THE MEDICAL COVENANT: A CORRECTIVE VISION?

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ABSTRACT

Contemporary bioethics is a field born of the necessity of its times. Its development and growth are largely propelled by the advances of medical technology, shaped by the wheel of crushing economics. Medical advances, by creating difficult moral dilemmas, probe the consciences of the profession and of society in general of the deeper ethical questions about humans, their humanity, their life and death.

Many theories or approaches have sprouted to meet the challenges or the tasks of solving these puzzling moral dilemmas. Of the maze of methods, the Four-Principle Approach espoused by Beauchamp and Childress seems to command the popularity of the field, of course, not without significant criticisms. The Medical Covenant is another method offered by William F. May and affirmed by others to be the "corrective lens" of contemporary bioethics. This dissertation seeks to contribute to the clarification project of the variegate bioethical methods, theories and approaches by examining this claim: Is the Medical Covenant a "corrective vision" to contemporary bioethics as reflected in the dominant Four-Principle Approach?

The dissertation attempts to answer this question by juxtaposing the two approaches side by side for five chosen topics in a method that includes A) an "unpacking" process, and B) a test of relevancy. The "unpacking" process attempts to unveil the underlying logic and philosophies of their positions and the bioethical options offered. A test of relevancy asks the question whether the "corrections," if any, offered by the Medical Covenant are relevant to the tasks of the bioethical enterprise. The dissertation finds the answers to both questions in the affirmative.
Introduction
Background

As we are writing, news items of tremendous bioethical implication break into the world scene almost every day. For instance, on June 27, 2000 the cross-Atlantic celebration of breaking the genetic code is on the front page of every newspaper. Flashy headline title like "Opening the book of life"¹ heralds in a new era of medicine, announcing the fact that the first drafts of the entire human genetic code has been successfully mapped. But the enthusiasm of this celebration between President Clinton and Mr. Blair is mixed with inspirational awe as well as certain misgivings about what it means to the future of humanity. Clinton captures the moment in inspirational and religious aura, "Today we are learning the language in which God created life ... We are gaining ever more awe for the complexity, the beauty, the wonder of God's most divine and sacred gift."² However, both Clinton and Blair warn of "the dangers that genetic information could be misapplied," and Clinton calls for "a joint effort to deal with the social, legal and ethical challenges" that the success of the Genome project has, unfortunately, imposed.

In the last four decades or so, bioethics as a field of study is practically shaped by headline news like this one. Advances in biomedical technology have catapulted the field of bioethics forward, leaving a trail of interesting but puzzling "social, legal and ethical challenges." For examples, in 1961 the technology for hemodialysis was invented. The first successful heart transplant was performed in 1967. Feats of human innovation like these stimulated debates about ethics of saving life and raised questions about the definition of death. Limited resources forced the

² Ibid.
formation of one of the first ethical committees consisting of laypersons (i.e. non-ethicists by profession) to decide literally “who should live, who should die,” in Seattle, Washington, where hemodialysis was developed. The list goes on and on.

Another key factor to shape the discipline of bioethics is the socio-economic contexts of the medical profession in the U.S. The medical profession traditionally employed a scheme called "fee-for-service" for the remuneration of its physicians. But embedded in this scheme is the tendency of the doctors to overtreat the patients with unnecessary tests and procedures, which resulted in unprecedented escalation of health care cost in the U.S. To stem the tide, the market place responds with the "managed care" movement, which features the health care insurers as middlemen who mixes health care with austere business ethics, interfering the contracted physicians and health care groups with skimpy compensation formula and cost-conscious medical procedures. This phenomenon also brings in a host of different ethical questions (to be explored in Chapter One), which also sends the field of bioethics clamoring for a response.

Out of the garden of bioethics bloom hundreds of flowers. This seems to be an apt description of the field of bioethics, particularly in the area of method, approach or theory construction. Historically, the first group of people in response to this challenge was the theologians, debating questions about experimentation and the protection of human subjects, about organ donations and transplants, about the definition of the beginning of life and that of death, about prenatal diagnosis and genetic engineering, and so on. The notable ones among them were Joseph Fletcher, Paul Ramsey, Daniel Callahan, James M. Gustafson, and Richard McCormick, just

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to name a few. Each of these ethicists drew heavily from their particular theological or religious traditions, Catholic, Protestant, or Jewish, shedding light on the morals of the new medicine. As a matter of fact, Daniel Callahan, one of the first moral philosophers in bioethics, acknowledged that when he "first became interested in bioethics in the mid-1960's, the only resources were theological or those drawn from within the traditions of medicine, themselves heavily shaped by religion."5

Other approaches proliferated, the casuists, the theoretical ethicists, the principlists, etc. Amidst the controversy of what constitutes the correct approach or method, the principlist approach, sometimes dubbed as "principlism," nevertheless, has achieved some kind of dominance. As Dubose, Hamel and O'Connell comment introducing their work, A Matter of Principles? Ferments in U.S. Bioethics, "Since its emergence some thirty years ago, bioethics in the United States has employed several methodologies, principlism - the use of moral principles to address issues and resolve case quandaries - has come to dominate."6 However, one hesitates to state that its hegemony is secured on a soundness of the basic approach or theoretical foundation. Rather its popularity comes as a result of the increasing secular nature of bioethics preferring more rationalistic approaches, therefore perceived as more neutral (rightly or wrongly), in formulation of public policies for bioethical matters in a pluralistic society. The shift from theological approach to rationalistic framework was signaled as the U.S. Government was drawn into bioethics through a series of national commissions appointed by the Presidents of the United States

5 Ibid., 1.
focusing on several pressing bioethical issues of the time. The most prominent one was the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, which produced *The Belmont Report* in 1978. It delineates three principles as pillars for treating human research subjects in bioethics: autonomy, beneficence, and justice. Despite its stated, limited scope, *The Belmont Report* has great influence in U.S. bioethics in general. The most significant of such influence would be *Principles of Biomedical Ethics*,\(^7\) co-authored by Beauchamp and Childress. The text, often used by the teaching and the practice of biomedical ethics in the U.S., has expanded the three principles contained in *The Belmont Report* into four (adding nonmaleficence) and redirected their scope from ethics of treating human research subjects to practice of bioethics in general. Thus Beauchamp and Childress' principlist approach is therefore sometimes referred to as the Four-Principle Approach. In a statement attesting to the dominance of Four-Principle approach, Dubose, Hamel and O'Connell state as a matter-of-factly, "*Principles of Biomedical Ethics* is a standard text in [bioethics] courses and a virtual bible to some practitioners."\(^8\)

Criticisms of the principlist approach arise from many quarters. Two major camps are most rigorous in their critiques of the approach. The first is a theory-based critique of "principlism", articulated by Clouser and Gert. They argue that principles in this approach are not meaningful as a guide of actions but "merely names for a collection of sometimes superficially related matters for consideration when dealing

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\(^7\) Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 4th ed. (New York: Oxford University Press, 1994). All quotation cited from this work will be from the 4th edition, unless otherwise indicated.

