A Comparison of Two Bioethical Theories

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ABSTRACT

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This thesis compares two bioethical theories in order to determine which theory is better for use by medical professionals. The two theories are Tom L. Beauchamp and James Childress’s “Principlism” and Bernard Gert, K. Danner Clouser, and Charles M. Culver’s “Moral Rules.” The structure of the paper is as follows: an explication of both theories, an examination of the similarities and differences between the theories, an evaluation of criticisms of both theories, and identification of the three advantages the Moral Rules theory has over Principlism. In the conclusion, I claim the Moral Rules is the better bioethical theory for the medical profession.

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CHAPTER 1: INTRODUCTION

This paper compares two theories of bioethics in order to determine which theory is better able for use by the medical profession. The theories are Tom L. Beauchamp and James Childress’s “Principlism” and Bernard Gert, K. Danner Clouser, and Charles M. Culver’s “Moral Rules.” The chapters in this paper unfold as follows. The first chapter is a synopsis of Principlism, the role of obligations, rules, its version of common morality, and specification. The second chapter is a synopsis of the Moral Rules with a focus on its version of the common morality, ten moral rules, and its rule violation process. The third chapter highlights similarities and differences between the two theories. The similarities between the theories are that each theory uses common morality is the foundational justification, both theories heavy reliance on principles and rules, and the overarching emphasis these theories being practical over philosophical. The central point of contention between these theories is the role beneficence to plays. The fourth chapter is a criticism of Principlism. This chapter illustrates the areas where Gert’s Moral Rules has distinct advantages over Principlism. The fifth chapter criticizes the application of the Moral Rules and the implied assumption that common morality is a consistent set of beliefs. The final chapter is why the Moral Rules gives the medical professional three advantages when dealing with bioethical dilemmas. The first advantage is the Moral Rule theory is systematic and therefore clear and concise for use by medical professionals. Second, the Moral Rules places greater emphasis on the inevitability of moral disagreement than Principlism. Third, the Moral Rules emphasis on nonmaleficence
makes it better equipped to deal with future dilemmas resulting from medical and technological breakthroughs.

**Principlism**

Principlism is an ethical theory created by Tom L. Beauchamp and James Childress to serve as a guideline (or “chapter headings”) in evaluating and guiding decisions in bioethical cases.¹ Principlism is not just four principles; its foundation is in a common morality and the use of a process called specification to fill out the features of a case. Specification balances and ranks these principles. This chapter divides into five sections: an overview of the four principles, the common morality foundation from which Principlism draws its moral norms from, the process of specification and the rules it entails, how to rank the principles in applications to cases, and finally an in-depth analysis of the individual principles. The majority of this chapter will deal with the principles of autonomy, nonmaleficence, and beneficence. The principle of justice warrants a longer and thorough explanation, but for the purposes of this paper, it receives a brief exposition. The two reasons for shortchanging justice is that to do a fair assessment on the principle of justice would take an enormous amount of explication in simply defining various theories of justice and length restraints prevent this for the paper. The second reason is that I am unclear as to the impact or use of this principle as Beauchamp and Childress intend. For the purposes of this paper, we will subsume the principle of justice under the principle of beneficence. This is certainly an unfair position on the principle of justice, for Beauchamp and Childress highlight issues of justice and injustice in the health care system. While there are clear issues of justice in the health

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¹ Although the term “Principlism” was not the moniker given by the authors, through its ubiquitous use by other philosophers the term has stuck.
care system, it is unclear how these relate to Beauchamp and Childress’s principle of justice. Nonetheless, for the purpose of the paper we will minimize the explication of the principle of justice.

Principlism is composed of four principles: autonomy, nonmaleficence, beneficence, and justice. These are all obligations that members of the medical profession must consider when faced with bioethical dilemmas. “(1) Respect for autonomy (a norm of respecting the decision-making capacities of autonomous persons). (2) Nonmaleficence (a norm of avoiding the causation of harm). (3) Beneficence (a group of norms for providing benefits and balancing benefits against risk and costs). (4) Justice (a group of norms for distributing benefits, risks, and costs fairly)” (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 12). Beauchamp and Childress also define the obligations with reference to norms as the following. While certain case specifics may emphasize one principle over another, no principle has prima facie authority over another principle. The specifics of the case determine which principle is important. In certain cases, beneficence may be more important than respecting the patient’s autonomy. An example is vaccination of children. The benefits of vaccination of the infant outweigh infringing on the parent’s autonomy. In this example, the principle of beneficence overrides the principle of autonomy.

Principlism attempts to provide medical professionals with an ethical guide to work with when making rather difficult bioethical decisions. Beauchamp and Childress insist they have not created a general ethical theory, but a practical guide for the medical community to use.
Common morality

Beauchamp and Childress claim Principlism has a foundation in ‘common morality’. Defined by Beauchamp and Childress, common morality is a set of moral norms that most cultures already use in practice or agree with. Anyone who is serious about being a moral person would already grasp the core dimensions that morality entails. As Beauchamp writes about the people who grasp what morality entails, “they know not to lie, not to steal property, to keep promises, to respect the rights of others, not to kill or cause harm to innocent persons, and the like” (Beauchamp, 2001, p.3). Beauchamp and Childress’s conception of the “common morality” is similar to a common sense idea of morality, i.e., if you are a person who wants to act morally, then these are the moral norms you would follow (and largely, most in society already do). These moral norms are not individualistic, but cultural and societal.

While the general norms of Principlism stem from a common morality, the philosophical underpinning of Principlism contains diverse selections of other philosophical theories: utilitarianism, contract theory, communitarianism, Kant, and Rawl’s theory of justice. Principlism as a philosophical theory is an aggregate theory influenced by, and constructed from, selected sections of other philosophical theories. However, Principlism applies terms from other philosophical theories in nonstandard ways. An example is the use of the Kantian notion of autonomy. One cannot deny the influence Kant’s concept of autonomy has on the principle of autonomy. However, Kant’s notion of autonomy was quite different, “Persons have ‘autonomy of the will’ for Kant if and only if they knowingly act in accordance with the universally valid principles that pass the requirements of the categorical imperative” (Beauchamp and Childress,
Principles of Biomedical Ethics 2001, 351). Beauchamp and Childress’s principle of autonomy focuses on the ability to make decisions. This nonstandard use of “classic” philosophical terms often results in a more concise use of the terms. Nonetheless, despite the fact that within Principlism there is mixture of differing philosophical theories, it would be a misunderstanding to consider Principlism a purely philosophical theory. As Beauchamp and Childress state, “we have found that careful attention of actual moral practices often yields more insight into the moral life than general theories” (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 338).

The Process of Principlism: Specification, and Rules

For Beauchamp and Childress specification is the act of filling out relevant facts of the case in accordance with a principle or in conjunction with multiple principles. Beauchamp describes the process of specification as “a process of reducing the indeterminateness of general norms to give them increased action guiding capacity while retaining the moral commitments of the original norm.” The principles move from vague abstract concepts to fine-grain prescriptive rules. The principles are too general and abstract and when applied to a specific case they lack depth of content. “Specification involves a progressive filling in and development of abstract content of principles, shedding their indeterminateness and thereby providing action-guiding content” (T. L. Beauchamp 2000, 344). Specification is the range and scope of the bioethical dilemma. An easy example of specification of a principle is a patient diagnosed with dementia. The principle of autonomy is the obligation to respect the decisions of an autonomous person. Specification of the principle removes the indeterminateness and clarifies the content. After specification, the restating of the principle is, “if the patient is found to be
incompetent then the decision-making authority passes to the family.” In this example, the range and scope of the principle focuses on the specific context of the patient’s diagnosis of brain dementia.

The importance of specification is the removal of theoretical abstractness for a specified principle. “Increase of substance through specification is essential for decision-making in clinical and ethical research ethics, as well as for the development of policy (institutional policies and public policies)” (T. L. Beauchamp 2000, 343).

While each principle undergoes specification, these principles also support a subset of rules. The term “supports” means the principle, or principles, give the rule there justification. The rule builds up from a generalization to a specific rule from this base of justification. A principle supports a rule and this rule elaborates on the requirements of the principles in a general sense. The rule is a contextualized version of the principle applied to the dilemma or issue at hand. For example, the principle of nonmaleficence support the rule “do not cause pain and suffering.” The principle of autonomy supports the rule “protect confidential information.” Different principles can also support or justify the same rule, e.g. autonomy, nonmaleficence, and beneficence support the rule “protect confidential information.”

The rules prescribe or prohibit certain actions or acts. “Principles are general norms that leave considerable room for judgment in many cases. They thus do not function as precise action guides that inform us in each circumstance how to act in the way that more detailed rules and judgments do” (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 13). The subset of rules a principle, or principles, support are of three types: substantive rules, authority rules, and procedural rules. Examples of
substantive rules are ones of truth telling, confidentiality, informed consent, and “the rationing of health care providing more specific guides to action than do abstract principles.” Authority rules defend decisional authority i.e., “that is, rules regarding who may and should perform actions.” An example is the decision-making authority passed to family members when a patient becomes incompetent. Procedural rules are “rules that establish procedures to be followed” or defend these procedural rules. We rely on procedural rules if substantive rules and authoritative rules are indeterminate, such as in cases of scarcity of medical resources or specifically in cases of organ donations (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 13-15). An example of procedural rules is how consent for an autopsy obtained from the next of kin.

1. Surviving spouse. If none, then
2. Adult Children. If none, then
3. Parents. If none, then
4. Brothers and sisters. If none, then
5. Any relative (or friend) who assumes custody of the body.
6. If none of the above can be found 48 hours after death, hospital administration can give consent.2

Rules specifically prescribe and prohibit what the principles prescribe and prohibit generally. The principles are general norms; the process of specification provides specific rules. The rules and specification bring the principles to a state of reflective equilibrium.3 Without the specification, we can only rely on the principles. That is why some refer to the principles as being “chapter headings.” Upon revelation of the facts, the contents (rules) of the chapter present themselves. The rule is the final prescriptive or prohibitive action, but the principle is the final justification.

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2 (Junkerman and Schiedermaer 1998)
3 Reflective equilibrium is a philosophical confusing term. While the terms usage is ubiquitous amongst philosophers, rarely are its implications and entailments examined. The concept of “reflective equilibrium” is difficult. For the purpose of this paper I will not explore the problems of reflective equilibrium outside of noting them, but take reflective equilibrium as a given.
Ranking of principles

Ranking the principles in a bioethical case is in regards to the relation of the principle to the importance of the relevant features of the case. Through the process of specification, relevant features of the case become present. However, the principles must also be “balanced.” Balancing a principle is weighting the norms involved to help in dictating the rank of the principle. An example used by Beauchamp and Childress for understanding “balance” is the case of a physician who has promised to drop her son off at the library. Soon afterward, she encounters an emergency and may have to stay through the night. Does she break the promise to her son and attend to the patient, or does she break her obligation to the patient and drop her son off at the library. In this example, the obligation to the patient outweighs (or is stronger) than the obligation to the child.

Beauchamp and Childress provide six conditions for restrictions of balancing.

1. Better reasons can be offered to act on the overriding norm than on the infringed principle (e.g., if persons have a right, their interests generally deserve a special place when balancing those interests against the interests of persons who have no comparable right).
2. The moral objective justifying the infringement must have a realistic prospect of achievement.
3. The infringement is necessary in that no morally preferable alternative actions can be substituted.
4. The infringement selected must be the least possible infringement, commensurate with achieving the primary goal of action.
5. The agent must seek to minimize any negative effects of the infringement.
6. The agent must act impartially in regard to all affected parties; that is, the agent’s decision must not be influenced by morally irrelevant information about any party. ⁴

Beauchamp and Childress admit there is no methodology for ranking their principles and the process of ranking is more complex than just taking into account specification and balancing of principles. “In the process of specifying and balancing

⁴ (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 19-20)
norms and in making particular judgments, we often must take into account factual beliefs about the world, cultural expectations, judgments of likely outcomes, and precedents previously encountered to help fill out and give weight to rules, principles, and theories (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 387).

