Principlism and Its Alleged Competitors

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Kennedy Institute of Ethics Journal, Volume 5, Number 3, September 1995, pp. 181-198 (Article)

Published by The Johns Hopkins University Press
DOI: 10.1353/ken.0.0111

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ABSTRACT. Principles that provide general normative frameworks in bioethics have been criticized since the late 1980s, when several different methods and types of moral philosophy began to be proposed as alternatives or substitutes. Several accounts have emerged in recent years, including: (1) Impartial Rule Theory (supported in this issue by K. Danner Clouser), (2) Casuistry (supported in this issue by Albert Jonsen), and (3) Virtue Ethics (supported in this issue by Edmund D. Pellegrino). Although often presented as rival methods or theories, these approaches are consistent with and should not be considered adversaries of a principle-based account.

IN THE EARLY HISTORY of modern bioethics, principles were invoked to provide frameworks of general guidelines that condensed morality to its central elements and gave people from diverse fields an easily grasped set of moral standards. Principles gave an anchor to a youthful bioethics in the 1970s and early 1980s and contributed a sense that the field rests on something firmer than disciplinary bias or subjective judgment.

After the mid-1980s, however, serious questions were raised about the adequacy and sufficiency of frameworks of general principles. Several different methods or types of moral philosophy then came into prominence in bioethics. Although often presented as rival methods or theories, I believe these approaches are compatible with principles. I will argue for this thesis after outlining the approach to biomedical ethics that James Childress and I have defended since the mid-to-late 1970s, primarily in Principles of Biomedical Ethics.¹ Ours is not the only principle-based approach in bioethics, as Robert Veatch (1995) points out in his defense of a version of principles in this issue of the Kennedy Institute of Ethics Journal, but it is the only version I will discuss.
THE NATURE AND ROOTS OF PRINCIPLES

Childress and I use the term "principles" to designate the most general normative standards of conduct. Our set of principles was developed specifically for biomedical ethics and was never presented as a comprehensive ethical theory. In this respect, our account is similar to Edmund Pellegrino's and Robert Veatch's theories of medical ethics, but differs from Albert Jonsen's casuistry and K. Danner Clouser and Bernard Gert's impartial rule theory, which are general ethical theories developed independently of bioethics and then used to treat its problems. Childress and I use four principles as the basis of many more specific rules for health care and research ethics. However, neither rules nor judgments can be deduced directly from the principles, because additional interpretation, specification, and balancing of the principles is needed in order to formulate policies and decide about cases. Our system is therefore not an example of what has been called deductivism. We have been as interested in treating cases through the specification of principles as in the principles and rules themselves.

The principles in our framework are grouped under four general categories: (1) respect for autonomy, (2) nonmaleficence, (3) beneficence, and (4) justice. The choice of these four types of moral principle as the framework for moral decision making in health care derives in part from professional roles and traditions. Health professionals' obligations and virtues have for centuries been framed by professional commitments to provide medical care, to protect patients from the harms of disease, injury, and system failure, and to produce benefits that compensate for any harms introduced. These obligations have been expressed through rules of nonmaleficence and beneficence, and our principles build on this tradition.

But our structure of principles also reaches beyond these commitments by including parts of morality that traditionally have been neglected, especially respect for autonomy and justice. In the early days of modern bioethics, health care's traditional preoccupation with nonmaleficence-based and beneficence-based models of ethics needed correction toward an autonomy model of patient care at the same time as it needed to confront a wider set of moral and social concerns, particularly those of achieving social justice through the protection of vulnerable persons and through an appropriate social system for the distribution of
benefits and burdens. All four types of principle, then, are needed to provide a comprehensive framework for biomedical ethics.

Some writers distinguish sharply between principles and rules—see, for example, the discussion of Clouser and Gert, below—but Childress and I offer distinctions based only on differences in the level of abstraction. Principles and rules in our approach are explicated on the model of W. D. Ross's account of *prima facie* duties: Principles are always binding *unless* they conflict with other obligations (Ross 1939, pp. 19–36). When a conflict of norms occurs, some balance, harmony, or form of equilibrium between two or more norms must be found; or, alternatively, one norm overrides the other.

