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Can Principlism Save Medical Ethics?

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In 1982 Stephen Toulmin wrote an essay, “How Medicine Saved the Life of Ethics.”¹ He had two conclusions: 1) philosophical ethics in the first half of the twentieth century had stagnated into metaethics; and 2) medical issues following the Second World War focused the moral debate and resulted in a resurgent aspect of ethics henceforth known as bioethics. Bioethics effectively displaced the traditional Hippocratic medical-ethical tradition. However, bioethics has more recently been criticized for a variety of reasons, not the least of which is that its midlevel principles lack ethical cogency. Traditional medical ethics, eclipsed for several decades, has certain core moral values that could possibly benefit principlism, the now dominant methodology of bioethics. Conceivably “medicine can again save the life of ethics.”

How Medicine Saved Ethics

Toulmin argued that ethics in the first half of the twentieth century was mired in metaethics. Metaethics was the arcane intellectual stalemate that resulted from the efforts to reconcile the various philosophical schools of ethics dominant in American universities at that time. This impasse was further complicated by the then current psychological and sociological theories of human behavior.

In a word, metaethics was too theoretical and too abstract. Toulmin felt that there was a need to go beyond esoteric general principles and rules and deal with

specific kinds of “cases.” Medicine provided these clinical cases for ethical discussion. The most dramatic, by far, were the Nazi human experimentation atrocities revealed at the Nuremberg trials. The United States also had its own examples of medical experimentation without informed consent, for example, the experimentation that took place at Tuskegee on African-Americans, and at Willowbrook on children. Other medical ethical issues included the definition of death, the allocation of kidney dialysis resources, as well as organ transplantation. These questions required practical solutions. Doctors, patients, the federal government, and society in general awaited answers. Seminars were held and commissions were appointed, the most prominent of which was the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research which issued the Belmont Report in 1979. This Report mandated informed consent prior to any human experimentation. These commissions were made up of a cross section of experts, principally scientists, but also including ethicists.

In forming the National Commission in 1974 the Congress specifically charged it with the task of developing ethical standards. In the Commission’s Belmont Report a small group of eleven experts, attempting to find a public consensus on common moral ground settled on three principles: respect for persons, beneficence, and justice as their basic ethical foundation. These core principles form the basis of “principlism,” the regnant methodology of contemporary bioethics.

Subsequent federal legislation mandated institutional review boards (IRB’s) to approve institutional research and still later hospital ethics committees to review ethical questions arising in hospital settings. This proliferation of mandated committees required a geometric increase in the numbers of ethical “experts” to staff the thousands of IRB’s and hospital ethics committees. There are now, in addition, hundreds of bioethical institutes, think tanks, and consulting services that also have to be staffed.

Toulmin was prescient in 1982 when he wrote that medicine saved ethics. Medical questions have provided the subject matter for ethical discussions, and bio-

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6National Research Act, 88 STAT 342.

7Ibid., Action 212(a).

ethics is arguably the most prolific aspect of all contemporary ethical endeavors. These issues have indeed also created a bioethical-consulting industry that may have exceeded its mandate and mission. These excesses have created academic criticism and even a popular press backlash.9

Bioethical Dilemma

From the time the term “bioethics” was first recognized in 197210 until about 1990, the discipline enjoyed relatively unquestioned growth and success. The book *Principles of Biomedical Ethics* by Tom Beauchamp and James Childress,11 first published in 1979, and with four subsequent editions, became the bible of the movement. It explicated the three principles of the Belmont Report, added a fourth, nonmaleficence, and came to define the methodology known as “principlism.”

Principlism is an ethical method that allows an analysis of medical-moral cases by utilizing four midlevel principles: respect for persons (or, as it is now known, autonomy), beneficence, nonmaleficence, and justice. These four principles are applied after judgments and rules (the lowest level of ethical decision making) are rendered in specific clinical cases. For all practical purposes theory (the highest level of decision making) is not utilized. Since no basic (and oftentimes conflicting) theories, such as utilitarianism or deontology, are considered, there is usually a smooth consensus.

The discipline of bioethics is made up of several areas: theoretical bioethics, regulatory policy, cultural bioethics, and finally clinical bioethics.12 Most bioethicists, dealing with societal health care issues in a pluralistic society, can appropriately resolve them by consensus. However the area of clinical bioethics involves individual patients confronting illness and disease. The latter situations involve moral issues specific to human illness and suffering, and how patients and physicians resolve them. Clinical bioethics compromised its moral credibility when, in its effort to achieve consensus, it ignored the potential conflict between nonmaleficence and autonomy. For example, autonomy can violate the principle of nonmaleficence if the physician accedes to a patient’s request for a potentially harmful treatment, e.g., cosmetic surgery.

However, in spite of this apparent ecumenical ethic, bioethics as a discipline has come under increasingly more severe criticism. Dubose published a series of

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essays both criticizing principlism as well as suggesting a number of other ethical approaches to biomedical problems. The main criticism of principlism is the fact that it offers autonomy, beneficence, nonmaleficence, and justice as midlevel guidelines to be supported by theories which are left undefined. Consensus on ethical issues is more important than theoretical agreement in a pluralistic society. Disagreement over basic deontologic or utilitarian theories needs to be avoided. The four operative principles are noncontroversial and agreed to by practically everyone. It should be noted that over the years the principle of autonomy has assumed pride of place and now trumps most other considerations in ethics discussions.