While the process of ranking involves specification and balancing, it also involves arriving at level of “coherence” or “reflective equilibrium.” Reflective equilibrium is concept taken from John Rawls. Reflective equilibrium means to adjust, re-adjust, and match our judgments until there is coherence with our general moral norms (or in Beauchamp’s case principles). As explained by Carson Strong, “According to this idea (reflective equilibrium/coherence), when our considered judgments about cases conflict with our ethical principles, the principles and judgments should be modified until there is no conflict- until an equilibrium is reached” (Strong 2000, 324-325). An example of reflective equilibrium is that if one does not believe in an afterlife, one should re-adjust their judgments such that organ donation is no longer an unethical decision for them. The process of ranking a case is as follows. The process of specification determines the range and the scope while balancing weights principles/norms, and achieving reflective equilibrium by adjusting the rule until coherence between it (the rule) and the principles. Beauchamp and Childress fully understand the complexities of this approach and fully acknowledge the difficulty in ranking principle. “Honesty about the process of balancing and overriding compels us to return to our earlier discussion of dilemmas and

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5 This is, admittedly, a weak example. Again, the problems of reflective equilibrium are unexplained. The apparently impact of reflective equilibrium on a moral theory is quite vague. What is the impact of “re-adjustment of considered judgments” on the overarching moral theory? How is one to know if a post reflective equilibrium is correct? As Gert states, “Reflective equilibrium not only mistakenly seems to presuppose that there is a unique right answer to all moral questions, it also mistakenly seems to regard a moral theory as generating answers” (B. Gert, Morality: Its Nature and Justification 2005, 381)
acknowledge that in some circumstances we will not be able to determine which moral norm is overriding” (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 21).⁶

**Autonomy**

*The obligation to respect the decisions of an autonomous person*

If medical professionals did not respect a patient’s autonomous decision-making capacity the medical profession would reduce into paternalism because the patients would have no ability to choose or refuse treatments. Paternalism removes the decision-making process from the patient and allows the medical professional to decide all treatments without properly consulting or accounting for the patient’s preference.

However, common sense indicates with the complexity of medical procedures and people’s beliefs coming in all varieties, conflict will undoubtedly occur during which patients may request or refuse certain treatments. Although Beauchamp and Childress explicate autonomy first, it does not have priority over the other principles. Autonomy’s use is as a concept to examine an individual’s decisions within the healthcare profession. Beauchamp and Childress’s principle of autonomy must be able to navigate a minefield of practical and philosophical problems:

> We aim to construct a concept of respect for autonomy that is not excessively individualistic (neglecting social nature of individuals and the impact of individual choices and actions on others), not excessively focused on reason (neglecting emotions), and not unduly legalistic (highlighting legal rights and downplaying social practices).

The concept of autonomy presented by Beauchamp and Childress is fluid and pliable, making it applicable to the medical professional.

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⁶ Beauchamp and Childress provide no examples of problems for specification. However, reexamination of this issue occurs in the section of criticism on Principlism
The principle of autonomy states that a medical professional has the obligation to respect a person’s decisions: “to respect an autonomous agent is, at a minimum to acknowledge that person’s right to hold views, to make choices, and to take actions based on personal values and beliefs” (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 63). Beauchamp and Childress insist on its importance, noting that, “the fundamental requirement is to respect a particular person’s autonomous choices. Respect for autonomy is not a mere ideal in health care it is a professional obligation. Autonomous choice is a right, not a duty of patients” (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 63). It is not the duty of the patient to make every medical decision. However, patients do have the right to decide whether to accept or deny the treatment. On the other hand, there are restrictions on who is autonomous, the following is an incomplete list of restrictions, but it gives a brief overview on types of restrictions to a person’s autonomy. Age restrictions limit the decision-making process for some, e.g., infants and children. There are restrictions on those who are mentally handicapped or those who are incapable of competency due to incapacitation by pain or to drug dependence. There are restrictions on adults who have lost the capacity to make autonomous decisions, e.g. an elderly patient suffering from advanced dementia does not have the decision-making capacity for decisions regarding treatments.

7 Emphasis in original
Competence

Competence is the key concept in understanding and determining who is autonomous. Autonomy is also another concept that is fluid and pliable, therefore hard to define. Beauchamp and Childress contend the core meaning of competency as “the ability to perform a task.” In this core sense and medical context, Beauchamp and Childress take competency as the patient has the ability to perform the task of decision-making for their own well-being. Beauchamp and Childress make a clear distinction between two types of competence: global and specific. A global definition of competence is a person able to perform all the tasks life requires. However, this is not always adequate, e.g., there are people who are competent drivers, but utter failures when it comes to be balancing their finances. Both activities contain complex movements, thoughts, and considerations, but inevitably, some people are incompetent in one area and not the other. Nevertheless, would we view these people as being incompetent? The approach of globally confirming competence falsely assumes that because the patient (person) cannot properly make decisions about one area of their life (finances), they cannot make proper decisions in the other areas (driving). For Beauchamp and Childress, it is best to understand competency in a specific medical context. A person is incompetent if they cannot perform the required task of making decisions regarding their medical treatment. The three areas of decision-making capacity (competence) that physicians examine are ability to understand, ability to evaluate, and ability to communicate.

Ability to understand:
- The ability to comprehend the given information about the diagnosis and treatment and to identify the issues at hand (to test this, ask the patient to paraphrase the discussion.)
• The ability to appreciate the impact of the disease and its consequences (To test this, ask the patient to state the major options and the most likely outcome for each option.)

Ability to evaluate:
• The ability to deliberate in accordance with one’s own values.
• The ability to manipulate information rationally and to compare risks and benefits of the options
• The ability to make choices that are not irrational and to give reasons for them
• The ability to maintain a consistent choice over time.

Ability to communicate:
1. The ability to communicate choices (To test this, ask the patient to state his or her choice of treatment options.)

This process for examining the patient’s decision-making capacity is not definitive, for there are varying degrees of competence. The problem is that no succinct definition or ranking of competency can adequately avoid all the pitfalls of certain cases. Therefore, if the procedure or risk involved in a treatment is low, the level of competence should be proportional to the risk. For Beauchamp and Childress there are no levels of competency, but a threshold- is the patient able to make informed decisions about his/her medical treatment. A patient who fulfills many areas of competence, such as communicate with others, can identify and understand the issues are hand, and understand the consequences, but persists in cutting themselves fails to be competent. A patient who denies medical treatment, because of religious doctrines, is still competent, though denial of medical treatment seems irrational or incompetent. Treating an adolescent or young child against their will is permissible assuming the physician follows correct procedure. In this case, the adolescent or child has not reached a threshold level of competency. Beauchamp and Childress establish a threshold of level of competency, in order to deal with wide ranging cases of competency.

8 (Junkerman and Schiedermaer 1998, 41-43)
Autonomy as a Negative and Positive Obligation

Beauchamp and Childress believe both Mill and Kant’s theories endorse a principle of autonomy that has both a negative and positive obligation. Mill’s view is that so long as an agent’s action does not harm others, one should not interfere with the agent’s decision. According to Mill, one must respect and allow the agents decisions, although one can attempt to persuade the agent otherwise. For Kant, a violation of a person’s autonomy is a violation of the second categorical imperative, treating an agent as a means not as an end. Kant states, “act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as means, but always at the same time as an end” (Kant 1964, 96). By treating the agent as a means, the agent no longer is in control of his/her life or moral destiny. This reading of Kant endorses a negative obligation view of autonomy. As Beauchamp and Childress say, “Mill’s position requires both not interfering with and actively strengthening autonomous expression, whereas Kant’s entails a moral imperative of respectful treatment of persons as ends in themselves” (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 64). Beauchamp and Childress’s principle of autonomy is both a positive and negative obligation.

The principle of autonomy as stated is a negative obligation; “autonomous actions should not be subjected to controlling constraints by others” (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 64). During specification, insertion of an exceptive claim (rule) is possible, such as “autonomous actions should not be subjected to controlling constraints by others, unless the person is not competent.”
As a positive obligation the principle of autonomy is stated as the, “principle requires respectful treatment in disclosing information and fostering autonomous decision-making” (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 64). A medical professional has the positive obligations to disclose the appropriate information, ensuring the patient understands the complexities or circumstances of his/her case, and cultivating the patient’s decision-making abilities.

The principle of respect for autonomy with its negative and positive facets supports many rules

1. Tell the truth
2. Respect the privacy of others.
3. Protect confidential information.
4. Obtain consent for interventions with patients.
5. When asked, help others make important decisions.

It is again worthwhile to note the principle of respect for autonomy and the specific rules it creates are only *prima facie*. Beauchamp and Childress provide numerous examples of rules overriding the principles e.g., “if our choices endanger the public health, potentially harm others, or require a scarce resource for which no funds are available, others can justifiably restrict our exercise of autonomy” (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 65). Two cases highlight problems relating to autonomy.

*Case #1*

An extreme example (overly simplified in its presentation here) is the Tarasoff case. In this case, the patient disclosed to his psychologist an intention to kill a woman. Despite this, the psychologist’s supervisor refused detaining the patient and notifying the women in danger. The patient later murdered the woman. In the context of the case, the
psychologist has the moral duty to notify the police and the potential victim, overriding the rule “Protect confidential information.” The use of this extreme example is helpful for two reasons: first, it easily illustrates the obligation the psychologist has to protect others from potential harm. Second, it illustrates that the justification threshold for violating a patient’s autonomy is high. Justification for overruling someone’s autonomy is a serious matter. However, in most cases, the problem is never this black-and-white and the reasons for violating the rule are not as dramatic as the need to protect another life.

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9 The legal obligation a psychologist has to inform the authorities developed because of this case.
Case #2

A 69-year-old patient’s test results show an incurable and inoperable cancer of the liver. The cancer is slow in progressing with no signs of advancement. This patient is in a fragile mental state. His wife died following a prolonged bout with cancer after which the patient went into a state of severe depression and attempted suicide. The patient has recently begun to make progress with his life and is planning an anticipated trip to Australia. Discovery of the cancer occurs during a pre-departure visit to the doctor. The patient asks the doctor if he has cancer. Due to the type of the cancer, the patient’s history of depression, the short time period of the trip, and the cancer not being advanced the doctor states that the patient is as good as he was ten years ago. While the doctor feels uncomfortable about lying, he feels it is justified. This is a case of violating a patient’s autonomy. The justification the doctor provides is one of beneficence. However, is beneficence enough justification to override the principle of respecting autonomy?\(^\text{10}\) The doctor is violating the patient’s autonomy by not supplying the patient with the appropriate information, and therefore denying the patient control of his own well-being.

Conclusion

Autonomy for Beauchamp and Childress is a fluid and pliable concept. Beauchamp and Childress’s define autonomy as being competent enough to make adequate and informed decisions about medical treatments and conditions. If a patient is competent, the physician and other medical professionals must respect the patient’s decision. Overriding a competent patient’s decision is rare because the medical professional has an obligation to respect it. The obligation to respect an autonomous person’s decisions supports

\(^{10}\) We will return to the problem of paternalism later in the paper.
specific rules, such as *Tell the truth*, *Respect the privacy of others*, and *Protect confidential information*. In addition, the principle of autonomy has positive and negative obligations. Negative in that we must not infringe on a patient’s decisions and positive in that we respect those decisions.

The principle of autonomy is an obligation to respect the decisions made by a competent patient in regards to their treatments, e.g. a competent patient can chose or refuse a treatment and the medical professional must respect that decision as long as the person is competent. The focus of the principle of autonomy is exclusively on the patient’s ability to have a choice in their medical treatments. The obligation does not necessarily follow outside of the medical context.

Case 1: person A sees person B preparing to jump off a building, person A is justified grabbing person B, thereby preventing person B from committing suicide and violating the obligation respecting person B’s autonomy.

Case 2: person A is a physician, and person B is a patient who refuses food and treatment, assuming person B is competent person A must respect person B’s decision.

While both cases seem similar, there is a contextual difference between the two. In the second case, the physician has an obligation to respect the patient’s choice. The physician has this obligation because physicians have duties to their patients. One of the duties a physician has is to respect autonomy. A physician, by virtue of being a physician, must respect a patient’s autonomy. However, in the first case, person A has no *prima facie* obligation to respect the patient’s decision to commit suicide. The person may be

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11 In this example, I use “Duty” as the larger concept and “Obligation” as a subsection of duty. In this use duty is the overarching concept doctors have beyond non-doctors. These duties entail certain obligations. These obligations outline specific actions, whereas, the duty is more general.
morally praiseworthy for stopping the suicide or worthy of moral condemnation for not stopping it. However, in neither case is person A obligated to stop person B.