This way of handling conflict seems to our critics problematic, because principles seem too flexible and unable to resolve hard cases by themselves. Childress and I handle this problem through an account of balancing and specification, both of which involve the exercise of judgment in resolving conflicts. We see no reason why judgment by appeal to general principles should be condemned as "subjective" or merely "intuitive"—two terms of abuse at the hands of many writers in contemporary moral philosophy. From our perspective, the principles are not merely intuitive, and if an agent takes seriously the demands of the applicable set of principles and associated rules, then the judgments are neither subjective nor unprincipled.

However, this viewpoint requires amplification if principles are to be extended to policies and judgments. Many authors have pointed out that all general norms exhibit an indeterminacy that needs reduction, and principles are prime examples: They underdetermine almost all moral judgments because there is too little content in abstract principles themselves to determine concrete judgments. How is the underdetermined to become *determining*? How does one fill the gap between abstract principles and concrete judgments?

The answer is that norms must be specified to overcome their lack of content and to handle moral conflict. Specification is the progressive filling in and development of principles and rules, shedding their indeterminateness and thereby providing action-guiding content (Richardson 1990; DeGrazia 1992). Increase of substance through specification is essential for both policy and clinical decision making, but it is, in my judgment, more useful for the formulation of policy—itself a statement
of general norms—than for decision making in a particular case, which usually involves a balancing of moral considerations in a specific context.

Principles should therefore be understood less as norms that are applied, in the model of “applied ethics,” and more as guidelines that are interpreted and made specific for policy and clinical decision making. A coherent development of principles and rules, not merely an application, is essential. Clouser (1995) rightly insists in his article in this volume that we do not invent morality, in the sense of creating its basic norms. However, when we put general norms to work in particular contexts, we do invent through specification and judgment. That is, the norms are not invented, but inventiveness and imaginativeness in their use is essential and to be encouraged (Mackie 1977, pp. 30–49, 105–10, 122–24).

Moral progress is made through this work of specification, which often involves a balancing of considerations and interests, a stating of additional obligations, or the development of policy. Through progressive specification, bioethics becomes increasingly more practical, while maintaining fidelity to the original principles and rules. This specification is also connected, in our account, to a larger method of coherence: The best method for justifying a proposed specification is not determined by the model of specification, but by a coherence theory of justification.

In the current issue of this journal, Robert Veatch suggests that balancing models such as the one Childress and I adopt produce “strongly counter-intuitive implications” (p. 209), though he himself adopts a balancing model with constraints. He mentions problems in the history of medical research in which patients were, without their consent, exploited to the ends of science for the benefit of society. Presumably he has in mind Tuskegee-type cases or some of the more recent examples of unregulated human radiation experiments in the 1940s and 1950s. If public utility is sufficiently large in such cases, he suggests, “balancers” must allow it to override the considerations of autonomy on which rules of consent are based.

Veatch evidently would support a model of basic moral protections that cannot be violated under any circumstances, even if there is a clear and substantial benefit for society. His deontological restrictions are analogous to constitutional rights that constrain conduct and prohibit balancing of interests in various political and social matters. Writing in
the liberal individualist and contractarian traditions, he holds that a specified social space should be carved out within which the individual is absolutely protected against state or other forms of social intrusion. As he puts it in his prime example, we might “choose a rule that flatly prohibits research without consent.”

Veatch’s goal and the motivation behind it are commendable, but every attempt to carry it out in moral philosophy—through rules or other constraints that, in effect, are absolute—has failed. This approach to bioethics itself produces highly counter-intuitive results, because society and individual actors are absolutely rather than contingently constrained in many cases in which balancing is justified. A good example is the current absolute prohibition of physician-assisted suicide in physician ethics and social policy, even though a significant percentage of both the physician population and the public believes that at least some cases of physician-assisted suicide are justified. The absence of an appropriate mechanism for balancing patient needs and protection of society has led to serious problems because of an inability to meet the needs of dying patients in these cases.

