the real work of policy development and moral judgment begin.

II. ALTERNATIVE PARADIGMS

Several alternative paradigms have arisen in recent years, some of whose proponents have been sharply critical of principles. I will now consider three such alternatives. Although my primary goal is to place criticisms of principles in a proper perspective, I have a secondary goal as well. Critics have often appropriately pointed to *limits* in the principles paradigm, especially limits of scope, practicability, or justificatory power. Much can be learned from this commentary about the points at which even carefully specified principles are inadequate to provide a comprehensive understanding of the moral life. Alternative paradigms usually exhibit their primary strength at these points. In my assessments below, I maintain that these alternatives can be made coherent with and therefore are not rivals of a principle-based account.

8. This method was initially formulated by John Rawls for use in general ethical theory. JOHN RAWLS, *A THEORY OF JUSTICE* 20, 46-49, 195-201, 577 (1971).

A. Casuistry as an Alternative Paradigm

"Casuistry," derived from the Latin *casus* for case, is a term now used primarily to refer to a method of using cases to analyze and propose solutions for moral problems. A casuist is one who is positioned to make recommendations about specific cases; thus, clinical bioethics is by its very nature casuistical. But casuistry also usually refers to a specific *method* of analyzing and generalizing from cases. The essence of the casuistical method is to start with paradigm cases whose conclusions are settled, and then to compare and contrast the central features in these settled cases with the features of cases to be decided. Maxims drawn from past cases and specific analogies are used to support recommendations for new cases. To use an analogy to case law and the doctrine of precedent, when judicial decisions become authoritative, these decisions have the potential to become authoritative for other judges confronting similar cases in similar circumstances and with similar facts.

In casuistical ethics, moral authority proceeds from the settled paradigm cases and maxims, but there are no rigid rules or principles because particular circumstances and their features alter the way cases are handled and decided. Just as case law (legal rules) develops incrementally from cases, so the moral law (a set of moral rules) develops incrementally in casuistry.⁹ However, these rules only pick out the salient features of cases and must be used with caution and discernment. In clinical medical ethics, for example, prior cases allow us to focus by analogical reasoning on practical decision-making in new cases, but, depending on their novel features, very different conclusions still may be reached in the new cases. Characteristic features of contemporary casuistry include this premium on case interpretation together with a strong preference for analogical reasoning over theory.¹⁰

1. A Rejection of Principles and Theory

Several contemporary casuists are dissatisfied with principle-based theories, especially in clinical contexts. The casuist views clinical medical ethics as a discipline arising from clinical practice rather than from an application of general ethical principles to cases.¹¹ It is not always clear, however, why contemporary casuists react as vigorously to principles as they often do. In the great Latin traditions of casuistry emanating from Cicero, students were taught

9. See ALBERT R. JONSEN & STEPHEN TOULMIN, *THE ABUSE OF CASUISTRY* 16-19, 66-67 (1988); John D. Arras, *Getting Down to Cases: The Revival of Casuistry in Bioethics*, 16 J. MED. & PHIL. 31-33 (1991); Albert Jonsen, *Casuistry and Clinical Ethics*, 7 THEORETICAL MED. 67, 71 (1986) [hereinafter Jonsen, *Clinical Ethics*]; and Albert Jonsen, *Casuistry as Methodology in Clinical Ethics*, 12 THEORETICAL MED. 298 (1991) [hereinafter Jonsen, *Casuistry as Methodology*].

10. Cf. John D. Arras, *Common Law Morality*, 20 HASTINGS CENTER REP. July/Aug. 1990, at 5. Arras makes the following constructive recommendations after criticizing casuistry: Use real and lengthy cases, present complex sequences of cases that build on one another, and be cautious regarding the limits of casuistical methods.

11. Cf. David C. Thomasma, *Why Philosophers Should Offer Ethics Consultations*, 12 THEORETICAL MED. 129 (1991).

how to use both principles *and* analogies from prior cases to propose resolutions in a new case. Both Rabbinical and Roman common-law traditions of casuistry continued this practice.