\(^8\) A Matter of Principles? i.
with a moral problem." These principles are drawn together in an ad hoc manner without an integrating or unifying moral theory behind it. Another major criticism comes from the camp of casuists. In contrast to the moral theorists, "a casuistry-based critique holds that "principlism" fails to give independent and sufficient attention to particular judgments about cases."\(^9\)

The Writings of William F. May

Amidst this milieu come the writings of William F. May in what May himself calls and Meilaender affirms the "corrected vision for medical ethics."\(^11\) In the fifteenth anniversary of the Hastings Center Report, six major figures of biomedical ethics were asked to name an article from the Report that had made a difference in their thinking or in the development of the field of bioethics. As if it was a demonstration of the impact of that "corrective vision," two of them independently named articles by William F. May.\(^12\) Alexander Morgan Capron remembered May's "Attitudes toward the Newly Dead." Robert Veatch singled out May's "Code, Covenant, Contract, or Philanthropy" and suggested that it had "contributed significantly to a shift in public views about codes of ethics."\(^13\)

If we are familiar with the corpus of May's writings, we would certainly recognize the Medical Covenant as a symbolic expression of May's "corrective vision" to bioethics, a field that has been inundated by principlist approaches. Assuredly May did not reject "principlism" per se, but he is far more interested in the


\(^12\) "On William F. May," 106.

symbols and images of human relationship that enable us to fathom the greater depth and meanings of our existence. Story, image, ritual and symbol are prominent in May's writings. In *The Physician's Covenant*, he uses five images to symbolize the relationship between the physician and the patient, of which the "physician's covenant" forms the overarching paradigm. In this approach, May believes that he has opened up new insights and possibilities for ethical decisions in matters of health, life or death, where the deductive method of "principlism" normally cannot reach.

For May, part of the task of ethics is to supply "a type of corrective lens" that enables us seeing "the distinction between what is and what ought to be." This seeing goes one step beyond the normal deductive method of logic and philosophy, which starts with what is known or certain and applies the reasoning in a downward fashion in reaching a conclusion. The "corrective vision", however, enables us to see the obscure, what is not known or distorted to begin with, therefore, rendering the conclusion or decision reached more whole. In this fashion, ethical theory as a corrective vision "opens up a wider horizon in which they [moral quandaries] may be seen for what they are and thus become other than they were."

In his essay, "On William F. May – Corrected Vision for Medical Ethics," Meilaender indeed thinks May's vision does provide the needed correction for bioethics. He affirms that, by going to May's writings, "we will learn ... something of what it means to think theologically, to let our ethical vision be corrected and

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14 The five images are: parent, fighter, technician, the physician's covenant, and the teacher. See William F. May, *The Physician's Covenant*.

15 Ibid., 13.

16 Ibid., 15.
transferred by the insights of Christian theology." He further points out the areas where he thinks May's view is corrective to current bioethics in general, but left them to the readers for verification. But if Meilaender is correct in affirming May's claim, it would be an illuminating and fruitful venture if May's vision for bioethics is juxtaposed with the field's mainstream method, the Four-Principle Approach of Beauchamp and Childress. This is something, somehow, Meilaender has not done.

The Chief Question Posed for the Dissertation

The chief concern or question that this dissertation is trying to address is therefore more specifically: Is the Medical Covenant envisioned by May a corrective vision to the mainline thinking of current bioethics as reflected in the Four-Principle approach of Beauchamp and Childress? In order to answer this question, the project for this dissertation has been conceived.

Method of Comparison

However, at this juncture, a legitimate question can be asked: In what way or method are we to compare these two approaches to bioethics? Childress in his defense for his approach has provided an interesting comparison of "principlism" with the theory-based approach of Clouser and Gert and the casuistry-based approach of Jonsen and Toulmin, using a practical issue of human fetal tissue transplantation research for discussion. In this discussion, he compares the resulting position of each approach, the logic and the rules or principles used to arrive at the position. He also discusses the nuance or implications of the resulting positions. His method,

18 What he has done instead is to espouse several reasons why he thinks May's vision is corrective to current thinking of bioethics, and also use two hard cases to illustrate his thesis. The areas he points out are the ethical interpretation of religious activities, the sentiment side of ethics, the covenantal framework of the physician-patient relationship, death not an ultimate evil. There is no direct interaction with bioethics' mainstream method, the Four-Principle approach.
though informal, can provide this dissertation a basic direction for comparison. Therefore, in our perusal of the two approaches, we need first to identify several key topics for the comparison, and secondly, we need to understand the basic philosophy or logical reasoning or belief that is behind the resulting positions. Meilaender, in his assessment of the methods employed in bioethics, makes the following observation, "No method, no theory, operates apart from a collection of background beliefs that inform the theory's use, but it is possible to ignore those background beliefs and suppose that we can 'do' bioethics without uncovering or unpacking them. Such attempts are, I think, ultimately futile." More often than people may suspect, it is the background beliefs or philosophies that drive the conclusions or whatever position people happen to adopt on given issues. Thus, "unpacking" the respective positions of the two approaches on selected topics will be the main stay of our method. However, the method of "unpacking" merely gives us an inside picture where the two camps are coming from. It still does not resolve the question whether May's positions on selected topics constitute "a corrective vision." In order to be a corrective measure to something, the measure must in some ways help or facilitate the solving of a problem or a puzzle, which the measure is designed to address in the first place. In other word, the correction must be relevant to the problem at hand. So is a bioethics theory or approach. Bioethical theories or approaches are not invented as idle intellectual exercises. They arise to address a problem, "not merely thinking about them," as asserted by the bioethics historian, Albert Jonsen. Thus, the guiding force of this comparison must be a measure of how well the two approaches

19 See Practical Reasoning in Bioethics, Chapter 2.
facilitate the addressing of the selected bioethical topics for the patients and their families. We believe it is therefore reasonable to consider that the human side of the equation is of paramount importance to bioethics. Chapter One of this dissertation, by going into the socio-economics contexts of bioethics in the U.S. shall give us a more comprehensive grasp of the bioethical problems that have surfaced in the U.S. By understanding the problems at hand, we may have a more accurate handle of what constitutes "a corrective vision." By listening to the seriously ill patients and their families, we may form a better picture of what are the problems and needs to be addressed. In such background perusal as provided in Chapter One, we come up with three key questions that can help us make the assessment of the two methods. The first key question is: Is the approach adequately addressing the human concerns of the seriously ill patients and their families? Second, what is the purported goal of the approach? The stated goal of the approach often determines whether the human side of bioethical issues will receive adequate priority or coverage. In Chapter One, we will see that some health care insurers mix the goal of profit with health care, and as a consequence, some patients suffer from that as the organization drives to provide health care at less cost. Third, what is the posited relationship between the physician and the patient in the approach? The physician-patient relationship taken often reflects the extent to which the approach is to take account of the human factors of many of these bioethical issues. All these three questions will help us see more clearly to what extent does the approach take account of the human side of bioethics. These three questions will form what we call "a relevancy test" in our comparison effort. Thus our project can be summarized as follows:
1. Topics for comparison:

A list of representative bioethical topics will be selected for the purpose of direct comparison between The Medical Covenant and the Four-Principle Approach. The list shall include topics that both sides have dealt with substantively so that substantive conclusions can be drawn. Minor issues where conclusions are tentative will be excluded. Topics that do not span mutual interests will be excluded. Time and space are also considerations. Therefore the list will not be exhaustive, and needs not it be. The purpose is to obtain a representative picture from the comparison that will enable us to answer the chief question posed for this dissertation. Thus we divide the topics of comparison into three categories according to the nature of issues. We will have topics that deal with issues 1) of personal nature, with patient or a single bioethical event as center, 2) that have broader social and professional implications, and 3) that concerns methodology. After all these considerations, the threefold comparison scheme includes:

I. Issues of personal nature, with patient or a single bioethical event as center (presented in Chapter Four):

   Euthanasia,
   Assisted suicide.

II. Issues that have broader social and professional implications (Chapter Five):

   Health care reform,
   Physician-patient relationship

III. Issues that concerns methodology (Chapter Six):

   Method

The threefold comparison scheme therefore consists of five topics to be compared. As devised, the comparison is still quite limited, but is believed to be
sufficient in covering the central concepts of The Medical Covenant - May's philosophy in bioethics. It should afford us a fair comparison of the two approaches in major areas. Under each of these topic headings, many issues are being discussed on both sides. For example, under the topic of euthanasia the following issues will be discussed: the principle of respect for the patient's autonomy, "informed consent," the definition of death, the difference between withdrawing and withholding treatment, the concept of medical futility and so on. Thus the breadth of these topics is wide enough for substantial comparison of the two approaches.

However, one limitation of this comparison method must be acknowledged. It is devised to answer the chief question (see above) for the dissertation. Therefore, one will find the comparison effort is largely geared toward that end and must not be considered as a comparison in general.

2. Method of Comparison

A. "Unpacking" of the respective positions

First of all, the resulting positions respective to the two approaches in regard to first four topics will be presented and compared. The respective methods or principles used to reach the resulting positions will then be analyzed. What is the logic used? What rules or concepts have been applied? Which philosophical, cultural, or religious tradition is the root of such thinking? What options are presented with the positions? Under each topic, these questions will guide the unpacking or the analyzing process of the two approaches. The fifth topic, method, is of different nature. The comparison is not a general comparison on method per se. The discussions will concentrate on identifying distinctive features of their methods
and illustrating how the methods used are actually linked to their conceptions of the task of bioethics.

B. Concluding the comparison and a test of relevancy

The second part of the method of comparison will seek the answer to the question posed in this dissertation: Is the Medical Covenant a corrective vision to the Four-Principle approach in bioethics? If yes, how is it a corrective vision? The three key questions mentioned above, as uncovered in Chapter One, will form a test of relevancy and will be used to guide the answer. Bioethics as a fledging discipline is called to address the health related problems of humankind. Any theories or approaches, if successful, need to address the human concerns well. It may be useful to repeat the three key questions here without elaboration. The first key question is: Is the approach adequately addressing the human concerns of the seriously ill patients and their family? Actually this is a question of relevancy. Second, what is the purported goal of the approach? Third, what is the posited relationship between the physician and the patient in the approach? The last two questions are useful in facilitating the answer for the question of relevancy. This part of the comparison will be presented in the concluding section of the dissertation at the end.

Introduction of Chapters

Chapter 1: The Socio-Economics Contexts of Bioethics in the U.S.

This chapter traces the rise of bioethics as the byproduct of the rapid advances of medical technology, which roughly have begun in the 1960s, and which have seen no end in sight heretofore. It also gives a brief description of the "managed care" movement, its success in controlling medical cost and, what is more important, its mishaps in patient care, as it attempts to mix austere business practices
with health care. A reflection of the socio-economics contexts of bioethics in the U.S. leads us back to the fundamental question of what gives rise to the discipline in the first place. Is it not human concerns, matters that deeply affect the seriously ills and their families that call the ethics of medicine into being? The measure of success of a bioethical theory or approach must be in large part how well it does address these concerns. With this in mind, three key questions are then identified in this chapter to guide us in the comparison of the two approaches.

Chapter 2: The Four-Principle Approach

This chapter gives an overall description of the Four-Principle Approach of Beauchamp and Childress. The description is based on the fourth edition of their text, *Principles of Biomedical Ethics*. Since their text provides a very systematic and comprehensive account of their approach, the presentation here is relatively straightforward.

Chapter 3: The Medical Covenant

The presentation of the Medical Covenant is not as straightforward as that of the Four-Principle Approach, for William F. May has yet to produce a systematic and comprehensive account of the Medical Covenant in one single volume. However, one can gather a fairly good picture through several pieces of his works, chief among which are *The Physician's Covenant*, and *Testing the Medical Covenant: Active Euthanasia and Health Care Reform*. Other essays are also instrumental in bringing closure to the picture, like "Code, Covenant, Contract, or Philanthropy."

Besides bringing out what May views as the physician's tasks, it is also attempted to bring out how May views the physician, the patient and the medical
institution as moral agents. The essential features of the Medical Covenant, its goal, its scope as well as its biblical root are also delineated.

Chapter 4: Comparison, Part I: Euthanasia and Assisted Suicide

Part I of the comparison covers the first two topics, euthanasia and assisted suicide. These two topics are related in a way, but actually involve different principles. Debates in euthanasia center on the distinction between killing and letting die, whereas assisted suicide pits patient's autonomy against the paternalism of the physicians or the caretakers. This chapter will reveal the positions of Beauchamp and Childress and May, and the respective arguments for their stands.

Chapter 5: Comparison, Part II: Health Care Reform and Physician-Patient Relationship

Part II of the comparison turns to two broader topics of health care, health care reform and physician-patient relationship. Health care reform in the U.S. has had a beleaguered history. By various sources, there are 40 million Americans without health insurance. The principle involved is distributive justice of health care resources. Both Beauchamp and Childress and May agree that if a significant portion of the community is excluded from health care, the system cannot be called just. Both call for health care reform in the U.S. health system, but they diverge in their justifications for doing so.

Their views on the physician-patient relationship also diverge markedly. For Beauchamp and Childress, the four principles that they espouse are central to their system, physician-patient relationship then consists of a set of rules derived from these principles. However, May view the relationship central in the Medical Covenant. Ethical behaviors then emanate from the understanding of the nature of
this relationship. These two frameworks produce markedly different results and make for an interesting comparison.