A model of balancing keeps options open without “flatly prohibiting” them, as Veatch puts it. Consider, for example, how organ procurement policies might be restructured in the U.S. by balancing the interests of all who are affected by these policies. Protection of individual rights were paramount when the Uniform Anatomical Gift Act was adopted in the late 1960s and early 1970s, giving individuals the right to make decisions about the donation of their organs through a donor card. However, few individuals sign donor cards, and the signatures of those who do sign are often not available when they die. As a result, our capacity to promote the common good through more collectivist public policies has been paralyzed by a public policy entirely protective of autonomy rights. An absolutist account of individual rights leaves no opportunity to formulate more stringent policies for the procurement of tissues and organs, which I believe must be handled by balancing principles of public utility and respect for autonomy. The social ideals of beneficence are as critical to social morality as individual rights are.

With this account of principles before us, the discussion can now shift to contemporary writers in bioethics who present models that deemphasize principles, even if they do not altogether reject them. Several accounts have emerged in recent years, but I will consider only those
reflected in the other articles in the present issue of this journal. These alternatives are (1) Impartial Rule Theory (as defended in this issue by Clouser), (2) Casuistry (as defended in this issue by Jonsen), and (3) Virtue Ethics (as defended in this issue by Pellegrino). I will argue that these alternatives are consistent with and not rivals of a principle-based account.

CLOUSER AND GERT'S ALTERNATIVE: IMPARTIAL RULE THEORY

Dan Clouser and Bernard Gert coined the term "principlism" in an article that alleged certain defects or forms of incompleteness in the account of principles that Childress and I propose (Clouser and Gert 1990). Paradoxically, Clouser and Gert are probably as close to us in their conception of the content of morality and philosophical method as they are to any other writers in biomedical ethics. The problem is that, although they accept general rules of obligation, they do not believe that principles provide a reliable framework. They look to more specific rules arranged in a structured system as the proper surrogate.

Clouser and Gert have brought several accusations against principles, many of which are restated in Clouser's article in this issue of the Journal. In particular, they maintain that "principles" function more like chapter headings in a book than as directive rules and theories. That is, principles indicate important moral themes by providing a general label for those themes, but they do not function as practical action guides. Therefore, receiving no directive guidance from the principle, a moral agent thinking through a problem is free to deal with it in his or her own way and may give the principle whatever weight he or she wishes.

Clouser is particularly fond of pointing to these deficiencies in the principle(s) of justice. There is, he says, no specific guide to action or any theory of justice in the "principle(s)." Principlism instructs the agent to "Be alert to matters of justice" and "Think about justice," nothing more. Since this injunction vastly underdetermines solutions to problems of justice, the agent is free to decide what is just and unjust, as he or she sees fit. Other moral considerations besides the principle(s) of justice, such as intuitions and theories, are certain to be beckoned to determine the solution. Although more obvious in the case of justice, Clouser thinks the same problem afflicts all general principles. Our four-principle schema allegedly fails to provide a theory of justification or any kind of moral theory that systematically unifies the principles and situates
them in a tidy and integrated theory that can handle conflict among the principles (Clouser and Gert 1990, 1994; Green, Gert, and Clouser 1993).

These accusations are serious and merit sustained attention. For many years before Clouser and Gert stepped forward to critique our formulations, Childress and I viewed these problems as needing a deeper resolution than we had provided. We have tried to address a number of them by developing a coherence model of justification and the aforementioned methods of specification and balancing (Beauchamp and Childress 1994, Chs. 1–2). I cannot summarize these accounts here, but I do need to consider whether the rule-based alternative presented by Clouser and Gert is itself free of the problems they direct at us. If their system is free of these defects, then it clearly is a superior system. However, I believe their theory of impartial rules fares no better than our account and inconsistently incorporates some of the very views that it explicitly claims to reject.

The first matter of importance is the specificity and directiveness of general norms. Clouser and Gert maintain that our principles lack what their rules provide: a deep and directive moral substance. This point is obviously correct for unspecified principles, but their unspecified rules have a near-identical problem, one level down. Their rules, being one tier less abstract than principles, reside on the first level of the specification of principles; and it is only for this reason that their rules have a more directive and specific content. Childress and I have noted this problem about general principles since the first edition of Principles of Biomedical Ethics (in 1979). We have insisted that many rules must be much more specific than even the rules presented by Clouser and Gert and that mere unspecified principles are insufficient for practical decision making.