A general ethical theory could endorse or condemn person B’s decision of suicide. However, Principlism is not a general ethical theory or moral guide for use outside of medicine. Principlism assists and informs medical professions of their obligations in the medical context. Principlism is clumsy when applied to moral dilemmas outside of medicine. This clumsiness stems from Principlism’s contextually sensitive to medical dilemmas, not general moral or ethical dilemmas. Principlism’s success or failure as a general moral theory is irrelevant, because is design as for application to medical dilemmas.

Nonmaleficence

*An obligation not to inflict harm on others.*

Beauchamp and Childress address the principle of nonmaleficence by conceding that the distinction between beneficence and nonmaleficence is not as sharp as some philosophers would prefer. A clean distinction is difficult because elements of nonmaleficence blend into beneficence. Many ethical theories have nonmaleficence as the foundational concept, e.g. Gert’s Moral Rules, while others, e.g. William Frankena, claim it is a mixture of both beneficence and nonmaleficence. Some, e.g. W.D. Ross, contend beneficence is the single most important concept. Beauchamp and Childress assert that enough of a distinction exists between the concepts to warrant separate principles. Additionally, merging nonmaleficence and beneficence is problematic because of the loss of relevant differences. According to Beauchamp and Childress, the distinction between nonmaleficence and beneficence is one of negative obligation versus positive
obligation. Nonmaleficence is the negative obligation not to inflict harms or to prevent harms, whereas beneficence is the more positive obligation of promoting the good or well-being. Therefore, attempting to completely disentangle the concepts of nonmaleficence and beneficence is not Beauchamp and Childress’s project, and they approach nonmaleficence and beneficence as two separate principles.

The Concept of Harm

If nonmaleficence is intentionally refraining from acts that harm, the question remains as to what is “harm?” If one defines harms too broadly, the scope of what could be harmful becomes too great, as every medical action possible results in harm of some sort, e.g. surgical procedures might not be acceptable since they inflict harm.

There are two senses of harm: normative and non-normative. If a person steals your wallet, we consider this harm a wrong, so it falls into the normative sense of harm. The non-normative sense of harm is harm without the notion of “wrongdoing.” Cases of this type of harm are disease, bad luck, or accidents (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 116). Beauchamp and Childress use harm in the non-normative sense in order to avoid prejudging the cases. The harm is to the person’s interests; they are set back because of the harm. If a non-normative harm occurs, a person’s interest is set back, but with no notion of “wrongness.” If a person’s interest is in walking again, the potential pain and suffering associated with physical therapy does not constitute as “harm.” If the person’s interest is in walking again and the physical therapy produces such pain and suffering that the person cannot walk again, then this is harm. While this example uses pain and suffering, it is important to understand that harm is not always physical suffering. Another example is of non-physical suffering (not physical
pain) is after an operation a patient’s insurance company refuses to cover the medical bills. While the patient is not in physical pain or physical suffering, the patient is suffering a set back of their interests. Beauchamp and Childress also note that a person’s interest is not always in sustaining life (although in most cases it is). In certain treatments, the amount of pain endured is so severe that a patient may not see it in her best interest to continue treatment. An example of the pain of treatment not being in the patient’s interests is an elderly patient in the advanced stages of liver, lung, and brain cancer going through chemotherapy. Beauchamp and Childress say, “Though harm is a contested concept, everyone agrees that significant bodily harms and other set backs to significant interest are paradigm instances of harm” (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 117).

The definition of harm is broad, but within the biomedical context of Principlism, the focus is on the set back to the patient’s physical and psychological interests, “We will concentrate on physical harms, especially pain, disability, and death, without denying the importance of mental harms and setbacks to others interests” (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 117). In conclusion, Beauchamp and Childress define harm as a non-normative set back to the patient’s interest.

Beneficence

The third principle is beneficence: a moral obligation to act for the benefit of others. An understanding of Principlism requires two clear distinctions about the principle of beneficence. The first already noted, is that in certain cases beneficence and nonmaleficence are so similar it is nearly impossible to differentiate between the two. The second distinction is that while in many cases it is difficult to differentiate acts of
beneficence from acts of nonmaleficence, within the medical profession, there is still a positive obligation to act for others. This positive obligation is why Beauchamp and Childress keep the principle of beneficence from absorption into the principle of nonmaleficence. Nonmaleficence is a mandatory obligation; one must always refrain from intentionally harming someone. Beneficence is not mandatory, but optional. As Beauchamp and Childress state, “Also, failing to act nonmaleficently toward a party is (prima facie) immoral, but failing to act beneficently toward a party is very often not immoral. Nonetheless, we (all persons) are obligated to follow impartially some of the rules of beneficence, such as those requiring efforts to rescue strangers under conditions of minimal risk” (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 268). In other cases, the obligation of beneficence is so strong it overrides obligations of nonmaleficence. An example Beauchamp and Childress use is that of mass vaccinations for infants: the good produced, saving millions of infant’s lives, vastly outweighs the harm, momentary pain from injection or fever resulting from the injection. Some may claim this is the double effect, which is where an action causes harm as a side effect, but is attempting to promote a good. However, in this case there is no double effect because the goal of vaccination is to save the infants lives, not just prevent disease. Additionally, the infraction on the individual’s rights is relatively minor in this case.

Paternalism

The filling out of the principle of beneficences is important because the issue of beneficence is one of the problems at the heart of paternalism. Beauchamp and Childress define paternalism as “the intentional overriding of one person’s known preferences or actions by another person, where the person who overrides justifies the action by the goal
of benefitting or avoiding harm to the person whose preferences or actions are overridden” (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 179). Paternalism arises from a conflict between beneficence and autonomy.

Paternalism is a prevalent problem in medicine, because medicine brings two unequal people together: a physician and someone outside the medical profession. The duties of caring for patients by helping, treating, and educating may easily lead physicians to make decisions on behalf of the patients or to lead in subtle ways. However, paternalism is not always wrong. Beauchamp and Childress build on a distinction made by Joel Feinberg between weak and strong paternalism.

Weak paternalism’s definition is, “an agent intervening on grounds of beneficence or nonmaleficence only to prevent substantially non-voluntary conduct—that is, to protect person against their own substantially non-autonomous action(s)” (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 181). Substantially non-voluntary, or non-autonomous action, occurs when the patient’s ability to make autonomous decisions is affected through depression, drugs, or incapacitation. In these cases, paternalism is a good thing, as the person is in no position to make decisions for his/her well-being.

Beauchamp and Childress define Feinberg’s strong paternalism as overstepping the bounds of what weak paternalism allows, “Strong paternalism, by contrast, involves interventions intended to benefit a person, despite the fact that the person’s risky choices and actions are informed, voluntary, and autonomous” ¹² (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 181).

¹² By autonomous Beauchamp and Childress’s mean proper use of decision-making abilities.
Justice

Beauchamp and Childress use the principle of justice to address the problems and concerns with distributive justice and fairness in the medical profession. However, Beauchamp and Childress admit that no single theory of justice can adequately answer all the questions and problems in modern medicine. The sheer scope of these problems alone could be another book in itself. For the purposes of this paper, the principle of justice is a subset of beneficence. Beauchamp and Childress divide justice into two different aspects: a formal principle of justice and a material principle of justice.

The formal principle states equals must receive equal treatment. Beauchamp and Childress find this principle going as far back as Aristotle. It is “formal” because it identifies no manner in which equals are treated equally and because it identifies no characteristics that make persons equal. The formal principle, “merely asserts that whatever respects are relevant persons equal in those respects should be treated equally” (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 227). The material principle specifies the characteristics for equal treatment, “they identify the substantive properties for distribution” (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 228). There are many factors, but the substantive factor is fundamental needs; if needs not met, harm occurs. These factors deal with distributive justice of medicine.

Both of these aspects of justice are vague. However, the principle of justice lends itself to the notion of “fair opportunity.” Fair opportunity is the notion that “no persons should receive social benefits on the basis of underserved advantageous properties (because no persons are responsible for having these properties) and that no persons should be denied social benefits on the basis of underserved disadvantageous properties
(because they also are not responsible for properties)” (Beauchamp and Childress, Principles of Biomedical Ethics 2001)\textsuperscript{13}. Even with accepting the notion of fair-opportunity, as Beauchamp and Childress do, there is a bit of ground that needs to be covered. Beauchamp and Childress advocate an enforceable minimum of health care, but there are limits and restrictions on eligible for this health care. However, at the core of the principle of justice is the idea that all health care systems should be re-examined to see if the systems are following the obligation of fairness in distribution of risks and benefits. Are eligible person’s fundamental needs being met?

Again, this question forces an examination of the entire health care system. However, that is outside the scope of this paper. The principle of justice creates an obligation for physicians to examine the entire health care profession and decide who qualifies for health care and what the fundamental needs (standards of care) are. It is commendable that Beauchamp and Childress use this principle as part of an overview of the entire health care system. However, the principle of justice and decisions about the health care system are outside the scope of the current project.

\textsuperscript{13} Beauchamp and Childress use the term \textit{responsible} in sense that no agent is “responsible” for being born into a higher (or lower) social position.
CHAPTER 2: MORAL RULE

In *Bioethics: A Systematic Approach*, Bernard Gert, K. Danner Clouser, and Charles M. Culver put forth ten moral rules that guide and justify bioethical decisions. This approach consists of ten specific moral rules and a two-step procedure for determining whether a rule violation is justified. The Moral Rules base is on Bernard Gert’s conception of the common morality.

Gert, Clouser, and Culver, like Beauchamp and Childress, believe they are not building a new ethical theory. Instead, their bioethical system builds upon the framework of common morality, “Because everyone already knows the general features of common morality, they also know a great deal about bioethics. Common morality is the framework on which bioethics is appropriately built. That is why people are able to have sophisticated discussions about moral problems within biomedicine without ever having a course in ethics or moral theory” (Gert, Culver and Clouser, *Bioethics: A Systematic Approach* 2006, 3-4). In order to understand Gert, Clouser, and Culver’s bioethical theory, we must understand their conception of morality. After the explanation of morality, the rest of the chapter divides into sections dealing with the major components of the moral rules. These sections deal with how morality is an informal public system; the roles of irrationality, rationality, impartiality, the three types of beliefs and their uses as justification for violations, the ten rules, the rule violation process; a section on applying the rules to cases, and finally a summary conclusion.
Morality

Gert presents morality’s purpose as a method to avoid evils and harms. If persons were to act without regard to morality, life would be in Thomas Hobbes’ words, “solitary, poor, nasty, brutish, and short.” Therefore, morality is a guide for the behavior of others, or as Gert states, “Morality is best conceived as a guide to behavior that rational persons put forward to govern the behavior of others, whether or not they plan to follow that guide themselves” (B. Gert, Morality: Its Nature and Justification 2005, 9). Morality has one purpose, “the goal of lessening the amount of evil or harm suffered” (B. Gert, Morality: Its Nature and Justification 2005, 9). By lessening the amount of evils and harms suffered, social interaction is possible because calamities, evils, and harms are limited and avoided. A rough and ready understanding of Gert’s morality is reducible to two aspects: (1) morality is concerned with the behavior of others and (2) morality’s goal is in lessening the amount of evil or harm suffered.

Gert insists there is a “common” morality because of the widespread agreement among people on most moral matters. “Everyone agrees that such actions as killing, causing pain or disability, and depriving of freedom or pleasure are immoral unless there is an adequate justification for doing them” (Gert, Culver and Clouser, Bioethics: A Systematic Approach 2006, 23). While people may disagree over the scope of morality as to what should be considered a moral agent, e.g. embryos, animals, etc., most people agree that killing a moral agent is wrong. Rational persons on a common sense level understand what it means to be moral. As Gert says, “Although it is difficult even for philosophers to provide an explicit precise, and comprehensive account of morality, most cases are clear enough that most everyone knows whether or not some particular act is
morally acceptable” (Gert, Culver and Clouser, Bioethics: A Systematic Approach 2006, 23). Despite disagreement regarding the scope of morality or the in the ranking of harms, most people understand what it means to be moral- whether they follow this understanding or not. Disagreement is not a problem in Gert’s morality; it is inevitable.

