Eighth Edition

Principles of Biomedical Ethics

Tom L. Beauchamp
James F. Childress

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To

Georgia, Ruth, and Don

I can no other answer make but thanks,
And thanks, and ever thanks.

Twelfth Night

PREFACE TO THE EIGHTH EDITION

Biomedical ethics, or bioethics, was a youthful field when the first edition of this book went to press in late 1977, now over forty years ago. The word *bioethics* was a recently coined term when, in the mid-1970s, we began as a team writing in this field and lecturing to health professionals on the subject of moral theory and principles. The field had virtually no literature that engaged moral theory and methodology. Massive changes have since occurred both in the field and in this book. We have tried to stay as close to the frontiers of this field as we could, even though the literature is now sufficiently extensive and rapidly expanding that it is difficult to keep abreast of new topics under discussion.

For those who have stayed with us through the previous editions of *Principles of Biomedical Ethics*, we express our gratitude for your critical and constructive suggestions—for us a constant source of information and insight, as well as inspiration. Substantial changes have appeared in all editions after the first, and this eighth and perhaps final edition is no exception. No new changes have been made in the book's basic structure, but the revisions are thoroughgoing in every chapter. We have attempted to sharpen our investigations, strengthen our arguments, address issues raised by critics, and both reference and assess new published material. As in previous editions, we have made changes in virtually every section and subsection of the book's ten chapters.

Our clarifications, additions, expansions, and responses to critics can be crisply summarized as follows:

Part I, *Moral Foundations*: In Chapter 1, "Moral Norms," we have clarified, augmented, and tightened our accounts of the common morality, universal morality, and how they differ from particular moralities. We have also clarified in this chapter and Chapter 10 the ways in which the four-principles framework is to be understood as a substantive framework of practical normative principles and a method of bioethics. We have had a major commitment to the virtues and moral character since our first edition. In Chapters 2 and 9 we have clarified and modestly expanded our discussion of the nature and importance of moral virtues, moral ideals, and moral excellence; and we have also revised our account of the lines that separate what is obligatory, what is beyond obligation, and what is virtuous. In Chapter 3, "Moral Status," we have revised our account of theories of moral status in several ways and revised our presentation in the section on "Guidelines Governing Moral Status: Putting Specification to Work." We also engage some moral problems that have emerged about the use of human-nonhuman chimeras in biomedical research. We there concentrate on whether functional integration of human neural cells in a nonhuman primate brain (and the brains of other species) would cause a morally significant change in the mind of the animal, and, if it did so, what the consequences should be for the moral status of the animal if it were born.

Part II, *Moral Principles*: The principles of basic importance for biomedical ethics are treated individually in Part II. In Chapter 4, "Respect for Autonomy," we have expanded our presentations in several sections including addition of an analysis of the distinction between the *justification* of informed consent requirements and the several *functions* served by the doctrine, institutions, and practices of informed consent. Also added is a significant clarification of our theory of intentional nondisclosure in clinical practice and research and the conditions under which intentional nondisclosure is justified. In Chapter 5, "Nonmaleficence," we have updated and deepened our constructive proposals about "Distinctions and Rules Governing Nontreatment," proper and improper uses of the best-interest standard, and the place of anticipated quality of life in decisions regarding seriously ill newborns and children. The sections on decisions about physician-assisted dying are updated and arguments adjusted in light of global developments, especially in North America (Canada and several US states). In Chapter 6, "Beneficence," we deepened our analysis of policies of expanded and continued access to investigational products in research as well as our discussions of the ethical value of, concerns about, and constraints on risk-benefit, cost-benefit, and cost-effectiveness analyses. In Chapter 7, "Justice," we updated and expanded the discussions of theories of justice, with restructured presentations of communitarian theories, capability theories, and well-being theories. Also updated are sections on problems of health insurance coverage, social implementation of the right to health care, and the right to a decent minimum of health care—as well as revised analyses of whether individuals forfeit this right through risky actions and what the fair opportunity rule requires by way of rectifying disparities in health care. Chapter 8, "Professional-Patient Relationships," has expanded sections on "Veracity" and "Confidentiality," each of which incorporates new cases. The section on arguments for intentionally limiting communication of bad news has been updated. In particular, we have deepened our account of when physicians' decisions to use staged disclosures are ethically justified.

Part III, *Theory and Method*: Chapter 9, "Moral Theories," has an expanded section on "Virtue Theory" that fills out our account of the virtues introduced in Chapter 2 and furthers the application of our theory to biomedical ethics. We have also augmented and clarified the section on rights theory. Significant additions appear in the section on "The Rights of Incompetent, Disadvantaged, and Unidentified Members of Populations." In Chapter 10, "Method and Moral Justification," we have strengthened our critiques of theories of justification in what we call top-down models and casuistry. We have also expanded our accounts of common-morality theory, moral change, reflective equilibrium, considered judgments, and the ways in which our theory is committed to a global bioethics. Each of these parts has been recast to clarify and deepen our positions.

Finally, we want to correct some long-standing misinterpretations of our theory that have persisted over the forty years of editions of this book. Several critics have maintained that our book is committed to an American individualism in which the principle of respect for autonomy dominates all other moral principles and considerations. This interpretation of our book is profoundly mistaken. In a properly structured account of biomedical ethics, respect for autonomy has no distinctly American grounding and is not excessively individualistic or overriding. We do not emphasize individual rights to the neglect or exclusion of social responsibilities and communal goals. We do not now, and have never, treated the principle of respect for autonomy in the ways several of our critics allege. To the contrary, we have always argued that many competing moral considerations validly override this principle under certain conditions. Examples include the following: If our choices endanger public health, potentially harm innocent others, or require a scarce and unfunded resource, exercises of autonomy can justifiably be restricted by moral and legal considerations. The principle of respect for autonomy does not by itself determine what, on balance, a person ought to be free to do or what counts as a valid justification for constraining autonomy.

Our position is that it is a mistake in biomedical ethics to assign priority a priori to any basic principle over other basic principles—as if morality is hierarchically structured or as if we must value one moral norm over another without consideration of particular circumstances. The best strategy is to appreciate the contributions and the limits of various principles, virtues, and rights, which is the strategy we have embraced since the first edition and continue throughout this edition. A number of our critics have mistakenly maintained—without textual warrant—that our so-called principlism overlooks or even discounts the virtues. We have given a prominent place in our theory—since the first edition—to the virtues and their significant role in biomedical ethics. We maintain and further develop this commitment in the present edition.

Fortunately, we have always had a number of valuable—and often constructive—critics of our theories, especially John Arras, Edmund Pellegrino, Raanan Gillon, Al Jonsen, Stephen Toulmin, Michael Yesley, Franklin

Miller, David DeGrazia, Ronald Lindsay, Carson Strong, John-Stewart Gordon, Oliver Rauprich, Jochen Vollmann, Rebecca Kukla, Henry Richardson, Peter Herissone-Kelly, Robert Baker, Robert Veatch, Tris Engelhardt, Robert "Skip" Nelson, and Neal W. Dickert. Our book owes a great deal to these critics and friends. We again wish to remember with great fondness and appreciation the late Dan Clouser, a wise man who seems to have been our first—and certainly one of our sternest—critics. We also acknowledge the penetrating criticisms of Clouser's friend, and ours, the late Bernard Gert, whose trenchant criticisms showed us the need for clarifications or modifications in our views. We also thank John Rawls for a lengthy conversation, shortly before his untimely death in 2002, about communitarian and egalitarian theories of justice that led to significant improvements in our chapter on justice.

We have continued to receive many helpful suggestions for improvements in our work from students, colleagues, health professionals, and teachers who use the book. Jim is particularly grateful to his University of Virginia colleagues: the late John Arras, already mentioned; Ruth Gaare Bernheim; Richard Bonnie; and the late John Fletcher for many illuminating discussions in team-taught courses and in other contexts. Discussions with many practicing physicians and nurses in the University of Virginia's Medical Center, on its Ethics Committee, and with faculty in the Center for Biomedical Ethics and Humanities have been very helpful. In addition, Jim thanks the faculty and graduate students of the Centre for the Advanced Study of Bioethics at the University of Münster for gracious hospitality and vigorous and valuable conversation and debate, particularly about paternalism and autonomy, especially during extended visits in 2011 and 2016; Bettina Schöne-Seifert, Thomas Gutmann, and Michael Quante deserve special thanks. Jim also expresses his deep gratitude to Marcia Day Childress, his wife for the last twenty-two years, for many valuable suggestions along with loving and unstinting support throughout the preparation of the eighth edition as well as the preceding three editions.

Tom likewise wishes to thank his many colleagues in Georgetown University's Philosophy Department and Kennedy Institute of Ethics, as well as his colleagues in research at the Berman Institute of Bioethics of The Johns Hopkins University. Henry Richardson and Rebecca Kukla have been penetrating, as well as constructive, critics from whom several editions of this book have greatly benefited. Between the sixth and seventh editions, Tom benefited hugely from his work with colleagues at Johns Hopkins on an NIH grant to study the need to revise our understanding of the research–practice distinction: Ruth Faden, Nancy Kass, Peter Pronovost, Steven Goodman, and Sean Tunis. When one has colleagues this talented and well informed, multidisciplinary work is as invigorating as it is instructive.

Tom also wishes to express appreciation to five undergraduate research assistants: Patrick Connolly, Stacylyn Dewey, Traviss Cassidy, Kekenus Sidik, and

Patrick Gordon. Their research in the literature, their editing of copy, and their help with previous indexes have made this book more comprehensive and readable. Likewise, Jim wishes to thank three superb research and teaching assistants, Matt Puffer, Travis Pickell, and Laura Alexander, for their helpful contributions. Other teaching assistants in a lecture course at the University of Virginia that used this book also made valuable suggestions.

We also acknowledge with due appreciation the support provided by the Kennedy Institute's library and information retrieval systems, which kept us in touch with new literature and reduced the burdens of library research. We owe a special debt of gratitude to Martina Darragh, who retired as the last chapter of this eighth edition was being completed. Martina gave us help when we thought no help could be found.

Retrospectively, we express our gratitude to Jeffrey House, our editor at Oxford University Press for the first thirty years of this book. Jeff encouraged us to write it before a single page was written, believed in it deeply, and saw it through all of its formative editions. He was an emulable editor. We also thank Robert Miller for efficiently facilitating the production of the recent editions of this book.

We dedicate this edition, just as we have dedicated each of the previous seven editions, to Georgia, Ruth, and Don. Georgia, Jim's beloved wife of thirty-five years, died in 1994, just after the fourth edition appeared. Our dedication honors her wonderful memory and her steadfast support for this project from its inception. Tom also acknowledges the love, devotion, and intellectual contribution to this book of his wife, Ruth Faden, who has been the deepest influence on his career in bioethics, and salutes Donald Seldin, a brilliant physician and an inspiration to Tom and to biomedical ethics since the early years of the field. Don passed away at age ninety-seven in 2018, when we were in the midst of preparing this eighth edition. He will be sorely missed, and never forgotten.

Washington, DC, and *Chilmark, MA* T.L.B.
Charlottesville, VA J.F.C.
January 2019

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PART I

MORAL FOUNDATIONS

1

Moral Norms

In the last third of the twentieth century, major developments in the biological and health sciences and in biomedical technology strikingly challenged traditional professional ethics in much of clinical medicine, nursing, and biomedical and behavioral research.[1] Despite a remarkable continuity in medical ethics across millennia, the widely revered Hippocratic tradition could not adequately address modern concerns such as informed consent, privacy, access to health care, communal and public health responsibilities, and research involving human subjects. Professional ethics was also ill equipped to provide an adequate framework for public policy in a pluralistic society.

