1. Respect for Autonomy

Respect for autonomy centers on respecting persons’ capacities to make decisions for themselves.[6] In clinical settings, physicians typically evaluate patients’ decision-making capacities by checking whether patients can understand the diagnosis and available treatment options, appreciate the risks and benefits of treatments, and offer reasons for their decisions.[7] Competent adults are generally assumed to be able to decide what to do with their own healthcare, so long as medical professionals explain the diagnosis and treatment options in ways patients understand.

But autonomy comes in degrees. So, even though children do not have capacity to approve complicated, invasive procedures, they can choose their lunch or TV channel.[8]

However, patients’ capacities to make decisions can be impaired, for example by sedation or falling unconscious. To respect patient autonomy in these circumstances, practitioners should encourage advance directives, living wills, and clear conversations with loved ones about quality of life and what should happen if the patient needs resuscitation (e.g., CPR) or life support (e.g., breathing and feeding tubes). These documents and conversations enable medical teams and families to respect a patient’s autonomy, even when the patient cannot decide at that moment.[9]

2. Non-Maleficence and Beneficence

Non-maleficence means avoiding harm, and beneficence means doing good. Together, they represent two sides of the same coin, as medicine often sets health as its destination but painful, risky treatments as its path. You may hear medical practitioners say, “First, do no harm,” which aligns with non-maleficence. Or, “Cure sometimes, treat often, comfort always,” which lists the good things practitioners do, especially by being human in the alienating, stressful, and disempowering situations that patients face.[10] In conversations about non-maleficence and beneficence, practitioners often balance the harms and benefits of available options.

However, non-maleficence and beneficence sometimes conflict with autonomy. For example, doctors used to be comfortable with paternalism, or overriding patients’ wishes to do what is good for them. A paternalistic doctor in the 1970s might not have told a patient about their untreatable, terminal
lung cancer to avoid distressing them, non-maleficence thus overriding autonomy.\textsuperscript{[11]} Today, such paternalism is often condemned.\textsuperscript{[12]}

However conflicts between principles still occur. Consider a patient with a strict religious code who refuses simple-yet-life-saving treatments like blood transfusions. Medical practitioners might recommend the transfusion to help the patient survive (beneficence), but they may respect the autonomy of the patient to refuse, even if it leads to death.\textsuperscript{[13]}

3. Justice

Justice concerns the distribution of benefits and burdens in society: people should get what is fair. For medical ethics, this means asking who an institution serves, and at what cost to whom.\textsuperscript{[14]} For example, many wealthy countries provide their citizens access to state-funded healthcare. They think that providing medicine for citizens is fair, and that easy access to primary care physicians and preventive medicine bring overall costs down and health outcomes up. Some countries choose to redistribute wealth through taxes to contribute toward the flourishing of their citizens, not just those who can afford private insurance or emergency expenses.

Systemic issues are complex, involving policy, administrators, and legislators. Some physicians respond, therefore, that healthcare practitioners cannot address justice at the bedside and should just care for the patients in front of them. But practitioners can advocate for justice. They can always ask whether a practice, department, or organization can better accommodate marginalized groups or improve access to resources.\textsuperscript{[15]}

One contemporary example is offering gender-affirming categories on paperwork and shifting to specific questions that a practice needs to know (rather than relying on sex- or gender-based generalities). For example, rather than a colorectal surgeon asking whether patients are “male,” she could ask for age and whether they have prostates. Specific qualities or questions might be more relevant than gender or sex.\textsuperscript{[16]} Some trans patients report that bias or stigma prevents them from seeking medical care. As citizens with rights to healthcare, they shoulder unnecessary burdens and lack fair access to medical resources. But providing better training to healthcare teams, reevaluating intake procedures, and considering patient experiences can improve access to community resources. And this is all more just.

4. Conclusion: A Team Effort

*Respect for autonomy, non-maleficence, beneficence, and justice* work best together: no single principle always takes priority. In situations where principles conflict, Beauchamp and Childress argue that ethicists must work to balance the competing demands of the principles with the cases.\textsuperscript{[17]} While this guarantees no particular verdict, Beauchamp and Childress argue that this critical and open dialogue, involving all stakeholders, provides the best chance to resolve ethical problems. Given the influence of their approach, they may very well be right.\textsuperscript{[18]}

Notes

\textsuperscript{[1]} For introductions to two of these ethical theories see Deontology: *Kantian Ethics* by Andrew Chapman and Consequentialism by Shane Gronholz.