Moral Disagreement

Moral disagreement will always exist. As Gert says, “Most moral disagreement is due to disagreement about the facts, including the probability of the consequences of the proposed action and of alternative courses of actions” (B. Gert, Common Morality: Deciding What To Do 2004, 13). In these cases, it is not values in dispute. An example is whether having a particular risky treatment will have beneficial results. This type of disagreement is a dispute over the facts of the case, not over particular values. However, besides cases where there is a disputing of the facts, there are four types of un-resolvable moral disagreements. These four types are:

1. People having different beliefs as what counts as a moral agent, i.e. are fetuses moral agents
2. People disagreeing on the ranking of harms and benefits, e.g., acceptable levels of suffering worse than death
3. Differences on estimating the consequences of allowing (or not allowing) a rule violation to be public policy
4. People disagree on classifying certain actions, e.g., is turning off a ventilator letting someone die or killing.14

While these types of disagreement are inevitable, they represent a small group of disagreement among the moral community. Rational persons agree on a staggering amount of moral issues (do not kill, do not cause pain, do not disable, etc). The reason for attention to areas of disagreement is that these moral disagreements are un-resolvable.

The strength of the common morality system is that it does not attempt to affix unique

answers to all moral questions, but ultimately realizes that a small percentage of problems will always be in dispute.

Morality as an informal public system

Morality, according to Gert, is an informal public system. There are three important points to understanding an informal public system: (1) the requirements for participation in the informal system, (2) the two characteristic informal systems have, and (3) why morality is analogous to a game. Gert states, “Morality is an informal public system applying to all rational persons, governing behavior that affects others, and includes what are commonly known as moral rules, ideals, and virtues and has the lessening of evil or harm as its goal” (B. Gert, Morality: Its Nature and Justification 2005, 27). The only requirement for participation is being a rational agent. By virtue of being a rational agent, one is already functioning in the common morality. Irrational persons do not participate in the moral system. We do not hold schizophrenics accountable for their behavior because they have mental defects making it impossible for them to control their behavior. We hold persons without the capacity for rationality to different standards than rational persons. Removal of these persons and placement in managed care for their well-being is acceptable, but punishment for their behavior beyond their control is not acceptable.

All public systems have two necessary characteristics: (1) all persons to whom the public system applies understand it; and (2) it is not irrational for any of these persons to accept guidance and judgment by the public system. For morality, fulfillment of the first characteristic is due to all rational persons participating in morality. Because of the intuitive nature of morality, rational persons already understand what it means to be
moral. Morality is analogous to grammar: while we may not know every rule of
grammar, we still are able to understand and use it correctly the majority of the time.
“Just as all and only speakers of a language who can use its grammar in speaking
intelligibly and in understanding the speech of others are considered competent, so all
and only those who can apply the moral system in making moral decisions and judgments
are considered moral agents” (B. Gert, Common Morality: Deciding What To Do 2004,
16). Morality applies to all who understand it. While a moral agent may not understand
all the complexities of morality (or grammar), it is not irrational for moral agents to use
this morality as a guide for a moral agent’s own behavior. Morality has both of the
characteristics of an informal system.

The third point of an informal public system is that morality is analogous to a
game. All participants of a game choose to play by the designated rules and accept
punishment for rule violations. “Morality is a public system that applies to all moral
agents; all people are subject to morality simply by virtue of being rational persons who
are responsible for their actions” (Gert, Culver and Clouser, Bioethics: A Systematic
Approach 2006, 24). Morality is a public system because it applies to all rational people;
it is informal because there are no moral authorities. One cannot appeal to someone being
in a higher moral position. No one has access to “privileged” moral information. We all
operate under the same rules and same base of moral knowledge. No person has a more
privileged access to morality than anyone else does.
Irrational and Rational

It is noteworthy that Gert’s use of the terms irrational and rational is not the standard philosophical use. In Gert’s use for something to be rational, it only needs to be not irrational. Gert states, “A rational action is one that is not irrational. Any action that is not irrational counts as rational; that is, any action that does not have (is not believed to have) harmful consequences for yourself or those for whom you care is rational” (Gert, 2005, p.85). The foundation of the moral rules is not rationality, but irrationality. Irrationality is definable by a list of actions to avoid. Therefore, a rational action is definable in terms of irrationality. “A person correctly appraises an action as irrational when she correctly believes (1) it will cause, or significantly increase the probability of, the agent’s suffering (avoidable) death, pain, disability, loss of freedom, or loss of pleasure, and (2) there is no objectively adequate reason for the action” (B. Gert, Common Morality: Deciding What To Do 2004, 23). A claim that something is irrational is a strong claim. “To appraise an action as irrational is to want neither you nor anyone for whom you are concerned do it” (B. Gert, Morality: Its Nature and Justification 2005, 29). An example is it is irrational to hurt yourself without an adequately justified reason. An adequately justified reason is one that would make an otherwise irrational action justified, e.g. the use of surgery to remove a tumor. Hence, to remove a healthy limb is irrational, but to remove a gangrenous limb is fine because the adequate justification that the limb is gangrenous justifies the previously irrational act.
Impartial

Impartiality plays a pivotal role in common morality. Justification of a rule violation is by impartial rational persons. Impartial persons can only use rational required beliefs for justification of a rule violation. We will return to these types of beliefs later in the paper, but first we will explain the role of impartiality in Gert’s system. Gert defines impartial as, “A is impartial in respect to R with regard to group G if and only if A’s actions in respect to R are not influenced by which member(s) of G benefit or are harmed by these actions” (B. Gert, Morality: Its Nature and Justification 2005, 132). Impartiality is different from consistency: Impartiality is an indifference to the outcome of a moral situation, while consistency is about regularity. It is possible to be consistent in your decision without being impartial. An example is an employer hiring males over female employees.

An impartial person receives neither benefit nor punishment from the person (or group) he/she is judging. An example of impartiality the amount of indifference toward those it judges is in the example of a gunman walking into a fast-food restaurant and shooting everyone indiscriminately. The shooter targets men, women, and children without concern or preference. This un-tasteful example highlights the level of indifference an impartiality Gert intends. The role impartiality is strict because in cases of moral rule violations, one must consider publicly advocating the moral position of the rule violator. If ties to the parties benefiting exist, the justifying moral weight of an impartial decision is lost. As Gert says, “All that impartiality guarantees is that actions or decisions in the specified respect will not be influenced by whether they benefit or harm

*Three types of beliefs*

“In order for all rational persons to know what morality prohibits, requires, discourages, encourages, and allows, knowledge of morality cannot involve beliefs that are not held by all rational persons” (Gert, Culver and Clouser, Bioethics: A Systematic Approach 2006, 24). Gert classifies beliefs as falling into three different categories: irrational beliefs (rationally prohibited), rational required beliefs (the only belief that is adequate justification for an irrational act), and rationally allowed beliefs.

1. **Irrational beliefs (rationally prohibited)**

   “A belief is irrational if and only if (1) it conflicts, either empirically or logically, with a great number of beliefs that the person knows to be true, and (2) almost all people with similar beliefs, intelligence, and knowledge would not only hold the belief to be a false but would regard the conflict between it and the other beliefs as obvious.”

   An example is that it is irrational to want to remove your arm because you do not like its aesthetic appearance. This is a rationally prohibited belief. Gert says, “To say of a belief that it is irrational is to say something very strong about it, much stronger than saying that the belief is mistaken (B. Gert, Morality: Its Nature and Justification 2005, 36). Gert uses the example that while it is arguable and rational to believe that Lee Harvey Oswald participated in the assassination of John F. Kennedy, it is irrational to advocate that JFK was not assassinated (B. Gert, Morality: Its Nature and Justification 2005, 36)

2. **Rational Required Beliefs**

   

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Rational required beliefs are ones that all rational persons would agree upon. “I am mortal”; “I can suffer pain”; “I can be disabled”; “I can be deprived of freedom”; “I can be deprived of pleasure.”

These required beliefs, Gert says, “include general beliefs such as: we all know some things about the world, but no one knows everything, i.e. people have limited knowledge; also people are mortal, can suffer pain, etc” (Gert, Lecture, p.18). Rationally required beliefs are small in number are the only ones that justify violating the moral rules. If we review a previous example of removing a limb to protect one’s health, while it is irrational to want to remove an arm, the rationally required belief that removal of the limb to stop the spread of an infection is justifiable. However, rational required beliefs do not necessarily have uniform agreement in a ranking of importance by all rational agents. The ranking and assignment of value is not universal e.g., there is no universally agreement upon level of pain that is worse than death. The emphasis for Gert is not on having a complete agreement in rational required beliefs, but a minimum threshold of beliefs that all impartial rational persons would agree upon as justifiable in cases of rule violations.

3. Rationally Allowed Beliefs

Rationally allowed beliefs are beliefs that certain rational persons hold to be true, while other rational persons hold them to false, e.g. beliefs about religion and about science. Gert states, “Although rationally allowed beliefs cannot be part of the moral system or used in justifying it, they not only can, but also, must be used in supporting particular moral judgments” (B. Gert, Morality: Its Nature and Justification 2005, 39). Rationally allowed beliefs are not justifications in the moral system, but are applicable to

16 (B. Gert, Morality: Its Nature and Justification 2005, 37)
the moral system because they provide a means of understanding particular actions, institutions, and practices. Gert concedes that the concept of rationality is a hybrid concept. Therefore, sharp distinctions between the types of rational beliefs and their influence are not distinct and crisp.

Rationally prohibited beliefs (irrational beliefs) are ones that all persons agree are bad without justification. No rational person would advocate that cutting off your nose without an adequate reason is a good idea. Nonetheless, while only rationally required beliefs can justify a violation of the moral rules, such as removal of the nose because it is infected and gangrenous, it does not mean that rationally allowed beliefs play no role. The majority of beliefs a person holds are rationally allowed beliefs, such as religious and scientific beliefs. While these lack the ability to be a justifying force, they contribute to the context of the moral decision, such as why some Christians are opposed to abortion or why the government does not negotiate with terrorists.

The Rules

There are ten moral rules, divided into two sections. The first five rules prohibit directly causing harms. If you do not follow the first five rules, you will cause harm immediately. The rules six through ten when not followed in specific cases may not immediately cause harm, but when not followed in general always cause harm. If you do not follow the second five rules, the immediate action may not cause harm, but eventually harm will occur. An example being if you “do not keep your promise,” it might work that no harm occurred the first time you did not keep your promise, but eventually harm will occur.
The Ten Moral Rules

1. Do not kill (includes permanently loss of consciousness)
2. Do not cause pain (including mental pain, e.g., sadness and anxiety)
3. Do not disable (more precisely, do not cause loss of physical, mental, or volitional abilities)
4. Do not deprive of freedom (includes freedom from being acted upon as well as depriving one of the opportunity to act).
5. Do not deprive of pleasure (includes source of pleasure)

6. Do not deceive (includes more than lying, i.e. omissions)
7. Keep your promises (do not break your promise)
8. Do not cheat (primary involves violating rules of a voluntary activity, e.g., a game)
9. Obey the law (do not break the law)
10. Do your duty (do not neglect your duty)\(^\text{17}\)

\(^{17}\) (Gert, Culver and Clouser, Bioethics: A Systematic Approach 2006)
Duty

The use of the term duty, in rule number ten, is not in the same way philosophers typically use it. In philosophy, duty usually refers to an obligation of how one “ought” to act i.e., an obligation for acting morally. For Gert the term adheres to common language use of the term duty, such as a person has a duty (private or professional) to act in a certain manner. Examples of private duties are the duty a parent has for their children, a duty a son has towards his family. Examples of professional duties are a firefighter’s duty to fight fires, police officer having the duty to protect and serve, the duty a lawyer has to act in the best interests of their clients, and a doctor has a duty towards this patients. Each of these named occupations (firefighter, police officer, lawyer, and doctor) has a differing professional ethic. As Gert states, “Each profession or each domain of activity has practices, understanding, and dilemmas that call for a specific fashioning of the various moral rules and ideals to deal with the particulars of its activities” (Gert, Culver and Clouser, Bioethics: A Systematic Approach 2006, 88). These duties grow out particular roles and relationships amongst people in society. These duties are not universal, but particular to the position and the particular society. For example, a doctor hears intimate details about a patient’s life and the implicit assumption is that the doctor should not violate the confidentiality of the patient. A violation of a patient’s confidential information causes harm to the patient. It violates rule number two and ten, and in this case, the violations are not justified. In the profession of medicine, maintaining a patient’s confidential information is mandatory, whereas, in other professional ethical codes, such as police officer, confidential information is not always mandatory.
Rule Violations

The ten moral rules are not absolute; there are justified rule violations. Everyone can imagine scenarios in which breaking a rule is justified, such as cases of killing in self-defense. On the other hand, everyone can imagine scenarios in which deciding on a rule violation is very hard, e.g., end of life issues. For rule violations to be justified, three criteria must be satisfied. (1) Impartiality is satisfied, so that no person or group is unfairly benefiting from the violation. Would one still commit the rule violation if everyone knew this kind of rule violation would be allowable? (2) It is rational for everyone to violate the rule in that circumstance. (3) “Finally, there is general agreement that a violation is justified only if it is rational to favor that violation even if everyone knows that this kind of violation is allowed” (Gert, Culver and Clouser, Bioethics: A Systematic Approach 2006, 38). The last requirement, the consensus agreement component, emphasizes that with complex moral problems it is difficult to come to a judgment unless one has the facts of the case.