In this book, we acknowledge and draw from the great traditions of medical ethics,[2] but we also draw from philosophical reflections on morality. This approach helps us to examine and, where appropriate, challenge common assumptions in the biomedical sciences, health care, and public health.

NORMATIVE AND NONNORMATIVE ETHICS

The term *ethics* needs attention before we turn to the meanings of *morality* and *professional ethics*. *Ethics* is a generic term covering several different ways of examining and interpreting the moral life. Some approaches to ethics are normative, others nonnormative.

Normative Ethics

General normative ethics addresses the question, "Which general moral norms should we use to guide and evaluate conduct, and why?" Ethical theories seek to identify and justify these norms, which are often referred to as principles, rules, rights, or virtues. In Chapter 9 we examine several types of general normative ethical theory and offer criteria for assessing them.

Many practical questions would remain unanswered even if a fully satisfactory general ethical theory were available. The term *practical ethics*, as used here, is synonymous with *applied ethics* and stands in contrast to *theoretical ethics*.[3] *Practical ethics* refers to the use of moral concepts and norms in deliberations about moral problems, practices, and policies in professions, institutions, and public policy. Often no direct movement from general norms, precedents, or theories to particular judgments is possible. General norms are usually only starting points for the development of more specific norms of conduct suitable for contexts such as clinical medicine and biomedical research. Throughout this book we address how to move from general norms to specific norms and particular judgments and from theory to practice.

Nonnormative Ethics

Two types of nonnormative ethics are distinguishable. The first is *descriptive ethics*, which is the factual investigation of moral beliefs and conduct. It often uses scientific techniques to study how people reason and act. For example, anthropologists, sociologists, psychologists, and historians determine which moral norms are expressed in professional practice, in professional codes, in institutional mission statements and rules, and in public policies. These researchers study phenomena such as surrogate decision making, treatment of the dying, the use of vulnerable populations in research, how consents are obtained from patients, and refusal of treatment by patients.

The second type of nonnormative ethics is *metaethics*, which involves analysis of the language, concepts, and methods of reasoning in normative ethics.[4] For example, metaethics addresses the meanings of terms such as *right*, *obligation*, *virtue*, *justification*, *morality*, and *responsibility*. It is also concerned with moral epistemology (the theory of moral knowledge), the logic and patterns of moral reasoning and justification, and the nature and possibility of moral truth. Whether morality is objective or subjective, relative or nonrelative, and rational or nonrational are prominent questions in metaethics.

Descriptive ethics and metaethics are nonnormative because their objective is to establish what factually or conceptually *is* the case, not what ethically *ought to be* the case or what is ethically *valuable*. For example, in this book we often rely on reports in descriptive ethics when investigating the nature of professional conduct and codes of ethics, current forms of access to health care, and physician attitudes toward hastening the deaths of patients who have requested aid in dying. In these investigations we are interested in how such descriptive information assists us in determining which practices are morally justifiable as well as in resolving other normative issues.

THE COMMON MORALITY AS UNIVERSAL MORALITY

In its most familiar sense, the word *morality* (a broader term than *common morality*, which is discussed immediately below in the section on "The Nature of the Common Morality," and in more detail in Chapter 10, pp. 444–57) refers to norms about right and wrong human conduct that are widely shared and form a stable societal compact. As a social institution, morality encompasses many standards of conduct, including moral principles, rules, ideals, rights, and virtues. We learn about morality as we grow up, and we learn to distinguish between the part of morality that holds for everyone and moral norms that bind only members of specific communities or special groups such as physicians, nurses, or public health officials.

The Nature of the Common Morality

Some core tenets found in every acceptable particular morality are not relative to cultures, groups, or individuals. All persons living a moral life know and accept rules such as not to lie, not to steal others' property, not to punish innocent persons, not to kill or cause harm to others, to keep promises, and to respect the rights of others. All persons committed to morality do not doubt the relevance and importance of these universally valid rules. Violation of these norms is unethical and will generate feelings of remorse. The literature of biomedical ethics virtually never debates the merit or acceptability of these central moral norms. Debates do occur, however, about their precise meaning, scope, weight, and strength, often in regard to hard moral cases or current practices that merit careful scrutiny—such as when, if ever, physicians may justifiably withhold some aspects of a diagnostic finding from their patients.

We call the set of universal norms shared by all persons committed to morality *the common morality*. This morality is not merely *a* morality, in contrast to other moralities.[5] It is applicable to all persons in all places, and we appropriately judge all human conduct by its standards. The following norms are examples (far from a complete list) of generally binding *standards of action* (that is, rules of obligation) found in the common morality: (1) Do not kill, (2) Do not cause pain or suffering to others, (3) Prevent evil or harm from occurring, (4) Rescue persons in danger, (5) Tell the truth, (6) Nurture the young and dependent, (7) Keep your promises, (8) Do not steal, (9) Do not punish the innocent, and (10) Obey just laws.

The common morality also contains standards other than obligatory rules of conduct. Here are ten examples of *moral character traits*, or virtues, recognized in the common morality (again, not a complete list): (1) nonmalevolence (not harboring ill will toward others), (2) honesty, (3) integrity, (4) conscientiousness, (5) trustworthiness, (6) fidelity, (7) gratitude, (8) truthfulness, (9) lovingness, and

(10) kindness. These virtues are universally admired traits of character.[6] A person is deficient in moral character if he or she lacks such traits. Negative traits that are the opposite of these virtues are *vices* (for example, malevolence, dishonesty, lack of integrity, cruelty, etc.). They are universally recognized as substantial moral defects. In this chapter we will say nothing further about moral character and the virtues and vices, because they are investigated in both Chapter 2 and a major section of Chapter 9 (pp. 31–45, 409–16).

In addition to the obligations and virtues just mentioned, the common morality supports *human rights* and endorses *moral ideals* such as charity and generosity. Philosophers debate whether one of these regions of the moral life—obligations, rights, or virtues—is more basic or more valuable than another, but in the common morality there is no reason to give primacy to any one area or type of norm. For example, human rights are not more basic than moral virtues in universal morality, and moral ideals should not be downgraded morally merely because people are not obligated to conform to them. An undue emphasis on any one of these areas or types of norms disregards the full scope of morality.[7]

Our account of universal morality in this chapter and Chapter 10 does not conceive of the common morality as ahistorical or a priori.[8] This problem in moral theory cannot be adequately engaged until our discussions in Chapter 10, and we offer now only three clarifications of our position: First, the common morality is a product of human experience and history and is a universally shared product. The origin of the norms of the common morality is no different in principle from the origin of the norms of a particular morality for a medical or other profession. Both are learned and transmitted in communities. The primary difference is that the common morality has authority in all communities, whereas particular moralities are authoritative only for specific groups. Second, we accept moral pluralism in *particular* moralities, as discussed later in this chapter (pp. 5–6), but we reject moral pluralism, understood as relativism, in the *common* morality. (See the section in Chapter 10 on “Moral Change” for further clarification.) No particular moral way of life qualifies as morally acceptable unless it conforms to the standards in the common morality. Third, the common morality comprises moral *beliefs* that all morally committed persons believe. It does not consist of timeless, detached standards of truth that exist independently of a history of moral beliefs. Likewise, every *theory* of the common morality has a history of development by the author(s) of the theory.

Ways to Examine the Common Morality

Various statements about or references to the common morality might be understood as normative, nonnormative, or possibly both. If the appeals are normative, the claim is that the common morality has normative force: It establishes moral standards for everyone, and violating these standards is unethical. If the references are nonnormative, the claim is that we can empirically study whether the common morality is present in all cultures. We accept both the normative force of the common morality and the objective of studying it empirically.

Some critics of our theory of the common morality (see Chapter 10) have asserted that scant anthropological or historical evidence supports the empirical hypothesis that a universal common morality exists.[9] Accordingly, they think we need to consider how good the evidence is both for and against the existence of a universal common morality. This problem is multifaceted and difficult to address, but in principle, scientific research could either confirm or falsify the hypothesis of a universal morality. It would be absurd to assert that all persons do in fact accept the norms of the common morality, because many amoral, immoral, or selectively moral persons do not care about or identify with its moral demands. Our hypothesis is that all persons *committed to morality* accept the standards in the common morality.

We explore this hypothesis about the empirical study of the common morality in Chapter 10 (pp. 449–52). Here we note only that when we claim that the normative judgments found in many parts of this book are derived from the common morality, we are not asserting that *our theory* of the common morality gets the common morality perfectly right or that it interprets or extends the common morality in just the right ways. There undoubtedly are dimensions of the common morality that we do not correctly capture or depict; and there are many parts of the common morality that we do not even address.[10] When we attempt to build on the common morality in this book by using it as a basis for critically examining problems of biomedical ethics, we do not mean to imply that our extensions can validly claim the authority of the common morality at every level of our interpretation of this morality.

PARTICULAR MORALITIES AS NONUNIVERSAL

We shift now from universal morality (the common morality) to particular moralities, which contain moral norms that are not shared by all cultures, groups, and individuals who are committed to morality.

The Nature of Particular Moralities

Whereas the common morality contains moral norms that are abstract, universal, and content-thin (such as “Tell the truth”), particular moralities present concrete, nonuniversal, and content-rich norms (such as “Make conscientious oral disclosures to, and obtain a written informed consent from, all human research subjects”). Particular moralities are distinguished by the specificity of their norms, but these norms are not morally justified if they violate norms in the common morality. Specific moralities include the many responsibilities, aspirations, ideals, sentiments, attitudes, and sensitivities found in diverse cultural traditions, religious traditions, professional practice, and institutional guides. Explication of the values in these moralities sometimes requires a special knowledge and may involve refinement by experts or scholars over centuries—as, for example, in the body of Jewish religious, legal, and moral norms in the Talmudic tradition; well-structured moral systems to provide methods for judgments and to adjudicate conflicts in Roman Catholic casuistry; and Islamic reliance on Shari'ah-based principles. Each tradition continues today to elaborate its commitments through the development of detailed, and hopefully coherent, systems of medical ethics. These elaborations are often derived from the common morality, not merely from the scriptures of a particular religious tradition.

Professional moralities, which include moral codes and standards of practice, are also particular moralities. They may legitimately vary from other moralities in the ways they handle certain conflicts of interest, research protocol reviews, advance directives, and similar matters. (See the next section below on "Professional and Public Moralities.") *Moral ideals* such as charitable goals and aspirations to rescue suffering persons in dangerous situations provide another instructive example of facets of particular moralities. By definition, moral ideals such as charitable beneficence are not morally *required* of all persons; indeed, they are not required of any person.[11] Persons who fail to fulfill even their own personal ideals cannot be blamed or criticized by others. These ideals may nonetheless be critically important features of personal or communal moralities. Examples are found in physicians' individual commitments or physician codes that call for assumption of a significant level of risk in circumstances of communicable disease. It is reasonable to presume that all morally committed persons share an admiration of and endorsement of moral ideals of generosity and service, and in this respect these ideals are part of shared moral beliefs in the common morality; they are universally *praiseworthy* even though not universally *required* or universally *practiced*. When such ideals are regarded by those who embrace them as obligations (as they are, for example, in some monastic traditions), the obligations are still parts of a particular morality, not of universal morality.

Persons who accept a particular morality sometimes presume that they can use this morality to speak with an authoritative moral voice for all persons. They operate under the false belief that their particular convictions have the authority of the common morality. These persons may have morally acceptable and even praiseworthy beliefs, but their particular beliefs do not bind other persons or communities. For example, persons who believe that scarce medical resources, such as transplantable organs, should be distributed by lottery rather than by medical need may have good moral reasons for their views, but they cannot claim that their views are supported by the common morality.