In the 1970s bioethics was not established as a field, though there was increasing pressure for it, especially coming on the heels of the *Nuremberg Code* (1949), *The Declaration of Helsinki* (1964), and *The Belmont Report* (1976), which all proposed guidelines for human research and argued that scientists and healthcare practitioners have moral obligations to uphold. (In fact, Tom Beauchamp was intimately involved with *The Belmont Report.*) Beauchamp and Childress’s method was new for bioethics. But it shares many similarities with: W. D. Ross, *The Right and the Good* (Oxford: Clarendon Press, 2002 [1930]), esp. ch. II. Ross also develops a set of what he calls “prima facie” duties that combines many traditions, where no single value takes absolute priority.

Medical ethics as a field was born of scientific and medical atrocities in the 20th century. For example, American scientist Charles Benedict Davenport, who earned his Ph.D. from and taught at Harvard, led the American eugenics movement. Many universities had eugenicist groups too, including Yale, Columbia, and Johns Hopkins. The Nazis took the ideas of the American movement and employed them through medical experiments on prisoners to find ways to sterilize minorities and facilitate genocide. Josef Mengele’s work at Auschwitz is the most infamous,

There were many other American experiments that brought wide scrutiny to medicine and science. The most notorious was the forty-year Tuskegee Syphilis Study in Tuskegee, Alabama. The United States government oversaw and funded experimenters to observe Black men infected with syphilis. These experimenters actively prevented the men from seeking treatment, and they continued observing the ill effects of syphilis for nearly two decades after the discovery and availability of penicillin as a treatment. Only media pressure stopped the experiment, as internal reviews done by doctors and scientists reached consensus to continue the experiment. For a history and analysis of ethical problems, see Allan M. Brandt, “Racism and Research: The Case of the Tuskegee Syphilis Study,” *Hastings Center Report*, rep. 8, no. 6 (Dec. 1978): pp. 21-9. For extensive histories of unethical medical research, see Harriet Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* (New York: Harlem Moon, 2006); Allen M. Hornblum, *Acres of Skin: Human Experiments at Holmesburg Prison* (New York: Routledge, 1998); and Carl Elliot, *White Coat, Black Hat: Adventures on the Dark Side of Medicine* (Boston: Beacon Press, 2011), esp. pp. 16-17, 147.

[3] Beauchamp and Childress were also conscious of how new technologies affected the field of bioethics. For example, consider the definition of death. In the past, doctors could reliably call a patient dead after he stopped breathing and began decaying. But the ventilator changed that. A corpse could keep “breathing” via mechanical aid, so the cessation of breathing did not seem an appropriate definition in all cases. Also, surgeons can save many lives by using the organs and tissues from a single corpse to provide transplants for ill patients. But these organs must be fresh. So, a definition of death needed to be precise enough to accurately declare a patient dead before the organs began decaying. Ventilators and organ transplantation techniques gave rise to new debates in bioethics. The same could be said about in vitro fertilization, genetic screening, and internet-enabled prostheses. Beauchamp and Childress think that their principles of biomedical ethics can help guide people moving forward.

[4] Beauchamp and Childress hold that these principles can help ethicists and practitioners do serious ethical work and avoid debates about ethical theories. Beauchamp and Childress did not seek absolute principles; instead, they wanted to facilitate reflection guided by earnest, critical conversants who sought to balance competing views with the goal of solving practical problems. Kantians might prioritize autonomy, consequentialists benifice and non-maleficence, natural law traditions justice, and virtue ethicists a mix. But Beauchamp and Childress want to avoid these theoretical debates and show that their principles can do useful work in bioethical contexts.

Yet it is precisely the combination of principles that has led some critics to say that Beauchamp and Childress's approach is incoherent, as the principles conflict so much as to be useless. See K. Danner Clouser and Bernard Gert, “A Critique of Principilism,” *The Journal of Medicine and Philosophy*, vol. 15, iss. 2 (Apr. 1990): pp. 219-36. Other critics argue that Beauchamp and Childress must add more principles to their system to get it to work because four principles alone will not capture the core values that all humans have. See Tom Walker, “What Principlism Misses,” *Journal of Medical Ethics*, vol. 35, iss. 4 (2009): pp. 229-31.