The first step of the rule violation procedure begins by specifying the relevant facts of the violation and determining the type of rule violation. Gert presents ten questions attention to the facts of the case. It is important to remember there are objective facts of the case. Specifically in medical cases, the empirical facts indicate whether the violation is justified or not. In order to use those empirical facts, a filling out of the type of violation must occur. The questions concerning morally relevant facts attempt to focus on the content of the violation. Understanding the type of rule violation and relevant facts makes the decision of justification much easier.
1. What moral rule is being violated?

2. A. What harms are being caused in the violation?  
   B. What harms are being avoided (not being caused) by violating the rule?  
   C. What harms are being prevented by the violation?

3. A. What are the relevant desires of the person toward whom the rule is being violated?  
   B. What are the relevant beliefs of the person toward whom the rule is being violated?

4. Is the relationship between the person violating the rule and the persons toward whom the rule is being violated such that the former has a duty to violate moral rules with regard to the latter independent of their consent?

5. What goods (including kind, degree, probability, duration, and distribution) are being promoted by the violation?

6. Is the rule being violated toward a person in order to prevent her from violating a moral rule when the violation would be (1) unjustified or (2) weakly justified? (p.231)

7. Is the rule being violated toward a person because he has violated a moral rule (1) unjustifiably, or (2) with a weak justification?

8. Are there any alternative actions or policies that would be preferable?

9. Is the violation being done intentionally or only knowingly?

10. Is the situation an emergency such that no person is likely to be in that kind of situation?  

The second step is determining the consequences of publicly allowing that violation.

The question, as stated by Gert is, “What would be the consequences if this kind of deception were publicly allowed” (Gert, Culver and Clouser, Bioethics: A Systematic Approach 2006, 45). This question forces moral agents to conceive of the ramification of

making the rule violation public policy. This second question shows that certain rule violations seem tolerable in specific contexts, but are not justified when applied as a “public policy.” Using the example of Case #2 from the chapter on Beauchamp’s and Childress’s principle of autonomy, we realize the problems allowing deceptions as a public policy.19 As a public policy we would not advocate doctor’s being able to withhold information from the patient. “What is important is that you think of your decisions as if they were setting a public policy, one that everyone could act on when the morally relevant features were the same” (Gert, Culver and Clouser, Bioethics: A Systematic Approach 2006, 45). In this manner, Gert, Culver, and Clouser pattern the Moral Rules in a similar fashion as Kant’s kingdom of ends, “A rational being belongs to the kingdom of ends as a member, when although he makes it universal laws, he is also himself subjects to these laws” (Kant 1964, 100).

Applying the Moral Rules to Cases

How are medical professionals to apply the Moral Rules to medical dilemmas? Gert’s answer is that the medical professionals already is, and have been, applying the common morality to cases. The Moral Rules are not a new ethical theory, but an explication of the common morality already in practice by medical professionals. Common morality does not set rules of behavior to follow; it sets a standard of behavior not to violate. As long as physicians are following the common morality, they are being moral. If a physician commits a rule violation that, 1) no rational impartial person would endorse, or 2) the consequences of the rule violation would not work as public policy,

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19 A 69-year-old patient’s test results show him to have incurable, inoperable cancer of the prostate. The patient is going on an anticipated vacation to Australia and has a history of depression.
then the physician is in violation of the common morality. The following two cases illustrate the process of applying the Moral Rules to cases.

Case #1

A Jehovah’s Witness refuses a potentially life-saving blood transfusion on religious grounds. The patient is competent and not impaired, but contends that receiving a blood transfusion is a violation of their religious beliefs. The patient is not in critical condition, however, without the blood transfusion their prognosis will deteriorate.

Is the doctor justified in violating moral rules two, seven, and ten? After going through the two-step rule-violation process it is clear the physician is not justified in overriding the patient’s refusal of treatment. While the physician may think she is helping the patient, the physician is actually violating moral rule #4, do not deprive of freedom. Denying a patient’s refusal of treatment is a violation of the patient’s freedom. Gert’s ten morally relevant questions clarify that the violation is not justified; the violation fails as a public policy. Rational persons do not want doctors to be able override the patient’s decisions.

However, if we change the specifics of the case, the Jehovah Witness is a child, what would the moral system say? Common morality would dictate it is justifiable for the physician to violate the patient’s refusal of treatment. The justification is that a public policy that violates religious beliefs in order to save children is acceptable because children are not fully competent. Since children do not have the cognitive ability to make well-formed decisions that affect their life’s outcome, a policy overriding

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20 Do not cause pain (including mental pain, e.g., sadness and anxiety)
7. Keep your promises (do not break your promise)
10. Do your duty (do not neglect your duty)

21 A child may not understand the implications of refusing treatment and child do not decide their religious affiliation.
children’s decision-making policy is justifiable. As Gert states, “Infants and very young children are not moral agents, because they do not understand the rules. Older children who can understand some of the moral rules are partial moral agents” (B. Gert, Common Morality: Deciding What To Do 2004). Since the children do not completely understand common morality or the implications of their religious beliefs, the medical profession has an obligation to prevent harm from occurring to them.

Case #2

A son who is concerned his father may have Alzheimer’s disease takes a man in his late sixties to the physician. However, the son asks the physician if the diagnosis of Alzheimer’s disease is confirmed, to refrain from informing his father. The physician feels conflicted because the testing for Alzheimer’s disease is “unusually imprecise” and a patient’s ability to respond to treatments varies so greatly. Whereas most patients generally want to know if they have cancer, patients facing a diagnosis of Alzheimer’s disease are more wary to hear the diagnosis.22

In this case, the difficulties of the case dissolve upon application of the moral rule’s systematic approach. Deceiving the patient is a violation of moral rule #6, *do not deceive*, and moral rule #10, *do your duty*. The physician would violate moral rule #6 if he/she does not inform the patient of the diagnosis of Alzheimer’s disease. By not informing the patient of the diagnosis, the physician is violating moral rule #10 because they are not fulfilling their duty to provide all relevant information to the patient. A rational, impartial person would not advocate a public policy allowing doctors to deceive a patient. Nonetheless, a counterexample often used is in the act of delaying profoundly bad news to patients during high stress times when the occurrence of cardiac arrest is high. However, this is not a good counterexample, because the information is not

22 (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 419).
withheld from the patient, it is only “delayed” until an appropriate time. A critic may ask what is an “appropriate” time is. A plausible answer is not during times of high stress where a cardiac arrest may occur.

An additional moral rule violation in case #2 is of moral rule #2 *Do not cause pain (including mental pain, e.g., sadness and anxiety)*. Up until now, the analysis has stayed away from moral rule #2. The reason is that while case #2 is about harm, a far greater implication is in the potential problems a policy that allows deception in the doctor and patient relationship would cause. Deception in the doctor and patient relationship corrosively affects the larger paradigm of doctors and their duties to patients. A doctor denying all relevant information to their patient takes away the patient’s ability for decision-making. However, an examination of the claim, “the doctor was attempting to not cause harm” also fails as an adequate justified reason. This claim fails because by not informing the patient, the doctor has deliberately not allowed the patient the option of starting treatment. In most cases, delaying treatment is always a bad idea. In the worst-case scenario, even if the treatment proves to be futile the patient’s treatment is a positive step forward, albeit a mental or motivation one. Delaying treatment almost never results in any positive mental, physical, or motivation attributes. Hence, the above claim of avoiding harm has little merit.
Principlism and the Moral Rules are two philosophical theories containing three similar themes. First, both of these theories work off a foundation of common morality. Second, each theory advocates a structural approach to medical dilemmas since both use principles and rules as guidelines for physicians. Third, the theories stress the importance of being practical over philosophical.

A Common Morality Foundation

Principlism and the Moral Rules ground their theories in a common morality. Both Principlism and the Moral Rules use common morality as justification for their principles and rules. Beauchamp and Childress claim that the principles they put forth are general moral norms taken from common morality. While it is possible to claim that Gert’s Common Morality is a moral theory, Gert would disagree, “I do not revise common morality; I only describe, explain, and justify it” (B. Gert, Common Morality: Deciding What To Do 2004, 5). Gert asserts his moral theory is merely a description of the morality people already use. This is why some critics call Gert’s theory a descriptivist theory. Gert’s common morality is similar to Beauchamp and Childress in the claim that most rational persons in society recognize certain moral norms (such as “do not kill”) as fundamental to morality. There are acts and prohibitions all persons who are serious about morality would consider fundamental. On this level, both Beauchamp and Childress, and Gert agree.

Both theories claim that common morality is justification for the principles and each of their theories moral norms find support in common morality for their principles and rules.
Use of Principles and Rules

The nicknames applied to these theories, respectively Principlism and Moral Rules, are misleading. Specifically, the names only pick out the major elements of the theories i.e., bioethics as guided by principles or bioethics as guided by rules. However, in Principlism each of the principles supports rules. As Beauchamp and Childress state, “We also operate with only a loose distinction between rules and principles. Both are general norms that guide actions” (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 12). While Gert’s Moral Rules is composed of specific moral rules, it is not merely a “rules” based system. The moral rules are the most “basic general moral norms.” All of the moral rules stem from the common morality the overarching principle of nonmaleficence. Therefore, it is reasonable to state Gert’s theory as a set of ten rules supported by a single principle of nonmaleficence i.e., Gert’s theory is a mixture of rules and a principle. Both Gert and Beauchamp would agree that any good bioethical system is a complex aggregate of rules and principles.

Practical over the Philosophical

Principlism and the Moral Rules consistently focus on practicality. Academic oriented philosophical theories sometimes fail to be functional as real world guides or policies. While both Principlism and the Moral Rules are academically rigorous, both attempt to provide applicable guides to bioethical problems. The authors of Principlism and the Moral Rules have an interest in getting bioethical dilemmas resolved and not bogging down their theories in excessive philosophical matters. An example of choosing practicality over philosophical, is in admitting that in some cases distinction between an act of beneficent and nonmaleficent is nearly impossible. Beauchamp and Gert insist if
taken too far, emphasizing the differences between the theories becomes philosophical squabbling and provides little help in resolving problems. In an example of striving for the practical over the philosophical, both theories use the notion of common morality. While both Beauchamp and Childress, and Gert have different theories of common morality, both have chosen to identify the common morality as supplying their systems with its justificatory power. By using the common morality as justification, these theories are able to (or at least attempt to) sidestep the pratfalls of other theories e.g., Kant’s anti-consequentialism or utilitarianism's dependence on the principle of utility.

**Differences**

*The Place of beneficence*

The role of beneficence differs in Principlism than its role in the Moral Rules. According to Gert, defining an act as either being a beneficent act or a nonmaleficence act is too confusing. Attempting to distinguish the two acts becomes a philosophical problem, not a practical one. Is a doctor’s treatment of a patient a beneficent act (trying to help the patient) or an act of nonmaleficence (trying to prevent further pain)? For Gert these questions gain no new ground, but merely retread a philosophical puzzle. For Gert, acting beneficently is morally commendable, but the focus of morality is in not violating nonmaleficence as opposed to not acting beneficently.

According to Beauchamp, beneficence has a long historical priority within the medical community. In many cases, it is the duty of the medical professional to fulfill this obligation. Nonetheless, it is not always mandatory. It is in this respect that Gert and Beauchamp are merely talking around each other. Beauchamp contends that beneficence has a role in the medical profession. Certain acts a medical professional does go beyond
nonmaleficence and qualify as beneficent. Gert takes a different approach and contends that acts beyond the nonmaleficence are morally commendable, but we are not obligated to act beneficently. In this manner, the difference between Gert and Beauchamp is only a verbal problem and not a theoretical problem. Nonetheless, Beauchamp does place importance on beneficence (giving it an entire chapter), whereas it plays no role for Gert in formulating the moral rules.