Professional and Public Moralities

Just as the common morality is accepted by all morally committed persons, most professions have, at least implicitly, a professional morality with standards of conduct that are generally acknowledged and encouraged by those in the profession who are serious about their moral responsibilities. In medicine, professional morality specifies general moral norms for the institutions and practices of medicine. Special roles and relationships in medicine derive from rules or traditions that other professions will likely not need or accept. As we argue in Chapters 4 and 8, rules of informed consent and medical confidentiality may not be serviceable or appropriate outside of medicine, nursing, biomedical research, and public health, but these rules are justified by general moral requirements of respecting the autonomy of persons and protecting them from harm.

Members of professions often adhere to moral guidelines such as rules prohibiting discrimination against colleagues on the basis of gender, race, religion, or national origin (some of these guidelines now have legal backing). In recent years formal codifications of and instruction in professional morality have increased through codes of medical and nursing ethics, codes of research ethics, corporate policies of bioethics, institutional guidelines governing conflict of interest, and the reports and recommendations of public commissions. Before we assess these guidelines, the nature of professions in general needs brief discussion.

In a classic work on the subject, Talcott Parsons defines a profession as "a cluster of occupational roles, that is, roles in which the incumbents perform certain functions valued in the society in general, and, by these activities, typically earn a living at a full-time job."[12] Under this definition, circus performers, exterminators, and garbage collectors are professionals. It is not surprising to find all such activities characterized as professions, inasmuch as the word *profession* has come, in common use, to mean almost any occupation by which a person earns a living. The once honorific sense of *profession* is now better reflected in the term *learned profession*, which assumes an extensive education in the arts, humanities, law, sciences, or technologies.

Professionals are usually distinguished by their specialized knowledge and training as well as by their commitment to provide important services or information to patients, clients, students, or consumers. Professions maintain self-regulating organizations that control entry into occupational roles by formally certifying that candidates have acquired the necessary knowledge and skills. In learned professions such as medicine, nursing, and public health, a professional's background knowledge is partly acquired through closely supervised training, and the professional is committed to providing a service to others.

Health care professions specify and enforce obligations for their members, thereby seeking to ensure that persons who enter into relationships with these professionals will find them competent and trustworthy.[13] The obligations that professions attempt to enforce are determined by an accepted role. These obligations comprise the "ethics" of the profession, although there may also be role-specific customs such as self-effacement that are not obligatory. Problems of professional ethics commonly arise either from conflicts over appropriate professional standards or conflicts between professional commitments and the commitments professionals have outside the profession.

Because traditional standards of professional morality are often vague, some professions codify their standards in detailed statements aimed at reducing vagueness and improving adherence. Their codes sometimes specify rules of etiquette in addition to rules of ethics. For example, a historically significant version of the code of the American Medical Association (AMA) dating from 1847 instructed physicians not to criticize fellow physicians who had previously been in charge of a case.[14] Such professional codes tend to foster and reinforce member identification with the prevailing values of the profession. These codes are beneficial when they effectively incorporate defensible moral norms, but some codes oversimplify moral requirements, make them indefensibly rigid, or make excessive and unwarranted claims about their completeness and authoritativeness. As a consequence, professionals may mistakenly suppose that they are satisfying all relevant moral requirements by scrupulously following the rules of the code, just as some people believe that they fully discharge their moral obligations when they meet all relevant legal requirements.

We can and should ask whether the codes specific to areas of science, medicine, nursing, health care, and public health are coherent, defensible, and comprehensive within their domain. Historically, few codes had much to say about the implications of several pivotal moral principles and rules such as veracity, respect for autonomy, and social justice that have been the subjects of intense discussion in recent biomedical ethics. From ancient medicine to the present, physicians have generated codes without determining their acceptability to patients and the public. These codes have rarely appealed to general ethical standards or to a source of moral authority beyond the traditions and judgments of physicians themselves.[15] The articulation of such professional norms has often served more to protect the profession's interests than to offer a broad and impartial moral viewpoint or to address issues of importance to patients and society.[16]

Psychiatrist Jay Katz poignantly expressed reservations about traditional principles and codes of medical ethics. Initially inspired by his outrage over the fate of Holocaust victims at the hands of German physicians, Katz became convinced that a professional ethics that reaches beyond traditional codes is indispensable:

> As I became increasingly involved in the world of law, I learned much that was new to me from my colleagues and students about such complex issues as the right to self-determination and privacy and the extent of the authority of governmental, professional, and other institutions to intrude into private

> life. . . . These issues . . . had rarely been discussed in my medical education. Instead it had been all too uncritically assumed that they could be resolved by fidelity to such undefined principles as *primum non nocere* ["First, do no harm"] or to visionary codes of ethics.[17]

The Regulation and Oversight of Professional Conduct

Additional moral direction for health professionals and scientists comes through the public policy process, which includes regulations and guidelines promulgated by governmental bodies. The term *public policy* refers to a set of normative, enforceable guidelines adopted by an official public body, such as an agency of government or a legislature, to govern a particular area of conduct. The policies of corporations, hospitals, trade groups, and professional societies are private, not public, even if these bodies are regulated to some degree by public policies and sometimes have an impact on public policy.

A close connection exists between law and public policy: All laws constitute public policies, but not all public policies are, in the conventional sense, laws. In contrast to laws, public policies need not be explicitly formulated or codified. For example, an official who decides not to fund a newly recommended government program with no prior history of funding is formulating a public policy. Decisions not to act, as well as decisions to act, can constitute policies.

Policies such as those that fund health care for the indigent or that protect subjects of biomedical research regularly incorporate moral considerations. Moral analysis is part of good policy formation, not merely a method for evaluating existing policy. Efforts to protect the rights of patients and research subjects are instructive examples. Over the past few decades many governments have created national commissions, national review committees, advisory committees, and councils to formulate guidelines for research involving human subjects, for the distribution of health care, and for addressing moral mistakes made in the health professions. Morally informed policies have guided decision making about other areas of practice as well. The relevance of bioethics to public policy is now recognized in most countries, some of which have influential standing bioethics committees.[18]

Many courts have developed case law that sets standards for science, medicine, and health care. Legal decisions often express communal moral norms and stimulate ethical reflection that over time alters those norms. For example, the lines of court decisions in many countries about how dying patients may be or must be treated have constituted nascent traditions of moral reflection that have been influenced by, and in turn have influenced, literature in biomedical ethics on topics such as when artificial devices that sustain life may be withdrawn, whether medically administered nutrition and hydration is a medical treatment that may be discontinued, and whether physicians may be actively involved in hastening a patient's death at the patient's request.

Policy formation and criticism generally involve more specific moral judgments than the judgments found in general ethical theories, principles, and rules.[19] Public policy is often formulated in contexts that are marked by profound social disagreements, uncertainties, and differing interpretations of history. No body of abstract moral principles and rules can fix policy in such circumstances, because abstract norms do not contain enough specific information to provide direct and discerning guidance. The implementation of moral principles and rules, through specification and balancing, must take into account factors such as feasibility, efficiency, cultural pluralism, political procedures, pertinent legal requirements, uncertainty about risk, and noncompliance by patients. Moral principles and rules provide a normative structure for policy formation and evaluation, but policies are also shaped by empirical data and information generated in fields such as medicine, nursing, public health, veterinary science, economics, law, biotechnology, and psychology.

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

We are not defending any of these moral judgments. We are maintaining only that the connections between moral norms and judgments about policy or law are complicated and that a judgment about the morality of particular actions does not entail a comparable judgment about law or policy.

Moral Dilemmas

Common to all forms of practical ethics is reasoning through difficult cases, some of which constitute dilemmas. This is a familiar feature of decision making in morality, law, and public policy. Consider a classic case[20] in which judges on the California Supreme Court had to reach a decision about the legal force and limits of medical confidentiality. A man had killed a woman after confiding to a therapist his intention to do so. The therapist had attempted unsuccessfully to have the man committed but, in accordance with his duty of medical confidentiality to the patient, did not communicate the threat to the woman when the commitment attempt failed.

The majority opinion of the court held that "When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger." This obligation extends to notifying the police and also to warning the intended victim. The justices in the majority opinion argued that therapists generally ought to observe the rule of medical confidentiality, but that the rule must yield in this case to the "public interest in safety from violent assault." These justices recognized that rules of professional ethics have substantial public value, but they held that matters of greater importance, such as protecting persons against violent assault, can override these rules.

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

This case presents moral and legal dilemmas in which the judges cite relevant reasons to support their conflicting judgments.[21] Moral dilemmas are circumstances in which moral obligations demand or appear to demand that a person adopt each of two (or more) alternative but incompatible actions, such that the person cannot perform all the required actions. These dilemmas occur in at least two forms.[22] (1) Some evidence or argument indicates that an act is morally permissible and some evidence or argument indicates that it is morally wrong, but the evidence or strength of argument on both sides is inconclusive. Abortion, for example, may present a terrible dilemma for women who see the evidence in this way. (2) An agent believes that, on moral grounds, he or she is obligated to perform two or more mutually exclusive actions. In a moral dilemma of this form, one or more moral norms obligate an agent to do *x* and one or more moral norms obligate the agent to do *y*, but the agent cannot do both in the circumstance. The reasons behind alternatives *x* and *y* are weighty and neither set of reasons is overriding. If one acts on either set of reasons, one's actions will be morally acceptable in some respects and morally unacceptable in others. The withdrawal of life-prolonging therapies from patients suffering from a wakeful unconscious state (formerly called a persistent, continuing, or continuous vegetative state) is sometimes regarded as an instance of this second form of dilemma.

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

Conflicts between moral requirements and self-interest sometimes create a *practical* dilemma, but not, strictly speaking, a *moral* dilemma. If moral reasons compete with nonmoral reasons, such as self-interest, questions about priority can still arise even though no moral dilemma is present. When a moral reason conflicts with a personal reason, the moral reason is not always overriding. If, for example, a physician must choose between saving his or her own life or that of a patient, in a situation of extreme scarcity of available drugs, the moral obligation to take care of the patient may not be overriding.

Some moral philosophers and theologians have argued that although many practical dilemmas involving moral reasons exist, no irresolvable moral dilemmas exist. They do not deny that agents experience moral perplexity or conflict in difficult cases. However, they claim that the purpose of a moral theory is to provide a principled procedure for resolving deep conflicts. Some philosophers have defended this conclusion because they accept one supreme moral value as overriding all other conflicting values (moral and nonmoral) and because they regard it as incoherent to allow contradictory obligations in a properly structured moral theory. The only *ought*, they maintain, is the one generated by the supreme value.[23] (We examine such theories, including both utilitarian and Kantian theories, in Chapter 9.)

In contrast to the account of moral obligation offered by these theories, we maintain throughout this book that various moral principles, rules, and rights can and do conflict in the moral life. These conflicts sometimes produce irresolvable moral dilemmas. When forced to a choice, we may “resolve” the situation by choosing one option over another, but we also may believe that neither option is morally preferable. A physician with a limited supply of medicine may have to choose to save the life of one patient rather than another and still find his or her moral dilemma irresolvable. Explicit acknowledgment of such dilemmas helps deflate unwarranted expectations about what moral principles and theories can do. Although we find ways of reasoning about what we should do, we may not be able to reach a reasoned resolution in many instances. In some cases the dilemma becomes more difficult and remains unresolved even after the most careful reflection.

A Framework of Moral Principles

Moral norms central to biomedical ethics rely on the common morality, but they do not exhaust the common morality. Some types of basic moral norms are treated in this section, especially principles, rules, and rights. The virtues are the subject of Chapter 2, and the principles of primary importance for biomedical ethics are treated individually in Part II of this book. Most classical ethical theories accept these norms in some form, and traditional medical codes incorporate or presuppose at least some of them.