Moreover, a set of rules almost identical to Clouser and Gert's is already included in our account of principles and rules. We maintain that principles lend support to more specific and directive moral rules, including those accepted by Clouser and Gert, and that more than one principle—respect for autonomy and nonmaleficence, say—may support a single rule—of, for example, medical confidentiality. Below is a comparison between a sample of the rules we defend under the heading of the principle of nonmaleficence and a directly related sample of basic moral rules defended by Gert and Clouser:
4 Rules Based on Nonmaleficence

1. Do not kill.
2. Do not cause pain.
3. Do not incapacitate.
4. Do not deprive of goods.

No substantive moral difference distinguishes these two sets of rules. The method of deriving and supporting the rules is different in our accounts, but at present I only want to show that their rules either do not or need not differ in content from ours and that their rules are no more specific and directive than ours.

Second, Gert and Clouser are critical of us for making both non-maleficence and beneficence principles of obligation. They maintain that there are no moral rules of beneficence that state obligations; our only obligations in the moral life, apart from duties encountered in roles and other stations of duty, are captured by moral rules of nonmaleficence, which prohibit causing harm or evil. Their reason is that the goal of morality is the minimization of evil, not the promotion of good. Rational persons can act impartially at all times in regard to all persons with the aim of not causing evil, but they cannot impartially promote the good for all persons at all times. As Clouser puts it in his article in this journal (pp. 230-31):

Each of the moral rules admonishes us to avoid causing a harm...Thus the moral rules are formed around these harms to be avoided...They are all prohibitions...[By contrast,] moral ideals can only be encouraged...[The] principle of beneficence [a moral ideal] fails to recognize the limits, constraints, and dangers of the action-guide: “Help others.”

This thesis is neither morally correct nor supported within their own account of moral obligations. The major implication of this claim is that one is never morally required, i.e., obligated by moral rules, to prevent or remove harm or evil, but only to avoid causing it. There is no requirement to do anything, only to avoid causing harmful events. Childress and I believe this thesis misreads common morality. The following cases of what one is not obligated to do in the official Clouser-Gert account of obligations of beneficence indicate why we think their view is incorrect:

1. Mr. X's life is in great peril, but if I warn him through a phone call...
of the peril, he will be fine. I am not obligated to make the phone call.

2. A young toddler has wandered onto a busy street, having become separated from his mother. I can save his life simply by picking him up. It would be nice of me to do so, but I am not obligated to do so. After all, there are no obligations, ever, to prevent harm, apart from roles that fix obligations for us. A policeman would be obligated to lift the child from the street, but not I.

3. A blind man on the street has obviously lost his way, and he asks me for directions. I am not obligated to provide the directions.

4. I am the only witness to a serious automobile accident that has left the drivers unconscious. I am neither obligated to stop nor to pick up my car telephone and call an ambulance as I speed on my way.

These examples suggest that there are moral obligations of beneficence and that they should be included in any system whose goal is to capture the nature and scope of morality. If Clouser and Gert believe that we are never under such obligations and that a morality of obligations does not contain at least as much beneficence as these four examples suggest, then we do indeed deeply disagree about the content of morality. However, as Gert (1988) points out in his book, *Morality: A New Justification of the Moral Rules*, which Clouser acknowledges to be "the basis" of his understanding of method and content in ethics (p. 221), Gert does believe that one is morally obligated to act in circumstances precisely like those in my four examples. His reason is his acceptance of the general rule "Do your duty," which he gives an interpretation broad enough to incorporate the principle of beneficence. He explains his system and its commitments as follows:

Although duties, in general, go with offices, jobs, roles, etc., there are some duties that seem more general...A person has a duty...because of some special circumstances, for example, his job or his relationships...In any civilized society, if a child collapses in your arms, you have a duty to seek help. You cannot simply lay him out on the ground and walk away. In most civilized societies one has a duty to help when (1) one is in physical proximity to someone in need of help to avoid a serious evil, usually death or serious injury, (2) one is in a unique or close to unique position to provide that help and (3) it would be relatively cost-free for one to provide that help. (Gert 1988, pp. 154-55)
Although Gert insists that these requirements are all supported by the moral rule, “Do your duty,” they are effectively identical to those obligations that follow from what Childress and I call—following moral tradition in the eighteenth, nineteenth, and twentieth centuries—beneficence. It therefore cannot be the case that in Gert’s system there are no obligations of beneficence in our sense of beneficence. Gert and Clouser cannot be criticizing our views about beneficence, because we are in effect in agreement on all the substantive issues about what is morally required, even if our methods differ. Often when Clouser and Gert criticize our views it appears that they want to categorize all obligations of beneficence as moral ideals, but it would be inconsistent to take this line about our account of beneficence, given the latent commitments to beneficence in Gert’s book.

To generalize, a great deal in principlism that Clouser and Gert appear to reject can be situated in their account under Gert’s final rule, “Do your job” (or “Don’t avoid doing your job”). If this interpretation is correct, our theories are far more compatible than they allow, though it is always worth bearing in mind that Childress and I are defending only a professional ethics, not a general moral theory like Gert’s. But it is hard to see how the impartial rule theory of Clouser and Gert provides any real alternative to our substantive claims about the nature and scope of obligations. I have not here discussed methodology, but our methods are also, in many respects, compatible. Gert and Clouser therefore seem much more like good friends than hostile rivals.

I will now argue that much the same conclusion should be reached about Albert Jonsen’s defense of casuistry.

JONSEN’S ALTERNATIVE: CASUISTRY

Jonsen sees ethics as rooted in the experience of deciding hard cases. Like classical rhetoricians, the casuist is concerned about the resolution of cases that are unique in their circumstances, yet similar in relevant respects to other cases. Each change in the circumstances changes the case—a fact, Jonsen claims, that has been forgotten in recent moral philosophy. The casuistic method begins with paradigm cases whose moral features and conclusions have already been decided; it then compares the salient features in the paradigm cases—i.e., morally determinate cases—with the features of cases that require a decision. Analogical reasoning links one case to the next and serves as the primary model of moral rea-

As I understand him, Jonsen does not dismiss principles, but he does downgrade them in importance because he thinks moral reasoning starts at a different point. He places weight on shared maxims, which are normative statements that reflect a consensus of opinion, for example, "the intended effect must be to alleviate pain." These maxims inform judgment about the case by providing what Jonsen calls "the 'morals' of the story." In difficult cases, several morals emerge because maxims give conflicting advice. The casuist's job is to determine which maxim is to rule in the case and how powerfully it is to rule.

In a very important statement in his article in this journal, Jonsen writes:

When maxims, such as "Do no harm" or "Informed consent is obligatory," are invoked, they represent, as it were, cut-down versions of the major principles relevant to the topic, such as beneficence and autonomy cut down to fit the nature of the topic and the kinds of circumstances that pertain to it. (Jonsen 1995, p. 244)

This statement is no rejection of principles, and Jonsen rightly points out, in his informative segment on principles, that casuistry is "complementary to principles" in a manner that still needs to be worked out in moral philosophy (p. 249). In my view, in using the language of "cut-down versions"—one could also think of them as "built-up," since there is a specification of content rather than a pruning—Jonsen points in the same direction that Childress and I do in using the language of "specification," "support," and the like. Like us, Jonsen sees an intimate connection between principles and what we call progressive specification to rules (maxims, etc.) in order to meet the demands of particular contexts. His fear, which we share, is that principles will be interpreted inflexibly, without regard to the nuances of cases, generating a gridlock of conflicting principled stands.2 While Jonsen insists that principles and rules are too indeterminate to serve as the only basis of moral judgments and that the "application" of a principle to a case cannot be the basic model of moral reasoning, again, Childress and I quite agree.

In his early writings on casuistry, Jonsen seemed to many interpreters to say that cases lead to moral paradigms, analogies, and judgments by reference to the salient features of the case and without making any appeal to hidden evaluative assumptions (Wildes 1993). However,
Jonsen recognizes in his recent work that this way of portraying the case is improper. The salient moral features of cases cannot be recognized as such without assuming values already recognized as morally important. No fact or set of facts will lead to a moral conclusion unless some general value premises play a role in the reasoning. Jonsen’s account of maxims and principles now thoroughly appreciates this point.

