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[Book Review of] *Principles of Biomedical Ethics*, by Tom L. Beauchamp and James F. Childress

Terrence R. Ackerman

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beauty — entails dualism and dualism is a false position. Few people will deny that dualism is false, but dualism may be a red herring here. Perhaps the point at issue really concerns the extent to which the human biological body as we know it is an intrinsic good of a human person. It appears that for Grisez and Boyle the coverage extends to the entire biological body: arms and legs, heart and lungs. The compelling quality of their account may not be seen or felt, however, as one looks for the intrinsic good in the total human biological body of the self-respiring but brain-damaged person who is living out his life in an irreversible comatose state.

The service that Grisez and Boyle provide to the pro-life movement through *Life and Death with Liberty and Justice* should be reiterated. It will surely be advantageous for furthering pro-life objectives if people within the movement give the book the careful study it deserves.

— Patrick J. Coffey, Ph.D.
Associate Professor of Philosophy
Marquette University

Principles of Biomedical Ethics

Tom L. Beauchamp and James F. Childress

Oxford University Press, New York, N.Y., 1979. x + 314 pp., \$7.95 (paper).

Principles of Biomedical Ethics is an innovative book. Until now, most efforts to treat the full range of moral issues in medicine from the standpoint of a systematic moral theory have been provided by authors writing in one of the major theological traditions. This volume represents an attempt by moralists with scholarly facility in 20th century philosophical ethics to construct a set of moral principles for use in analyzing a broad spectrum of ethical dilemmas in health care. The philosophical elegance of the principles is commendable. Somewhat less satisfactory, however, is the manner in which the principles are applied to clinical medicine. What the volume seems to lack is a firm sense for some important philosophical lessons regarding the physician-patient relationship which clinical experience provides.

The authors propose to examine medico-moral issues primarily from the perspective of four principles: autonomy, nonmaleficence, beneficence and justice. Certain other principles, sometimes thought to be *sui generis*, are derived from some member of this set. For example, the duty of veracity is derived from the principle of autonomy. Autonomy requires consent by the patient or subject, and "consent cannot express autonomy unless it is informed, and it therefore depends on communication and ultimately on truth-telling" (p. 203). However, duties of fidelity, which are also a significant feature of professional-patient relationships, are created by voluntary actions such as the making of contracts. Oftentimes they "hinge on the terms of the relationship itself rather than on external principles" (p. 201). The various principles formulate *prima facie* duties — they indicate duties that "are on all occasions binding *unless* they are in conflict with stronger duties" (p. 45). Thus, the interpretation of principles, as well as some of their content, derives from W. D. Ross.

Each of the centrally important middle chapters focuses upon one of the four major principles. In each case, the relevant principle is explicated and then used to examine bioethical issues to which it is deemed to be most relevant. Although the

strategy is familiar, it raises some conceptual concern. If the important issues in medicine are generated by a conflict in the demands of competing principles, might not the strategy result in a less-than-balanced treatment of competing moral requirements?

The principle of autonomy is formulated in two moral rules. In regard to self-regarding conduct, persons should be free to perform whatever actions they wish. Moreover, in evaluating that conduct, we ought to respect them as persons with the same right to their judgments as we have to our own (p. 59). Applying the principle to the disclosure requirements for informed consent, the authors suggest that "whatever a reasonable person would judge material to the decision-making process should be disclosed, and, in addition, any remaining information material to an individual patient should be offered through a process of asking a patient what else he or she wishes to know . . ." (p. 73). The criterion nicely combines two prominent disclosure criteria discussed in the literature.

But the discussion fails to clarify the aim of the disclosure process, and consequently, the role of the physician in it. On one hand, respect for autonomy may require that the physician encourage the patient to determine for himself the appropriate plan of treatment. On this model, the physician should be an information provider only, seeking to elicit a decision from his patient on the basis of the disclosed information. On the other hand, respect for autonomy may only require that the physician be sure that his plans do not violate the patient's considered wishes. On this model, the physician should offer a determinate recommendation regarding treatment, using the informed consent process to ensure that the patient does not object to what he proposes.

The authors seem to favor the former interpretation. They support Capron's view that informed consent functions to *promote* autonomy and that it serves to provide persons with "the right to make decisions affecting their lives" (p. 63). They also suggest that informed consent serves to "promote individual thought and initiative" (p. 64). But if we accept the first interpretation of what autonomy requires, serious problems arise for the medical practitioner. Few patients wish to actively choose a plan of treatment themselves. If asked to do so, they are typically shocked, dismayed or confused. They prefer that the physician make the decision, subject to their approval. At any rate, since it makes for a considerable difference in the clinician's role, the authors might have been clearer about the demands placed upon the physician by the principle of autonomy in the informed consent setting.