Principles

The set of pivotal moral principles defended in this book functions as an analytical framework of general norms derived from the common morality that form a suitable starting point for reflection on moral problems in biomedical ethics.[24] These principles are general guidelines for the formulation of more specific rules. In Chapters 4 through 7 we defend four clusters of moral principles: (1) *respect for autonomy* (a norm of respecting and supporting autonomous decisions), (2) *nonmaleficence* (a norm of avoiding the causation of harm), (3) *beneficence* (a group of norms pertaining to relieving, lessening, or preventing harm and providing benefits and balancing benefits against risks and costs), and (4) *justice* (a cluster of norms for fairly distributing benefits, risks, and costs).

Nonmaleficence and beneficence have played central roles in the history of medical ethics. By contrast, respect for autonomy and justice were neglected in traditional medical ethics and have risen to prominence in this field only recently. In 1803, British physician Thomas Percival published *Medical Ethics*, the first comprehensive account of medical ethics in the long history of the subject. This book served as the backbone of British medical ethics and as the prototype for the American Medical Association's first code of ethics in 1847. Percival argued, using somewhat different language, that nonmaleficence and beneficence fix the physician's primary obligations and triumph over the patient's preferences and decision-making rights in circumstances of conflict.[25] Percival understated the critically important place of principles of respect for autonomy and distributive justice for physician conduct, but, in fairness to him, these considerations are now prominent in discussions of ethics in medicine in a way they were not when he wrote *Medical Ethics*.

That these four clusters of moral principles are central to biomedical ethics is a conclusion the authors of this work have reached by examining *considered moral judgments* and the *coherence of moral beliefs*, two notions analyzed in Chapter 10. The selection of these four principles, rather than some other clusters of principles, does not receive an argued defense in Chapters 1 through 3. However, in Chapters 4 through 7, we defend the vital role of each principle in biomedical ethics.

Rules

The framework of moral norms in this book encompasses several types of normative guidance, most notably principles, rules, rights, and virtues. Principles are more comprehensive and less specific than rules, but we draw only a loose distinction between them. Both are norms of obligation, but rules are more specific in content and more restricted in scope. Principles do not function as precise guides in each circumstance in the way that more detailed rules and judgments do. Principles and rules of obligation have correlative rights and often corresponding virtues. (See the discussion of rights in Chapter 9 and of virtues in Chapter 2.)

We defend several types of rules, the most important being substantive rules, authority rules, and procedural rules.

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

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

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

Procedural rules. We also defend rules that establish procedures to be followed. Procedures for determining eligibility for organ transplantation and procedures for reporting grievances to higher authorities are typical examples. We often resort to procedural rules when we run out of substantive rules and when authority rules are incomplete or inconclusive. For example, if substantive or authority rules are inadequate to determine which patients should receive scarce medical resources, a resort to procedural rules such as queuing and lottery may be justifiable.[26]

CONFLICTING MORAL NORMS

Prima Facie Obligations and Rights

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

Actions that harm individuals, cause basic needs to go unmet, or limit liberties are often said to be either wrong *prima facie* (i.e., wrongness is upheld unless the act is justifiable because of norms that are more stringent in the circumstances) or wrong *pro tanto* (i.e., wrong to a certain extent or wrong unless there is a compelling justification)—which is to say that the action is wrong in the absence of other moral considerations that supply a compelling justification.[27] Compelling justifications are sometimes available. For example, in circumstances of a severe swine flu pandemic, the forced confinement of persons through isolation and quarantine orders might be justified. Here a justifiable infringement of liberty rights occurs.

W. D. Ross's distinction between *prima facie* and *actual* obligations clarifies this idea. A *prima facie* obligation must be fulfilled unless it conflicts with an equal or stronger obligation. Likewise, a *prima facie* right (here we extend Ross's theory) must prevail unless it conflicts with an equal or stronger right (or conflicts with some other morally compelling alternative). Obligations and rights always constrain us unless a competing moral obligation or right can be shown to be overriding in a particular circumstance. As Ross put it, agents can determine their *actual* obligations in situations of conflict by examining the respective weights of the competing prima facie obligations. What agents ought to do is determined by what they ought to do all things considered.[28]

Imagine that a psychiatrist has confidential medical information about a patient who also happens to be an employee in the hospital where the psychiatrist practices. The employee seeks advancement in a stress-filled position, but the psychiatrist has good reason to believe that this advancement would be devastating for both the employee and the hospital. The psychiatrist has several prima facie duties in these circumstances, including those of confidentiality, nonmaleficence, beneficence, and respect for autonomy. Should the psychiatrist break confidence in this circumstance to meet these other duties? Could the psychiatrist make "confidential" disclosures to a hospital administrator and not to the personnel office? Addressing such questions through moral deliberation and justification is required to establish an agent's actual duty in the face of the conflicting prima facie duties.

These matters are more complicated than Ross suggests, particularly when rights come into conflict. We may need to develop a structured moral system or set of guidelines in which (1) some rights in a certain class of rights (for example, rights of individuals while alive to decide whether to donate their tissues and organs after death) have a fixed priority over others in another class of rights (for example, rights of family members to make decisions about the donation of their deceased relatives' tissues and organs) and (2) morally compelling social objectives such as gathering information in biomedical research can generally be overridden by basic human rights such as the right to give an informed consent or refusal.

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

Moral Regret and Residual Obligation

An agent who determines that a particular act is the best one to perform in a situation of conflicting obligations may still not be able to discharge all aspects of moral obligation by performing that act. Even the morally best action in the circumstances may still be regrettable and may leave a moral residue, also called a moral trace.[29] Regret and residue over what is not done can arise even if the right action is clear and uncontested.

This point is about continuing obligation, not merely about feelings of regret and residue. Moral residue occurs because a prima facie obligation does not simply disappear when overridden. Often we have residual obligations because the obligations we were unable to discharge create new obligations. We may feel deep regret and a sting of conscience, but we also realize that we have a duty to bring closure to the situation.[30] We can sometimes make up for not fulfilling an obligation in one or more of several ways. For example, we may be able to notify persons in advance that we will not be able to keep a promise; we may be able to apologize in a way that heals a relationship; we may be able to change circumstances so that the conflict does not occur again; and we may be able to provide adequate compensation.

Specifying Principles and Rules

The four clusters of principles we present in this book do not by themselves constitute a general ethical theory. They provide only a framework of norms with which to get started in biomedical ethics. These principles must be specified in order to achieve more concrete guidance. Specification is a process of reducing the indeterminacy of abstract norms and generating rules with action-guiding content.[31] For example, without further specification, "do no harm" is too bare for thinking through problems such as whether it is permissible to hasten the death of a terminally ill patient.

Specification is not a process of producing or defending general norms such as those in the common morality; it assumes that the relevant general norms are available. Specifying the norms with which one starts—whether those in the common morality or norms previously specified—is accomplished by narrowing the scope of the norms, not by explaining what the general norms mean. We narrow the scope, as Henry Richardson puts it, by "spelling out where, when, why, how, by what means, to whom, or by whom the action is to be done or avoided."[32] For example, the norm that we are obligated to "respect the autonomy of persons" cannot, unless specified, handle complicated problems in clinical medicine and research involving human subjects. A definition of "respect for autonomy" (e.g., as "allowing competent persons to exercise their liberty rights") clarifies one's meaning in using the norm, but it does not narrow the scope of the general norm or render it more specific in guiding actions.

Specification adds content. For example, as noted previously, one possible specification of "Respect the autonomy of patients" is "Respect the autonomy of competent patients by following their advance directives when they become incompetent." This specification will work well in some medical contexts, but it will confront limits in others, where additional specification will be needed. Progressive specification can continue indefinitely, but to qualify all along the way as a specification some transparent connection must be maintained to the initial general norm that gives moral authority to the resulting string of specifications. This process is a prime way in which general principles become practical instruments for moral reasoning; and it also helps explain why the four-principles approach is not merely an abstract theory limited to four general principles.[33]

An example of specification arises when psychiatrists conduct forensic evaluations of patients in a legal context. Psychiatrists cannot always obtain an informed consent, but they then risk violating their obligations to respect autonomy, a central imperative of medical ethics. A specification aimed at handling this problem is “Respect the autonomy of persons who are the subjects of forensic evaluations, where consent is not legally required, by disclosing to the evaluee the nature and purpose of the evaluation.” We do not claim that this formulation is the best specification, but it approximates the provision recommended in the “Ethical Guidelines for the Practice of Forensic Psychiatry” of the American Academy of Psychiatry and the Law.[34] This specification attempts to guide forensic psychiatrists in discharging their diverse moral obligations.

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

A survey of practicing physicians’ attitudes toward deception illustrates how some physicians reconcile their dual commitment to patients and to nondeception. Dennis H. Novack and several colleagues used a questionnaire to obtain physicians’ responses to difficult ethical problems that potentially could be resolved by use of deception. In one scenario, a physician recommends an annual screening mammography for a fifty-two-year-old woman who protests that her insurance company will not cover the test. The insurance company will cover the costs if the physician states (deceptively in this scenario) that the reason is “rule out cancer” rather than “screening mammography.” The insurance company understands “rule out cancer” to apply only if there is a breast mass or other objective clinical evidence of the possibility of cancer, neither of which is present in this case. Almost 70% of the physicians responding to this survey indicated that they would state that they were seeking to “rule out cancer,” and 85% of this group (85% of the 70%) insisted that their act would not involve “deception.”[35]

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

All moral rules are, in principle, subject to specification. All will need additional content, because, as Richardson puts it, "the complexity of the moral phenomena always outruns our ability to capture them in general norms."[36] Many already specified rules will need further specification to handle new circumstances of conflict. These conclusions are connected to our earlier discussion of particular moralities. Different persons and groups will offer conflicting specifications, potentially creating multiple particular moralities. In any problematic case, competing specifications are likely to be offered by reasonable and fair-minded parties, all of whom are committed to the common morality.

To say that a problem or conflict is resolved or dissolved by specification is to say that norms have been made sufficiently determinate in content that, when cases fall under them, we know what must be done. Obviously some proposed specifications will fail to provide the most adequate or justified resolution. When competing specifications emerge, the proposed specifications should be based on deliberative processes of reasoning. Specification as a method can be connected to a model of justification that will support some specifications and not others, as we argue in Chapter 10 (pp. 456–57).

Some specified norms are virtually absolute and need no further specification, though they are rare. Examples include prohibitions of cruelty that involve unnecessary infliction of pain and suffering.[37] "Do not rape" is a comparable example. More interesting are norms that are intentionally formulated with the goal of including all legitimate exceptions. An example is "Always obtain oral or written informed consent for medical interventions with competent patients, *except* in emergencies, in forensic examinations, in low-risk situations, or when patients have waived their right to adequate information." This norm needs further interpretation, including an analysis of what constitutes an informed consent, an emergency, a waiver, a forensic examination, and a low risk. This rule would be absolute if all legitimate exceptions had been successfully incorporated into its formulation, but such rules are rare. In light of the range of possibilities for contingent conflicts among rules, even the firmest and most detailed rules are likely to encounter exceptive cases.

Weighing and Balancing

Principles, rules, obligations, and rights often must be balanced in circumstances of contingent conflict. Does balancing differ from specification, or are they identical?

