MAJOR MORAL PRINCIPLES

Making moral decisions is always a difficult and demanding task. Abstract discussions of morality never quite capture the feelings of uncertainty and self-doubt we often experience when called upon to decide what ought to be done or to judge whether someone did the right thing. There are no mechanical processes or algorithms we can apply in a situation of moral doubt. There are no computer programs to supply us with the proper decision when given the relevant data.

In a very real sense, we are on our own when it comes to making ethical decisions. This does not mean that we are without resources and must make arbitrary or naive decisions. When we have the luxury of time, when the need to make a decision is not pressing, we may attempt to work out an answer to a moral question by relying upon a general ethical theory, such as those discussed earlier or those addressed in this chapter's final section. However, in ordinary life we rarely have the opportunity or time to engage in an elaborate process of reasoning and analysis.

One approach to this problem, sometimes called *principlism*, is to apply freestanding moral principles that have been derived from and justified by various moral theories. A principle such as "Avoid causing needless harm" can serve as a more direct guide to action and decision-making than, say, Kant's categorical imperative. It can help establish a set of moral obligations for medical practitioners to use their knowledge and skills to protect patients from injury. For example, they should not expose a patient to the needless risk of a diagnostic test that does not promise to yield useful information.

In this section, we will present and illustrate five moral principles. All are of special relevance to decisions regarding medical care and research. These principles have their limitations and they are in no sense complete. Moral issues arise, even in the context of medicine, for which they can supply no direct guidance. In other situations, the principles themselves may come into conflict and point toward incompatible solutions. (How can we both avoid causing harm and allow a terminally ill patient to die?) The principles themselves indicate no means of resolving such conflicts, for, even if grouped together, they do not constitute a coherent moral theory. To resolve conflicts, it may be necessary to employ a more comprehensive moral theory, of the kind addressed in the preceding and following sections.

It is fair to say, however, that each of the five basic moral theories we have discussed endorses the legitimacy of these principles. Not all of these theories would formulate them in the same way, and not all would grant them the same moral weight. Nevertheless, each theory would accept them as expressing appropriate guidelines for moral decision-making.

Indeed, the best way to think about the principles is as guidelines. They are in no way rules that can be applied automatically. Rather, they express standards to be consulted in attempting to arrive at a justified decision. As such, they provide a basis for evaluating actions or policies as well as for making individual moral decisions.

The principles help guarantee that our decisions are the result of genuine moral inquiry and not of our whims or prejudices. By attempting to apply these principles, we are more likely to reach decisions that are reasoned, consistent, and applicable to similar cases.

The Principle of Nonmaleficence

"Above all, do no harm" is perhaps the most famous and most quoted of all moral maxims in medicine. It captures in a succinct way what is widely considered to be the overriding duty of anyone responsible for patient care. We believe that, in treating a patient, physicians and others should not by carelessness, malice, inadvertence, or avoidable ignorance do anything that will cause injury to the patient.

The maxim is one expression of what is sometimes called in ethics the *principle of nonmaleficence*. The principle can be formulated in various ways, but here is one relatively uncontroversial way of stating it: *We ought to act in ways that do not cause needless harm or injury to others*. Stated in a positive fashion, the principle tells us that we have a duty to avoid maleficence—that is, to avoid harming or injuring other people.

In the most obvious cases, we violate the principle of nonmaleficence when we intentionally do something we know will cause someone harm. For example, suppose that, during the course of an operation, a surgeon deliberately severs a muscle, knowing that, by doing so, she will cripple the patient. Then the surgeon is guilty of maleficence and is morally (as well as legally) blameworthy for her action.

The principle may also be violated when no malice or intention to do harm is involved. A nurse who carelessly administers the wrong medication and causes a patient to suffer irreversible brain damage may have had no intention of causing the patient any injury. However, the nurse is negligent in his actions and fails to exercise due care in discharging his responsibilities. His actions result in an avoidable injury to his patient. Hence, he fails to meet his obligation of nonmaleficence.

The duty imposed by the principle of nonmaleficence is not a demand to accomplish the impossible. We cannot reasonably expect perfection in the practice of medicine. The results of treatments are often unpredictable and may cause more harm than good. Our knowledge of diseases is only partial and decisions about diagnosis and therapy typically involve judgment calls with no guarantee of success. Consequently, we recognize that we cannot hold health professionals accountable for every instance of death and injury involving patients under their care.

Nevertheless, we can demand that physicians and others live up to reasonable standards of professional responsibility. In their conduct as practitioners, we can expect them to be cautious and diligent, patient and thoughtful. We can expect them to pay attention to what they are doing and to deliberate about whether a particular procedure should be performed. In addition, we can expect them to possess the knowledge and skills relevant to the proper fulfillment of their duties.

These criteria and others like them make up the standards of performance that define what we have a right to expect from physicians and other health professionals. In the language of the law, these are the standards of "due care," and it is by reference to them that we evaluate the medical care given to patients. Failure to meet the standards opens practitioners (physicians, nurses, dentists, therapists) to the charge of moral or legal maleficence.

In our society, we have attempted to guarantee that at least some due-care standards are met by relying upon such measures as degree programs, licensing laws, certifying boards, and hospital credentials committees. Such an approach offers a way of ensuring that physicians and others have acquired at least a minimum level of knowledge, skill, and experience before assuming the responsibilities attached to their roles.