Although the sources of contemporary hostility to principles and theory are difficult to pinpoint, we can briefly treat some mainstream objections. A first reason is the close connection some casuists see between principles and theory, particularly when theory is depicted by its proponents as a unified theory with impartial and universal principles. The underlying aspiration of such theories has been to emulate the natural sciences by locating what is most general and universal in ethics, expressed in precise principles that enjoy the high measure of confidence found in scientific principles. Casuists reject this vision, holding that ethics is neither a science nor a theory fashioned along the lines of traditional ethical theories such as utilitarianism and Kantianism. Rather ethics is based on seasoned practices rooted in experience.¹² Consider an analogy to the way a physician thinks when making a diagnosis and then a recommendation to a patient. Many individual factors, including the patient's medical history, the physician's successes with similar patients, and paradigms of expected outcomes, will play a role in formulating a judgment and recommendation to a patient. Such recommendation may be very different from the recommendation that will be made to the next patient with the same malady.

A second reason for hostility to principles is that moral philosophers have typically regarded cases as merely a set of facts that illustrate principles and exemplify problems, but lack all means to resolve the moral problems presented by the cases. Casuists maintain, instead, that when reasoning through cases, one sometimes legitimately finds that appeal to principles, rules, rights, or virtues is not necessary. For example, when principles, rules, or rights conflict, and appeals to higher principles, rules, or rights have been exhausted, one still makes reasoned moral judgments. Here moral reasoning invokes not principles, but narratives, paradigm cases, analogies, models, classification schemes, and even immediate intuition and discerning insight.¹³

Third, when principles are interpreted inflexibly, irrespective of the nuances of cases, some casuists find the principles "tyrannical" on grounds that they obstruct compromise and the resolution of moral problems by generating a gridlock of conflicting principled stands. Moral debate then becomes intemperate. Often this impasse can be avoided, from the casuists' perspective, only by focussing on points of agreement about cases, not on abstract principles.¹⁴

12. Although some casuists are critical of theory, others encourage principles and theory construction. See BARUCH A. BRODY, *LIFE AND DEATH DECISION MAKING* 13 (1988). For a different view, see Albert R. Jonsen, *Practice Versus Theory*, 20 HASTINGS CENTER REP. July-Aug. 1990, at 32, 32-34. Brody defends theory construction; Jonsen challenges the presumption that "theory is an inseparable companion to practice" and opposes theory construction to practice and casuistry. *Id.* at 34.

13. See BRODY, *supra* note 12, at 12-13, 15; JONSEN & TOULMIN, *supra* note 9, at 11-19, 66-67, 251-54, 296-99; Arras, *supra* note 9, at 31-33; Jonsen, *Clinical Ethics*, *supra* note 9, at 67, 71; Jonsen, *Casuistry as Methodology*, *supra* note 9, at 299-302.

14. See Stephen Toulmin, *The Tyranny of Principles*, 11 HASTINGS CENTER REP. Dec. 1981, at 31.

Fourth, casuists maintain that principles and rules are typically too indeterminate to yield specific moral judgments (for reasons already discussed above). It is therefore impossible, casuists insist, that there be a unidirectional movement of thought from principles to cases. Indeed, *specified* principles will assume an adequately determinate form only *after* reflection on particular cases; the determinate content in practical principles will therefore at least in part be fixed by reflection on cases.

Fifth, casuists argue that even carefully specified principles still must be weighed and balanced in accordance with the demands and nuances of particular circumstances. Interpreting, weighing, and balancing of principles is essential whenever the particular features of cases cannot have been fully anticipated by a prior process of specification. For example, a physician's judgment about the decisions a particular patient should be encouraged to make or discouraged from making is often influenced by how responsible the physician thinks the patient is. Every case presents a person at a different level of responsibility. So, again, a principle is less an applied instrument than a part of a wider process of deliberation.

It does not follow from these five observations that casuists need be hostile to all principles, but only that principles must be interpreted to be coherent with the casuist's paradigm of moral reasoning. Reasonable casuists find the gradual movement from paradigm cases to other cases to be an endeavor that eventuates in principles, which in turn can be helpful in spotting the morally relevant features in new cases. Cases can be ordered under a principle through paradigm and then extended by analogy to new cases. As abstract generalizations, they help express the received learning derived from the struggle with cases and capture the connections between cases. However, from the casuists' perspective, principles, so understood, are merely *summaries of our experience in reflecting on cases*, not norms that are independent of cases.