Chapter 6: Comparison, Part III: Method

Chapter six finds that it is necessary to present a comparison of the two methods. As one understands more clearly the philosophies or logic behind Beauchamp and Childress and May's many positions, one begins to gain a significant appreciation of the different methods they employ. Beauchamp and Childress basically employ a deductive method centered on a cluster of principles, rules and procedures. May, in contrast, employed a method that centers on a cluster of symbolic images, among which the covenant image serves as the main guiding one. In this chapter, we will find that the methods that they have chosen to present their approaches actually presage very much their views. That is why a study of method is important.

Conclusion: A Corrective Vision?

The conclusion attempts to give a definitive answer to the chief question posed in this dissertation and delineate the reasons why we draw such a conclusion. Furthermore, it uses the three key questions (see above) uncovered in Chapter One to guide the assessment. The three key questions thus framed actually constitute what we call a relevancy test. The final section will include a summary of some other findings that we believe are important.

Distinctive Features of the Dissertation

Thus is a brief description of the structure of this dissertation, which we would very much liken as a journey into the field of bioethics. There are a couple distinctive features of this journey that we'd like to mention. First of all, this is
probably the very first journey that a reader partakes that is actually crossing the boundary between the Christian and secular perspectives in bioethics. This dissertation undertakes the task of comparing two of these perspectives directly side by side. There have been very few of such interactions in the forum of bioethics. Many such interactions, if done at all, were done in an off-hand manner, or in a scope much smaller (like essays) than the one we are engaging. In the course of our research, many serious comparison studies surfaced, but they normally respect that gulf between religious and non-religious views. Secondly, we believe we are applying a very distinctive method for the comparison. Besides the threefold comparison scheme, the method includes 1) an unpacking process, and 2) a test of relevancy. In absence of any standard comparison procedures or methods, we believe the method employed represents a very fresh approach in the field of bioethics in this kind of endeavor.

22 We know of one exception. That is the Ph.D. dissertation of Virginia A. Sharpe, How the Liberal Ideal Fails as a Foundation for Medical Ethics or Medical Ethics "In a Different Voice," 1991.
Chapter 1

The Socio-Economic Contexts of Bioethics in the U.S.
Introduction

The rise of biomedical ethics as a discipline has a very brief, but interesting history. Many scholars date its beginning from the 1960s or 1970s only. But the brevity of its history really belies the social impact and turmoil of its events. As will be evident, the discipline of biomedical ethics in the United States arises largely out of necessity. One may characterize its development as a collective response from the academic world and society, to events driven by technological advances and the market phenomena of health care services. Many ethical theories, which we shall discuss later in this chapter, emerge from this ethos. The Four-Principle Approach to biomedical ethics of Beauchamp and Childress, and the Medical Covenant of William May, are two such streams of thoughts that attempt to make moral sense of this contemporary ethos of the medical world in the United States. In order to put these two schools of thoughts in proper perspective, a perusal of the technological and socio-economic contexts that give rise to their existence is necessary. In what follows, we shall trace very briefly the history of the predecessor of biomedical ethics - the old medical ethics, the role of technological advances, the market changes and the ascent of public bioethics. Although not exhaustively, we shall also lead a brief tour of the various ethical theories or models for biomedicine. With such an overview, it is believed that their conglomerate effects on the discipline, and the two schools of thought under examination, will be better fathomed.

1.0 The Rise of Bioethics

Despite the fact that the discipline of biomedical ethics has only emerged recently, its predecessor - medical ethics - has an antiquated history. Biomedical ethics has not made its appearance out of nothing. Though of significantly different
character, biomedical ethics in the United States finds some of its roots in the old medical ethics. As a matter of fact, medical ethics in its traditional form was still pervasive throughout the first half of the 20th century.

1.1 The Old Medical Ethics

According to Albert Jonsen, a bioethicist-historian, the old medical ethics can be recognized by the "three persistent themes" that constitute its traditional patterns and character.23 The first theme largely set forth the qualities of the physician in terms of decorum and deportment: how the doctor should behave toward her patient: gently, pleasantly, discreetly and firmly. These qualities are important in maintaining a favorable and trusting relationship. The second theme centered on the duties of the physician toward her patient, such as those embodied in the Hippocratic Oath. The classical injunction was the most often cited exhortation "to-benefit-the-sick-and-do-them-no-harm." Other duties also emerged frequently in the literature of the old medical ethics, such as keeping confidence, and refraining from monetary and sexual exploitation of vulnerable patients.

The third theme placed with greater emphasis on the physician's responsibility toward her society. As medicine was being taught in universities, and as guilds and colleges were established, the social dimension of medical ethics received prominence. Professional competence became a main component of that ethic, as physician's skills were honed for the services of the greater community. Thomas Percival, a professor of medicine in the University of Edinburgh, wrote the first book bearing the name Medical Ethics in 1803.24 He advocated the idea that

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23 Birth, 6-7.
24 Ibid., 7.
"the duties of 'office' had been granted to doctors by society as 'public trusts."' The Code of Ethics published by American Medical Association in 1847 was largely based on Percival's Medical Ethics. The Code of Ethics has received several revisions subsequently. The emphasis has been on social components like the physician's duty of gratuitous care for the sick poor, the forbidding of advertising and repudiation of quackery, etc. The emphasis on gratuitous care for the sick poor however, as we shall see with the drive of the economic engine in the U.S., seems to be relegated to much lesser importance in the new biomedical ethics.

That has been more or less the picture of old medical ethics, which prevailed until the middle of the 20th century. Albert Jonsen, the bioethics historian, noting the relatively benign character of the field prior to the birth of contemporary bioethics, makes the following comments in introducing his book, The Birth of Bioethics: "... they [writers of old medical ethics] seldom expressed perplexity before moral dilemmas. In all of this, the medical ethics of the past differs from the bioethics described in this book." However, as the human intellect soars to new heights expressed in the form of medical technological advances, that tranquillity in medical ethics has since been broken at a pace that caught many off-guard. Medical technology, leading the way to frontiers hitherto not crossed by humans, has unleashed waves of ethical questions and created serious medical dilemmas that challenge the conscience, and the traditional concepts of humanity. The impact of such sociological change, to be sure, is not limited to just a narrow sector of society, nor is its burden borne by just a single field. Many sectors of society and fields of disciplines are jostled by such phenomenal changes. In fact, contemporary

25 Ibid.
26 Ibid., 11.
biomedical ethics welds together the forces and minds of many disciplines, such as law, medicine, politics, economics, philosophy and theology. In what follows, we will present a brief sketch of the technological advances that have given birth to and propelled the movement of contemporary biomedical ethics.

1.2 Medical Technology

In the mid-twentieth century, the science of medicine broke much new ground, and the strongholds of many obstinate diseases began to crumble and yield to treatments. For example, in 1946, streptomycin was distributed widely as an effective cure for tuberculosis, and 1947 saw the first use of the drug methotrexate for treatment of acute leukemia. Polio vaccines were introduced in the mid-1950s. The first open-heart surgery was performed successfully in 1952 to replace a human heart valve. The indispensable modern respirator in today's intensive care units was invented roughly around 1952. The discovery of DNA by Watson and Crick was broached to the public in 1953. This important discovery empowered the modern eugenics movement that promises improvement of the human gene pool and treatments of hereditary diseases by manipulation of the genes. The renal dialysis machine was ushered onto the medical scene in 1962, and has since saved many lives from kidney failure. This series of events opened the second half of the twentieth century with high hopes and a sanguine optimism in the field of medicine that human intelligence and technology could one day conquer many dreaded diseases and ailments.