This approach is also designed to foster such virtues as diligence, prudence, and caution, but there is of course no way of guaranteeing that physicians will exhibit those virtues in particular cases. Haste, carelessness, and inattention are always possible, as is the potential that a patient will suffer injury as a result.

The standards of due care are connected in some respects with such factual matters as the current state of medical knowledge and training, and the immediate circumstances in which a physician provides care. For example, in the 1920s, it was not at all unusual for general practitioners to perform relatively complicated surgeries, particularly in rural areas. In performing such surgeries, these physicians were acting in a reasonable and expected fashion and could not legitimately be charged with violating the principle of nonmaleficence.

Over the past century, however, changes in medical practice have altered our beliefs about what is reasonable and expected. Today, a general practitioner who performs surgery without special training and board certification may be legitimately criticized for maleficence. The standards of due care in surgery are now higher and more exacting than they once were, and the general practitioner who undertakes to perform most forms of surgery causes her patients to undergo an unusual and unnecessary risk.

This hypothetical case also illustrates the point that no actual harm or injury need occur for someone to have violated the principle of nonmaleficence. The general practitioner performing surgery may not cause any injury to her patients, but she exposes them to a possibility of harm that is greater than it needs to be. It is in this respect that she is not exercising due care in her treatment and so can be charged with maleficence. She has subjected her patients to *unnecessary risk*—risk greater than they would take in the hands of a trained surgeon.

It is important to stress that the principle of nonmaleficence does not require that a physician subject a patient to no risks at all. Virtually every form of diagnostic testing and medical treatment involves some degree of risk to the patient, and to provide medical care at all, a physician must often act in ways that involve the risk of permanent injury. For example, a physician who takes a thorough medical history, performs a physical examination, and then treats a patient's bacterial infection with a safe and well-established antibiotic cannot be held morally responsible if the patient suffers a severe drug reaction. That such a thing might happen is a possibility that cannot be foreseen in an individual case.

Similarly, a serious medical problem may justify subjecting a patient to serious risk, (assuming the patient provides informed consent). A life-threatening condition, such as an occluded right coronary artery, may warrant coronary-bypass surgery with all its attendant dangers.

In effect, the principle of nonmaleficence tells us to avoid needless risk and, when risk is an inevitable aspect of an appropriate test or treatment, to minimize the risk as much as is reasonably possible. A physician who orders a lumbar puncture for a patient who complains of occasional headaches is acting inappropriately, given the nature of the complaint, and is subjecting his patient to needless risk. By contrast, a physician who orders such a test after examining a patient with severe and recurring headaches, a fever, pain and stiffness in his neck, and additional symptoms of meningitis is acting appropriately. The risk to the patient from the lumbar puncture is the same in both cases, but the risk is warranted in the second case and not in the first. A failure to act with due care violates the principle of nonmaleficence, even if no harm results, whereas acting with due care does not violate the principle, even if harm does result.

The Principle of Beneficence

"As to diseases, make a habit of two things—to help or at least to do no harm." This directive, from the Hippocratic writings of ancient Greece, stresses that the physician has two duties. The second ("at least to do no harm") we discussed in connection with the principle of nonmaleficence. The first ("to help") we will consider here in connection with the principle of beneficence.

Like the previous principle, the principle of beneficence can be stated in various ways. Here is one formulation: *We should act in ways that promote the welfare of other people.* That is, we should help other people when we are able to do so.

Some philosophers have expressed doubt that we have an actual duty to help others. We certainly have a duty not to harm other people, but it has seemed to some that there are no grounds for saying that we have a duty to promote their welfare. We would deserve praise if we did, but we would not deserve blame if we did not. From this point of view, being beneficent is beyond the scope of duty.

We need not consider whether this view is correct in general. For our purposes, it is enough to realize that the nature of the relationship between a physician and a patient does impose the duty of acting in the patient's welfare. That is, the duty of beneficence is inherent in the role of physician. A physician who was not acting for the sake of the patient's good would, in a very real sense, not be acting as a physician.

That we recognize the principle of beneficence as a duty appropriate to the physician's role is seen most clearly in cases in which the physician is also a researcher and her patient is also an experimental subject. In such instances, there is a possibility of a role conflict, for the researcher's aim of acquiring knowledge is not always compatible with the physician's aim of helping the patient. (See Chapter 1 for a discussion of this problem.)

The duty required by the principle of beneficence is inherent in the role not only of physicians but of all health professionals. Nurses, therapists, clinical psychologists, social workers, and others accept the duty of promoting the welfare of their patients or clients as an appropriate part of their responsibilities. We trust nurses and other health professionals to act in our best interests; it is this expectation that makes them part of what we call "the helping professions."

The extent to which beneficence is required as a duty for physicians and others is a more difficult problem. In practice, we recognize limits on what can be expected even from those who have chosen to make a career of helping others. We do not expect physicians to sacrifice completely their self-interest and welfare on behalf of their patients. We do not think their duty demands that they be thoroughly selfless. If some are, we may praise them as secular saints or moral heroes, but that is because their actions exceed the demands of duty. At the same time, we would have little good to say of a physician who always put his interest above that of his patients, who never made a personal sacrifice to promote their interests.

