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WMA 15 mins presentation at Berlin 6.10.22 Scientific Session on Medical Ethics in a Globalised World

Thanks so much for allowing me to present my support for the 'four principles approach' to medical ethics. I should declare a career-long enthusiasm for those Beauchamp and Childress four principles[1] and how pleased I am that, with the addition of a commitment to practise fairly and justly in the current proposed revision of the International Code of Medical Ethics, the WMA will (assuming that the revised code is accepted by the WMA Assembly in a few days time) have committed doctors to adopting, in addition to the original and ancient Hippocratic principles of beneficence and non maleficence also first a principle of respect for autonomy (added by the WMA in 2017 to the Declaration of Geneva, its updated version of the Hippocratic Oath), and now in 2022 the principle of justice or fairness, assuming as I said that the WMA *does* adopt the revised version of the Declaration of Geneva's companion document, the International Code of Medical Ethics.

In this talk I won't repeat a description of the 4pa or 'principlism' as it is more commonly called, which has just been summarised for us by one of its creators, Tom Beauchamp himself. Instead, in this conference about a globalised medical ethics, I want to focus on the international and intercultural advantages for the medical and other health care professions of adopting it – as so many doctors around the world already have.

Let me start however by acknowledging that the approach does not provide an ethical panacea. The principles as Tom has indicated are prima facie and there is no universalizable or generally acceptable approach to dealing with conflicts between the principles when they or their specifications conflict: as he indicated we need to use that mysterious capacity we have for making judgments- and as your famous philosopher Immanuel Kant pointed out we can't have a rule for making judgments between conflicting principles on pain of an infinite regress. Nor does the 4pa provide a method for deciding on the ***scope*** of these principles- to whom or even to what do we owe those prima facie moral obligations? And in the case of justice or fairness , which of several alternative principles should we chose? I'll suggest my own answer later. I along with Beauchamp and Childress simply acknowledge these inadequacies. Nonetheless acceptance of the four prima facie principles does provide some important advantages for medical ethics and especially for international and intercultural

[1] Beauchamp T, Childress J. Principles of biomedical ethics, 8th ed. New York, Oxford; Oxford University Press, 2019 (1st ed 1979).

medical ethics and in the next twelve minutes I'd like to focus on those advantages.

So what are those advantages?

The first major advantage as I see it is that the 4pa provides a set of very widely acceptable basic high level moral *commitments* to which the vast majority of the world's doctors could commit themselves - as many indeed already have- independently of, but consistent with, their *'overall'* moral perspective, whether this is religious, secular, philosophical, political or simply personal. Such acceptance is of huge benefit to a profession whose members and whose patients and populations may, and increasingly often do, have different '*overall*' moral perspectives and come from different cultures with different 'overall' religious or secular moral traditions.

As well as providing a set of four widely agreeable moral ***commitments*** that individual doctors and other health care workers can accept in their practice, whatever their *'overall'* approach to moral issues, the second major advantage of the four principles approach is that it can provide a moral and intellectual underpinning for the vast range of substantive and more specific moral norms and commitments accepted by doctors in their practice, and represented in the details of the proposed revision of the ICOME and in the many other ethics-orientated documents published by the WMA. Related advantages are that the 4pa can provide an ***analytic framework*** for thinking about medical ethical issues, and it also can provide important basic elements of an international and intercultural ***moral language***.

Benefit and harm in health care ethics

Let me look briefly at how the principles can morally underpin some of the numerous obligations we have as doctors. Beneficence and non-maleficence together underpin the moral commitment and obligation of clinician doctors to **benefit their *patients*' health** – one criterion for which is their ***wellbeing*** – and in the case of public health doctors their *populations'* health -- and to do so **with as little harm as possible and always with a justifiable expectation of net benefit**. This ancient moral commitment can be **found in the Hippocratic Oath**- or more accurately in the Hippocratic corpus of writings- and – unlike much else in that Oath- it **remains a basic moral commitment of the medical profession across the globe**. I call it **the Hippocratic Commitment** and it underpins a variety of more specific medical obligations. For example the obligation to undergo a **rigorous medical education and**

training and to continue updating these throughout a doctor's professional career. It also underpins the medical commitment **to carry out medical research** so as to discover more and better ways of providing health benefits, and- increasingly importantly- to discover more and better ways of minimising the inevitable harms and/or risks of harm that any attempts to benefit others carry with them. This is why of course the principle of beneficence must always be combined with the principle of non-maleficence, though the reverse is not necessarily true: there may be circumstances where we don't accept an obligation of beneficence but in which we nonetheless owe an obligation of non-maleficence. I may not owe the beggar in the street an obligation of beneficence but I certainly mustn't kick him in the face as I pass him by. And that incidentally is why we also need a basic principle of non-maleficence in addition to a principle of beneficence, as a sort of moral backstop for when we don't acknowledge, in any particular case or type of case, that we *have* an obligation of beneficence.

