

## *What Is Wrong with Global Bioethics? On the Limitations of the Four Principles Approach*

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Within the latter half of the 30-year history of bioethics there has been an increasing pressure to address bioethical issues globally. Bioethics is not traditionally a theory-based enterprise, rather the focus has been problem related. With the introduction of the global perspective, theory has, however, become more important. One of the best known, probably *the* best known, theory of bioethics is the one presented by Tom L. Beauchamp and James F. Childress in their *Principles of Biomedical Ethics* in 1979.<sup>1</sup> This theory is known as the “four principles” or the “Georgetown mantra” approach or “mid-level principlism.” It is the attempt to create a global framework for bioethics on the four principles—autonomy, justice, beneficence, and nonmaleficence—that I will scrutinize in this paper.

This paper grew out of boredom, emotional and cognitive. Ever since the publication of the *Principles of Biomedical Ethics*, the four principles have been widely criticized. Yet every time its proponents speak, they start with the conviction that the principles are universal. I, too, have had my share of this in various international conferences and seminars. Hence my boredom. In what follows, I will try, as many others have tried before me, to show that their assumption is wrong.

### **The Champions of the Four Principles**

The four principles approach is a theory that started out with the conviction that a consequentialist and a deontologist can share an understanding concerning morals, and thus a commonsense framework to fit all purposes was formulated. From the Western tradition, only one of the three main ethical theories, namely Aristotelianism, was left out, not to mention the ethical traditions of the rest of the world. The four principles are not intended to serve as an exhaustive theory but rather as a general set of principles. Nonetheless, two of the most prominent champions of the principles, Tom Beauchamp and Raanan Gillon, hold that the principles are a worthwhile instrument for developing global bioethics.<sup>2,3</sup>

In defense of the four principles, Gillon asks which, if any, of Beauchamp and Childress’s *prima facie* moral principles his reader would personally reject—and why? He seems to believe, correctly I assume, that the majority of his readers, if not all, will answer “none.” But then he goes on to argue that:

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[A]n analytic framework, elements of *common moral language* and a basic moral commitment for health care ethics that is neutral . . . and can be *shared by all regardless of their background* is surely too important a moral prize to be rejected carelessly, or for the fun of being a “Socratic gadfly” [emphasis added].<sup>4</sup>

I agree that if there were a possibility of a *common moral language that could be shared by all regardless of their background* it should not be carelessly rejected. But as a critic of the principles I still have two other options. I can either argue that there is no common moral language, or I can reject the four principles only after careful analysis. I will take the former route, although I believe that showing the shallowness of the presupposition of common moral language will qualify as “careful analysis” as well.

### **Everything That Is Good Is Good**

To be sure, we have the four principles—autonomy, justice, beneficence, and nonmaleficence—that we all agree upon. We all think that autonomy is good, that justice is good, that it is good to do good, and that it is good not to inflict harm. In short, by definition, we think that good is good. It is what constitutes the good in various circumstances that we cannot agree upon, and that is why I think that common words are not enough to build global ethics on.

In the spring of 1999, there was again in Finland the time for parliamentary elections. During the campaigns it became obvious that there was an overwhelming consensus among the rival parties that justice is important and that we should aim for a more just society. The only small difference between the parties was in the understanding of what justice is and what measures should be taken that justice would prevail. The right wing thought that by lowering the taxation of property and high salaries we would be able to do this. Meanwhile, the suggested solution from the left wing was to lower the taxation of the lower income groups and reaffirm the welfare rights, such as free education, free healthcare, and reasonable unemployment benefits. The political middle, representing the interests of agricultural Finland, reckoned that above all the government should fund the farmers. Same word, but different interpretations of what justly belongs to whom. Is it to everyone according to their need? An egalitarian principle to be found in Marxist thought as well. Or should we follow the libertarian idea of everyone owning their natural properties in good and in bad. If you happen to be faster, better, and smarter than the rest, you should have the benefits. And equally, if you get a raw deal in the natural lottery, it is your own problem. Should we in principle guarantee that everyone has equal opportunities, or should we go further and give fair equal opportunities for all? Within the sphere of bioethics, these questions arise especially in an age of scarcity. If we cannot help all patients, by which criteria are we able to say that X is to be treated whereas Y is to be left on his own? Political philosophy has struggled throughout its history with the question of what justice is. How can it suddenly become a nonquestion in bioethics?

The categories of beneficence and nonmaleficence are every bit as problematic. What does it mean to do good? Are “good” and “bad” objective or subjective categories? If objective, who is to be trusted to know what the objective truth is? If subjective, who is the one whose opinion we should listen to? The

patient, the customer, the doctor, the ethics committee, family members, or who? Questions of this type are often at the core of bioethical dilemmas. And good or bad to whom or to what? In bioethics we tend to say that surely it is the good of the patient. This, however, is just to hide behind yet another unclear concept. Is the patient to be understood as an individual, as a family member, or as a citizen? Is the good that we are aiming at good for her as an individual, as a family member, or good for her as a part of a social construction or another, or good for her in relation to, say, some divine truth? As most of these questions overlap with the themes that need to be considered in dealing with the principle of autonomy, I will now turn my attention directly to that principle.