Just as there are standards of due care that implicitly define what we consider to be right conduct in protecting patients from harm, so there seem to be implicit standards of beneficence. We obviously expect physicians to help patients by providing them with appropriate treatment. More than this, we expect physicians to be prepared to make *reasonable* sacrifices for the sake of their patients. Even in an age of "health care teams," a single physician assumes responsibility for a particular patient when that patient is hospitalized or treated for a serious illness. It is this physician who is expected to make the crucial medical decisions, and we expect her to realize that discharging her responsibility may involve an interruption of private plans and activities. A surgeon who is informed

that her postoperative patient has started to bleed can be expected to cancel her plan to attend a concert. Doing so is a reasonable duty imposed by the principle of beneficence. If she fails to discharge the duty, then, in the absence of mitigating circumstances, she will become the object of legitimate disapproval from her patient and her medical colleagues.

It would be very difficult to spell out exactly what duties are required by the principle of beneficence. Even if we limit ourselves to the medical context, there are so many ways of promoting someone's welfare and so many different circumstances to consider that it would be virtually impossible to provide anything like a catalogue of appropriate actions. However, such a catalogue is hardly necessary. Most people can distinguish between reasonable and unreasonable expectations in common medical scenarios, and it is this sense that we rely on in making judgments about whether physicians and others are fulfilling the duty of beneficence in their actions.

The principles of nonmaleficence and beneficence also impose broader social duties. In the most general terms, we look to society to take measures to promote the health and safety of citizens. The great advances made in public health during the nineteenth century were made because many societies recognized a responsibility to attempt to prevent the spread of disease. Water treatment plants, immunization programs, and quarantine restrictions all reflect, to varying degrees, a recognition of society's duty of nonmaleficence.

Although it has done so to a lesser extent than most other industrialized democracies, the United States has also recognized duties of beneficence and nonmaleficence in connection with the distribution of health care and health insurance. The Medicaid insurance program for the poor and the Medicare insurance program for the elderly are major efforts to address at least some of the health needs of a large segment of the population. The Affordable Care Act is a broad-based effort to extend insurance coverage to tens of millions of Americans who could not previously afford it and did not qualify for Medicaid or Medicare. Prenatal programs for pregnant women and public clinics are among the other investments societies have made to promote the health of citizens.

Less obvious than programs that provide direct medical care are those that support medical research and basic science. Directly or indirectly, many of these programs make a substantive contribution to meeting society's health care needs. Much basic research is relevant to acquiring an understanding of the processes involved in both health and disease, and much medical research is specifically aimed at developing effective diagnostic and therapeutic measures.

In principle, social beneficence has no limits, but in practice it must. Social resources, like tax revenues, are finite, and each society must decide how they are to be spent. Housing and food for the poor, education, defense, the arts, and the humanities are just some of the areas demanding support in the name of social beneficence. Medical care is one among many claimants, and we must decide as a society what proportion of our social resources we want to commit to it. Are we prepared to guarantee to all a high level of medical care or are citizens entitled to only minimal "catastrophic" care? Should opportunities for longer and healthier lives currently available to some (the rich or well insured) be made available to all (the poor and uninsured)? Just how beneficent we are obligated to be—and can afford to be—in health care distribution is still a matter of intense debate. (See Chapter 9 for more.)

The Principle of Utility

The principle of utility can be formulated as follows: *We should act in such a way as to bring about the greatest benefit and the least harm*. As we discussed earlier, this principle

is the foundation of the moral theory of utilitarianism. However, the principle need not be regarded as unique to utilitarianism. It can be thought of as one moral principle among others that present us with a prima facie duty; as such, it need not always take precedence over others. In particular, we should question whether it is ever justified to deprive someone of important rights on the grounds that in doing so we could bring benefit to many others.

We need not repeat the discussion of the principle of utility presented earlier, but it may be useful to consider here how that principle relates to the principles of nonmaleficence and beneficence. When we consider the problem of distributing social resources, it becomes clear that acting in accordance with the principles of nonmaleficence and beneficence usually involves trade-offs. To use our earlier example, as a society we are concerned with providing for the health care needs of our citizens. To accomplish this end, we may support various programs—Medicare, Medicaid, legislation such as the ACA, hospital-building programs, medical research, and so on.

However, there are limits to what we can do. Medical care is not the only focus of social concern. We are interested in protecting people from harm and in promoting their interests, but there are many forms of harm and many kinds of interest to be promoted. With finite resources at our disposal, the more money we spend on health care, the less we can spend on education, housing, law enforcement, non-medical science, the humanities, and so on. Furthermore, at a certain level of funding, health care spending only produces marginal improvements in health.

The aim of social planning is to balance the competing needs of the society. Taken alone, the principles of nonmaleficence and beneficence are of no help in resolving conflicts among social needs. Here the principle of utility can serve to establish and rank such needs and to help determine the extent to which it is possible to satisfy a given social need in comparison with others. In effect, the principle imposes a duty on us all to use our collective resources to do as much good as possible. That is, we must do the most good *overall*, even when this means we are not able to meet all needs in a particular area.