2. Some Problems with Casuistry

Although much in these casuistical arguments is acceptable, proponents have sometimes overstated the promise and output power of their account while understating their reliance on theory and principles. Casuists often write as if cases lead to moral paradigms, analogies, or judgments by their facts alone. But, as the great classical casuists readily acknowledged, this premise is dubious. The properties that one observes to be of moral importance in cases are picked out by the values (and perhaps the theories) that one has already accepted as being morally important. Consider the following fact which one might discover in a case: "Person *M* cannot survive without person *S*'s bone marrow." What is the moral conclusion? Nothing, a casuist might say, until one knows the full range of facts in the case. But no matter how many facts are stacked one on top of the next, one will still need some sort of *value* premise—for example, "everyone ought to help others survive through bone marrow transplant donations" in order to reach a conclusion such as, "*S* ought to donate his bone marrow." The value premise, which is

a principle or rule, bridges the gap between factual premises and the clearly evaluative conclusion. But, prior to adding this premise, it was not possible to reach the conclusion. The casuist will face this same general problem in every case.

Appeals to "paradigm cases" only mask this fact. Paradigm cases become paradigms because of prior commitments to central values (and perhaps theoretics) that are preserved from one case to the next case. Principles typically play a legitimate role in determining the acceptability of what is transferred from case to case. For the casuist to move constructively from case to case, a norm of moral relevance must connect the cases. Rules of relevant features across cases will not themselves be a part of the case, but a way of interpreting and linking cases. Even to recognize a case as a paradigm case is to accept the principles or rules that allow the paradigms to be extended to other cases.

Jonsen treats this problem by distinguishing descriptive elements in a case from moral maxims that inform judgment about the case: "These maxims provide the 'morals' of the story. For most cases of interest, there are several morals, because several maxims seem to conflict. The work of casuistry is to determine *which maxim should rule the case* and to what extent."¹⁵ So understood, casuistry *presupposes* principles (maxims or rules) and takes them to be essential elements in moral reasoning. The principles are present prior to the decision, and are then selected and weighed in the circumstances. This is precisely the principles paradigm, not a rival paradigm.

Moral reasoning can here again be made analogous to legal reasoning in courts: If a legal principle commits a judge to an unacceptable judgment, the judge needs to modify or supplement the principle in a way that renders the judge's beliefs about the law as coherent as possible. If a well-founded principle demands a change in a particular judgment, the overriding claims of consistency with precedent may require that the judgment be adjusted, rather than the principle.¹⁶ Sometimes both judgments and principles need revision. Either way, principles play a central role.

Casuists also have a problem with conflicting judgments that suggests a need for principles. Cases are typically amenable to competing judgments, and it is inadequate to be told that cases extend beyond themselves and evolve into paradigms. Perhaps cases will evolve in disastrous ways because they were improperly treated from the outset by a perilous analogy. Casuists have no clear methodological resource to prevent a biased development of cases and a neglect of relevant features of cases. This problem caused the decline of casuistry after 1650, when it became increasingly evident that opposite conclusions could be easily "justified" by competing casuistical forms of argument. It was so-called "moral laxity" that destroyed classical casuistry. The same laxity will doom contemporary casuistry unless it is fortified by more stable principles.

15. Jonsen, *Casuistry as Methodology*, *supra* note 9, at 298 (emphasis added).

16. Cf. JOEL FEINBERG, *SOCIAL PHILOSOPHY* 34 (1973).

Finally, how does *justification* occur in casuistry? Given the many different types of appeal that might be made in any given case (analogies, generalizations, character judgments, etc.), there apparently can be several different "right" answers on any given occasion. This problem exists, of course, for virtually all moral theories and is not a problem unique to casuistry. Without a stable framework of norms, however, casuists leave too much room for judgment and have too few resources to prevent prejudiced or poorly formulated social conventions.

In the end, casuists seem ambivalent about principles. On the one hand, casuists acknowledge a limited, conditional role. Jonsen explicitly says, "This casuistic analysis does not deny the relevance of principle and theory."¹⁷ On the other hand, casuists denounce firm and firmly held principles as tyrannical and criticize appeals to principles as "moralistic" and "not a serious ethical analysis."¹⁸ Proponents of casuistry seem most deeply concerned not about a reasonable use of reasonable principles, but only about the *excessive* reliance in recent philosophy on universal principles. It is, then, incorrect to make an account based on principles an instant rival of casuistry. Casuists rightly point to the gap that exists between principles and good decision-making, but their own account will fall victim to the same charge if it leaves a similar gap between cases and good decision-making.