[5] As far as Beauchamp and Childress are concerned, no one principle takes priority. They explain, “Our position is that it is a mistake in biomedical ethics to assign priority a priori to any basic principle over other basic principles—as if morality is hierarchically structured or as if we must value one moral norm over another without consideration of particular circumstances. The best strategy is to appreciate the contributions and the limits of various principles, virtues, and rights, which is the strategy we have embraced since the first edition and continue throughout this edition.” *Principles*, p. ix. In other words, the four principles work together, and they often work in concert with other philosophical and religious traditions. For a critical discussion of such core principles, see Matti Häyrý, “European Values in Bioethics: Why, What, and How to Be Used?” *Theoretical Medicine and Bioethics: Philosophy*

[6] It is important to note that Beauchamp and Childress have been criticized for being too American, which pejoratively amounts to being too individualistic or too focused on individual autonomy. They explicitly deny this, “In a properly structured account of biomedical ethics, respect for autonomy has no distinctly American grounding and is not excessively individualist or overriding. We do not emphasize individual rights to the neglect or exclusion of social responsibilities and communal goals ... we have always argued that many competing moral considerations validly override [autonomy] under certain conditions.” Principles, p. ix.

Another complication is considering whether an individual ought to make the decisions, or whether a family might do so on behalf of the patient, as some Confucian traditions suggest. In other words, is the unit of autonomy an individual or a family? For example, if a patient is diagnosed with terminal cancer in China, the practice might choose to inform the family before informing the patient to see what the family wishes to tell the patient. The family may then decide not to reveal the diagnosis to the patient. It is a philosophical controversy as to whether this violates individual autonomy or affirms filial autonomy. See Daniel Fu-Chang Tsai, “Ancient Chinese Medical Ethics and the Four Principles of Biomedical Ethics,” Journal of Medical Ethics, vol 25 (1999): pp. 315-21.

[7] Usually physicians will assess capacity for autonomous decision-making, as they work closely with patients. But sometimes psychiatry departments may assist, and patients deemed unable to decide can be assigned parties to decide for them.

[8] Patient autonomy does not always trump physician autonomy. A patient must also be able to find a physician willing to perform the medical intervention. For example, healthy patients who would like their limbs amputated often face difficulty finding physicians to perform such procedures. It is not clear in these cases whether the patient’s autonomous decision to have their limbs amputated should be respected over a physician’s autonomous decision not to provide services to the patient without some illness that merits putting the patient at risk for the procedure. For contemporary cases, see Carl Elliot, “A New Way to Be Mad,” The Atlantic (Dec. 2000).

[9] Deciding things in a moment of crisis is more stressful than considering things ahead of time. During medical emergencies, incapacitated patients cannot decide for themselves, and families (if present at all) might find it difficult to think lucidly under duress or make life-altering or life-ending decisions on behalf of the patient. But advance directives and early, frank conversations between loved ones and the medical team can ensure that a patient’s autonomy is respected, and they can remove some of the burden from surrogate decision makers. Moreover, patients can revoke advance directives if there is a change of heart, so patients need not feel locked in.

[10] Both sayings are often attributed to Hippocrates, but, to my knowledge, neither can be traced to extant writings.


[12] In fact, detractors of paternalism argue that you cannot even understand what is good for patients without open conversations (thus undermining the assumed good of the paternalistic decision). But there are significant populations of physicians who assume that their patients would not like to know distressing information, even if they themselves would. And some patients do, in fact, prefer for physicians to make the best decisions for them. See L.J. Fallowfield, V.A. Jenkins, and H.A. Beveridge, “Truth may hurt but deceit hurts more: communication in palliative care,” Palliative Medicine, vol. 16 (2002): pp. 297-303. The authors, however, stress: “The important clinical point is, of course, to ensure that vigorous attempts are made to ascertain an individual’s preferences whatever his or her cultural background rather than to make assumptions about needs” (p. 298). This is especially important because patients witness their own health deteriorating. And if other family members know about a terminal diagnosis, not only might the truth slip out, but keeping the diagnosis from the patient
might discourage direct confrontation of things that need to be discussed before the patient’s death (p. 302).