### One Man's Autonomy Is Another Man's Prison

The concept of autonomy can be clarified with terms such as "self-rule" and "self-sufficiency," yet understood in various ways. The concept, even if not itself older than a couple hundred years, has its roots in ancient thought and its interpretations can roughly be divided into two. I will call them the rationalist and the empirical. What is it to be autonomous? According to the rationalist reading, a person is divided into a higher and a lower self. Usually the higher self is associated with reason and the lower with passions, desires, and the like. To be autonomous, according to this view, is to obey the higher self. According to the empirical concept, autonomy has mainly to do with others *not interfering* with one's own decisions, whether they are based on rational or emotional considerations.

The history of autonomy as rationality can be traced back to the beginning of Western philosophy as we know it. To Plato, a human soul was divided into three: reason (*nous*), courage (*thýmos*), and desire (*epithymia*). Of these, reason was the highest and should thus rule the person. If the term "autonomy" had been around, Plato could have said that an autonomous man is ruled by his reason. For Aristotle, the human soul was divided into the rational and the irrational parts, which were both further divided into subcategories. The true human *telos* was to be found on the rational side. Thus, the same reason-related prenotation of autonomy is to be found in Aristotle as well.<sup>5</sup> From the same era, we find the Stoics, who were preoccupied with the idea of a determined world to the degree that the role they had for reason was only to understand that we cannot change the world. But as this is the most we can do, they could as well have said (had they had the term) that the autonomous man is the one who calmly accepts the world as it is. From the eighteenth century, we find the paramount theorist of the rationalist interpretation of autonomy, namely Immanuel Kant. For Kant, to be autonomous, or positively free, is to be rational.<sup>6</sup> In bioethics, this opens the door for paternalistic interventions. To put it in other words, within the Kantian principle, the patient is allowed to make decisions concerning his treatment only as long as they are rational. If he fails to make rational decisions, he is no longer acting autonomously and thus his will can be overridden by other considerations. The problem is, of course, who is to determine which decisions are rational and how can a patient avoid Catch 22-situations?

Another understanding of autonomy can be found, in its classical form, in John Stuart Mill's *On Liberty*.<sup>7</sup> In this formulation, the one I have called empir-

ical, rationality plays an important role, but autonomous decisions are allowed to be based on other individual considerations as well. As an example of how these two different interpretations of autonomy lead to completely different practical conclusions, let me mention the question of genetic knowledge. According to Rosamond Rhodes, the Kantian concept of autonomy requires us *prima facie* to know every relevant thing regarding our health status. We cannot make fully informed decisions unless we know every relevant fact concerning our well-being, and therefore, we have at least a moral obligation to know about our genetic constitution.<sup>8</sup> According to the Millian reading, one is allowed to disregard genetic information, if one so wishes, and base her self-regarding considerations on other factors.<sup>9</sup>

### **Much Ado about Nothing**

In the brief analysis above there were probably more questions asked than answered, but that was rather the point. My argument is that the four principles are too vague to serve as a common ground for such a gigantic enterprise as global bioethics. As a starting point they have the problem of involving very thick concepts. We all read into them our own intuitions, and we have problems in analyzing them dispassionately. On the other hand, they are, I must admit, very useful in the political sphere, where agreement can, at the manifesto level, be reached and yet everyone can keep their own opinions. As an example of this, I will briefly look into two attempts to create global ethical standards for biomedical issues. These are the *Global Summit of National Bioethics Commissions: Tokyo Communique*<sup>10</sup> and *Standards for Hospitals* by the Joint Commission International Accreditation (a prepublication draft distributed by Mary Carroll Sullivan at the Second Annual International Bioethics Retreat in Florence, 1999).

The *Tokyo Communique* was intended to serve as “general guidelines for national bioethics commissions,” but it turned out to be a list of issues that those committees are likely to face. In short, it says that there are “ever more complex issues” that bioethical commissions are likely to face and it provides an open list of some of these, including scarcity of resources and selecting the sex of children. Then it takes up some issues that are likely to have international ramifications and concludes by stating that subjects of mutual interests should be studied further. This was a communique the participants—representing more than 30 countries and all continents—happily agreed to sign (I, too, I must confess). In the preparation phases there were suggestions to add some normative clauses to the communique, but lack of agreement on any of the issues made this impossible. Arguably, if the summit had started out with the four principles, the result might have looked different.