B. *Virtue Theory as an Alternative Paradigm*

Recent ethical theory, including bioethics, has also returned to another prominent classical paradigm: *character* and *virtue* as central moral categories. This paradigm has been exploited to pose a challenge to principle-based theories, which typically attend to *actions* and *obligations* rather than *agents* and their *virtues*. The language of principles and obligations, it is claimed, descends from (rather than determines) virtue, character, and motives.¹⁹ Major writers in the virtue tradition have long held that, to cite an observation of Hume's, "If a man have a lively sense of honour and virtue, with moderate passions, his conduct will always be conformable to the rules of morality; or if he depart from them, his return will be easy and expeditious."²⁰ Various writers in biomedical ethics have adopted this perspective. They argue that the attempt in an obligation-oriented account to make principles, rules, codes, or procedures paradigmatic will result in worse rather than better decisions and actions because the only reliable protection against unacceptable ethical behavior is virtuous character.²¹ From this perspective, character is more

17. Albert R. Jonsen, *Case Analysis in Clinical Ethics*, 1 J. CLINICAL ETHICS 63, 65 (1990); see also JONSEN & TOULMIN, *supra* note 9, at 10.

18. Albert R. Jonsen, *American Moralism and the Origin of Bioethics in the United States*, 16 J. MED. & PHIL. 113, 117, 125-28 (1991).

19. See PHILIPPA FOOT, *VIRTUES AND VICES* (1978); Gregory Trianosky, *Supererogation, Wrongdoing, and Vice: On the Autonomy of Ethics of Virtue*, 83 J. PHIL. 26 (1986).

20. David Hume, *The Sceptic*, in *ESSAYS* 176 (Eugene Miller ed., 1987).

21. A classic treatment is Henry K. Beecher, *Ethics and Clinical Research*, 274 NEW ENG. J. MED. 1354 (1966). See also GREGORY E. PENCE, *ETHICAL OPTIONS IN MEDICINE* 177 (1980).

important, both in institutions and in personal encounters, than conformity to principles.

This line of argument has merit, but needs to be buttressed by a more careful statement of the nature of the virtues and their connection to principles. A moral virtue is a trait of character valued for moral reasons. Virtue requires properly motivated dispositions and desires when performing actions, and therefore is not reducible to acting in accordance with or for the sake of principles of obligation. One cares morally about a person's motivation, and particularly about *characteristic* forms of motivation. Persons motivated by compassion and personal affection meet our approbation when others who act the same way but from different motives would not. For example, imagine a physician who meets all of her moral obligations but whose underlying motives and desires are morally inappropriate. This physician detests medical work and hates having to spend time with every patient she encounters. This physician cares not at all about being of service to people or creating a better environment in her office. She only wants to make money and avoid malpractice suits. Although this person meets her moral obligations, her character is deeply defective. The admirable compassion guiding the lives of many dedicated health professionals is absent in this person, who merely engages in following the socially required principles and rules of behavior.

Properly motivated persons do not merely follow principles and rules; they have a morally appropriate desire to act as they do. One can be disposed by habit to do what is right in accordance with the demands of principles and yet be inappropriately motivated. To speak of a good or virtuous action done from principle is usually elliptical for an evaluation of the motive or desire underlying the action.²² For example, if a person's act of benefiting another person is to elicit moral praise, the person's motive must be to benefit; it cannot be a motive such as the desire to be rewarded for supplying the benefit. Right motive is essential for virtue, and a virtuous character is constituted by an appropriate motive or motivational structure. Persons who characteristically perform morally *right actions* from principles without a right set of motives and desires are not *morally virtuous*, even if they always perform the right action from the right principle.

This paradigm of the moral person succeeds in addressing the *moral worth* of persons more adequately than does a principle-based theory of right action. The paradigm appropriately indicates that virtue cannot be reduced to right action in accordance with principles or rules. Kindness, for example, cannot be reduced to a rule-structured action or precept, as if kindness were a matter of following a recipe. Kindness is a disposition to treat people in certain ways from specific motives and desires. We are often more concerned about these motives and desires in persons than about the conformity of their acts to rules. For example, when a physician takes care of us, we expect his or her actions

22. This formulation is indebted to DAVID HUME, A TREATISE OF HUMAN NATURE 478 (L.A. Selby-Bigge ed., 1960) and JOHN L. MACKIE, HUME'S MORAL THEORY 79-80 (1980).

to be motivated from a sense of principled obligation to us, but we expect more as well. We expect the physician to have a desire to take care of us and to want to maintain our hope and keep us from despair. The physician or nurse who acts exclusively from principles may lack the virtue of caring that is implied by the term "medical care." Absent this virtue, the physician or nurse is morally deficient. Accordingly, to look at principled actions without also looking at virtues is to miss a large segment of the moral life.