The application of the principle of utility is not limited to large-scale social issues, such as how to divide our resources among medical care, defense, education, and so on. We may also rely on the principle when we are deliberating about the choice of alternative means of accomplishing an aim. For example, our society might decide to institute a mandatory screening program to detect phenylketonuria (PKU) in infants but decide against a program to detect Tay-Sachs, another serious genetic condition. PKU can often be treated successfully if discovered early enough, whereas early detection of Tay-Sachs makes little or no difference in the outcome of the disease. Furthermore, PKU is widely distributed in the population, whereas Tay-Sachs is mostly limited to patients of Ashkenazi Jewish ancestry. Health officials might decide that additional money spent on screening for Tay-Sachs would not be justified by the results. The money could do more good, and produce more benefits, were it spent some other way.

The principle of utility is also relevant to making decisions about the diagnosis and treatment of individuals. For example, as we mentioned earlier, no diagnostic test can be justified if the risk of harm it imposes on the patient is greater than the value of the information likely to be gained. Invasive procedures are associated with a certain rate of injury and death (morbidity and mortality). It would make no sense to subject a patient to a kidney biopsy if the findings were not likely to affect the course of treatment or if the risk from the biopsy were greater than the risk from the suspected disease. Medical policy analysts already employ the formal tools of decision theory to

assist physicians in determining whether a particular mode of diagnosis, therapy, or surgery can be justified in individual cases. Underlying such analysis is the principle of utility, which directs us to act in a way that will bring about the greatest benefit and the least harm.

Principles of Distributive Justice

We expect (and can demand) to be treated justly in our dealings with other people and with institutions. If our insurance policy covers up to thirty days of hospitalization, then we expect a claim against the policy for that amount of time to be honored. If we arrive in an emergency room with a broken arm before the arrival of someone else with an injury of equal severity, we expect to be attended to before that person.

We do not always expect that being treated justly will work to our direct advantage. We should recognize that we have an obligation to pay our fair share of taxes, even if we do not directly benefit from all the roads, sanitation, scientific research, law enforcement, and other services government provides. If a profusely bleeding person arrives in the emergency room after we do, we recognize that she is in need of immediate treatment and should be attended to before we are.

Justice has at least two major aspects. Seeing to it that people receive that to which they are entitled, that their rights are recognized and protected, falls under the general heading of *noncomparative justice*. By contrast, *comparative justice* is concerned with the application of laws and rules and with the distribution of burdens and benefits.

The concern of comparative justice that is most significant to the medical context is *distributive justice*. As the name suggests, distributive justice concerns the distribution of such social benefits and burdens as medical services, tax credits, welfare payments, public offices, and military service. In general, the distribution of income and wealth has been a primary focus of distributive justice analysis. In medical ethics, the focus has been the distribution of health care and health insurance. Are all in the society entitled to receive health care benefits, whether or not they can afford to pay for them? If so, then is everyone entitled to the same amount of health care? (See Chapter 9 for a discussion of these issues.)

Philosophical theories of justice attempt to resolve questions of distributive justice by providing a detailed account of the features of individuals and society that will justify our making distinctions in the ways we distribute benefits and burdens. If some people are to be rich and others poor, if some are to have greater opportunities or powers or privileges than others, then there must be some rational and moral basis for such distinctions. We look to theories of justice to provide us with such a basis. (This is, for example, a primary objective of Rawls's "justice as fairness.")

Theories of justice differ significantly, but at the core of all of them is the basic principle that "Similar cases ought to be treated in similar ways." The principle expresses the notion that justice involves fair treatment. For example, it is manifestly unfair to award different grades to two people who give the same answers on a multiple-choice exam. If two cases are the same, then it is arbitrary or irrational to treat them differently. To justify different treatment, we would have to show that the cases are also dissimilar in some relevant respect.

This fairness principle is known as the *formal* principle of justice. It is called formal because, like a sentence with blanks, it must be filled in with information. Specifically, we must be told what factors or features are to be considered *relevant* in deciding whether two cases are similar. If two cases differ in relevant respects, we may be justified in treating them differently. We may do so without being either irrational or arbitrary.

Theories of distributive justice present us with *substantive* (or *material*) principles

of justice. The theories present us with arguments to show why certain features or factors should be considered relevant in deciding whether cases are similar. The substantive principles can then be referred to in determining whether particular laws, practices, or public policies can be considered just. Further, the substantive principles can be employed as guidelines for framing laws and policies and for developing a just society.

Arguments in favor of particular theories of justice are too lengthy to present here. However, it will be useful to consider briefly four substantive principles that have been advanced by various theorists. To a considerable extent, differences among these principles help explain ongoing disagreements in our society about how such social goods as income, education, and health care should be distributed. Although the principles themselves direct the distribution of burdens (taxation, public service, and so on) as well as benefits, we will focus here on benefits. The basic question answered by each principle is "Who is entitled to what proportion of society's goods?"

The Principle of Equality

According to the principle of equality, all benefits and burdens are to be distributed equally. Everyone is entitled to the same sized slice of the pie, and everyone must bear an equal share of the social burdens. The principle, strictly interpreted, requires a thoroughgoing egalitarianism: everyone is to be treated equally in the distribution of social goods.

The principle of equality has a great deal of intuitive plausibility for societies that are not too far above the margin of production. When there is enough to go around but not much more, then it is manifestly unfair for some to have more than they need and for others to have less than they need. When a society is more affluent, however, debate often arises about questions of *desert*—who, if anyone, deserves or merits a larger share of social goods.