Criticism of Principlism

I. Principlism is not a systemized approach

    Principlism claims there are four general obligations (principles) that medical professionals must obey. These principles, through the process of specification, support several types of rules. However, Principlism is not a systemized approach and two problems occur. The first problem is that Beauchamp has no methodological approach towards determining which specific principle is at issue in a particular bioethical dilemma. Principlism has no theoretical or practical system to determine the specific principle in question. Since there is no methodology for determining the principle involved, it is possible to classify certain cases as violating one or all principles. It is possible to look at one case and see numerous principle violations, all violations having seemingly equal merit. It is possible, using one specific case, to argue the primacy of the other principles just as strongly as the one Beauchamp and Childress put forth. For example, consider a doctor not disclosing to a patient the discovery of a slow progressing pancreatic cancer. Beauchamp and Childress insist this is a case of the doctors violating the principle of autonomy and not allowing the patient to make an autonomous decision,
because the doctor overrides the patient’s decision-making ability by not disclosing the complete information. However, it is easy to argue that in this case in which a violation of all of the principles has occurred. The following are examples of how it is possible to view the previously mentioned case as a violation of one of the other principles. These explanations are as strong as the one Beauchamp and Childress put forth.

**Nonmaleficence:** The doctor’s act of deception is a case of harming the patient (harm being a set back of the patient’s interests). The doctor is intentionally going against the interests of the patient. The patient’s interest is in living, delaying the chemotherapy is setting back the patient’s interests. The doctor is obligated to work for the patient’s physical well-being, the patient’s interest. The patient’s interest commands the doctor to begin chemotherapy immediately. Instead, the doctor violates the patient’s interest by not starting the chemotherapy and letting him travel.

**Beneficence:** The doctor has the moral obligation to act for the benefit of the patient. By not informing the patient of his condition, the physician is not acting for the benefit of the patient. The risks for the patient when traveling overseas, while small due to the type of cancer, are certainly far worse than if he began chemotherapy immediately. In this case, the doctor does not properly weigh the risks and benefits and violates the principle to act beneficently.

As these examples show, it is hard to determine the primary principle involved. In this area of weakness for Beauchamp and Childress, Gert’s Moral Rules has a distinct advantage over Principlism. Gert’s view is superior in its ability to identify the relevant factors of a case. Using the Moral Rules theory, the doctor’s deception clearly violates moral rule #4 *do not deprive of freedom*, because the doctor’s deception deprives the
patient of the opportunity to act, and moral rule #6 do not deceive, for the deception is an act of omission. There is the addition dilemma that such deceptions cause pain, and violates moral rule #2, however, for length constraints the discussion will only deal with violation of #6 and #4.

The second problem is that Principlism has no way to resolve a conflict in principle. What happens when there is conflict between two principles? If making a decision in a difficult ethical case involves violating one principle, how is it determined which principle to violate. In a case such as that, both principles are in conflict and there is a need for a methodology to determine which principle is more important. Beauchamp and Childress provide no resolution methodology for principles in conflict. An example is during a routine check up a male patient tests positive for genital herpes. The patient and his wife are attempting to conceive and it is quite clear the patient has not informed his wife of his condition. The physician is now in a dilemma: does the physician respect the patient’s autonomy (decision-making capacity), assuming the patient will inform his wife?23 Alternatively, does the physician follow the principle of beneficence and inform the wife because of the complications it could cause the potential pregnancy? In a case such as this, Beauchamp and Childress offer no system to defuse or resolve the conflict. Beauchamp and Childress do respond by claiming the principles balance each other and limit the scope of the other principles through the ranking process. However, the complexity of certain medical cases makes this problematic. Indeed, Beauchamp and Childress admit, “Honesty about the process of balancing and overriding compels us to return to our earlier discussion of dilemmas and acknowledge that in some circumstances

23 This question leaves aside the question of confidentiality.
we will not be able to determine which moral norm is overriding” (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 21). It is one thing to admit that the process is difficult; it is another to admit that Principlism has no method or system for dealing with relatively simple cases.

In this situation, Gert’s Moral Rules bypasses the problems that Principlism encounters and is better able to handle the situation. In the case of the Moral Rules, there is no need to wait for specification in order to come up with a prescriptive or prohibitive action the medical professional must take. Gert’s Moral Rules emphasizes the relevant factors in the case by looking the possible moral rule violations the doctor’s actions would cause. If the physician does not inform the wife, he/she is violating moral rule #2 do not cause pain, because the herpes will cause physical and mental pain, in addition to jeopardizing the couples chances for conceiving a child. Not informing the wife will also violate moral rule #6 do not deceive, because the doctor is deceiving by omission, and moral rule # 10 do your duty, because the doctor has an obligation to inform the patient before a possible infection and pregnancy complications ensure. If the doctor informs the patient’s wife, there is no violation of moral rules, therefore, the doctor should follow the moral rules and inform the wife.

Both of these problems, determining primary principles and principle conflict resolution, stem directly from a lack of systemization or methodology in Principlism. Instead of methodology, Beauchamp and Childress claim that “specification” will determine the appropriate facts to the case. The problems of specification are for a later section. However, specification itself cannot make up for a lack of methodology for
Principlism. There is no cohesion or structure to the principles. This problem leads directly into the second problem

II. Principlism is a freestanding ethical theory; it has no attachment to a general moral theory.

This is the main criticism of Gert, Culver, and Clouser against Principlism. They contend that Beauchamp and Childress have not shown how Principlism is justified with morality, “Principlism presents only a schema of an account of morality and no attempt to justify it at all” (Gert, Culver and Clouser, Bioethics: A Systematic Approach 2006, 99). Because there is no justification by morality, Principlism is merely an “ad hoc” account of bioethics. Principlism does not explicate or justify how morality relates to the principles or how morality justifies the actions of physicians obeying the principles. Beauchamp and Childress do attempt to tie Principlism to a “common morality,” but their conception of the common morality is a collection of socially agreed upon norms, not a formulized system. Principlism presents no explanation of morality or how these general moral norms interact or even what is a general moral norm. Due to the lack of clarity in the system, Principlism can only approach medical cases from an “ad hoc” perspective. Principlism therefore lacks the prescriptive power of Gert’s system. Comparatively, Moral Rules theorists argue that their system is justified by common morality. The Moral Rules merely systematized morality; therefore, it can make prescriptive/prohibitive rules. While it is possible to disagree with the Moral Rules, compared to Principlism it is more organized and explicit as to why its system is justified, the role of the rules (general moral norms), and how they can interact.

III. Specification is a strange and mysterious concept that does all the work
Within Principlism, it seems that the process of specification is the answer to all its problems. Principlism is overly reliant on specification. Beauchamp and Childress conceive general principles as “chapter headings.” However, only through the process of specification do these principles become specific rules or prohibitive actions. Nonetheless, specification contains the same problem that plagues the whole of Principlism- it is not a systematic approach. As Gert, Clouser, and Culver contend, “Specification does nothing about the crucial flaw of Principlism, which conceives of morality as consisting of several freestanding principles rather than recognizing that these principles must be embedded in a system” (Gert, Culver and Clouser, Bioethics: A Systematic Approach 2006, 125). The problem for Principlism, is an over reliance on specification, a problem Beauchamp and Childress are well aware of, “Overconfidence in specification can lead to a dogmatic certainty similar to that found in the pronouncement of some professional associations” (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 17). Many of the problems associated with Principlism are “solved” by specification:

- How does Principlism move from abstract principle to specific rules or prohibitive actions-specification!
- How do the abstract principles filled out to support specific prescriptive/prohibitive rules-specification!
- What is the methodology for determining which principle is at issue-specification!
- If one principle is in conflict with another principle what is the process for determining which has the precedent-specification!

This overreliance is troubling because specification essentially becomes the methodology for Principlism. Specification has no system, method, or specific general guidelines on “how” one is to do specification. Theoretically, specification’s intention is
to limit the range and scope of the issue, while working in conjunction with balancing the weight and strength of norms, and aiming for coherence amongst the principles. However, in the schema of Principlism it becomes the methodology for arranging the principles. While that may sound good, it is quite problematic. As Jeffery Brand-Ballard points out, an ethicist can unduly specify the principle to conform with her moral opinion in hard cases, “If she does this, she can still claim to have specified the principles in questions and ‘resolved’ the case…Her specifications have justificatory force for no one but those who already share her idiosyncratic convictions about the hard case” (Brand-Ballard 2003, 244). An example is the physician who does not inform the patient about their cancer before they travel to Australia. The physician has the conviction that bad news is easier to receive after a period of prolonged happiness. The physician could specify the principle of beneficence to the rule, “Do not upset the patient’s fragile mental state until necessary.” In this case, the physician specified the principle to a rule that matched their idiosyncratic conviction.

Since there is no system or methodology for specification, it is possible for the ethicist to specify the principles to fit their preconceived notions, while still having balance and coherence with the other principles. In addition, it is possible for two physicians/ethicists to use specification and come up with completely different conclusions. Two physicians coming to completely different outcomes from the same case in effect robs Principlism of any justificatory power. Beauchamp and Childress may counter this by claiming that it is just a hard case and there cannot be any moral agreement. However, in principle it seems possible for this difference over specification to occur over any case. In the case of a husband concealing his herpes from his spouse, a
physician could specify the principle of autonomy to state, “Do not violate a patient’s confidentiality.” Another physician could specify the principle of autonomy, “Violate a patient’s autonomy if another patient’s life is in danger.” It is the same case, the same principle and two different specifications. While some may contend this is an uncharitable use of specification, the reply is, “I would gladly apply specification correctly, just show me how.” By not explicating a methodology for specification, Beauchamp and Childress cannot deny misuse of specification. Again, there is no system or methodology to prevent variation of specification over every case. How is Principlism useful as a guide, when it is possible to specify the principles to conform to the physicians/ethicists specific preconceived view?

Again, the Moral Rules has an advantage over Principlism because Gert’s Moral Rule is not overly reliant on specification. The Moral Rules do not use specification to arrange the order of the moral rules, only the rules violated are of importance. The range and scope of the issues involved for the Moral Rules is not determined through specification, but through the relevant facts of the case, i.e. what moral rule violations occurred and were these violations justified. In the Moral Rules, there is no adjustment, re-adjustment, and specifying to the particulars of the case. There is only a question of whether the rule violation is justified. It is possible, using Principlism, for a physician to specify the principles to conform to his/her preconceived beliefs. Using the Moral Rules, a physician does not have to specify their actions for justification, the rule violation process determines whether the violation was justified or not.
Conclusion

The problem with Principlism is that it suffers from “50 yard” syndrome: that is it “good from far,” but after further inspection, it is “far from good” or in this case “far from a complete system.” Upon first learning about Principlism, it initially has outstanding aspects. All the principle obligations are clear and concise and it is easy to see the relevance of these obligations applying to bioethics. The cases and situations that Beauchamp and Childress present are compelling and deal with many key issues in bioethics. In fact, the index of cases at the end of the book is an extremely helpful chapter. Nonetheless, problems arise when it comes time to apply the principles to real cases. As mentioned earlier, because there is no system or methodology within Principlism, there is no real way to employ the rules as guidelines. It is hard to go from abstract principle to application in hard case, without a specific detailed methodology. Failure to systematize Principlism causes a lack of cohesion. The principles are then freestanding principles that lack justificatory power, and the system as a whole ends up as being *ad hoc* instead of prescriptive. If we briefly return to Case #2, it is possible to highlight this shortcoming of Principlism. In Case #2, Principlism would use the process of specification to derive an action-guide. In Case #2, the doctor in question is not respecting the patient’s autonomy for decision-making, by not informing the patient of the diagnosis. The problem for Principlism is exactly how does one get from this violation of a principle to any type of action guide or rule? It is possible for a Principlist to gesture towards typical hospital protocol, currently policies, and legal precedent as paving a potential path for an action guide or rule. Yet, this is not the path of
specification. Specification is supposed to remove the indeterminateness and clarify
the content of principles so they are applicable for use. But how? Again, it is not and
never was clearly stated the method or methodology that Beauchamp and Childress use to
get from A. (principles) to B. (specific rule). The specification of rules that Beauchamp
and Childress would apply to this case seem ad hoc because, these rules are already the
typical hospital protocol, currently policies, and legal precedent in use!