The process of weighing and balancing. Balancing occurs in the process of reasoning about which moral norms should prevail when two or more of them come into conflict. Balancing is concerned with the relative weights and strengths of different moral norms, whereas specification is concerned primarily with their range and scope, that is, their reach when narrowing the scope of pre-existing general norms (while adding content). Balancing consists of deliberation and judgment about these weights and strengths. It is well suited for reaching judgments in *particular cases*, whereas specification is especially useful for developing more *specific policies* from already accepted general norms.

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

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

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

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

Consider the following discussion with a young woman who has just been told that she is HIV-infected, as recorded by physician Timothy Quill and nurse Penelope Townsend:[38]

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

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

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

How physicians and nurses balance different moral considerations often involves sympathetic insight, humane responsiveness, and the practical wisdom of discerning a particular patient's circumstance and needs.[39] Balancing is often a more complex set of activities than those involved in a straightforward case of balancing two conflicting principles or rules. Considerations of trust, compassion, objective assessment, caring responsiveness, reassurance, and the like may all be involved in the process of balancing.

In many clinical contexts it may be hopelessly complicated and unproductive to engage in specification. For example, in cases of balancing harms of treatment against the benefits of treatment for incompetent patients, the cases are often so exceptional that it is perilous to generalize a conclusion that would reach out to other cases. These problems are sometimes further complicated by disagreements among family members about what constitutes a benefit, poor decisions and indecision by a marginally competent patient, limitations of time and resources, and the like.[40]

We do not suggest that balancing is inescapably intuitive and unreflective. Instead, we propose a model of moral judgment that focuses on how balancing and judgment occur through practical astuteness, discriminating intelligence, and sympathetic responsiveness that are not reducible to the specification of norms. The capacity to balance many moral considerations is connected to what we discuss in Chapter 2 as capacities of moral character. Capacities in the form of virtues of compassion, attentiveness, discernment, caring, and kindness are integral to the way wise moral agents balance diverse, sometimes competing, moral considerations.

Practicability supplies another reason to support the conclusion that the model of specification needs supplementation by the model of balancing. Progressive specification covering all areas of the moral life would eventually mushroom into a body of norms so bulky that the normative system would become unwieldy. A scheme of comprehensive specification would constitute a package of potentially hundreds, thousands, or millions of rules, each suited to a narrow range of conduct. In the model of specification, every type of action in a circumstance of the contingent conflict of norms would be covered by a rule, but the formulation of rules for every circumstance of contingent conflict would be a body of rules too cumbersome to be helpful.

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

1. Good reasons are offered to act on the overriding norm rather than the infringed norm.
2. The moral objective justifying the infringement has a realistic prospect of achievement.
3. No morally preferable alternative actions are available.[41]
4. The lowest level of infringement, commensurate with achieving the primary goal of the action, has been selected.
5. All negative effects of the infringement have been minimized.
6. All affected parties have been treated impartially.

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

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

Finally, consider this example: The principle of respect for autonomy and the principle of beneficence (which requires acts intended to prevent harm to others) sometimes come into contingent conflict when addressing situations that arise in governmental and professional responses to serious infectious-disease outbreaks, such as severe acquired respiratory syndrome (SARS). Persons exposed to SARS may put other persons at risk. The government, under its public health responsibilities, and various health professionals have an obligation based on beneficence and justice to protect unexposed persons whenever possible. However, respect for autonomy often sets a prima facie barrier to infringements of liberty and privacy even in the context of public health concerns. To justify overriding respect for autonomy, one must show that mandatory quarantine of exposed individuals is necessary to prevent harm to others and has a reasonable prospect of preventing such harm. If it meets these conditions, mandatory quarantine still must pass the least-infringement test (condition 4), and public health officials should seek to minimize the negative effects of the quarantine, including the loss of income and the inability to care for dependent family members (condition 5). Finally, impartial application of the quarantine rules is essential for both fairness and public trust (condition 6).[42]

In our judgment, these six constraining conditions are morally demanding, at least in some circumstances. When conjoined with requirements of coherence presented in Chapter 10 (pp. 439–44), these conditions provide protections against purely intuitive, subjective, or biased balancing judgments. We could introduce further criteria or safeguards, such as “rights override nonrights” and “liberty principles override nonliberty principles,” but these provisions are certain to fail in circumstances in which rights claims and liberty interests are relatively minor.

Moral Diversity and Moral Disagreement

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

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

Different parties may emphasize different principles or assign different weights to principles even when they agree on which principles and concepts are relevant. Disagreement may persist among morally committed persons who appropriately appreciate the basic demands that morality makes on them. If evidence is incomplete and different items of evidence are available to different parties, one individual or group may be justified in reaching a conclusion that another individual or group is justified in rejecting. Even if both parties have some incorrect beliefs, each party may have good reasons for holding those beliefs. We cannot hold persons to a higher practical standard than to make judgments conscientiously in light of the available norms and evidence.

When moral disagreements arise, a moral agent can—and usually should—defend his or her decision without disparaging or reproaching others who reach different decisions. Recognition of legitimate diversity—by contrast to moral violations that warrant criticism—is vital in the evaluation of the actions of others. One person's conscientious assessment of his or her obligations may differ from another's when they confront the same moral problem, and both evaluations may be appropriately grounded in the common morality. Similarly, what one institution or government determines it should do may differ from what another institution or government determines it should do. In such cases we can assess one position as morally preferable to another only if we can show that the position rests on a more coherent set of specifications and interpretations of the common morality.[43]

Conclusion

In this chapter we have presented what is sometimes called the *four-principles approach* to biomedical ethics, now commonly called *principlism*.[44] The four clusters of principles in our moral framework descend from the common morality, but when specifying and balancing these principles in later chapters we will also call on historical experience in formulating professional obligations and virtues in health care, public health, biomedical research, and health policy. Although various assumptions in traditional medical ethics, current medical and research codes, and other parts of contemporary bioethics need further reform, we are deeply indebted to their insights and commitments. Our goal in later chapters is to develop, specify, and balance the normative content of the four clusters of principles, and we will often seek to render our views consistent with professional traditions, practices, and codes.

Principlism is not merely a list of four abstract principles. It is a theory about how these principles are linked to and guide practice. In the nine chapters hereafter we show how principles and other moral norms are connected to an array of understandings, practices, and transactions in health care settings, research institutions, and public health policies.

NOTES

1. See Albert Jonsen, *The Birth of Bioethics* (New York: Oxford University Press, 1998), pp. 3ff; Jonsen, *A Short History of Medical Ethics* (New York: Oxford University Press, 2000); John-Stewart Gordon, "Bioethics," in the *Internet Encyclopedia of Philosophy*, especially section 2, available at https://www.iep.utm.edu/bioethics/ (accessed March 23, 2018); and Edmund D. Pellegrino and David C. Thomasma, *The Virtues in Medical Practice* (New York: Oxford University Press, 1993), pp. 184–89.

2. A comprehensive treatment of this history that ranges worldwide is Robert B. Baker and Laurence McCullough, eds., *The Cambridge World History of Medical Ethics* (Cambridge: Cambridge University Press, 2009).

3. The language of "applied ethics" can be misleading insofar as it suggests one-way traffic from ethical theory and principles and rules to particular judgments about cases. In fact, particular case judgments interact dialectically with and may lead to modifications of theories, principles, and rules. See our discussion in Chapter 10, pp. 404–10.

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

5. Although there is only one universal common morality, there is more than one theory of the common morality. For a diverse group of theories, see Alan Donagan, *The Theory of Morality* (Chicago: University of Chicago Press, 1977); Bernard Gert, *Common Morality: Deciding What to Do* (New York: Oxford University Press, 2007); Bernard Gert, Charles M. Culver, and K. Danner Clouser, *Bioethics: A Return to Fundamentals,* 2nd ed. (New York: Oxford University Press, 2006); W. D. Ross, *The Foundations of Ethics* (Oxford: Oxford University Press, 1939); and the special issue of the *Kennedy Institute of Ethics Journal* 13 (2003), especially the introductory article by Robert Veatch, pp. 189–92.

For challenges to these theories and their place in bioethics, see John D. Arras, "The Hedgehog and the Borg: Common Morality in Bioethics," *Theoretical Medicine and Bioethics* 30 (2009): 11–30; Arras, "A Common Morality for Hedgehogs: Bernard Gert's Method," in Arras, *Methods in Bioethics: The Way We Reason Now*, ed. James F. Childress and Matthew Adams (New York: Oxford University Press, 2017), pp. 27–44; B. Bautz, "What Is the Common Morality, Really?" *Kennedy Institute of Ethics Journal* 26 (2016): 29–45; Carson Strong, "Is There No Common Morality?" *Medical Humanities Review* 11 (1997): 39–45; and Andrew Alexandra and Seumas Miller, "Ethical Theory, 'Common Morality,' and Professional Obligations," *Theoretical Medicine and Bioethics* 30 (2009): 69–80.

6. See Martha Nussbaum's thesis that in Aristotle's philosophy, certain "non-relative virtues" are objective and universal. "Non-Relative Virtues: An Aristotelian Approach," in *Ethical Theory, Character, and Virtue,* ed. Peter French et al. (Notre Dame, IN: University of Notre Dame Press, 1988), pp. 32–53, especially pp. 33–4, 46–50. In a classic work in philosophical ethics, David Hume presents a theory of the virtues as objective and universal, though his theory is somewhat different from Aristotle's. See Hume's *An Enquiry concerning the Principles of Morals*, ed. Tom L. Beauchamp, in the series "Oxford Philosophical Texts Editions" (Oxford: Oxford University Press, 1998).

7. For a broad and engaging account of common morality, see Rebecca Kukla, "Living with Pirates: Common Morality and Embodied Practice," *Cambridge Quarterly of Healthcare Ethics* 23 (2014): 75–85. See also Bernard Gert's insistence on the role of the *whole moral system* (not merely rules of obligation) and the perils of neglecting it, an often overlooked point with which we agree. See Gert's *Morality: Its Nature and Justification* (New York: Oxford University Press, 2005), pp. 3, 159–61, 246–47; and see also his "The Definition of Morality," in *The Stanford Encyclopedia of Philosophy*; revision of February 8, 2016, available at https://plato.stanford.edu/entries/morality-definition/ (accessed February 9, 2018).

8. This mistaken interpretation of our theory is found in Leigh Turner, "Zones of Consensus and Zones of Conflict: Questioning the 'Common Morality' Presumption in Bioethics," *Kennedy Institute of Ethics Journal* 13 (2003): 193–218; and Turner, "An Anthropological Exploration of Contemporary Bioethics: The Varieties of Common Sense," *Journal of Medical Ethics* 24 (1998): 127–33.

9. See David DeGrazia, "Common Morality, Coherence, and the Principles of Biomedical Ethics," *Kennedy Institute of Ethics Journal* 13 (2003): 219–30; Turner, "Zones of Consensus and Zones of Conflict"; Donald C. Ainslee, "Bioethics and the Problem of Pluralism," *Social Philosophy and Policy* 19 (2002): 1–28; Oliver Rauprich, "Common Morality: Comment on Beauchamp and Childress,"

Theoretical Medicine and Bioethics 29 (2008): 43–71; and Letícia Erig Osório de Azambuja and Volnei Garrafa, "The Common Morality Theory in the Work of Beauchamp and Childress," *Revista Bioética* 23 (2015), available at http://www.scielo.br/scielo.php?pid=S1983-80422015000300634&script=sci_arttext&tlng=en (accessed March 22, 2018). For a related, but distinguishable, criticism, see Anna E. Westra, Dick L. Willems, and Bert J. Smit, "Communicating with Muslim Parents: 'The Four Principles' Are not as Culturally Neutral as Suggested," *European Journal of Pediatrics* 168 (2009): 1383–87; this article is published together with a beautifully correct interpretation of our position by Voo Teck Chuan, "Editorial Comment: The Four Principles and Cultural Specification," *European Journal of Pediatrics* 168 (2009): 1389.