One of the strongest arguments for the principle of equality is that many, perhaps most, claims to a larger share of social goods appear to be rooted in *luck* rather than desert. If I am born into an affluent family and receive a first-class education, can I really be said to *deserve* the socioeconomic advantages that come with my good fortune? For that matter, if I am born with a high IQ or unusual physical strengths or talents, have I really done anything to *deserve* the advantages derived from my good luck in the "natural lottery"? Even the ability to make a sustained effort under adverse conditions, some social scientists have found, is strongly influenced by upbringing and other forms of natural and social luck. If these inherited advantages and disadvantages are, as John Rawls argues, "arbitrary from a moral point of view," then perhaps the principle of equality is the only just way of distributing society's benefits and burdens.

Although Rawls's theory remains an egalitarian one, he does not, as we have seen, ultimately endorse the principle of equality. Instead, his second principle of justice claims that unequal distributions of social benefits can be just, provided that the resulting inequality will work out to *everyone's* advantage. (This means ensuring that inequalities benefit those who are worst off in society.)

The Principle of Need

The principle of need is an extension of the egalitarian principle of equal distribution. If goods are parceled out according to individual need, those who have greater needs will receive a greater share. However, the outcome will be one of equality. Since the basic needs of everyone will be met, everyone will end up at the same level. The treatment of individuals will be equal, in this respect, even though the proportion of goods they receive will not be.

What is to count as a need is a significant question that cannot be answered by a

principle of distribution alone. Obviously, basic biological needs (food, clothing, shelter) must be included, but what about other needs, such as access to health care or police protection or social and religious affiliation? One way of analyzing needs is Rawls's concept of primary goods: the resources, rights, opportunities, and powers that allow a person to participate as a full member of a society and to pursue his own conception of a good life. Another account of needs is provided by the capabilities approach (see below), which proposes a minimal set of freedoms and entitlements that allow a person to lead a life of human dignity.

What constitutes a "basic" or "central" need is, of course, a matter of considerable controversy. The difficulty of resolving the question of needs is seen in the fact that even in our affluent society—the richest in the history of the world—we are still debating the question of whether health care should be available to all.

The Principle of Contribution

According to the principle of contribution, people should get back that proportion of social goods that is the result of their productive labor. If two people work to grow potatoes and the first works twice as long or twice as hard as the second, then the first should be entitled to twice as large a share of the harvest.

The difficulty with this principle in an industrialized, capitalistic society is that contributions to production can take forms other than time and labor. Some people risk their money in investments needed to make production possible, and others contribute crucial ideas or inventions. How are comparisons to be made? Furthermore, in highly industrialized societies it is the functioning of the entire system, rather than the work of any particular individual, that creates the goods to be distributed. A single individual's claim on the outcome of the whole system may be very small.

Nonetheless, it is individuals who make the system work, so a plausible argument can be made that individuals should benefit from their contributions. If it is true that it is the system of social organization itself that is most responsible for creating the goods, then this is an argument for supporting the system through taxation and other means. If individual contributions count for relatively little (although for something), there may be few substantive grounds for attempting to distinguish among them in distributing social benefits.

The Principle of Effort

According to the principle of effort, the degree of effort made by an individual should determine the proportion of social goods received by that individual. Thus, the administrative assistant who works just as hard as the CEO of a company should receive the same share of goods as the CEO. Those who exert less effort will receive proportionally less than those who work harder.

The advantage of the principle is that it captures one sense of what is fair—that those who do their best should be similarly rewarded, while those who do less than their best should be less well rewarded. The principle assumes that people have equal opportunities to do their best and that if they do not, it is their own fault.

One difficulty with this assumption, as discussed above, is that societies rarely provide individuals with genuinely equal opportunities. Individuals are born with different socioeconomic advantages and disadvantages, more or less effective parents, and are subject to different cultural and social expectations and prejudices. Even if these differences could somehow be equalized, individuals are still subject to the "natural lottery" discussed above, which, in addition to unevenly distributing talents, abilities, and disabilities, may also impact a person's willingness (or even capacity) to exert herself

under adverse conditions. The principle of effort is also hampered by the difficulty of measuring or comparing effort or "doing one's best" for different people under different social and individual circumstances.

Such difficulties do not necessarily disqualify the principle of effort, or any of the other principles just discussed, from playing a role in our moral deliberations. Each principle has its shortcomings, but this does not mean that adjustments cannot be made to correct the weaknesses. A complete theory of justice need not be limited in the number of principles that it accepts, and it is doubtful that any theory can be shown to be both fair and plausible if it restricts itself to only one principle. Although theories vary in their application and elaboration, they can be grouped according to which principles they emphasize. For example, Marxist theories select need as basic, whereas libertarian theories stress personal contribution as the grounds for distribution. Utilitarian theories employ that combination of principles which promises to maximize both private and public interests.