It is perhaps inevitable that bioethics would be declared a “sick patient” in need of a cure. This is precisely what Dubose’s book does. Without an intellectual and philosophical foundation, the principles are simple platitudes to be manipulated to justify any ethical solution. This is especially true of the principle of autonomy. Autonomy, carried to its extreme, allows a person to do practically anything.

To address this issue many ethical alternatives have been offered including feminism, communitarianism, and casuistry. One option that has not been suggested is the Hippocratic ethic.

Medical Ethics to the Rescue

Medical ethics had been, for over two millennia, essentially the Hippocratic tradition. Hippocrates (460 B.C.–377 B.C.) was a Greek physician who founded the school of medical ethics that bears his name. His followers added medical treatises to the Hippocratic corpus; and the Hippocratic tradition was also influenced by Pythagorean philosophy. The Hippocratic Oath summarizes medical ethics as it was practiced for twenty-five hundred years up until about 1970 when it was supplanted by principlism.

The Oath is a covenant, or commitment, between the physician, the patient, and the gods. It begins with a sacred dedication and continues with a requirement for clinical competence and a promise to help, if possible, but certainly not to harm, the patient. The physician will maintain confidences and not take advantage of his position. Finally, he will respect and pass on his profession. The Oath is a moral commitment.

The two critical elements of the Hippocratic ethic are: 1) it is a covenantal bond between the physician and the patient; and 2) it is a pledge never to harm the patient. A covenant is more than a contract. The latter is legally binding and represents the level of ethical commitment. The former, a covenant, involves not only the physician and the patient but also a higher power, and it also assigns a moral imperative on the two parties.

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Secondly, the Oath commits the physician, again in a morally binding manner, not to harm the patient, even if requested. Bioethics, under the principle of autonomy, allows a patient to select a therapeutically harmful option. The physician in the Hippocratic tradition might understand the patient’s request, but he could not be the agent to execute a harmful request.

In the past century there have been profound influences on the practice of medicine. These include scientific and technological developments, government intervention, third party financing, and perhaps most importantly societal changes, particularly patient autonomy. Autonomy has led to the perception that the physician is now little more than a skilled technician to simply do what the patient wishes. Since ethical questions can now be resolved by bioethicists on the hospital bioethics committee, the physician need not even give moral issues much thought.

The principle of autonomy has been a wedge issue between principlism and the Hippocratic medical-ethical tradition, but it need not be. Our culture emphasizes, indeed absolutizes, autonomy, and criticizes medical ethics for paternalism or the denial of autonomy. But is there really an inevitable dichotomy? Edmund Pellegrino and David Thomasma address this conundrum with the concept of “beneficence in trust.” The physician can be no more paternalistic than the patient can be autonomous. In the Hippocratic tradition a physician is obligated to incorporate the patient’s values into decisions regarding that patient’s welfare. Likewise the patient, being sick and vulnerable, is never truly autonomous. The physician is covenantly obligated to respect the patient’s autonomy. Pellegrino’s “beneficence in trust” reconciles the apparent differences between paternalism and autonomy.

The Doctor—Patient Relationship

There are complex moral dilemmas in medicine, especially at the beginning and at the end of life. The command “not to harm” had been the cornerstone of medical ethics. Principlism recently displaced that dictum. The present decline of bioethics is largely the result of the void resulting from the replacing of the cornerstone of an ethical system that reflected moral wisdom derived from human experience over twenty-five centuries with self-centered autonomy. By the gradual erosion of the dictum “primum non nocere,” bioethics is approaching the irrelevance that metaethics assumed a century ago.

Contrary to the current bioethical outlook, the long Hippocratic tradition persists because there is an elemental human connection between a physician and a patient. The universal, intimate relationship between a competent healer and a suffering person has been, and will continue to be, a part of the human condition. As long as sickness and disease are part of human life there will be this unique doctor-patient bond. This relationship is simply an acknowledgment of the uniqueness and sacredness of the human person and his or her vulnerability. The Hippocratic tradition has added the covenantal bond and a pledge not to harm. Medicine is a moral act and “primum non nocere” sums up its ethic.

Bioethics can regain the moral high ground by reasserting the ethical tradition in the area of clinical bioethics. The doctor-patient moral relationship should be given pride of place in bioethics. The single essential imperative is not to harm. The human person deserves respect because he or she is unique and has inherent rights; and the acknowledgment of these rights is the hallmark of medical ethics. Medicine cannot but be a moral art.

Should bioethics recommit itself to a respect for the unique human person, it can regain the ethical stature it once had. Recorded history has noted the unique status of a knowledgeable, empathetic physician and a suffering fellow human person. This relationship was refined by the Hippocratic ethic and has served society well for twenty-five hundred years. Should bioethics acknowledge this concept it would restore much of the credibility it has lost. If so, Toulmin’s observation of “medicine saving ethics” would be repeated a second time.