10. Kukla reaches this conclusion in "Living with Pirates." See, in response, Tom L. Beauchamp, "On Common Morality as Embodied Practice: A Reply to Kukla," *Cambridge Quarterly of Healthcare Ethics* 23 (2014): 86–93; Carson Strong, "Kukla's Argument against Common Morality as a Set of Precepts: On Stranger Tides," *Cambridge Quarterly of Healthcare Ethics* 23 (2014): 93–99; and Kukla, "Response to Strong and Beauchamp—at World's End," *Cambridge Quarterly of Healthcare Ethics* 23 (2014): 99–102.

11. See Richard B. Brandt, "Morality and Its Critics," in his *Morality, Utilitarianism, and Rights* (Cambridge: Cambridge University Press, 1992), chap. 5; and Gregory Mellema, "Moral Ideals and Virtue Ethics," *Journal of Ethics* 14 (2010): 173–80. See also our discussion of moral ideals and supererogation in Chapter 2, pp. 45–49.

12. Talcott Parsons, *Essays in Sociological Theory,* rev. ed. (Glencoe, IL: Free Press, 1954), p. 372. See further Jan Nolin, *In Search of a New Theory of Professions* (Borås, Sweden: University of Borås, 2008).

13. See the excellent introduction to this subject in Edmund D. Pellegrino, "Codes, Virtues, and Professionalism," in *Methods of Bioethics,* ed. Daniel Sulmasy and Jeremy Sugarman, 2nd ed. (Washington, DC: Georgetown University Press, 2010), pp. 91–108. For an overview of codes of medical ethics, see Robert Baker, "Medical Codes and Oaths," *Bioethics* [Formerly *Encyclopedia of Bioethics*], 4th ed., ed. Bruce Jennings (Farmington Hills, MI: Gale, Cengage Learning, Macmillan Reference USA, 2014), vol. 4, pp. 1935–46. For a history and assessment of the Code of Ethics for Nurses of the American Nurses Association, see Beth Epstein and Martha Turner, "The Nursing Code of Ethics: Its Value, Its History," *Online Journal of Issues in Nursing* 20, no. 2 (May 2015), available at http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-20-2015/No2-May-2015/The-Nursing-Code-of-Ethics-Its-Value-Its-History.html (accessed June 3, 2018).

14. The American Medical Association Code of Ethics of 1847 was largely adapted from Thomas Percival's *Medical Ethics; or a Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons* (Manchester, UK: S. Russell, 1803). See Donald E. Konold, *A History of American Medical Ethics 1847–1912* (Madison, WI: State Historical Society of Wisconsin, 1962), chaps. 1–3; Chester Burns, "Reciprocity in the Development of Anglo-American Medical Ethics," in *Legacies in Medical Ethics,* ed. Burns (New York: Science History Publications, 1977); and American Medical Association, "History of the Code," available at https://www.ama-assn.org/sites/default/files/media-browser/public/ethics/ama-code-ethics-history.pdf (accessed March 23, 2018).

15. For a related and rigorous critical analysis of Hippocratic and other medical codes, see Robert M. Veatch's influential views in his *Hippocratic, Religious, and Secular Medical Ethics: The Points of Conflict* (Washington, DC: Georgetown University Press, 2012).

16. Cf. the conclusions reached about medicine in N. D. Berkman, M. K. Wynia, and L. R. Churchill, "Gaps, Conflicts, and Consensus in the Ethics Statements of Professional Associations, Medical Groups, and Health Plans," *Journal of Medical Ethics* 30 (2004): 395–401; Ryan M. Antiel, Farr A. Curlin, C. Christopher Hook, and Jon C. Tilburt, "The Impact of Medical School Oaths and Other Professional Codes of Ethics: Results of a National Physician Survey," *Archives of Internal Medicine* 171 (2011): 469–71; Robert D. Orr, Norman Pang, Edmund D. Pellegrino, and Mark Siegler, "Use of the Hippocratic Oath: A Review of Twentieth Century Practice and a Content Analysis of Oaths Administered

in Medical Schools in the U.S. and Canada in 1993," *Journal of Clinical Ethics* 8 (1997): 377–88; and A. C. Kao and K. P. Parsi, "Content Analyses of Oaths Administered at U.S. Medical Schools in 2000," *Academic Medicine* 79 (2004): 882–87.

17. Jay Katz, ed., *Experimentation with Human Beings* (New York: Russell Sage Foundation, 1972), pp. ix–x.

18. For an examination of different models of public bioethics, see James F. Childress, "Reflections on the National Bioethics Advisory Commission and Models of Public Bioethics," *Goals and Practice of Public Bioethics: Reflections on National Bioethics Commissions*, special report, *Hastings Center Report* 47, no. 3 (2017): S20–S23, and several other essays in this special report. See also *Society's Choices: Social and Ethical Decision Making in Biomedicine*, ed. Ruth Ellen Bulger, Elizabeth Meyer Bobby, and Harvey V. Fineberg, for the Committee on the Social and Ethical Impacts of Developments in Biomedicine, Division of Health Sciences Policy, Institute of Medicine (Washington, DC: National Academies Press, 1995).

19. See Allen Buchanan, "Philosophy and Public Policy: A Role for Social Moral Epistemology," *Journal of Applied Philosophy* 26 (2009): 276–90; Will Kymlicka, "Moral Philosophy and Public Policy: The Case of New Reproductive Technologies," in *Philosophical Perspectives on Bioethics,* ed. L. W. Sumner and Joseph Boyle (Toronto: University of Toronto Press, 1996); Dennis Thompson, "Philosophy and Policy," *Philosophy & Public Affairs* 14 (Spring 1985): 205–18; Andrew I. Cohen, *Philosophy, Ethics, and Public Policy* (London: Routledge, 2015); and a symposium on "The Role of Philosophers in the Public Policy Process: A View from the President's Commission," with essays by Alan Weisbard and Dan Brock, *Ethics* 97 (July 1987): 775–95.

20. *Tarasoff v. Regents of the University of California,* 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (Cal. 1976).

21. On the interactions of ethical and legal judgments (and the reasons for their interactions) on bioethical issues, see Stephen W. Smith, John Coggan, Clark Hobson, et al., eds., *Ethical Judgments: Re-Writing Medical Law* (Oxford: Hart, 2016).

22. See John Lemmon, "Moral Dilemmas," *Philosophical Review* 71 (1962): 139–58; Daniel Statman, "Hard Cases and Moral Dilemmas," *Law and Philosophy* 15 (1996): 117–48; Terrance McConnell, "Moral Dilemmas," *Stanford Encyclopedia of Philosophy* (Fall 2014 edition), ed. Edward N. Zalta, available at https://plato.stanford.edu/archives/fall2014/entries/moral-dilemmas/ (accessed March 23, 2018); H. E. Mason, "Responsibilities and Principles: Reflections on the Sources of Moral Dilemmas," in *Moral Dilemmas and Moral Theory,* ed. H. E. Mason (New York: Oxford University Press, 1996).

23. Christopher W. Gowans, ed., *Moral Dilemmas* (New York: Oxford University Press, 1987); Walter Sinnott-Armstrong, *Moral Dilemmas* (Oxford: Basil Blackwell, 1988); Edmund N. Santurri, *Perplexity in the Moral Life: Philosophical and Theological Considerations* (Charlottesville: University Press of Virginia, 1987). For an approach to dilemmas offered as an addition to our account in this chapter, see Joseph P. DeMarco, "Principlism and Moral Dilemmas: A New Principle," *Journal of Medical Ethics* 31 (2005): 101–5.

24. Some writers in biomedical ethics express reservations about the place of the particular principles we propose in this book. See Pierre Mallia, *The Nature of the Doctor–Patient Relationship*: *Health Care Principles through the Phenomenology of Relationships with Patients* (Springer Netherlands: Springer Briefs in Ethics, 2013), esp. chap. 2, "Critical Overview of Principlist Theories"; K. Danner Clouser and Bernard Gert, "A Critique of Principlism," *Journal of Medicine and Philosophy* 15 (April 1990): 219–36; Søren Holm, "Not Just Autonomy—The Principles of American Biomedical Ethics," *Journal of Medical Ethics* 21 (1994): 332–38; Peter Herissone-Kelly, "The Principlist Approach to Bioethics, and Its Stormy Journey Overseas," in *Scratching the Surface of Bioethics,* ed. Matti Häyry and Tuija Takala (Amsterdam: Rodopi, 2003), pp. 65–77; and numerous essays in *Principles of Health Care Ethics,* ed. Raanan Gillon and Ann Lloyd (London: Wiley, 1994); and *Principles of Health Care Ethics,* 2nd ed., ed. Richard E. Ashcroft et al. (Chichester, UK: Wiley, 2007) .

25. Thomas Percival, *Medical Ethics; or a Code of Institutes and Precepts, Adapted to the Professional Interests of Physicians and Surgeons* (Manchester: S. Russell, 1803 [and numerous later editions]). For commentary on this classic work and its influence, see Edmund D. Pellegrino, "Percival's Medical Ethics: The Moral Philosophy of an 18th-Century English Gentleman," *Archives of Internal Medicine* 146 (1986): 2265–69; Pellegrino, "Thomas Percival's Ethics: The Ethics Beneath the Etiquette" (Washington DC: Georgetown University, Kennedy Institute of Ethics, 1984), available at https://repository.library.georgetown.edu/bitstream/handle/10822/712018/Pellegrino_M269.pdf?sequence=1&isAllowed=n (accessed March 24, 2018); Robert B. Baker, Arthur L. Caplan, Linda L. Emanuel, and Stephen R. Latham, eds., *The American Medical Ethics Revolution: How the AMA's Code of Ethics Has Transformed Physicians' Relationships to Patients, Professionals, and Society* (Baltimore: Johns Hopkins University Press, 1999).

26. Procedural rules might also be interpreted as grounded in substantive rules of equality. If so interpreted, the procedural rules could be said to have a justification in substantive rules.

27. For a discussion of the distinction between *pro tanto* and *prima facie,* see Shelly Kagan, *The Limits of Morality* (Oxford: Clarendon Press, 1989), p. 17. Kagan prefers *pro tanto,* rather than prima facie, and notes that Ross used *prima facie* with effectively the same meaning, which some writers classify as a mistake on Ross's part. See further Andrew E. Reisner, "Prima Facie and Pro Tanto Oughts," *International Encyclopedia of Ethics* [online], first published February 1, 2013, available at https://onlinelibrary.wiley.com/doi/full/10.1002/9781444367072.wbiee406 (accessed March 24, 2018).

28. W. D. Ross, *The Right and the Good* (Oxford: Clarendon Press, 1930), esp. pp. 19–36, 88. On important cautions about both the meaning and use of the related notion of "prima facie rights," see Joel Feinberg, *Rights, Justice, and the Bounds of Liberty* (Princeton, NJ: Princeton University Press, 1980), pp. 226–29, 232; and Judith Jarvis Thomson, *The Realm of Rights* (Cambridge, MA: Harvard University Press, 1990), pp. 118–29.

29. Robert Nozick, "Moral Complications and Moral Structures," *Natural Law Forum* 13 (1968): 1–50, available at https://scholarship.law.nd.edu/cgi/viewcontent.cgi?article=1136...naturallaw_forum (accessed March 26, 2018); James J. Brummer, "Ross and the Ambiguity of Prima Facie Duty," *History of Philosophy Quarterly* 19 (2002): 401–22. See also Thomas E. Hill, Jr., "Moral Dilemmas, Gaps, and Residues: A Kantian Perspective"; Walter Sinnott-Armstrong, "Moral Dilemmas and Rights"; and Terrance C. McConnell, "Moral Residue and Dilemmas"—all in *Moral Dilemmas and Moral Theory,* ed. Mason.