1.2.1 Organ Transplant Technologies

But these dramatic advances also heralded in an era of medicine beset with ethical dilemmas and moral conflicts between the physician and the patient, or
between the interests of the patient and that of society. For example, Drs. Joseph Murray and John Merrill succeeded in transplanting a healthy kidney from Ronald Herrick to his twin brother Richard in 1954. Subsequent success in the development of the drug azathioprine to suppress immune response brought a wave of organ transplantation. These events brought with them many hardcore ethical questions.

Dr. G. E. W. Wolstenholme was indeed compelled to ask:

> In what circumstances could a volunteer donor be considered free from undue influence [in offering her own healthy organ for transplant]? Does a parent always have the right to accept or refuse treatment of his child? What special protection must be given to minors, people of low intelligence, or prisoners in regard to clinical trials or donation of tissues? ... does the law permit operations which mutilate the donor for the advantage of another person? ... to what extent must a community underwrite the cost, however great, of the latest means of sustaining life? 27

These questions, which poke at the conscience of physician, patient and society-at-large, invite no easy answers. Furthermore, the shortage of available organs for transplant underscores the issue of equitable distribution. What distribution scheme constitutes fairness? The novel clinical situations created by transplant technology, combined with scarce resources also raise questions of authority. When an insufficient number of organs is available, who is to decide who should live?

### 1.2.2 The Renal Dialysis Machine

A similar situation existed when the dialysis machine was invented in the 1960s. Dr. Scribner invented a plastic arteriovenous shunt and cannula that allows patients dying of renal failure to be hooked up to a hemodialysis machine for chronic treatment. However, the success of chronic dialysis treatment created a distribution problem, because there were not enough machines available for the patients. In the Seattle Artificial Kidney Center at Swedish Hospital, two committees were established to solve this problem of scarce resource allocation. The first committee
was composed of physicians who would select patients medically and psychologically suitable for dialysis. The second committee, composed of seven anonymous members from various backgrounds - ministry, law, homemaking, business, etc. - would select patients for treatment based on non-medical criteria. This "lay committee" drew up a list of criteria that it judged relevant to the selection: age, gender, marital status, number of dependents, income, educational background, occupation, past performance, and future potential. This list, later known as "social worth criteria," came under heavy attack by various segments of society. Journalist Shana Alexander of Life magazine called the event "the most awesome and disturbing story that I have ever worked on." The headline of a front-page story in The New York Times read: "Panel Holds Life or Death Vote in Allotting Artificial Kidney." David Sanders and Jesse Dukeminier actually leveled one of the most merciless attacks on the Seattle selection panel, accusing it as "... the bourgeoisie sparing the bourgeoisie ... [ruling out] the creative non-conformists, who rub the bourgeoisie the wrong way but who historically have contributed so much to the making of America. The Pacific Northwest is no place for a Henry David Thoreau with bad kidneys." The scarcity of critical medical resources like organs suitable for transplant and machines for renal dialysis has certainly uncovered many serious, searching ethical issues. The lay committee and its social critics actually herald in what is later dubbed as the "external view" of biomedical ethics, for it signals the insufficiency of ethical deliberations based on criteria generated within the medical profession. Society at large has a stake in the deliberation process. Distributive justice, human worth, and fidelity to patients who are the weaker members (children

27 Cited in Birth, 199.
28 Cited in Birth, 212.
or the sick and dying) of our society are but a few main themes with social components that have added ferment to the fledgling discipline of bioethics.

1.2.3 The Respirator

As transplant technology races ahead, saving a few but trampling some, another front of modern technology comes to the fore. This branch of technology has the uncanny ability to challenge our traditional understanding of medical ethics at the death-bed. For one thing, it exposes the inadequacy of the traditional definition of death. In 1968, led by Dr. Henry Beecher, the Harvard medical school published "A Definition of Irreversible Coma: Report of the Ad Hoc Committee at Harvard Medical School to Examine the Definition of Brain Death." The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, established in 1980, and largely responding to this ethical puzzle, incorporated the brain death definition to form a uniform legal definition of death.31 "Defining Death," a comprehensive report coming out of the President's Commission, succinctly states: "Death is the irreversible cessation of cardiorespiratory functions or the irreversible cessation of all functions of the brain, including the brain stem." Actually this frontal assault on the traditional understanding and definition of death has its modern accomplice. It is medical advances in the intensive care units that highlight the acute nature of the issue. In 1952, the modern respirator was invented, as a polio epidemic sped through

29 Cited in Birth, 216.
31 Birth, 108.
Denmark. Patients with severe breathing difficulties, sometimes considered as being in sure-death situations previously, were miraculously sustained by the machine. However, as physicians worked with the respirator, they began to encounter cases where some patients simply slipped into deep coma, and were only only artificially kept alive by the machine. Here is where the traditional definition of death baffles the contemporary caretakers. Can a patient in a deep, irreversible coma, sustained only by extraordinary means like a respirator, be considered dead? Is it moral to disconnect the machine, thereby "killing" the patient?

The famous Karen Quinlan case of 1975 really tested the limits of these ethical inquiries. On April 15, 1975, Karen Quinlan slipped into a deep coma and was sustained only by a respirator. This happened after she celebrated a friend's birthday at a bar, consuming several gin and tonics. After a period of ten days, during which her coma persisted without any signs of her recovery, her parents, Mr. and Mrs. Joseph Quinlan, in prayerful agony and after much consultation, requested the doctors to disconnect the machine and allow their daughter to die. However, the hospital, fearful of criminal charges, refused to discontinue life support. Karen Quinlan's physician, Dr. Robert Morse, declined the request "based on his conception of medical standards, practice and ethics." Mr. Quinlan did not take ethics generated within the profession for granted. He believed that he, as a family member, and society-at-large both had a say on this matter. He then sought legal help and the case was sent to the New Jersey Supreme Court, which ruled in favor of Mr. Quinlan. However, as the hospital removed the life support system from Karen Quinlan, she unexpectedly began to breathe on her own. The hospital then

32 Ibid., 110.
33 Ibid., 255
transferred her to a nursing home where she lived in a persistent vegetative state for ten years.

This tragic story taught American medicine the dark side of the miracle of intensive care and some of the undesirable consequences of medical technology. It heightened the awareness of the ethical dimensions of acute medical treatment in the intensive care unit: the ethics of foregoing life-sustaining treatment, the distinction between killing and letting die which has implication in passive and active euthanasia, and the legitimacy of surrogate decision-making in dire medical situations as in Mr. Quinlan's case.