Joel Feinberg, to whom the preceding discussion is indebted, is an example of a theorist who advocates for a combination of principles. Feinberg sees the principle of equality based on needs as the basic determination of distributive justice. After basic needs have been satisfied, the principles of contribution and effort should be given the most weight. According to Feinberg, when there is economic abundance, the claim to "minimally decent conditions" can reasonably be made for every person in the society. To have one's basic needs satisfied under such conditions amounts to a fundamental right. However, when everyone's basic needs are taken care of and society produces a surplus of goods, considerations of contribution and effort become relevant. Those who contribute most to the increase in goods or those who work the hardest to produce it can legitimately lay claim to a greater share.

The principles of justice we have discussed may seem at first to be intolerably abstract and thus irrelevant to the practical business of society. However, it is important to recognize that almost any criticism of a society's status quo laws and practices must draw on abstract arguments and principles. The claim that society is failing to meet the basic needs of all of its citizens and that this is unfair or unjust is a powerful charge. It can be a call to action in the service of justice. If the claim can be substantiated, it has more than rhetorical power. It imposes upon us all an obligation to eliminate the source of the injustice.

Similarly, in framing laws and formulating policies, we expect those who occupy positions of power and influence to make their decisions in accordance with principles. Prominent among these must be principles of justice. It may be impossible in the conduct of daily business to apply any principle directly or exclusively, for we can hardly remake our society overnight. Yet if we are committed to a just society, then the principles of justice can at least serve as guidelines for political, social, and economic decision-making. They can serve to remind us that it is not always fair for the race to go to the swift, especially if the runners have different starting places.

The Principle of Autonomy

The principle of autonomy can be stated as follows: *Rational individuals should be permitted to be self-determining*. According to this formulation, we act autonomously when our actions are the result of our own choices and decisions. Thus, autonomy and self-determination are equivalent.

Autonomy is associated with the status we ascribe to rational beings as persons in the morally relevant sense. This status is rooted in the notion that persons are

by their very nature uniquely qualified to decide what is in their own best interest. They are, to use Kant's terms, ends in themselves, not means to some other ends. As such, they have an inherent worth, and it is the duty of others to respect that worth and avoid treating them as though they were just ordinary parts of the world to be manipulated according to the will of someone else. A recognition of autonomy is a recognition of that inherent worth, and a violation of autonomy is a violation of our concept of what it is to be a person. To deny someone autonomy is to treat that individual as something less than a person.

This view of autonomy and its centrality to moral personhood is shared by several major ethical theories. At the core of each theory is a concept of the rational individual as a moral agent who, along with other moral agents, possesses an unconditional worth. Moral responsibility itself is based on the assumption that such agents are free to determine their own actions and pursue their own aims.

Autonomy is significant not only because it is a condition for moral responsibility, but because it is through the exercise of autonomy that individuals shape their lives. We might not approve of what other people do with their lives. It is sad to see talent wasted and opportunities for personal development rejected. Nevertheless, as we sometimes say, "It's his life." We recognize that people are entitled to attempt to make their lives what they want them to be and that it would be wrong for us to take control of their lives and dictate their actions, even if we could. We recognize that a person must follow her own freely chosen path.

Simply put, to act autonomously is to decide for oneself what to do. Of course, decisions are never made outside of a context, and the world and the people in it exert influence, impose constraints, and restrict opportunities. It is useful to call attention to three interrelated aspects of autonomy in order to get a better understanding of the ways in which autonomy can be exercised, denied, and limited. We will look at autonomy in the contexts of actions, options, and decision-making.

Autonomy and Actions

Consider the following situations: A police officer shoves a demonstrator off the sidewalk during an abortion protest. An attendant in a psychiatric ward warns a patient to stay in bed or be strapped down. A corrections officer warns a prison inmate that if he does not donate blood he will not be allowed out of his cell to eat dinner. A state law requires that anyone admitted to a hospital be screened for HIV.

In each of these situations, actual force, the threat of force, or potential penalties are employed to direct the actions of an individual toward some end. All involve some form of coercion, and the coercion is used to restrict the freedom of individuals to act as they might choose. Under such circumstances, the individual ceases to be the agent who initiates the action as a result of his or her choice. The individual's initiative is set aside, wholly or partially, in favor of someone else's or society's aims.

Autonomy is violated in such cases even if the individual intends to act in the way that is imposed or demanded. Perhaps the prison inmate would have donated blood anyway, and surely many patients would have wanted to be screened for HIV anyway. However, the use of coercion makes the wishes or intentions of the individual partly or totally irrelevant to whether the act is performed.

Autonomy as the initiation of action through one's own intervention and choice can clearly be restricted to a greater or lesser degree. Someone who is physically forced to become a subject in a medical experiment, as in a Nazi concentration camp, is almost entirely deprived of autonomy. The same is true of someone manipulated into becoming

a research subject without knowing it. In the infamous Tuskegee syphilis study, participants were led to believe they were receiving appropriate medical treatment when in fact such treatment was being actively withheld to study the effects of their disease. The situation is somewhat different for someone who agrees to become a research subject in order to receive needed medical care. Such a person is acting under strong coercion, but the loss of autonomy is less severe. It is at least possible to refuse to participate in the research, even if the cost of doing so may be extremely high.

In situations more typical than these, autonomy may be compromised rather than denied. For example, someone who is poor, medically unsophisticated, or simply has a passive disposition may find it very difficult to preserve his power of self-determination when he becomes a patient in a hospital. Medical authority, represented by physicians and the hospital staff, may prove so daunting that he does not feel free to exercise his autonomy. In such a case, even though no one may be deliberately attempting to infringe on the patient's autonomy, social and psychological factors may constitute a force so coercive that the patient feels he has no choice but to follow the recommendations of his caregivers.