My second example, the *Standards for Hospitals*, has done just that and is therefore more interesting for my present purposes. The *Standards for Hospitals* is a Western project that is intended to be accepted by hospitals around the world. In the spirit of the four principles it actually has managed to produce some normative standards. These include “Care is *considerate* and *respectful* of the patient’s personal values, and beliefs (PFR.1.2),” “The organization *respects* patient wishes and preferences to withhold resuscitative services and forgo or withdraw life-sustaining treatments (PFR.2.3),” and “The organization has processes to assess and manage pain *appropriately* (PFR.2.4).” Italics in the stan-

dards are mine, and I have added them to highlight the connection with the principles. The standards that include the word “respect” are derived from the “(respect for) autonomy” principle, but as shown earlier there is no guarantee of what this means in practice. If the empirical reading of autonomy is chosen, then these standards imply that patient’s wishes should be followed. But if autonomy is understood in rationalistic terms, there is no reason why the medical staff cannot go against the patient’s wishes when they feel that the patient’s wishes are foolish. In the case of a patient who wishes her life-prolonging care to be terminated, the following argument could be used: “We (the hospital) respect her as an autonomous person by *not* following her wishes to withdraw life support, as there still is a good chance for her to stay conscious, even if paralyzed from the neck down. And unlike her, we (the medical staff) all share the *right* intuition that being paralyzed is not so bad and anyway better than dying.” In short, *respect* (for autonomy) can mean almost anything. The third standard cited above has to do with the principles of beneficence and nonmaleficence. Is pain always bad or is some pain necessary? And I do not mean medically necessary (e.g., if a patient’s nervous system needs to be tested for its ability to feel pain, the pain is medically necessary) but, rather, something like the old Christian idea of pain being good for us as persons. This standard leaves the hospital relatively free to treat pain in the way its doctors see fit. There are no universally shared ideals of the appropriate management of pain.

### Concepts in Themselves Remain Empty

It is not clear what the spokesmen of the four principles wish to achieve globally. Beauchamp says that the principles are meant to work as general guidelines only and that they “must be specified to suit the needs of particular contexts.” This can be given a relativistic interpretation that would entail that the four principles are globally recognizable, but that different cultures have different understandings of what they mean. I think that this would not be much of a foundation for global bioethics. This does not, however, seem to be the position Beauchamp himself holds. He speaks of “core dimensions of morality” that are embedded in all moral societies and respected by all “morally committed persons.” These include that promises are kept, the rights of others are respected, innocent persons are not killed or harmed, and children are not abused. This list does not say anything more precise than the principles did. Only after we have explicated what the rights of others are, who is innocent, what it means to abuse children (does very strict religious upbringing count as abuse?), and what counts as harm can some substance be given to these “common moral standards.” The standard stating that promises must be kept seems to say something. But as these are only *prima facie* principles that should not be violated without “morally good reasons,” even the prohibition against breaking a promise turns out to be empty as a universal principle.<sup>11</sup>

In this paper, I have argued that there are too many ways to interpret the four principles and that I therefore see very little use for them as foundations for global bioethics. Furthermore, there are other problems with the principles, even if they were given more precise definitions. These have to do with the balancing of the principles, should they be in conflict with each other.<sup>12</sup> As a reply to Raanan Gillon’s challenge, presented at the beginning of this paper, I

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conclude that even if globally understandable, the principles are not the expression of a common moral language that is shared universally. If there only were such a language, it should not go wasted, but in the light of what I and other numerous critics of the “Georgetown mantra” have said, we probably should not cling to something that simply is not there.

### Notes

1. Now in its fourth edition. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*, 4th ed. London/New York: Oxford University Press, 1994.
2. Beauchamp TL. The mettle of moral fundamentalism: a reply to Robert Baker. *Kennedy Institute of Ethics Journal* 1998;8:398-401.
3. Gillon R. Editorial: defending “the four principles” approach to biomedical ethics. *Journal of Medical Ethics* 1995;21:323-4.
4. Gillon R. The four principles revisited: a reappraisal. In: Gillon R, ed. *Principles of Health Care Ethics*. New York: Wiley, 1994:319-333 at 333.
5. Although the Aristotelian notion of “autonomy” is not part of the original idea of the principles, it has, however, been used in applications of the four principles to animal ethics. There it entails that to be autonomous is to fulfill one’s natural *telos*, which for humans is rationality but for animals what is typical to their species. See, for example, Mepham B. Ethical analysis of food biotechnologies: an evaluative framework. In: Mepham B, ed. *Food Ethics*. London/New York: Routledge, 1996:101-19.
6. Kant I. *The Metaphysics of Morals* (1797). Reprinted in: *Ethical Philosophy*, 2nd ed., Ellington JW, trans. Indianapolis: Hackett Publishing Company, 1994:12.
7. Mill JS. *On Liberty* (1859). Reprinted in: *On Liberty and the Subjection of Women*. Ware, Hertfordshire: Wordsworth Classics of World Literature, 1996.
8. Rhodes R. Genetic links, family ties, and social bonds: rights and responsibilities in the face of genetic knowledge. *Journal of Medicine and Philosophy* 1998;23:10-30.
9. Takala T. The right to genetic ignorance confirmed. *Bioethics* 1999;13:288-93.
10. Global Summit of National Bioethics Commissions: Tokyo Communiqué. *Eubios Journal of Asian and International Bioethics* 1999;9:3-4.
11. See note 2, Beauchamp 1998:394-6.
12. See, for example, Holm S. Not just autonomy: the principles of American biomedical ethics. *Journal of Medical Ethics* 1995;21:332-8.