30. For a similar view, see Ross, *The Right and the Good,* p. 28.

31. Henry S. Richardson, "Specifying Norms as a Way to Resolve Concrete Ethical Problems," *Philosophy & Public Affairs* 19 (Fall 1990): 279–310; and Richardson, "Specifying, Balancing, and Interpreting Bioethical Principles," *Journal of Medicine and Philosophy* 25 (2000): 285–307, also in *Belmont Revisited: Ethical Principles for Research with Human Subjects,* ed. James F. Childress, Eric M. Meslin, and Harold T. Shapiro (Washington, DC: Georgetown University Press, 2005), pp. 205–27. See also David DeGrazia, "Moving Forward in Bioethical Theory: Theories, Cases, and Specified Principlism," *Journal of Medicine and Philosophy* 17 (1992): 511–39.

32. Richardson, "Specifying, Balancing, and Interpreting Bioethical Principles," p. 289.

33. For an excellent critical examination and case study of how the four-principles framework and approach can and should be used as a practical instrument, see John-Stewart Gordon, Oliver Rauprich, and Jochen Vollmann, "Applying the Four-Principle Approach," *Bioethics* 25 (2011): 293–300, with a reply by Tom Beauchamp, "Making Principlism Practical: A Commentary on Gordon, Rauprich, and Vollmann," *Bioethics* 25 (2011): 301–3.

34. American Academy of Psychiatry and the Law, "Ethical Guidelines for the Practice of Forensic Psychiatry," as revised and adopted May 2005, section III: "The informed consent of the person undergoing the forensic evaluation should be obtained when necessary and feasible. If the evaluee is not

competent to give consent, the evaluator should follow the appropriate laws of the jurisdiction. . . . [P]sychiatrists should inform the evaluee that if the evaluee refuses to participate in the evaluation, this fact may be included in any report or testimony. If the evaluee does not appear capable of understanding the information provided regarding the evaluation, this impression should also be included in any report and, when feasible, in testimony." Available at http://www.aapl.org/ethics.htm (accessed February 19, 2018).

35. Dennis H. Novack et al., "Physicians' Attitudes toward Using Deception to Resolve Difficult Ethical Problems," *Journal of the American Medical Association* 261 (May 26, 1989): 2980–85. We return to these problems in Chapter 8 (pp. 327–37).

36. Richardson, "Specifying Norms," p. 294. The word "always" in this formulation should be understood to mean "in principle always." Specification may, in some cases, reach a final form.

37. Other prohibitions, such as rules against murder and rape, may be absolute only because of the meaning of their terms. For example, to say "murder is categorically wrong" may be only to say "unjustified killing is unjustified."

38. Timothy Quill and Penelope Townsend, "Bad News: Delivery, Dialogue, and Dilemmas," *Archives of Internal Medicine* 151 (March 1991): 463–68.

39. See Alisa Carse, "Impartial Principle and Moral Context: Securing a Place for the Particular in Ethical Theory," *Journal of Medicine and Philosophy* 23 (1998): 153–69. For a defense of balancing as the best method in such situations, see Joseph P. DeMarco and Paul J. Ford, "Balancing in Ethical Deliberations: Superior to Specification and Casuistry," *Journal of Medicine and Philosophy* 31 (2006): 483–97, esp. 491–93.

40. See similar reflections in Lawrence Blum, *Moral Perception and Particularity* (New York: Cambridge, 1994), p. 204.

41. To the extent these six conditions incorporate moral norms, the norms are prima facie, not absolute. Condition 3 is redundant if it cannot be violated when all of the other conditions are satisfied; but it is best to be clear on this point, even if redundant.

42. See James F. Childress and Ruth Gaare Bernheim, "Public Health Ethics: Public Justification and Public Trust," *Bundesgundheitsblat: Gusundheitsforschung, Gesundheitsschutz* 51, no. 2 (February 2008): 158–63; and Ruth Gaare Bernheim, James F. Childress, Richard J. Bonnie, and Alan L. Melnick, *Essentials of Public Health Ethics: Foundations, Tools, and Interventions* (Boston: Jones and Bartlett, 2014), esp. chaps. 1, 2, and 8.

43. For a criticism of our conclusion in this paragraph, see Marvin J. H. Lee, "The Problem of 'Thick in Status, Thin in Content,' in Beauchamp and Childress's Principlism," *Journal of Medical Ethics* 36 (2010): 525–28. See further Angus Dawson and E. Garrard, "In Defence of Moral Imperialism: Four Equal and Universal Prima Facie Principles," *Journal of Medical Ethics* 32 (2006): 200–204; Walter Sinnott-Armstrong, *Moral Dilemmas,* pp. 216–27; and D. D. Raphael, *Moral Philosophy* (Oxford: Oxford University Press, 1981), pp. 64–65.

44. See Bernard Gert, Charles M. Culver, and K. Danner Clouser, *Bioethics: A Return to Fundamentals,* 2nd ed., chap. 4; Clouser and Gert, "A Critique of Principlism," pp. 219–36; Carson Strong, "Specified Principlism," *Journal of Medicine and Philosophy* 25 (2000): 285–307; John H. Evans, "A Sociological Account of the Growth of Principlism," *Hastings Center Report* 30 (September–October 2000): 31–38; Evans, *Playing God: Human Genetic Engineering and the Rationalization of Public Bioethical Debate* (Chicago: University of Chicago Press, 2002); and Evans, *The History and Future of Bioethics: A Sociological View* (New York: Oxford University Press, 2011). For a critical analysis of Evans's arguments, particularly in *Playing God*, see James F. Childress, "Comments," *Journal of the Society of Christian Ethics* 24, no. 1 (2004): 195–204.

2

Moral Character

Chapter 1 concentrated on moral norms in the form of principles, rules, obligations, and rights. This chapter focuses on moral character, especially moral virtues, moral ideals, and moral excellence. These categories complement those in the previous chapter. The moral norms discussed in Chapter 1 chiefly govern right and wrong *action*. By contrast, character ethics and virtue ethics concentrate on the *agent* who performs actions and the virtues that make agents morally worthy persons.[1]

The goals and structure of medicine, health care, public health, and research call for a deep appreciation of moral virtues. What often matters most in health care interactions and in the moral life generally is not adherence to moral rules but having a reliable character, good moral sense, and appropriate emotional responsiveness. Even carefully specified principles and rules do not convey what occurs when parents lovingly play with and nurture their children or when physicians and nurses exhibit compassion, patience, and responsiveness in their encounters with patients and families. The feelings and concerns for others that motivate us to take actions often cannot be reduced to a sense of obligation to follow rules. Morality would be a cold and uninspiring practice without appropriate sympathy, emotional responsiveness, excellence of character, and heartfelt ideals that reach beyond principles and rules.

Some philosophers have questioned the place of virtues in moral theory. They see virtues as less central than action-guiding norms and as difficult to unify in a systematic theory, in part because there are many independent virtues to be considered. Utilitarian Jeremy Bentham famously complained that there is "no marshaling" the virtues and vices because "they are susceptible of no arrangement; they are a disorderly body, whose members are frequently in hostility with one another. . . . Most of them are characterized by that vagueness which is a convenient instrument for the poetical, but dangerous or useless to the practical moralist."[2]

Although principles and virtues are different and learned in different ways, virtues are no less important in the moral life, and in some contexts are probably more important. In Chapter 9, we examine virtue ethics as a type of moral theory and address challenges and criticisms such as Bentham's. In the first few sections of the present chapter, we analyze the concept of virtue; examine virtues in professional roles; treat the moral virtues of care, caregiving, and caring in health care; and explicate five other focal virtues in both health care and research.

THE CONCEPT OF MORAL VIRTUE

A *virtue* is a dispositional trait of character that is socially valuable and reliably present in a person, and a *moral virtue* is a dispositional trait of character that is morally valuable and reliably present. If cultures or social groups approve a trait and regard it as moral, their approval is not sufficient to qualify the trait as a moral virtue. Moral virtue is more than a personal, dispositional trait that is socially approved in a particular group or culture.[3] This approach to the moral virtues accords with our conclusion in Chapter 1 that the common morality excludes provisions found only in so-called cultural moralities and individual moralities. The moral virtues, like moral principles, are part of the common morality.

Some define the term *moral virtue* as a disposition to act or a habit of acting in accordance with, and with the aim of following, moral principles, obligations, or ideals.[4] For example, they understand the moral virtue of nonmalevolence as the trait of abstaining from causing harm to others when it would be wrong to cause harm. However, this definition unjustifiably views virtues as merely derivative from and dependent on principles and fails to capture the importance of moral motives. We care morally about people's motives, and we care especially about their characteristic motives and dispositions, that is, the motivational structures embedded in their character. Persons who are motivated through impartial sympathy and personal affection, for example, are likely to meet our moral approval, whereas persons who act similarly, but are motivated merely by personal ambition, do not.

Consider a person who discharges moral obligations only because they are moral requirements while intensely disliking being obligated to place the interests of others above his or her personal interests and projects. This person does not feel friendly toward or cherish others and respects their wishes only because moral obligation requires it. If this person's motive is deficient, a critical moral ingredient is missing even though he or she consistently performs morally right actions and has a disposition to perform right actions. When a person characteristically lacks an appropriate motivational structure, a necessary condition of virtuous character is absent. The act may be right and the actor blameless, but neither the act nor the actor is *virtuous*. People may be disposed to do what is right, intend to do it, and do it, while simultaneously yearning to avoid doing it. Persons who characteristically perform morally right actions from such a motivational structure are not morally virtuous even if they invariably perform the morally right action.

Such a person has a morally deficient character, and he or she performs morally right actions for reasons or feelings disconnected from moral motivation. A philanthropist's gift of a new wing of a hospital will be recognized by hospital officials and by the general public as a generous gift, but if the philanthropist is motivated only by a felt need for public praise and only makes the gift to gain such praise, there is a discordance between those feelings and the performance of the praised action. Feelings, intentions, and motives are morally important in a virtue theory in a way that may be lost or obscured in an obligation-based theory.[5]

VIRTUES IN PROFESSIONAL ROLES

Persons differ in their sets of character traits. Most individuals have some virtues and some vices while lacking other virtues and vices. However, all persons with normal moral capacities can cultivate the character traits centrally important to morality such as honesty, fairness, fidelity, truthfulness, and benevolence. In professional life in health care and research, the traits that warrant encouragement and admiration often derive from role responsibilities. Some virtues are essential for enacting these professional roles, and certain vices are intolerable in professional life. Accordingly, we turn now to virtues that are critically important in professional and institutional roles and practices in biomedical fields.

Virtues in Roles and Practices

Professional roles are grounded in institutional expectations and governed by established standards of professional practice. Roles internalize conventions, customs, and procedures of teaching, nursing, doctoring, and the like. Professional practice has traditions that require professionals to cultivate certain virtues. Standards of virtue incorporate criteria of professional merit, and possession of these virtues disposes persons to act in accordance with the objectives of the practices.