A possible criticism is in this example the wrong principle was chosen. For a
moment, let us return to Case #2 and examine it in accordance with the principle of
nonmaleficence (a norm of avoiding the causation of harm). From this general principle,
how does the process of specification get to an action guide or rule? How is the
indeterminateness of this principle removed without an appeal to typical hospital
protocol, currently policies, and legal precedent? Again, Beauchamp and Childress give
no method or methodology on how to go from A. (principles) to B. (specific rule). Pick
any medical dilemma and pick any principle that applies, without reliance on prior rules
and policies, there is no clear way to go from principle to specific rule.

Unfortunately, for Beauchamp and Childress, the problems with Principlism are
the strong points of Gert’s Moral Rules. Because of the Moral Rules systemization, the
Moral Rules theory is able to pin point where and exactly what the ethical rule violation
occurs. In the Moral Rules, the physician does not have to take four principles and
specify them into specific prescriptive or prohibitive actions. The physician can apply the
ten moral relevant questions for this problem.
The ten questions for morally relevant facts

1. What moral rule is being violated?
   ✓ Moral rule #6, do not deceive
   ✓ Moral rule #10, do your duty

2. A. What harms are being caused in the violation?
   ✓ A delay in treatment for the patient
   ✓ Future emotional pain
   B. What harms are being avoided (not being caused) by violating the rule?
   ✓ Temporary emotional pain
   C. What harms are being prevented by the violation?
   ✓ Temporary emotional pain

3. A. What are the relevant desires of the person toward whom the rule is being violated?
   B. What are the relevant beliefs of the person toward whom the rule is being violated?

4. Is the relationship between the person violating the rule and the persons toward whom the rule is being violated such that the former has a duty to violate moral rules with regard to the latter independent of their consent?
   ✓ Yes, the doctor has duty to the patient for full disclosure

5. What goods (including kind, degree, probability, duration, and distribution) are being promoted by the violation?
   ✓ Temporary emotional pain

6. Is the rule being violated toward a person in order to prevent her from violating a moral rule when the violation would be (1) unjustified or (2) weakly justified?
   ✓ No

7. Is the rule being violated toward a person because he has violated a moral rule (1) unjustifiably, or (2) with a weak justification?
   ✓ No

8. Are there any alternative actions or policies that would be preferable?
   ✓ Yes

9. Is the violation being done intentionally or only knowingly?
   ✓ Intentionally

10. Is the situation an emergency such that no person is likely to be in that kind of situation?  

    ✓ No

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The answers to the morally relevant questions clarify that if the doctor does not fully disclose the information with the patient, the doctor has committed an unjustified Moral Rule violation. This simple procedure of answering the ten morally relevant questions directs the physician to the appropriate action or rule to follow.

Criticisms of the Moral Rules

There are three criticisms of the Moral Rules. The first of two criticisms is from Carson Strong. Strong’s criticizes Gert’s Moral Rules as yielding wrong answers to moral dilemmas. The criticism is not on the theoretical aspects of the theory, but on the practical application of the theory. Carson Strong claims the theory produces wrong answers in moral dilemmas. The production of wrong answers is from two problems. The first problem is the Moral Rules translates moral dilemmas into dilemmas of irrationality and there are no answers for those questions.

Strong uses one of Gert’s examples, the case of Mr. J:

Case I. Mr. J was a 50-year-old patient in a rehabilitation ward who was recovering from the effects of a stroke. A major part of the treatment consisted of daily visits to the physical therapy unit, where he was given repetitive exercises to increase the strength and mobility of his partially paralyzed left arm and legs. He was initially cooperative with Ms. Y, his physical therapist, but soon became bored with the monotony of the daily sessions and frustrated by his slow progress in regaining his ability to move his partially paralyzed limbs adequately. He told Ms. Y that he did not wish to attend the remaining three weeks of daily sessions. Ms. Y knew that patients like Mr. J rarely regress, that is, become worse than they presently are, if they stop exercising. But, her experience showed that if patients like Mr. J stopped the sessions early, they did not receive the full therapeutic benefit possible and might suffer for the remainder of their lives from a significantly more disabled arm and leg than would be the case if they exercised now in this critical, early post-stroke session. Accordingly, she first tried to persuade him to continue exercising. When this is not effective, she became rather stern and scolded and chastised him for two days. He then relented and began exercising again, but it was
necessary for Ms. Y to chastise him sternly almost daily to obtain his continued participation over the ensuing three weeks.\textsuperscript{25}

Gert considers Ms. Y’s actions to be justified because the harms Mr. J would suffer by not attending physical therapy are far greater than the harms suffered by persistent scolding. However, Mr. J thinks the harm involved (Ms Y’s chastising and the physical therapy) does outweigh the benefit of the therapy. Therefore, Mr. J ranks the harms differently than Ms. Y.

Strong contends that Gert’s two-step rule violation will imply that rational impartial persons will deem Mr. J’s ranking of harms as irrational. As Strong states, “A fully impartial rational person might imagine herself in the patient’s situation and conclude that she would want the therapist to prevent her from performing the irrational action…By this line of reasoning, or at least something similar to it, one can conclude that if a patient’s ranking of harms is irrational, then all fully informed rational persons would publicly advocate that the rule be violated in this type of case” (Strong 2006, 48). However, Strong disagrees with this conclusion. Strong claims that, it is an “add-on” because within Gert’s two-step process there is no discussion on what counts as an irrational ranking of harms. Strong states, “Gert provides no account of what would constitute as an irrational ranking of harms that is both justified and useful for producing answer in case 1 using the approach” (Strong 2006, 49). It is important to understand the claim that Strong is making. Strong is not denying that almost everyone would agree that Mr. J is irrationally ranking the harms.

What Strong is pointing out is that within the system of the Moral Rules, there is

no discussion, mechanism, or method for appropriately determining which ranking of harms is irrational. Strong feels that Gert’s theory takes moral problems (whether Ms. Y’s paternalistic actions are morally justified towards Mr. J) and translates them into questions of irrationality. Strong sees this as problematic for Gert, even though Gert concedes that rational persons do have disagreements due to different rankings of harms. As Strong concludes, “the main problem with Gert’s proposed method of resolving this case is that it transforms the moral issue into the question of whether a ranking of harms is irrational without providing a useful, justifiable approach to deciding what constitutes an irrational ranking” (Strong 2006, 49).

According to Strong, the second problem with Gert’s Moral Rules is that by varying the generality of the moral rule, the answers to these moral problems also vary. This is a damaging claim because the Moral Rules, like Principlism, places a high value on practicality. In Gert’s system, to be able to judge whether all impartial rational persons would agree on a rule violation, it is mandatory to translate the problem into a statement describing the specific harms involved so that all rational persons can understand it. However, Gert never sets a specific level of generality that is permissible, therefore, it is possible that the description of the harm will be either too specific or too general and influence the outcome. As Strong contends, “It seems, therefore, that Gert’s procedure is subject to yielding different answers, depending on the level of generality with which one describes the type of rule violation” (Strong 2006, 51). Harms description comes in a variety of manners. What some moral agent ranks as harm, for instance loss of confidential information, might not rank as harm by other moral agents? The problem with the level of generality and translation is in the process of translating the relevant
information into terms that are rationally required beliefs. Gert is very specific about the types of beliefs allowable for justifying a rule violation (rationally required beliefs). However, there is no mention or methodology for how to translate complex medical situations into terms of generality acceptable for Gert’s theory. As the complexity of the problem rises, the ability for translation into general terms accessible to all impartial rational persons becomes difficult. This is not to say that the moral complexity of the case becomes harder, rather it becomes more difficult to translate the appropriate general information to an impartial rational person. An example of the complexity and room for translation error is in “do not resuscitate” agreements. How can a complex concept like “DNR” translate into a rationally required belief that all impartial rational persons could understand? An adequate translation for DNR must encompass several hard to define concepts like quality of life, patient’s autonomy, ranking of pain vs. death, and many other culturally relevant topics that Gert would not consider rational required beliefs. Even with the specifics of the particular case filled out e.g., a male 32-year-old patient suffering from Hodgkin’s lymphoma that has undergone extensive treatment, is about to lose his health insurance due to high treatment costs, and signs a DNR order. Translating these facts into a set of rational required beliefs is difficult. The translation of these factors into a general enough form for all rational impartial persons to understand is difficult when one sees what types of beliefs qualify as rational required beliefs, such as “I can be deprived of freedom”, “people can suffer”, and “people have limited knowledge”. I am not even sure how the concept of “insurance” or “financial burden” is translatable into rational required, let alone the complexity of a DNR order.
The third criticism of the Moral Rules is from Jeffery Brand-Ballard. This criticism focuses on the assumption Gert, Clouser, and Culver make by contending the common morality is a consistent set of beliefs. Brand-Ballard wants a revision to the Moral Rules in order to reconsider what actually causes hard cases. For Brand-Ballard, impartial rational people having different rankings of harm do not causes disagreement, but inconsistency in moral beliefs causes disagreement in bioethical cases.

Common Morality and Inconsistencies

Jeffery Brand-Ballard has a different criticism of the Moral Rules theory. Brand-Ballard’s questions the assumption that the common morality is composed of a consistent normative system. Brand-Ballard poses this question, “what if common morality were, in fact, deeply inconsistent” (Brand-Ballard 2003, 231-232). In fact, Brand-Ballard claims that the common morality is inconsistent.

Brand-Ballard terms Gert, Clouser, and Culver as descriptivists because unlike Principlism, they claim their theory is merely describing the workings of the common morality. Brand-Ballard classifies the descriptivists approach as monistic because, “at the most fundamental level, descriptivism …is ‘monistic’- i.e. it includes a single, unified criterion for determining when an exception to a rule is permitted” (Brand-Ballard 2003, 233). The criterion Brand-Ballard reference is the last step of the rule violation process, which Brand-Ballard refers to as the “impartial criterion.” This criterion is whether an impartial rational person would advocate for the practice to be public policy. The criterion Brand Ballard points out allows the descriptivists theory classification to be a form of rule-consequentialism. Gert, Clouser, and Culver dispute the labeling or
association of their theory with rule-consequentialism, but the last step of the rule violation process makes it inevitable according to Brand-Ballard.

The objection raised by Brand-Ballard is that no form of rule-consequentialism can accommodate all impartial rational people’s convictions. The reason rule-consequentialism cannot accommodate all impartial rational people is that impartial people are not always consistent about their moral beliefs. The Moral Rule concedes that not all people have consistent rankings of harms, but it assumes all impartial rational persons do have consistency with their moral beliefs. Brand-Brandt comments if all impartial rational persons had a consistent set of moral norms, there would be some plausible answers to the “trolley problem.”26 A consistent set of moral beliefs would require, even if persons ranked harms differently, there at least be consistency in their answers to these types of problems. However, three decades of philosophical research and analysis has yielded little results. The “trolley problem” helps illustrate the inconsistency in beliefs impartial rational persons have in regards to morality. Brand-Ballard contends that that the monistic approach forces consistency to something that will always be inconsistent. “Perhaps the cases that Descriptivitists and Principlists cannot resolve simply reflect the latent inconsistency of peoples considered convictions” (Brand-Ballard 2003, 240). If common morality is consistent in the easy cases, why can this not carry over and limit the number of hard moral cases?

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26 The trolley problem is this: a train is traveling down the tracks; you can save the four people on the tracks by pushing one person into the way of the train, thereby killing that person. Most people agree that it intuitively feels “right” to kill that one person to save four. However, if the example is one of killing a random person and donating their organs to save four other people who will die if they do not receive the organs, strikes most as intuitively wrong.
Brand-Ballard is not criticizing the use of the ten moral rules as a bioethical theory for application. His criticism is that un-resolvable cases stem from inconsistency in moral beliefs, not inconsistency in ranking of harms. However, admission of inconsistency of moral beliefs is problematic for the Moral Rules because it requires that morality is a consistent core of moral norms, ten rules that most people have and already do follow. Brand-Ballard admits that the problem of consistency is a problem for academic philosophers and not just biomedical ethicists. He points out that there are implications for the future by accepting that common morality is inconsistent. As long as the assumption of consistency is accepted, the harder problems will persist and impede the development of viable theoretical solutions to bioethical problems.