[13] Some believe it is not the job of physicians to determine the good for their patients; it is only their job to communicate openly and let patients decide for themselves. See, for example, Richard Singelenberg, “Jehovah’s Witnesses—The Blood Transfusion Taboo,” Journal of Medical Ethics, vol. 27 (2001): p. 138. These cases are complicated when the patient needing the transfusion is a minor, setting a parent’s religiously-motivated wishes against the healthcare team’s concerns for the child’s physical health and future opportunities. For a discussion of future opportunities, see Dena S. Davis, “Genetic Dilemmas and the Child’s Right to an Open Future,” Hastings Center Report, vol. 27, no. 2 (1997): pp. 7-15.

[14] No theory of justice is assumed here. If readers are inclined to think through issues by trying to find consensus and paying special attention to fair distribution of resources, they may find the work of Norman Daniels helpful. See Just Health: Meeting Health Needs Fairly (Cambridge: Cambridge University Press, 2008). If readers are inclined to respect individual autonomy foremost and withhold as many judgments and values as possible from healthcare, they may find the work of H. Tristram Engelhardt, Jr. useful. See The Foundations of Bioethics, 2nd ed. (Oxford: Oxford University Press, 1996). If readers would rather focus on the list of goods and opportunities that make a life worth living, and using communities and institutions to ensure that people can flourish, they may find Martha Nussbaum’s work useful. See Creating Capabilities: The Human Development Approach (Cambridge, MA: Belknap, 2011). Each provides a different framework for asking questions about justice and determining what is owed to patients, citizens, practitioners, or others.

Elements of public health also deserve mention—e.g., access to clean air, water, and housing; access to grocery stores with nutritious food; and access to healthcare professionals and health education. So, the concern for justice will extend beyond the boundaries of a hospital. See Olga Khazan, “Being Black in American Can Be Hazardous to Your Health,” The Atlantic (July/Aug. 2018).

At the forefront of many people’s minds are legal concerns. Many large hospitals or medical companies employ legal teams, and private practitioners secure access to lawyers who specialize in medical law. Laws vary by region, and novel cases establish new precedent, so legal concerns surrounding medicine are best handled by those with proper credentials and abilities to give legal advice. However, it should be stressed that legal considerations are not equivalent to moral, ethical, social, or political concerns about justice. Legal actions are not necessarily just actions. Nazi experiments and segregation were legal but not just. And advocating for justice can lead to the courtroom.

[15] Gender and racial disparities in the American healthcare system are alarming. For example, Black women are three to four times more likely to die from pregnancy-related causes than white women. See Linda Villarosa, “Why America’s Black Mothers and Babies Are in a Life-or-Death Crisis,” New York Times Magazine (11 Apr. 2018). And pain reports by women are taken less seriously by physicians than those of men. See Joe Fassler, “How Doctors Take Women’s Pain Less Seriously,” The Atlantic (15 Oct. 2015).

[16] Lauren Freeman and Saray Ayala López, “Sex Categorization in Medical Contexts: A Cautionary Tale,” Kennedy Institute of Ethics Journal, vol. 28, no. 3 (Sept. 2019): pp. 243-80. The authors clarify: “... [W]hereas currently one of the first questions that patients are asked on patient in-take forms in medical contexts is whether they are male or female, we want to shift the focus away from this emphasis due to the many harmful consequences that can follow. The kind of change in thinking and practice that we are proposing requires a shift in medical education and training to include information about individual variability in relation to sex properties, controversies about determining someone’s sex, and information about the variety of bodies and needs, including those related to trans folks, intersex people, and those who are gender non-binary ... [W]ithin many medical contexts, relying on sex properties as opposed to sex categories can help to alleviate some of the harms faced by intersex, trans, and gender non-binary people.” (pp. 244-5).

[17] In clinical practices, decisions are best made by calling in nurses, doctors, social workers, chaplains, and ethicists, as well as patients and their families. Collaboration and open communication of the complexities of a decision almost always fare better than strong-arming a judgment. For a discussion of how Beauchamp and Childress address theoretical conflicts, see Principles, ch. 9.
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