The discussion of nonmaleficence is used as the basis for a careful discussion of decisions to withhold treatment for incompetents. Nonmaleficence is analyzed into duties to avoid intentional harm to others, to protect them from unjustified risk, and to exercise due care. Cases involving incompetents are classified into four types, the most controversial being that in which the patient has the ability to mentate, but no capacity to provide informed consent. This category includes defective newborns. The authors suggest that treatment decisions for these patients require a balancing of benefits and burdens for the patient. Although no comprehensive guidelines are proposed, some conditions are suggested. Following McCormick, it is claimed that unless a potential exists for meaningful human relationships, treatment is optional. Furthermore, mental retardation is not a legitimate consideration in deciding to withhold treatment. Finally, only the *patient's* interests should enter the calculation.

The discussion of decision-making procedures for incompetents is somewhat less acceptable. It is correctly suggested that final decisions should reside with the next of kin. But the role assigned to the physician is troublesome. Disagreeing with Robert Veatch who would limit the physician to the role of an information provider, the authors claim that the physician may "engage in moral discussions of the options" with families (p. 129). This is a step in the right direction. But they

fail to consider the significant clinical problem generated by families who are too guilty, remorseful or unrealistically hopeful to propose discontinuation of treatment for their loved ones. Once this problem is recognized, the physician may sometimes properly assume the task of firmly recommending the discontinuation of treatment.

The principle of beneficence is claimed to require the provision of certain minimal benefits and protection to each person, as well as the maximization of the balance of benefits over burdens we are able to produce in our actions (the latter requirement being the principle of utility, reduced to a *prima facie* duty). The analysis of beneficence sets the stage for a thorough discussion of medical paternalism — acting for a patient's good without his approval. The authors maintain that only "weak paternalism" is justified. That is, "to the extent one protects a person from harms produced by causes beyond his knowledge and control, the intervention has plausible claim to being morally justified, for his choices are substantially non-voluntary" (p. 163). Where the patient acts voluntarily, paternalistic behavior ("strong paternalism") is never justified. Thus, it may be permissible to temporarily continue the chronic uremia patient on dialysis, contrary to his stated wishes, if his refusal might be caused by the psychological effect of toxins in his blood. For if this factor is operative, his decision is due to a cause presently beyond his control.

A serious difficulty is that the authors concentrate almost exclusively on overriding a patient's *expressed desires*. However, paternalism might also involve the control of information which we convey to patients, and the best case for strong paternalism may relate to cases in the latter category. For example, a physician may believe it better to tell his patient that his chance to survive his cancer is "very guarded," rather than to say "it is less than 5%." Again, a physician may choose not to tell his patient that, within a few days, he will hemorrhage to death from the tumor which is eroding the blood vessels in his duodenal wall. In one case, a judgment is made that leaving some room for hope would be therapeutically best; in the other, that it would be cruel to tell the patient the grizzly details of how he will die. Yet in each case, the patient might be better able to specify his own wishes regarding care if the information were disclosed. Situations of this sort provide the best case for strong paternalism, but are not directly considered by the authors.

A related problem arises in the analysis of the duty of veracity in the chapter on the physician-patient relationship. Although a strong argument is made that deception, including lying, is not permissible in the therapeutic relationship, the argument does not show that non-deceptive *withholding* of certain information is not sometimes morally justified. (Cf. the above examples.)

Other discussions provide an insightful clarification of issues, but are less conclusive. In chapter six, for example, a helpful distinction is drawn among six different levels on which decisions regarding the just macro-allocation of health care monies must be made. No definitive theory of justice in macro-allocation is offered, but this suggests the complexity of the issues rather than any failing by the authors. What they do accomplish is a fine analysis of the various dimensions of the problem of justice and the distribution of health care goods.

In the final analysis, *Principles of Biomedical Ethics* offers the reader just what its title suggests — a useful framework of moral principles and distinctions for assessing moral issues in medicine. But the details of application, particularly as they relate to the role of the health care professional in the therapeutic relationship, remain to be worked out to the full satisfaction of ethicists and clinicians alike.

— Terrence F. Ackerman, Ph.D.
University of Tennessee Center for the Health Sciences