These arguments in defense of virtue ethics are entirely compelling, but giving the virtues a central place in the moral life does not indicate that a virtue-based paradigm should displace or take priority over a principle-based paradigm. The two approaches have different emphases, but they can be mutually reinforcing if one believes that ethical theory is richer and more complete if the virtues are included. The virtue paradigm's strength rests in the vital role played by the motivational structure of a virtuous person, which often is as serviceable in guiding *actions* as are rules and principles.²³ But the actions of persons with a virtuous character are not morally acceptable merely because they are performed by a person of good character. People of good character can perform improper actions because they have incorrect information about consequences, make incorrect judgments, or fail to grasp what they ought to do. People sometimes cannot evaluate a motive, a moral emotion, or a form of expression as appropriate or inappropriate unless they have some basis for the judgment that actions are obligatory, prohibited, or permissible. It is, therefore, doubtful that virtue ethics can adequately *explain* and *justify* assertions of the rightness or wrongness of actions without resort to principles and rules.

If we rely, as we should, on character traits such as sympathy and benevolence for moral motivation, we should also be prepared for our motives to be partial and in need of correction by impartial moral principles. For example, we are likely to judge persons more favorably when they are close to us in intimate relationships. Yet, sometimes those who are distant *deserve* to be judged more favorably than we are disposed to judge them. Rather than precluding impartial principles and rules, virtues sometimes rely on them. In addition, virtues such as wisdom and discernment involve understanding the relevance of principles and rules in a variety of circumstances. Principles and virtues are, in this respect, similar. They require attention and sensitivity attuned to the demands of a particular context. Respect for autonomy and beneficence will be as varied in different contexts as compassion and discernment. The ways in which health professionals manifest these principles and virtues in the care of patients will be as different as the ways in which devoted parents care for their children.

Many virtues dispose persons to act in accordance with principles and rules, and a person's virtuous character is often found in a practical understanding of how to employ a principle in a particular case. Understanding what needs

23. See David Solomon, *Internal Objections to Virtue Ethics*, 13 *MIDWEST STUDIES PHIL.* 428, 439 (1988).

to be done for patients, understanding how to do it, and then responding with sensitivity and caring are moral qualities of character; they are not merely forms of practical intelligence and judgment. These forms of caring sometimes open up discerning insights into what is at stake, what counts the most, and what needs to be done. At the same time, even a virtue such as moral integrity, which accommodates a wide variety of moral beliefs, is often principled. I would argue that moral integrity in science, medicine, and health care should be understood predominately in terms of principles and rules that can be identified in the common morality and in the traditions of health care. A vital aspect of moral integrity is faithfulness to these norms, and the person who violates them is likely to be rejected as a person without moral integrity. Many other virtues, such as conscientiousness, could be similarly treated in terms of a serious commitment to follow principles and rules.

Finally, it deserves notice that some areas of the moral life are not readily frameable or interpretable in the language of virtue theory. Committee review in hospitals and research centers provides a typical case in contemporary bioethics. When strangers meet in professional settings, character judgments will often play a less significant role than norms that express rights and appropriate procedures. The same is true in the enforcement of institutional rules and in framing public policy. Virtue theory's strong suit is not in these domains, and dispensing with specified principles and rules of obligation in these settings would be an unwarranted loss in the moral life.

C. Dartmouth Descriptivism and the Critique of Principlism

Not everyone who accepts norms of obligation agrees that *principles* provide the best framework for health care ethics. The self-described Dartmouth Descriptivists, K. Danner Clouser, Bernard Gert, and Ronald Green, are critics of this description. They refer to the account Childress and I have developed as "principlism" and reject it as inadequate.²⁴ Clouser and Gert bring the following accusations against systems of general principles: 1) principles are little more than checklists or headings for values and have no deep moral substance that can guide practice in the way moral rules do; 2) principle-analyses fail to provide a theory of justification or a theory that ties the principles together, with the consequence that principles are ad hoc constructions lacking systematic order; and 3) prima facie principles often compete in difficult circumstances, yet the underlying philosophical theory is too weak both to decide how to adjudicate the conflict in particular cases and to deal theoretically with the problem of a conflict of principles.