The best way to understand his idea of paradigm cases is as a combination or blend of (1) facts that can be generalized to other cases—for example, “The patient refused the recommended treatment”—and (2) settle values—for example, “Competent patients have a right to refuse treatment.” In a principle-based system, these settled values are called principles, rules, rights, maxims, and the like; and they are analytically distinguished from the facts of particular cases. In casuistry, rather than separate values from facts, the two are bound together in the paradigm case; however, the central values are generalizable and must be preserved from one case to the next. For a casuist to reason morally, one or more settled values must connect the cases, hence the necessity of maxims. The greater the level of generality in the norms the closer the connecting norm will come to status as a rule or principle. But if the generality is at a very high level, a loss of specific guidance will occur, and the reasoning cannot handle a case.

Casuists and principlists should be able to agree that when they reflect on cases and policies, they rarely, if ever, have in hand either (1) principles that were formulated without reference to experience with cases or (2) paradigm cases that have not become paradigmatic because of a prior commitment to general norms. When philosophers now speak, as they often do, about “the top” (principles, theories) and “the bottom” (cases, individual judgments) in moral philosophy, it is doubtful that these poles can be either a starting point or a resting point without some form of cross-fertilization and mutual development. Childress and I have emphasized this point since the first edition of Principles of Biomedical Ethics by pointing out the dialectical character of moral reasoning, and, in the fourth edition, by developing its connection to reflective equilibrium.

I doubt that Jonsen has ever had any doubts about the need for principles to be brought into close connection with reasoning about particular cases and circumstances. It is a little known fact, but a fact nonetheless, that the final comprehensive drafting of The Belmont Report of the National Commission for the Protection of Human Subjects (1978), widely interpreted as a principlist document, was done by three people
in a small room at NIH: Al Jonsen, Stephen Toulmin, and me. Toulmin and Jonsen made significant and commendable contributions to the polishing of the statement of principles in that report. I do not recall any objection that the strategy of using principles should be anything other than central to the Commission's statement of its ethical framework, especially in the attempt to justify its reasoning about cases. They did, as one would expect, mention that the Commission was engaged in casuistry, but they understood the Commission's casuistry to be consistent with and supported by its invocations of moral principles. So, despite what several commentators have made of our differences in interpreting the work of the Commission (Moreno 1995, pp. 76-78), I believe those differences to be minor and insignificant.

It is hard to understand, then, how casuistry is a rival paradigm to principlism, although it has been so received in contemporary bioethics. Moreover, I believe the methodology for bioethics that Childress and I have defended—a method of coherence, specification, and balancing—need not deviate from the methods and standards proposed by Jonsen. If so, principlism and casuistry also seem more like allies than enemies.

PELLEGRINO'S ALTERNATIVE: VIRTUE THEORY

In addition to principles, obligations, rights, and cases, there are the agents who perform actions, have motives, and make judgments in cases. Proficient use of principles requires judgment, which depends on personal characteristics, such as a sense of personal responsibility and integrity. These properties of persons cannot be reduced either to principles or to behavior that conforms to principles. Sensitive and judicious decisions are not "principled" in the sense of being straightforward applications of principles. They are simply the judgments of sensitive and judicious persons. Childress and I have therefore always considered the virtues to be central to our system, and we claim that a moral philosophy rooted in the virtues complements a framework of principles.

Writers in virtue theory today sometimes suggest that virtues are more basic than, or at least more valuable than, principles (MacIntyre 1981; Hauerwas 1984; and see commentary by K. Baier 1988). Among the most interesting recent theses tending in this direction is that of Annette Baier (1994), who has written extensively about how the virtuous and tender sentiments, as Hume called them, are more pervasive in the moral life than normative precepts such as Kantian moral laws. She finds sympathy, virtue, and various emotional capacities at least as fundamental in
the moral life as the categories of rationality, obligation, justice, and rights. She argues that moral philosophy should broaden its scope to consider virtues of caring, loving, trusting, gentleness, and the like, and deemphasize the reigning Kantian framework of principles of autonomy and categories of duty and law.