In the practice of medicine, several goods internal to the profession are appropriately associated with being a good physician. These goods include specific moral and nonmoral skills in the care of patients, the application of specific forms of knowledge, and the teaching of health behaviors. They are achievable only if one lives up to the standards of the good physician, standards that in part define the practice. A practice is not merely a set of technical skills. Practices should be understood in terms of the respect that practitioners have for the goods internal to the practices. Although these practices sometimes need to be revised, the historical development of a body of standards has established many practices now found at the heart of medicine, nursing, and public health.[6]

Roles, practices, and virtues in medicine, nursing, and other health care and research professions reflect social expectations as well as standards and ideals internal to these professions.[7] The virtues we highlight in this chapter are care—a fundamental virtue for health care relationships—along with five focal virtues found in all health care professions: compassion, discernment, trustworthiness, integrity, and conscientiousness, all of which support and promote caring and caregiving. Elsewhere in this chapter and in later chapters, we discuss other virtues, including respectfulness, nonmalevolence, benevolence, justice, truthfulness, and fidelity.

To illustrate the difference between standards of moral character in a profession and standards of technical performance in a profession, we begin with an instructive study of surgical error. Charles L. Bosk's influential *Forgive and Remember: Managing Medical Failure* presents an ethnographic study of the way two surgical services handle medical failure, especially failures by surgical residents in "Pacific Hospital" (a name substituted for the hospitals actually studied).[8] Bosk found that both surgical services distinguish, at least implicitly, between several different forms of error or mistake. The first form is *technical*: A professional discharges role responsibilities conscientiously, but his or her technical training or information still falls short of what the task requires. Every surgeon will occasionally make this sort of mistake. A second form of error is *judgmental*: A conscientious professional develops and follows an incorrect strategy. These errors are also to be expected. Attending surgeons forgive momentary technical and judgmental errors but remember them in case a pattern develops indicating that a surgical resident lacks the technical and judgmental skills to be a competent surgeon. A third form of error is *normative*: A physician violates a norm of conduct or fails to possess a moral skill, particularly by failing to discharge moral obligations conscientiously or by failing to acquire and exercise critical moral virtues such as conscientiousness. Bosk concludes that surgeons regard technical and judgmental errors as less important than moral errors, because every conscientious person can be expected to make "honest errors" or "good faith errors," whereas moral errors such as failures of conscientiousness are considered profoundly serious when a pattern indicates a defect of character.

Bosk's study indicates that persons of high moral character acquire a reservoir of goodwill in assessments of either the praiseworthiness or the blameworthiness of their actions. If a conscientious surgeon and another surgeon who is not adequately conscientious make the same technical or judgmental errors, the conscientious surgeon will not be subjected to moral blame to the same degree as the other surgeon.

Virtues in Different Professional Models

Professional virtues were historically integrated with professional obligations and ideals in codes of health care ethics. Insisting that the medical profession's "prime objective" is to render service to humanity, an American Medical Association (AMA) code in effect from 1957 to 1980 urged the physician to be "upright" and "pure in character and . . . diligent and conscientious in caring for the sick." It endorsed the virtues that Hippocrates commended: modesty, sobriety, patience, promptness, and piety. However, in contrast to its first code of 1847, the AMA over the years has increasingly de-emphasized virtues in its codes.

The 1980 version for the first time eliminated all trace of the virtues except for the admonition to expose “those physicians deficient in character or competence.” This pattern of de-emphasis regrettably still continues.

Thomas Percival’s 1803 book, *Medical Ethics*, is a classic example of an attempt to establish the proper set of virtues in medicine. Starting from the assumption that the patient’s best medical interest is the proper goal of medicine, Percival reached conclusions about the good physician’s traits of character, which were primarily tied to responsibility for the patient’s medical welfare.[9] This model of medical ethics supported medical paternalism with effectively no attention paid to respect for patients’ autonomous choices.

In traditional nursing, where the nurse was often viewed as the “handmaiden” of the physician, the nurse was counseled to cultivate the passive virtues of obedience and submission. In contemporary models in nursing, by contrast, active virtues have become more prominent. For example, the nurse’s role is now often regarded as one of advocacy for patients.[10] Prominent virtues include respectfulness, considerateness, justice, persistence, and courage.[11] Attention to patients’ rights and preservation of the nurse’s integrity also have become increasingly prominent in some contemporary models.

The conditions under which ordinarily praiseworthy virtues become morally unworthy present thorny ethical issues. Virtues such as loyalty, courage, generosity, kindness, respectfulness, and benevolence at times lead persons to act inappropriately and unacceptably. For instance, the physician or nurse who acts kindly and loyally by not reporting the incompetence of a fellow physician or nurse acts unethically. This failure to report misconduct does not suggest that loyalty and kindness are not virtues. It indicates only that the virtues need to be accompanied by an understanding of what is right and good and of what deserves loyalty, kindness, generosity, and the like.

The Central Virtue of Caring

As the language of *health care*, *medical care*, and *nursing care* suggests, the virtue of care, or caring, is prominent in professional ethics. We treat this virtue as fundamental in relationships, practices, and actions in health care. In explicating this family of virtues we draw on what has been called the *ethics of care*, which we interpret as a form of virtue ethics.[12] The ethics of care emphasizes traits valued in intimate personal relationships such as sympathy, compassion, fidelity, and love. *Caring* refers to care for, emotional commitment to, and willingness to act on behalf of persons with whom one has a significant relationship. *Caring for* is expressed in actions of “caregiving,” “taking care of,” and “due care.” The nurse’s or physician’s trustworthiness and quality of care and sensitivity in the face of patients’ problems, needs, and vulnerabilities are integral to their professional moral lives.

The ethics of care emphasizes what physicians and nurses do—for example, whether they break or maintain confidentiality—and how they perform those actions, which motives and feelings underlie them, and whether their actions promote or thwart positive relationships.

The Origins of the Ethics of Care

The ethics of care, understood as a form of philosophical ethics, originated and continues to flourish in feminist writings. The earliest works emphasized how women display an ethic of care, by contrast to men, who predominantly exhibit an ethic of rights and obligations. Psychologist Carol Gilligan advanced the influential hypothesis that "women speak in a different voice"—a voice that traditional ethical theory failed to appreciate. She discovered "the voice of care" through empirical research involving interviews with girls and women. This voice, she maintained, stresses empathic association with others, not based on "the primacy and universality of individual rights, but rather on . . . a very strong sense of being responsible."[13]

Gilligan identified two modes of moral thinking: an ethic of care and an ethic of rights and justice. She did not claim that these two modes of thinking strictly correlate with gender or that all women or all men speak in the same moral voice.[14] She maintained only that men tend to embrace an ethic of rights and justice that uses quasi-legal terminology and impartial principles, accompanied by dispassionate balancing and conflict resolution, whereas women tend to affirm an ethic of care that centers on responsiveness in an interconnected network of needs, care, and prevention of harm.[15]

Criticisms of Traditional Theories by Proponents of an Ethics of Care

Proponents of the care perspective often criticize traditional ethical theories that tend to de-emphasize virtues of caring. Two criticisms merit consideration here.[16]

Challenging impartiality. Some proponents of the care perspective argue that theories of obligation unduly telescope morality by overemphasizing detached fairness. This orientation is suitable for some moral relationships, especially those in which persons interact as equals in a public context of impersonal justice and institutional constraints, but moral detachment also may reflect a lack of caring responsiveness. In the extreme case, detachment becomes uncaring indifference. Lost in the *detachment* of impartiality is an *attachment* to what we care about most and is closest to us—for example, our loyalty to family, friends, and groups. Here partiality toward others is morally permissible and is an expected form of interaction. This kind of partiality is a feature of the human condition without which we might impair or sever our most important relationships.[17]

Proponents of a care ethics do not recommend complete abandonment of principles if principles are understood to allow room for discretionary and contextual judgment. However, some defenders of the ethics of care find principles largely irrelevant, ineffectual, or unduly constrictive in the moral life. A defender of principles could hold that principles of care, compassion, and kindness tutor our responses in caring, compassionate, and kind ways. But this attempt to rescue principles seems rather empty. Moral experience confirms that we often do rely on our emotions, capacity for sympathy, sense of friendship, and sensitivity to find appropriate moral responses. We could produce rough generalizations about how caring clinicians should respond to patients, but such generalizations cannot provide adequate guidance for all interactions. Each situation calls for responses beyond following rules, and actions that are caring in one context may be offensive or even harmful in another.

Relationships and emotion. The ethics of care places special emphasis on mutual interdependence and emotional responsiveness. Many human relationships in health care and research involve persons who are vulnerable, dependent, ill, and frail. Feeling for and being immersed in the other person are vital aspects of a moral relationship with them.[18] A person seems morally deficient if he or she acts according to norms of obligation without appropriately aligned feelings, such as concern and sympathy for a patient who is suffering. Good health care often involves insight into the needs of patients and considerate attentiveness to their circumstances.[19]

In the history of human experimentation, those who first recognized that some subjects of research were brutalized, subjected to misery, or placed at unjustifiable risk were persons able to feel sympathy, compassion, disgust, and outrage about the situation of these research subjects. They exhibited perception of and sensitivity to the feelings of subjects where others lacked comparable perceptions, sensitivities, and responses. This emotional sensitivity does not reduce moral response to emotional response. Caring has a cognitive dimension and requires a range of moral skills that involve insight into and understanding of another's circumstances, needs, and feelings.

One proponent of the ethics of care argues that action is sometimes appropriately principle-guided, but not necessarily always governed by or derived from principles.[20] This statement moves in the right direction for construction of a comprehensive moral framework. We need not reject principles of obligation in favor of virtues of caring, but moral judgment involves moral skills beyond those of specifying and balancing general principles. An ethic that emphasizes the virtues of caring well serves health care because it is close to the relationships and processes of decision making found in clinical contexts, and it provides insights into basic commitments of caring and caretaking. It also liberates health professionals from the narrow conceptions of role responsibilities that have been delineated in some professional codes of ethics.

FIVE FOCAL VIRTUES

We now turn to five focal virtues for health professionals: compassion, discernment, trustworthiness, integrity, and conscientiousness. These virtues are important for the development and expression of caring, which we have presented as a fundamental orienting virtue in health care. These five additional virtues provide a moral compass of character for health professionals that builds on centuries of thought about health care ethics.[21]

Compassion

Compassion, says Edmund Pellegrino, is a "prelude to caring."[22] The virtue of compassion combines an attitude of active regard for another's welfare together with sympathy, tenderness, and discomfort at another's misfortune or suffering.[23] Compassion presupposes sympathy, has affinities with mercy, and is expressed in acts of beneficence that attempt to alleviate the misfortune or suffering of another person.

Nurses and physicians must understand the feelings and experiences of patients to respond appropriately to them and their illnesses and injuries—hence the importance of empathy, which involves sensing or even reconstructing another person's mental experience, whether that experience is negative or positive.[24] As important as empathy is for compassion and other virtues, the two are different, and empathy does not always lead to compassion. Some literature on professionalism in medicine and health care now focuses on empathy rather than compassion, but this literature risks making the mistake of viewing empathy alone as sufficient for humanizing medicine and health care while overlooking its potential dangers.[25]

Compassion generally focuses on others' pain, suffering, disability, or misery—the typical occasions for compassionate response in health care. Using the language of *sympathy*, eighteenth-century philosopher David Hume pointed to a typical circumstance of compassion in surgery and explained how such feelings arise:

> Were I present at any of the more terrible operations of surgery, 'tis certain, that even before it begun, the preparation of the instruments, the laying of the bandages in order, the heating of the irons, with all the signs of anxiety and concern in the patient and assistants, wou'd have a great effect upon my mind, and excite the strongest sentiments of pity and terror. No passion of another discovers itself immediately to the mind. We are only sensible of its causes or effects. From *these* we infer the passion: And consequently *these* give rise to our sympathy.[26]

Physicians and nurses who express little or no compassion in their behavior may fail to provide what patients need most. The physician, nurse, or social worker altogether lacking in the appropriate display of compassion has a moral weakness. However, compassion also can cloud judgment and preclude rational