Another tragic accident in 1973, what is known as Dax's case, illustrates that these ethical concerns do not pertain only to isolated medical incidents. Dax's case, a subject of extensive discussion by our authors, Beauchamp and Childress and William F. May, will not receive excessive treatment here. In a later chapter, the ethical implications of this incident will be explored at length in our comparison of the two approaches. Basically it concerns a burn victim, Donald Cowart, who wished to die after his automobile exploded in the presence of a leaking propane gas tank. He adamantly refused treatments even though his physicians and caretakers were quite confident of a cure. In his mind, it was the dismal prospect of impaired living that thwarted his desire to live. The significance of this tragic incident not only touches upon the ethics of assisted suicide in foregoing life-sustaining treatment, but also upon the revelation of the tension between the patient's autonomy and the physician's paternalistic tendency to benefit the patient. Technological advances in the intensive care unit do not always portend a turn for the better, or a favorable ending for human tragedies. As illustrated in the Quinlan and Dax cases,
technological miracles often belie the agony and the long-term struggle of the surviving victims in terms of the bleak prospect of a gravely impaired quality of life.

1.2.4 The Genetic-Control Movement

Parallel to these technological and ethical developments in biomedicine, another frontal wave that has pounded relentlessly on its shore is the modern movement of genetic control. It began benignly with the discovery of the double helix called deoxyribonucleic acid molecule (DNA), a molecular structure present in all animal cells that contains the genetic information of that animal. One needs to distinguish the genetic-control movement from the earlier eugenic movement that ended with the Nazi's anti-Semitic eugenics policies, which Nobelist Hermann Muller described as a "perverted movement." The "genetic-control" movement is sometimes labeled as "reformed eugenics." The discovery of DNA has profound and far-reaching implications for both science and ethics. The possibilities of copying and altering the genetic material for the improvement of the human race were immediately recognized by the observers of the time. Pope Pius XII, addressing the First International Conference of Medical Genetics six months after the discovery, recognized that the purpose of genetics is "to influence the transmission of hereditary factors in such a way as to promote what is good and eliminate what is harmful," and he pronounced genetics "morally irreproachable" in this sense.

The contemporary genetic-control movement signaled its beginning as Hermann Muller (at a conference titled "Genetics and the Direction of Human Evolution," asked his audience: "Should we weaken or strengthen our genetic heritage?"

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34 Ibid., 173.
and social practices were in fact "endangering the genetic health of the world's population by increasing the load of deleterious genes." Thus he is an advocate for selective breeding by eugenics sperm banks. This is what is labeled as "positive eugenics," where deliberate selection of favorable physical and behavioral traits is made through reproductive choices. However, as Albert Jonsen observed, using "negative" eugenics to "breed out" undesirable characteristics by preventing reproduction was "an inevitable implication." Therefore, unsurprisingly, Joseph Fletcher advocated what he called "eugenic sterilization" for the feebleminded segment of society. "It is impossible to see," he wrote, "how the principle of social justice ... can be satisfied if the community may not defend itself and is forced to permit the continued procreation of feeble-minded or hereditarily diseased children." Paul Ramsey questioned the imperative of such genetic control or improvement by arguing: "humanity's dignity does not consist in assuring that those who come after us will be better than we are." He also questioned the capability of any human for selecting the "ideal" genotypes for eugenic purposes.

Promising favorable results, the genetic-control movement, similarly to advances in intensive care units, therefore, also casts a long shadow over the future of humanity. Indeed, it was riddled with this ethical uncertainty that the human genome project made its big splash in 1989. When Dr. James Watson was named the project's director, he was prudent enough to ensure that "a portion of the funding for human genome research be devoted to the ethical, legal, and social implications of mapping the human genome."
1.2.5 Human Reproductive Technology

Parallel and related to the eugenics movement, equally controversial in its ethical dimension, is the revolution in human reproductive technology. Early in the 1950s, experiments in hormonal control of mammalian reproduction produced what is now known as "the pill." In January 1957, Dr. Edris Rice-Wray reported 100% effectiveness for Enovid, the commercial name for the "pill," against pregnancy in women. In 1960, Enovid was approved by the U.S. government and millions of women worldwide are now on the pill. The pill has brought forth the gift of reproductive freedom to a whole new generation of women. Congresswoman Clare Booth Luce, excited by the opportunities such freedom might herald, commented aptly of this revolution, "Modern woman is at last free as a man is free, to dispose of her own body, to earn a living, to pursue the improvement of her mind, to try a successful career." The pill, besides liberating women from the strain of the reproductive cycle, has also planted the seed concept in American society that woman is entitled to the control of her own body. In a little more than a decade, that seed concept was to germinate in the Supreme Court of the United States in 1973, which upheld the right of the woman to her body, and which affirmed that "state law could not restrict the right of a woman, in accord with her doctor, to obtain an abortion during the first trimester of pregnancy." This decision, known as the Roe v. Wade decision, of course has ushered in decades of controversy on the morality of abortion, the right of woman versus the fetus, and the personhood of the fetus.

Not only honed to prevent birth, the reproductive revolution also has its positive side in the eugenics movement. Medicine has a long history in attempting to

\[40\] Ibid., 299.
\[41\] Ibid.
assist reproduction in women whose husbands (or they themselves) have fertility problems. Early in the 1860s, American gynecologists were already attempting artificial inseminations to impregnate women. Sporadic successes in these attempts led to the use of stored frozen sperms in 1953. In the 1960s, the technique of in vitro fertilization was being perfected. And on July 25, 1978, the world's first test-tube baby, a girl named Louise Joy, was born to Mrs. Leslie Brown. Professor R.G. Edwards and Mr. Steptoe, working with Mr. and Mrs. Brown, accomplished a medical breakthrough for infertile women and men in our generation. But such an accomplishment has its share of doubts and misgivings in certain religious segments of society. The conception of a child without sexual coitus appears to these people to be an unnatural campaign with far-reaching consequences. The concern that medical technology will open up wild opportunities for manipulating, designing, and cloning human beings were real for them. With hindsight from the vantage point of the year 2000, when cloning animals is already a reality, their concerns were not downright excessive. However, in the 1970s, Edwards and Stepoe defended their enterprise against such concerns saying that excessive concern over the "camel's nose... that cloning must follow from embryo transfer seems unworthy of serious consideration..."43

Of course, medical technology has really taken biomedical ethics to a depth unfathomable by many scholars and scientists some twenty or thirty years ago. Edwards and Steptoe were simply expressing the majority's myopia in a sincere and truthful manner. But the ethical dimensions unveiled by these technological advances - the meaning of humanhood, the definition of death, the foregoing life-

42 Ibid., 294.
43 Cited in Birth 306.
sustaining treatment, physician-assisted suicide, euthanasia, equitable distribution of scarce resources, etc. - have only exposed the inadequacy and the superficiality of traditional ethical or philosophical inquiries. Biomedical ethics as a fledgling discipline is therefore a continual response to these mounting challenges, forced to ponder the deeper meaning of human existence and destiny.