Edmund Pellegrino in his contribution to this issue rightly does not insist on some form of competition between virtues and principles (Pellegrino 1995). He proposes to relate virtue-based theory to principle-based theory in order to achieve a comprehensive account adequate for the health professions. To this end, he discusses various relationships between principles, rules, and virtues, which he had treated more fully in previous works (Pellegrino and Thomasma 1993, pp. xii, 19–27, 183–91). He seems to believe, as Childress and I do, that principles and virtues are mutually supportive, rather than mutually exclusive, despite the fact that he emphasizes the foundational importance of virtue theory and describes his account as a virtue-based ethic.

Pellegrino stands in the tradition of those writings in ancient, medieval, and modern medicine that conceive the health professional's obligations and virtues through professional commitments to provide care. His reconstruction of the traditional beneficence model moves without fear of loss or theoretical problem between principles and virtues. Note the following quite explicit appeal to principles in an earlier book he coauthored with David Thomasma: "Beneficence remains the central moral principle of the ethics of medicine...Our aim is to redefine, and refine, the notion of beneficence in terms of the new practicalities and dimensions of the physician-patient relationship today" (Pellegrino and Thomasma 1988, pp. 7–8).

The operative concept in the beneficence model embraced by Pellegrino is what he calls beneficence-in-trust, meaning that physicians and patients hold in trust "the goal of acting in the best interests of one another in the relationship" (Pellegrino and Thomasma 1988, pp. 54–55). The trust aspect is the cement of the relationship, and in this way Pellegrino can make appeals to the principle of beneficence simultaneously with appeals to the importance of the virtues of benevolence and trustworthiness in physicians (Pellegrino and Thomasma 1988, pp. 25, 32, 46). This structure is similar to that which Childress and I adopt in our chapter on the virtues.

Virtue theory is of the highest importance in a health-care context because a morally good person with the right motives is more likely to
discern what should be done, to be motivated to do it, and to do it. The person who simply follows rules and possesses no special moral character may not be morally reliable. Often the reactions people have to those in the past who wronged patients—in research, for example—is that they lacked discernment, compassion, and trustworthiness, not that they failed to act in accordance with a rule or principle. People recommend and hold up as a moral model not the rule follower, but the person disposed by character to be attentive, generous, caring, compassionate, sympathetic, fair, and the like.

Again, however, there is no reason to suppose that we need to dispatch or minimize the importance of principles and rules in order to embrace these virtues. The two kinds of theory have different emphases, but they are compatible. A moral philosophy is simply more complete if the virtues are integrated with principles. Again, then, we have grounds to declare virtue theory and principlism partners rather than competitors.

Pellegrino (1995, p. 273) observes in his essay that:

Today's challenge is not how to demonstrate the superiority of one normative theory over the other, but rather how to relate each to the other in a matrix that does justice to each and assigns to each its proper normative force.

I quite agree. In this essay I have tried to show only that principles can still provide defensible normative frameworks in bioethics despite the criticisms of principles that have emerged since the late 1980s. Impartial rule theory, casuistry, and virtue ethics are all consistent with rather than rivals of a principle-based account when it is properly conceived.

NOTES


2. Jonsen's collaborator in casuistry Stephen Toulmin aims at "the cult of absolute principles" (Toulmin 1981, p. 37). Prima facie principles of the sort Childress and I accept thus do not seem to fall within the scope of his critique. Of course, any type of general norms—whether principles, maxims, or rules—can be interpreted either rigidly or flexibly, just as the principles in a principle-based system can be. There is no escape from rigidity merely by emphasizing the importance of cases and maxims.

3. The philosophical basis for this view of medical morality was developed in their first book, A Philosophical Basis of Medical Practice (Pellegrino and Thomasma 1981, esp. Ch. 9; see also Pellegrino 1979).

4. However, the Pellegrino-Thomasma defense of the beneficence model has structural features that make it very different from our system. They maintain the absoluteness of the principle that physicians should "act in the patient’s best interest."

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