Autonomy and Options

Autonomy involves more than mere freedom from duress in making decisions. There must be genuine options to choose among. A forced option is no option at all, and someone who is in the position of having to take what he can get does not exercise genuine self-determination or freedom of choice.

In our society, economic and social conditions frequently limit the options available in medical care. As a rule, the poor simply do not have the same medical options available to them as the rich. Someone well-insured or financially well-off who might be helped by a heart transplant or a second-line cancer drug can decide whether or not to try these interventions. Such options are not generally available to someone who is uninsured or underinsured and struggling to make ends meet.

Similarly, a woman who depends on Medicaid and lives in a state in which Medicaid funds cannot be used to pay for abortions may simply not have the option of having an abortion. Her choice is not a genuine one, for she lacks the means to act otherwise. The situation is quite different for a wealthy woman faced with the same question. She may decide against having an abortion, but whatever she decides, the choice is real. She is autonomous in a way that the poor woman is not.

Those who believe that one of the goals of our society is to promote and protect the autonomy of individuals have frequently argued that we must do more to offer all individuals the same range of health care options. If we do not, they have suggested, then our society will continue to become more stratified and unequal, with reduced social mobility and genuine autonomy for those on the bottom strata. Since health is clearly a social good that gives the healthy greater opportunities and options, those who are rich will have greater freedom of action than those who are poor.

Autonomy and Decision-Making

More is involved in decision-making than merely saying yes or no. In particular, relevant information is an essential condition for genuine decision-making. We are exercising our autonomy in the fullest sense only when we are making *informed* decisions.

It is pointless to have options if we are not aware of them; we can hardly be said to be directing the course of our lives if our decisions must be made in ignorance of information that is available and relevant to our choices. This is part of why lying and other forms of deception are so destructive to autonomy. If someone with a progressive and ordinarily

fatal disease is not told about it by her physician, then she is in no position to decide how to shape what remains of her life. The lack of a crucial piece of information—that she is dying—is likely to lead her to make decisions different from the ones she would make were she in possession of that information.

Information is a key to protecting and preserving autonomy in most medical situations. A patient who is not informed of alternative forms of treatment and their associated risks is denied the opportunity to make his own wishes and values count for something in his own life. For example, someone with heart disease who is not informed of the relative merits of pharmaceutical treatments and lifestyle changes—but is told only that he is a candidate for coronary-artery bypass surgery—is in no position to decide what risks he wishes to take and what ordeals he is prepared to undergo. A physician who does not supply the patient with the information he needs is restricting his autonomy. The principle of autonomy requires *informed* consent, for consent alone does not involve genuine self-determination.

Making decisions "for the good" of others (paternalism), without consulting their wishes, deprives them of their status as autonomous agents. For example, some people at the final stages of a terminal illness might prefer to be allowed to die without heroic interventions, while others might prefer to sustain their lives for as long as medical skill and technology make possible. If physicians or family members assume responsibility for such a decision, without regard for the patient's explicit or implicit wishes, then no matter what the motive, they are denying to the patient the power of self-determination.

Because autonomy is so thoroughly bound up with informed consent and decision-making, special problems arise in the case of those unable to give consent and make decisions. Patients who are under anesthesia, comatose, severely brain damaged, psychotic, or seriously mentally impaired may be incapable of making decisions on their own behalf. The nature of their condition has already deprived them of their autonomy. Of course, this does not mean that they have no status as moral persons or that they have no interests. But, to varying degrees, it usually falls to others to see that their interests are served.

The situation is similar for those, such as infants and young children, who are incapable of understanding medical decisions. Any consent that is given must be given by others. But what are the limits of consent that can legitimately be given for some other person? Consenting to needed medical care seems legitimate, but what about rejecting needed medical care? What about consenting to becoming a subject in a research program? These questions are as crucial as they are difficult to resolve.

Restrictions on Autonomy

Autonomy is not an absolute or unconditional value. We would regard it as absurd for someone to claim that she was justified in committing a murder because she was only exercising her power of self-determination. Such a defense would be morally ludicrous. We do, however, value autonomy and recognize a general duty to respect it and even to promote its exercise. We typically demand compelling reasons to justify restricting the power of individuals to make their own choices and direct their own lives.

We will briefly examine four principles that are frequently appealed to in justifying restrictions on autonomy. These principles are typically addressed in the context of social and legal theory, for it is through laws and penalties that a society most directly regulates the conduct of its citizens. However, the principles can also be appealed to in justifying the policies and practices of institutions (such as hospitals) and the actions of individuals that affect other people.

Appealing to a principle can provide, at best, only a prima facie justification for restricting autonomy. Even if the principle

can be used to justify a particular restriction of freedom, we may still value the lost freedom more than what is gained by restricting it. Furthermore, the principles themselves are frequently the subjects of controversy, and, with the exception of the harm principle, it is doubtful that any of the principles would be consistently endorsed by philosophers and legal theorists.