1.3 The New Economics of Medicine

From the foregoing description, one can certainly appreciate how the field of bioethics emerges from the interplay between modern technology and morality. In the last thirty years or so technology was the catalyst of many ethical concerns not contemplated by our society heretofore. However, technology is not the only player in the formation of the field of biomedical ethics in the United States. Another pivotal player loomed its head quite early in the 1970s in corroboration of such a formation. The significance of this player is by no means less than that of technology. Its dominance is, perhaps, in some ways far greater. The player is one whose presence permeates every level of society. Every individual, well or sick, is driven by its tempo in some form of contemporary life. This player is a familiar one - economics.

1.3.1 Fee for Service

The economics of traditional medicine prior to the new era of biomedical ethics is largely termed as "fee for service." It refers to "the traditional mechanism that reimburses physicians for each service performed."\(^{44}\) Trust in the medical

profession was high and health insurers normally allowed "the medical community wide latitude to decide what treatment each patient needed."\textsuperscript{45} However, embedded in this mode of practice is a tendency to overtreatment by physicians toward their patients. This mode of practice invites the doctor to prescribe more for the patient than is medically necessary, since the system by design rewards more tests, more operations, more patient visits or longer hospital stay. Coupled with the high cost of life-saving technology, this traditional payment method spells great economic disaster for medicine.

As an example of the spiraling increase of the cost of medicine, in 1946, a night's stay in a U.S. hospital was reported to cost $9.39 on average.\textsuperscript{46} Twenty years later the cost leapt to $45. By 1985, the basic room rate topped $600. Nowadays, a simple hospital bed is packed with switches and controls of high-tech medicine. George Anders, in his book \textit{Health against Wealth}, reports a cost of $10,000 for such a hospital bed. The skyrocketing cost of U.S. medicine manifests itself even more dramatically in term of percentage of GNP. In the late 1940s, health care costs amounted to only 4% of GNP. But within the last two decades, the picture has dramatically changed. One set of statistics reads as follows:\textsuperscript{47}

- 10 percent of GNP in 1985
- 12 percent of GNP in 1990-91
- 15 percent of GNP in 2000, consisting of 1.5 trillion dollars, 5000 dollars per capita

\subsection*{1.3.2 Managed Care}

Back in the late 1980s, when medical cost in the U.S. was unrestrained, Allied Signal, a big American corporation with 76,000 employees, experienced a

\textsuperscript{46} Ibid., 20-21.
one-time annual cost increase of 39% in its employee health insurance plan.\textsuperscript{48} Double-digit annual increases had been the norm at the time, but it was rapidly getting out of hand. Determined to regain control of the runaway medical cost that had been ruining its business prospects, Allied Signal crusaded for a "businessman's revolt" against the medical establishment: the physicians, the hospital and the health insurers. The company adopted a wholesale conversion of its employee health insurance plan to "managed care," legitimizing the HMO (health maintenance organization) movement in the corporate world.\textsuperscript{49} Other big corporations began to follow suit: Southwestern Bell in 1987, Sears Roebuck in 1990, General Motor, Wells Fargo Bank, etc. Soon state and local governments also embraced managed care as the primary health care vehicle for their employees. California became a most aggressive state for managed care organizations with the health of nearly one million employees at stake. The "businessman's revolt" against the medical establishment is complete, as many smaller companies were able to band together later and also joined ranks for "managed care."

Inglehardt has a very apt description of "managed care." He describes it as a system that "in varying degrees integrates the financing and delivery of appropriate medical care through contracts with selected physicians and hospitals that provide comprehensive health care services to enrolled members for a predetermined monthly premium."\textsuperscript{50} A managed care network can consist of many forms, and all of them aim at reducing medical cost by controlling ("managing") the behavior of doctors and hospitals. Two of the most popular forms were the HMOs, health

\textsuperscript{47} Arthur J. Dyck, "Rationing Health Care: A Case of Justice Denied," in The Changing Face, 82
\textsuperscript{48} Health against Wealth, 22.
\textsuperscript{49} Health against Wealth, 30.
\textsuperscript{50} The Changing Face, 92.
maintenance organizations, and the PPOs, preferred provider organizations. HMOs are by far the most structured form of managed care, delivering health care services to their members through a closed network of primary care providers (general practitioners, family doctors, etc.) The primary care providers also serve as "gatekeepers," to coordinate care for specialty health services (surgeries, hospital care, etc.) However, any referrals to specialty health services need to obtain prior approval from the HMOs, or risk non-payment. Besides controlling cost through "gatekeepers" by reducing unnecessary use of specialty health services, HMOs also structure their payment through a fixed-fee scheme called capitation, in which physicians are paid a fixed amount per patient, regardless of the amount of care that patient requires or receives.

PPOs form a "preferred provider" network of health services for their members. Patients can choose providers outside this network for health care, but will receive less coverage or benefits. PPOs seek to control cost by receiving a discount from the preferred providers in the network. Other forms of managed care have also sprung up in addition to these two, like POS, Point of Service plans, Managed Indemnity Plans, etc. For further details on these plans, one may refer to Scott Daniels' article, "Managed Care's Financial Incentives."

So the "managed care" revolution marches on. It is a revolution that for the first time mixes austere business and marketplace principles with medicine. For the first time in the history of U.S. medicine, the goal of medicine is not the health of the patients, but health with market efficiency. Also for the first time in the history of U.S. medicine, we see a proliferation of for-profit health care organizations. Prior to

51 Scott Daniels, "Managed Care's Financial Incentives," in The Changing Face, 93.
the "managed care" revolution, most HMOs were nonprofit, but the picture has changed drastically. It is reported by George Anders that in 1990 "more than one third of the largest HMOs in the United States were for profit; by 1995, half the industry was for profit, according to researchers at InterStudy Publications, Minneapolis."52 This shift of orientation from non-profit to for-profit really works, as far as the business side of the equation - trimming cost - goes. As Rae and Cox readily concede: "There is little doubt that managed care medicine has succeeded in one of its primary objectives, that of keeping costs of medical care under tighter control."53 But the larger question of health care, the medical side of the equation - "at what cost to the quality of care?" - remains controversial.