I agree that these problems are worthy of careful and sustained reflection in moral theory. I doubt, however, that the Dartmouth Descriptivists have

24. See Danner K. Clouser & Bernard Gert, *A Critique of Principlism*, 15 J. MED. & PHIL. 219-36 (1990); Ronald M. Green et al., *The Method of Public Morality Versus the Method of Principlism*, 18 J. MED. & PHIL. (1993). A diverse, but less focused set of criticisms is found in RON P. HAMEL ET AL., *BEYOND PRINCIPLISM* (1993).

surmounted the problems they lay at the door of principle-based approaches. The primary difference between what Childress and I call *principles* and what they call *rules* is that their rules tend (as they note) to have a more directive and specific content than our principles, thereby seeming, superficially, to give more guidance in the moral life. But we have pointed out this same fact since our 1979 first edition. We have always insisted that specific rules, not mere unspecified principles, are essential for health care ethics.

Also, there is neither more nor less normative content in their rules than ours, and neither more nor less direction in the moral life. It is true that principles function to order and to classify as much as to give prescriptive guidance, and therefore principles do serve a labelling and organizing function. However, this feature only indicates again that principles are abstract starting points in need of additional specification. Moreover, Clouser and Gert mistakenly suggest that principles sort and classify rather than offer normative guidance. Logically, the function of principles is to guide conduct, and, in cases free of conflicting obligations we often do not need more specific rules. But principles are not stateable with an eye to eliminating the many possible conflicts among principles, because no system of guidelines (principles or rules) could reasonably anticipate the full range of conflicts or provide mechanical solutions for moral problems.

The major difference between our theory and Dartmouth Descriptivism seems to have nothing to do with whether principles or rules are primary or secondary normative guides in a theory, but rather lies within several aspects of their theory that I would reject. First, they assume that there is, or at least can be, what they call a "well-developed unified theory" that removes conflicting principles and consistently expresses the grounds of correct judgment—in effect, a canon of rules and theory that expresses the "unity and universality of morality." They fault us heavily for believing that more than one kind of ethical theory can justify a moral belief and insist that we must do the theoretical work of showing the *basis* of principles. They insist that to avoid relativism there can only be "a single unified ethical theory," and that there cannot be "several sources of final justification."²⁵ I reject each of these claims, but at the same time I recognize them as reasonable philosophical requests for further argument. They would require a more searching examination than I have undertaken here.

III. CONCLUSION

I have argued that the moral universe should not be divided into rival and incompatible theories that are principle-based, virtue-based, rights-based, case-based, rule-based, etc. We often coherently fuse appeals to principles, rules, virtues, analogies, precedents, and parables. To assign priority to one paradigm of biomedical ethics is a suspicious project; and I have not

25. Clouser & Gert, *supra* note 24, at 231-32; Ronald M. Green, *Method in Bioethics: A Troubled Assessment*, 15 J. MED. & PHIL. 179-97 (1990).

attempted to argue that the principles paradigm is somehow more serious or more worthy than other paradigms. Even theories with a single ultimate principle, such as utilitarianism and Kantianism, deserve careful attention for what they can teach us about moral reasoning and moral theory. The more general (principles, rules, theories, etc.) and the more particular (feelings, perceptions, case judgments, practices, parables, etc.) should be coherently united in the moral life and in moral philosophy, not ripped from their natural habitat and segregated into distinct and rival species.

A careful analysis and specification of principles is consistent with a wide variety of types of ethical theory, including virtue theory and some accounts that came to prominence only recently, such as communitarian theories, casuistical theories, and the ethics of care. Many authors in biomedical ethics mistakenly address the field as if a principle-based approach is a one-sided, exclusionary, and even tyrannical approach to bioethics. At the same time, the principles paradigm must address the fact that principles are initially attractive because they offer an impartial instrument to resolve our moral dilemmas, but in concrete circumstances conflicts among the principles often generate dilemmas rather than resolving them. A defender of principles will be grateful for help from any resource that can blunt or reduce intractable dilemmas. Every reasonable, insightful, and useful strategy is one we can ill afford to reject if we are to successfully handle the diverse set of issues needing treatment in contemporary bioethics.