Conclusion

Criticism of the Moral Rules is from several different vantage points. The criticisms of Carson Strong attacks Gert, Clouser, and Culver’s claim the Moral Rules are currently applicable to bioethics. Strong attacks this claim because within the Moral Rules system questions of morality translate into questions of irrationality. What was a moral dilemma is now a question of ranking irrationality. According to Strong, the descriptivists push back the moral question another level and sidestep the issue. Out of all the criticism, this is the weakest one against Moral Rules. As stated before, the question of irrationality comes down to list and it is clear what is acceptable. Physician, philosophers, and rational persons looking at the relevant facts of the case can answer the question of what is irrational. If the patient ranks harms such as several hours of discomfort during physical rehabilitation as too much even though the rehabilitation will prevent years of painful discomfort, the ranking is irrational. Some contend that the
ranking is self-destructive, but not necessarily irrational. This counter point is particularly difficult for Moral Rules to answer. However, the Moral Rules would again point to the ranking of harms (hours of painful discomfort versus years of painful discomfort) as irrational ranking.

The criticism over translating is a practical question. Gert does not show examples of how a complex medical dilemma translates into rational required beliefs that all rational persons understand. Until Gert provides a detailed example of the translation process, the translation process will be problematic and open to criticism.

Brand-Ballard concisely points out that the Moral Rules (and Principlism) build upon the assumption that morality is consistent. He contends that this assumption is problematic because the Moral Rules attributes moral disagreement to differences in ranking of harms, instead of the inconsistency of the common morality. An example of why the differences are due to inconsistencies of common morality and not differences in ranking harms is that while Gert claims everyone may rank harms differently, there is an assumption that everyone is in agreement on what is a harm. Common morality claims a consistency in identifying harm. Brand-Ballard claims that there is no consistent agreement on what is harm. Some groups, societies such as in Japan or Greece, perceive a slight to a family’s honor just as demoralizing as any set back of interests, while to those of us in the U.S. it is merely an insult, but not harm. By misconceiving morality as consistent, Brand-Ballard thinks there will be problems in bioethics in the future. “The longer we wait before addressing possible inconsistencies in common morality, the more these inconsistencies will infect our developing of solutions to hard cases” (Brand-
Ballard 2003, 255). The way to avoid future problems is by admitting that common morality is inconsistent in some of its beliefs.

Why the Moral Rules are Better

The Moral Rules gives medical professionals three advantages over Principlism when dealing with bioethical dilemmas. First, the Moral Rules not only admits, but also insists there will always be moral disagreement. Second, the Moral Rules is systematic and therefore more clear and concise for use by medical professionals. Third, the Moral Rules and its foundation in nonmaleficence make it ably equipped to deal with future dilemmas that result from medical and technological breakthroughs. These advantages make it better suited for use by medical professionals.

The first advantage for the Moral Rules is admittance and insistence of no unique answers to every moral question. There are and will always be un-resolvable moral disagreements. Disagreements arise because of different ranking of harms amongst rational agents. For medical professionals it is an important realization that, regardless of the available facts, there is no ubiquitous agreement on ethical dilemmas. Realization and acceptance of unavoidable disagreement helps the medical profession adjust their policies. Realization of moral disagreement leads to developing precise policies for intractable problems. An example would be a hospital policy of administering blood transfusions against a patient’s wishes if that patient is under the age of consent. In this instance, the medical profession and hospital can protect themselves from potential problems (lawsuits!) by having a policy in place. Another example is having a clear definition by which a person gains decision-making authority upon a patient becoming incompetent.
While Principlism also agrees there are un-resolvable moral disagreements, it does not explicitly identify this as resulting from different rankings of harm. Beauchamp and Childress claim moral disagreement is a problem of specification and balancing the principles. Beauchamp and Childress state, “On some occasions, moral dilemmas are so deep that specifying and balancing principles will not determine an overriding ought” (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 11).

Where the Moral Rules persistently and consistently assert of the existence of moral disagreement as part of the human condition, Principlism is not explicit enough in acknowledging moral disagreement. Principlism fails to convey the role moral disagreement in moral dilemmas. It is not a failure of specification and balance, but a reality of the human condition that there will not be agreement in all moral dilemmas.

The second advantage is the Moral Rule’s system is clear, concise, and aligns well with common sense. The delineation between the rules and the singular concept behind morality (nonmaleficence) is clear. Principlism is not systematic and the explanation of the interplay between principles, rules, and specification is vague and unclear. Beauchamp and Childress contend that while the roles of rules and principles rely on each other, they nonetheless different, “Principles are general norms that leave considerable room for judgment in many cases. They thus do not function as precise action guides that inform us in each circumstance how to act in the way that more detailed rules and judgments do” (Beauchamp and Childress, Principles of Biomedical Ethics 2001, 13). However, the explanation for the interplay between principles and rules is problematic. Beauchamp and Childress describe the interplay as the principles
providing support for rules, while the process of specification removes the abstraction and indeterminacy of the principle into something with action-guiding content. Despite this explanation, it remains unclear as to why a rule is not merely a transformed principle or a principle is an untransformed rule. Beauchamp and Childress use specification as the process of transforming principles into rules. As Beauchamp and Childress state, specification, “involves a progressive filling in and development of abstract content of principles, shedding their indeterminateness and thereby providing action-guiding content” (T. L. Beauchamp 2000, 344). Yet, specification still does not bring clarity to the issue of explaining interplay between principles and rules.

The Moral Rules is systematized, clear, and concise on the interplay between all its features, whereas, Principlism fails to provide an adequate explanation of the interplay between its features or at the least provide an “action guide” for medical professionals to follow. This failure to provide an adequate explanation of Principlism and the interplay between its features will result in medical professionals adhering to a system they do not clearly understand. For the medical professional it is time consuming and confusing to determine which principle takes precedence during an ethical dilemma, which principles support which rules, all the while using specification to achieve reflective equilibrium with these factors. Since the medical profession will not clearly understand the inner mechanics of Principlism, their explanations and justification for procedures will also be unclear and vague.

For the sake of clarity, the Moral Rules give the medical professional a better base. The Moral Rules specifically focuses in the rule violation. Principlism uses a
complex form of deliberation, whereas, the Moral Rules uses a checklist (the ten moral rules) to determine the specific focus of the ethical dilemma. Additionally, the two-step rule violation process allows for justification of violations. The second step strengthens the rule violation process. The second step determines whether impartial rational persons would endorse the rule violation as public policy. This allows a doctor to conceptualize the impact of decisions on medical policy as a whole and it forces doctors to realize, while certain decisions might be personally satisfying, they fail as public medical policy. An example fleshes out the advantage Moral Rules has and further criticizes the problems of Principlism.

An 18-year-old female patient visits her physician for a checkup. The patient claims not to be sexually active, but the physician considers her a good candidate for inoculation against HPV. Nonetheless, the patient claims because she is not sexually active the inoculation is unnecessary. The dilemma for the physician is deciding which principle to use as a guide for the course of action. The patient is clearly cogent so there is reason to respect the principle of autonomy (a norm of respecting the decision-making capacities of autonomous persons). However, another consideration for the physician is that the inoculation for HPV will prevent future harm; hence, the principle of Nonmaleficence comes into play. Alternatively, the physician claim that due to the principle of beneficence the cost of current inoculation, in terms of money or pain, outweighs the future risks/cost of a future case of cervical cancer.

In this case, the physician could choose one or all principles and have adequate justification since all the principles carry similar weight and scope. The evidence under-
determines the principle and herein is the problem: the physician’s preference makes the decision. In this case, Principlism does not provide a guide for the physician’s decision. In dealing with difficult cases, Principlism provides no guidance for the decision.

In this case, the application of the Moral Rules is superior. The Moral Rules act as binary operators. As the physician consults the rules, the rules either apply or not. We only consider those rules that apply. This application of the rules, “weeds out,” rules which do not directly apply. In this case, the one Moral Rule that is eligible for consideration is rule #6 *Do not deprive of freedom* (includes freedom from being acted upon as well as depriving one of the opportunity to act). In this case, failing to inoculate will result in greater pain for the future. Even if the risk of cervical cancer is low, the benefits of inoculation greatly exceed that risk. Next, the physician applies the ten morally relevant questions to the dilemma. In this case, question #2 specifically determines that failing to inoculate will cause greater future harm, thus the Moral Rules systemization not only provides a possible course of action, but also supplies a justification for the action. Principlism’s lack of systemization forces physicians to choose one of the principles by mere personal preference instead of providing the physician with a justified course of action. In doing so, Principlism fails as an adequate guide for the medical professional.

Some will contend the above example as unfair because of underdetermination. The evidence of the patient, inculcation, and HPV underdetermine the justification for a course of action. In other words, this means that since the evidence does not support any theory, such as Principlism, it would also not support the Moral Rules.
However, this criticism illustrates the third advantage of the Moral Rules. The third advantage is the Moral Rules concept of nonmaleficence. In determining the course of action for physicians, removing or reducing harm is always present. Therefore, even if the evidence is conflicting, unavailable, or underdetermined, the concept of nonmaleficence assists the physician in making a decision. The physician should always choose to do less harm. With Principlism, since there is no fundamental concept the decision comes down to doctor’s preference. With the Moral Rules, the concept of nonmaleficence provides minimum guidance for the physician. I use the phrase ‘guidance’ because it is important to note that I am not claiming that every case reduces to a case of nonmaleficence. I merely claim that the concept of nonmaleficence provides guidance when nothing else is available. In cases where there is no evidence to determine the course of action, then nonmaleficence guides the physicians into a course of action that reduces or avoids harm. Principlism has no fundamental concept and in these cases, as well as the example cited above, the physician has no guidance from Principlism and instead relies on personal preference. The advantage of nonmaleficence and the Moral Rules goes beyond the confines of medicine.

Nonmaleficence proactively guides other decisions, decisions that are at the intersection of medicine and policy. This is the third and final advantage of the Moral Rules: Moral Rules and its foundation in nonmaleficence make it ably equipped to deal with future dilemmas that result from medical and technological breakthroughs.
Nonmaleficence is able to guide policies in medicine as technologies advance. A recent example is the area of genetic engineering. The nonmaleficence concept in the Moral Rules allows for adopting a policy of removing the “harm” from human genetics, i.e. removal of hereditary diseases like Huntington’s disease, Cystic Fibrosis, etc. The Moral Rules provide scientists with a list of ten rules not to violate in their research or work. A scientist working in the field of cloning now has an underlying conceptual theme to follow i.e., avoid harm, in this case remove genetic diseases. By not violating the Moral Rules, the scientist has guidelines to keep their work ethical. This is one example, but the Moral Rules system is capable of dealing with the potential moral dilemmas any new technologies could supply, because the Moral Rules rule violation process has greater emphasis on public policy. The last part of the two –step rule violation procedure demands the person (or a community) envision the implications of allowing the rule violation. In this sense, the Moral Rules has its focus squarely on policy and policy implications. With this focus, the Moral Rules will facilitate the adoption of new public policies for advancing technologies. The Moral Rules state the rules to follow and, conversely, it provides a clear guide for action i.e., which actions do not violate the moral rules and which actions do violate the moral rules. Using the Moral Rules there is clear instructions on how to construct a useable policy as a guideline for future actions, specifically adhering to a policy of nonmaleficence.

27 It is more than likely that human cloning has already occurred in some fashion by private medical firms (Kick 2001). Even if alterations have not occurred, the likelihood is that in the future we will have the technology to alter human genetics. Now is the time for the medical profession and science to use the concept of nonmaleficence and create a policy before such problems occur.
Principlism has no overarching (or underlying) conceptual notion behind it, nor does it have a methodology for dealing with principles in conflict. What guidelines does Principlism provide for future scientist working with human genetics? Principlism is so contextually sensitive to current medical dilemmas it cannot deal or foresee future problems, and offers no potential guidelines to follow. Principlism is composed of four principles that are vague obligations, not prescriptive or prohibitive rules. The principle of respect for autonomy is specific to medical dilemmas involving a patient’s decision-making capacity. It does not provide any insight into guidelines beyond focus on patient’s decision-making capacity. This principle, along with the other principles, provides no insight to problems outside or just peripherally beyond the scope of current medicine. In the case of genetic engineering, Principlism does not tell the scientist a set of guidelines to follow; Principlism does not give a scientist working in the area of cloning a guiding concept to follow.

In conclusion, because of the three advantages of the Moral Rules, it is better bioethical theory for medical professionals.
REFERENCES