The Harm Principle. According to the harm principle, we may restrict the freedom of people to act if the restriction is necessary to prevent harm to others. In the most obvious case, we may take action to prevent violent acts such as robbery, assault, rape, or murder. We may act to protect someone who is at apparent risk of harm from the actions of someone else. The risk of harm need not be the result of an intention to harm. Thus, we might take steps to see that a surgeon whose skills and judgment have been impaired by drug use is not permitted to operate. The risk that he poses to his patients warrants the effort to keep him from acting as he wishes.

The harm principle may also be used to justify laws that exert coercive force and so restrict freedom of action. Laws against homicide and assault are clear examples, but the principle extends to the regulation of institutions and practices. People may be robbed at the point of a pen, as well as at the point of a knife, and the harm produced by fraud may be as great as that produced by outright theft. Careless or deceptive medical practitioners may cause direct harm to their patients, and laws that regulate the standards of medical practice restrict the freedom of practitioners for the protection of patients.

The Principle of Paternalism. In its weak version, the principle of paternalism is no more than the harm principle applied to the individual himself. According to the principle, we are justified in restricting someone's freedom to act if doing so is necessary to prevent him from harming himself. Thus, we might force an alcoholic into a treatment program and justify our action by claiming that we did so to prevent him from continuing to harm himself through drinking.

In its strong version, the principle of paternalism justifies restricting someone's autonomy if by doing so we can benefit her. In such a case, our concern is not only with preventing the person from harming herself, but also with promoting her good in a positive way. The principle might be appealed to even in cases in which our actions go against the person's known wishes. For example, a physician might decide to treat a patient with a placebo (an inactive drug), even if she has asked to be told the truth about her medical condition and her therapy. He might attempt to justify his action by claiming that if the patient knew she was receiving a placebo, then the placebo would be less likely to be effective. Since taking the placebo while believing that it is an active drug makes her feel better, the physician may claim that by deceiving her he is doing something to help her.

Paternalism may be expressed in laws and public policies, as well as in private actions. Some have suggested that criminal drug laws constitute a prime example of governmental paternalism. By making certain drugs illegal and inaccessible and by placing other drugs under the control of physicians, the laws aim to protect people from themselves. Self-medication is virtually eliminated, and the recreational use of some (but not other) drugs is prohibited. The price for such laws is a restriction on individual autonomy. Some have argued that the price is too high and that the most the government should do is educate the public about the consequences of using certain drugs.

The Principle of Legal Moralism. The principle of legal moralism holds that a legitimate function of the law is to enforce morality by outlawing actions or practices that are considered immoral. Hence, legal restrictions placed on autonomy are justified by the presumption

that the prohibited actions are immoral and so ought not to be performed.

To a considerable extent, laws express the values of a society and the society's judgments about what is morally right. In our society, homicide and theft are recognized as crimes, and those who commit them are guilty of legal, as well as moral, wrongdoing. Society attempts to prevent such crimes and to punish offenders.

The degree to which the law should embody moral judgments is hard to determine. It is particularly difficult to answer in a pluralistic society like ours, in which there may be sharp differences of opinion about the moral legitimacy of some actions. As recently as the mid-twentieth century, for example, materials considered obscene could not be freely purchased, information on contraceptives could not be freely distributed, birth control could not be legally prescribed in many states, and the conditions of divorce were generally stringent and punitive. Even now, all fifty states prohibit polygamous marriages and prostitution is illegal in all states except parts of Nevada. One foundation for such laws is the belief that the practices proscribed are morally wrong.

The ongoing debate over abortion reflects, in some of its aspects, a conflict between those who favor strong legal moralism and those who oppose it. Many who consider abortion morally wrong would also like to see it made illegal once more. Others, even though they may disapprove of abortion, believe that it is a private moral matter and that attempts to regulate it by law are unwarranted intrusions of state power.

The Welfare Principle. The welfare principle holds that it is justifiable to restrict individual autonomy if doing so will provide benefits to others. Those who endorse this principle do not generally present it as requiring major sacrifices of our autonomy or welfare in order to benefit others. Rather an ideal application of the principle would be the case in which we give up only a little autonomy to bring about a great deal of benefit to others.

For example, transplant organs are in short supply because their availability depends mostly on their being freely donated. The situation could be dramatically changed by a law requiring that organs from the recently deceased be harvested and made available for transplant. Such a law would end the present system of voluntary donation, and in doing so it would restrict our freedom to decide what is to be done with our bodies after death. However, it could be argued that the benefit others might gain from such a law easily outweighs the comparatively modest restriction of autonomy that it would involve.

The four principles we have just discussed are not the only ones that offer grounds for abridging the autonomy of individuals, but they are the most relevant to medical policy and decision-making. It is important to keep in mind that merely appealing to a principle is not enough to warrant restrictions of autonomy. A principle points in the direction of an argument, but it is no substitute for one. The high value we place on autonomy gives its preservation a high priority, and compelling considerations are required to justify compromising it. In the view of some philosophers who endorse the position taken by Mill, only the harm principle can serve as grounds for legitimately restricting autonomy. Other theorists find persuasive reasons to do so based on other principles.

BEYOND PRINCIPLISM

Most of traditional Western ethics is based on the assumption that ethical beliefs are best represented by a set of rules or abstract principles. Kant's categorical imperative, Mill's principle of utility, and Ross's list of prima facie duties attempt to supply guides