What about respect for autonomy in medical and health care ethics?

What about those two more recently adopted principles, respect for autonomy and justice? Respect for autonomy brings with it such normal moral concerns as **honesty and non-deceit and the need for doctors to obtain adequately informed consent** before they do things to patients (assuming of course that the patients are able to give such consent- that involves what I would call a ***scope*** issue, about which moral debate will continue even if we all accept the four principles). Obtaining informed consent requires doctors to find out where possible what autonomous **patients' own views** are about the harms and benefits of proposed interventions- and also to explain the basis for their own professional advice. **Respect for patients' confidences** is another requirement of respect for autonomy (though this is also justified by utilitarian welfare and harm/benefit considerations). Respect for autonomy underpins the normal moral obligation to **keep one's promises**- and therefore not to make promises that can't be kept. As Tom has pointed out the four principles are not prioritised so that one is more important than the others. I totally agree with them on this- but unlike them I have claimed that respect for autonomy is 'primus inter pares'- first among equals[2]- so the principles are still equals, but in relation to autonomous moral agents respect for their autonomy so often influences interpretation of the other three principles that in practice it ***tends*** to be 'first among equals'- but that doesn't mean that it shouldn't in many situations give

[2] Gillon R. Ethics needs principles- four can encompass the rest- and respect for autonomy should be 'first among equals' . JME 2003; 29: 307-312.

way to the other principles. However while I still defend my own claim, it's important to emphasise that my view is rejected in the canonical account of principlism, as Tom said in his talk.

Justice in health care ethics

As I've said, obligations of justice or fairness have increasingly been acknowledged to be a proper concern of medical ethics, especially in three of its aspects. **Distributive** justice requires fair allocation of scarce health care resources. **Rights based** justice requires recognition of people's rights and especially of their human rights. And **Legal justice** requires respect for ***morally acceptable*** laws. Doctors have been disinclined to incorporate into medical ethics meritocratic aspects of justice, concerned with reward for merit, and retributive or corrective aspects of justice concerned with punishment for dismerit, though occasionally some doctors do argue that these aspects of justice should also be incorporated into decisions about allocating scarce health care resources.

That said, doctors- like the societies in which we function- have found justice the most difficult of 'the four principles' to incorporate into medical ethics, and indeed even to explain just what 'the principle of justice' actually means.

Alas the fact is that we just don't *have* an agreed *substantive* theory of justice- indeed Beauchamp and Childress give accounts of no fewer than six *types* of substantive theory of justice[3] the relative merits of which, they write, '[w]e will not attempt to assess….Rather, ***we use them as resources***,(my emphasis), with special attention to recent egalitarian thinking and proposals about the distribution of health care and public health resources'.[3] The chances of widespread agreement by doctors and other healthcare workers to settle on any one of those six types of substantive theories of justice in the foreseeable future are very remote.

What we do have however is widespread agreement on Aristotle's formal theory of justice which focuses on relevant equalities and inequalities. Now Aristotle was somewhat hampered by the fact that the Greek word δίκη (dike), usually translated as justice, also linguistically implied equality in the sense of equal division. He pointed out that justice certainly

[3] What they call the four traditional theories of justice based on utilitarianism, libertarianism, communitarianism and egalitarianism, along with more recent capability theories and well-being theories—see fn1, pp 270–281

couldn't *simply mean* equality or equal division, on pain of as he put it, 'complaints and quarrels' from equals who were treated unequally and from or about those whose relevant *inequalities* meant that they deserved to be treated unequally- either better or worse or simply differently- depending on the relevant inequalities. So justice, (when it wasn't being used as an overall term for morality) Aristotle argued, was a relational concept in which equals should be treated equally (health economists sometimes call this horizontal equity), while unequals should be treated unequally in proportion to the relevant inequality (vertical equity). This formulation is known as Aristotle's formal theory of justice. As Beauchamp and Childress point out, it has very little substantive content, and people have ever since argued and disagreed about what the relevant equalities and inequalities ***are or should*** *be* in different circumstances.

But recently I have been arguing that perhaps we are underestimating the importance of Aristotle's formal theory, with its substantive pointer to the moral importance of equalities and inequalities especially in the context of health inequalities. Actually I think that Aristotle's formal theory formal of justice could become of considerable practical value in healthcare if across the globe we use it as a starting point that *ethically requires* us to focus on equalities and inequalities- especially health inequalities- and always to treat others as equals and treat them equally *unless* there are moral justifications for not doing so. Where such justifications exist, for example in the context of health inequalities, we *should* treat people unequally, in proportion to the extent of their needs- the underlying moral assumption of national health services.

Of course in 15 minutes one can only select some important points but I hope that as a minimum I've convinced you of the value of incorporating these four prima facie principles within a globalised medical ethics.

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