George Anders acknowledges the good "managed care" does for preventive medicine. "Data abounded on how well the plans and their doctors did at checking cholesterol and providing routine cancer screenings," he concedes.54 HMOs go out of their way to encourage physicians to engage in good preventive measures for their patients, such as stressing the importance of mammography. However, as George Anders contends, "HMOs took much longer to get interested in systematic ways to improve care for sick patients."55 HMO report cards are skewed in favor of simple primary-care measures, but contain "almost nothing on the hardest part of medicine: taking care of sick people... The result was a strangely lopsided picture of medical care, filled with healthy patients getting check-ups but devoid of anyone fighting a serious illness."56

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52 Health against Wealth, 61.
54 Health against Wealth, 41.
55 Ibid.
56 Ibid.
In their efforts to control cost, HMO directors preoccupy themselves with statistics that help them identify average performance, and best practices for efficiency gains. They arm themselves with bar charts showing doctors the most cost-effective way to handle a certain illness. Many of these experts are former physicians turned HMO directors. "These experts could pinpoint a medical issue - such as how long to hospitalize a heart attack patient or how best to care for asthmatic children - and then pick apart the problem with a computer-aided analysis of how 100,000 or more such patients were being treated," observes George Anders.\(^{57}\) In the bid to lower costs, HMO directors attempt to submerge the medical profession in statistical medicine that obliterates individual differences in illnesses. They shield themselves from distraction from individual cases that have gone wrong. They consider these individual cases as outlying statistics that prove the exception rather than the rule. However, Dr. Peeno's testimony before a congressional committee about her glimpses of managed care is worth considering. Dr. Peeno was one of the doctors hired by Humana, a major HMO in her hometown, to review medical cases. She is a graduate from The University of Louisville’s Medical School, then became a medical reviewer to help her HMO make coverage decisions for difficult cases. However, after a few years, she quit her job and became active in medical ethics. In 1993, she was called to Washington to testify before a congressional committee about managed care. Her testimony should quickly push HMO directors and bioethicists - or anyone who has anything to do with managed care - to do some soul-searching. She said before the committee, "There is no code of ethics. There is no oversight mechanism... I was involved in the design and

\(^{57}\) Ibid., 37.
administration of many processes whose goals were explicitly to achieve fewer payments of claims and an increase in profitability.\textsuperscript{58} Of the HMO directors who sit in their isolated, comfortable offices in reviewing cases, she said, "The whole system is organized to keep you from thinking about the human dimensions of what you do. As a medical director, you are distanced from the consequence of your action. It's just numbers and claims that people talk about."\textsuperscript{59} The mixed motives of many HMOs, health care with profit, really spell dire consequences for patients. George Anders has documented a whole series of extravagances and wealth awarded to HMO executives whose success depends on how well they achieve fewer payments and less coverage for the patients.\textsuperscript{60} What results is a series of horror stories of mistreatment of individual patients who have extenuating circumstances that don't fit well into statistical norms.

George Anders has also documented many of these stories in his book Health against Wealth. In a collective fashion, these stories penetrate the hard core of bioethics. They challenge the adequacy or the humanity of the minimalist ethics in medicine embodied in business or marketplace principles. It is through a deeper understanding of the human dimensions contained in these real-life stories that we may gain a truer and more accurate appreciation of the scope and context of biomedical ethics. For what is at stake at the center of the debates, ultimately we hope, is not mere abstract, philosophical positions, but human lives and destinies. For illustrative purposes, we will represent a couple of stories from Health against Wealth, chosen as more closely reflective of the issues that we will encounter in our comparison of the two approaches.

\textsuperscript{58} Ibid., 54.
\textsuperscript{59} Ibid.
\textsuperscript{60} Ibid.
1.3.3 The Dark Side of Managed Care

This is a story about a mother, Lamona Adams, worried about her six-month-old son, who had started a moderate fever the day before. The fever was worsening. She took her son to the doctor, who recommended Tylenol every four hours. But that didn't work, and at 3:30 a.m., Lamona awoke to find her son extremely hot, panting and moaning with a temperature of 104 degrees Fahrenheit. The health plan of the Adams family was under Kaiser Permanente, an established HMO. Lamona called the after-hours hot line provided by the HMO, asking what to do next. The hot line was standard procedure for Kaiser's members, put in place by the HMO to screen out non-emergency hospital visits. It is a managed care strategy used to reduce costs for emergency care. HMOs are convinced of the statistics which suggest that half of all emergency visits aren't real emergencies. Therefore, Kaiser requires all its members to call this hot line in advance to receive authorization for any emergency medical treatments.

It took a few minutes for the hot line nurse to instruct the Adams to take the baby to the emergency room of Scottish Rite Children's Medical Center, notwithstanding the fact that the hospital was a good 45 minutes away from the home of the Adams. That was the only hospital she could send the baby to, even though there were several closer ones, like the Egleston Children's Division of Emory University Hospital, a renowned pediatric center capable of handling almost any crisis. However, Scottish Rite Children's Medical Center was the only hospital approved by the HMO for emergency pediatric care for cost purposes. But the trip to the hospital proved too long for the baby's desperate condition, which the hot line

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60 See Health against Wealth, Chapter 4.
61 Ibid., 133.
nurse mistook for non-life-threatening emergency. About halfway to the designated hospital, the baby's heart stopped. The Adamses changed course and landed in the emergency room of a closer hospital, Kennestone Hospital. In that situation, Lamona, the mother, could only let out a couple of desperate cries, "Help my baby! Help my baby!" holding her baby as she rushed into the emergency room.

The baby survived the assault of what was later diagnosed to be Meningococcemia. But because of the brief stoppage of the heart, the trauma had already caused vast, devastating damage to the little boy. His hands and feet had to be amputated as a result of the heart attack which had occurred on the way. In a legal deposition for the court case brought against the HMO by the Adams family, Kaiser defended their decision to send the Adamses to Scottish Rite, 42 miles away - as standard practice. But Dr. Roger Barkin, chairman of the department of pediatrics at Rose Medical Center in Denver, testified that "if an ambulance had carried little James Adams to the nearest emergency room before his heart stopped, nearly all of the subsequent catastrophe could have been avoided." HMOs may be able to bring factory-like efficiency to certain routine aspects of medicine, including emergency care. They may very well have succeeded in cutting cost by eliminating the incentives for overtreatment in traditional fee-for-service medicine. However, as George Anders lamented, "there is a dark side to managed care, ... the individuality of each patient doesn't matter much anymore. ... What the [HMO] planners forget is that health care only seems like a vast industry ready to be conquered by statistical methods. Ultimately medicine is intensely personal; it is a service delivered one patient at a time."

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62 Ibid., 11.
63 Ibid., 14
Another story is about an elderly lady, Belva Johnson, who had been discharged from an acute-care hospital after suffering a major stroke. She was rehabilitating in a skilled-nursing facility called Hillhaven-Brookvue in California. According to her therapists, she was making excellent progress. In a short period of time, her strength and balance had improved to the point where she could take short walks. She began to recognize her two grandsons and was able to tell them apart. Her right arm and hand had recovered some strength so that she could sign her own name. She was hoping to return to her own home and enjoy her garden. However, before all this progresses, at a crucial stage of her recovery, her HMO denied coverage for continued treatment. Health Net was the HMO for Mrs. Johnson. After she had been at Hillhaven for less than 20 days, the HMO sent a messenger to her bedside announcing with a letter the decision of discontinued payment. "Health Net has determined that the care you are receiving at Hillhaven-Brookvue no longer meets Medicare guidelines or Health Net Senior Security Guidelines. You will be responsible for all services provided to you by that facility after October 25, 1994," announced the HMO letter. This news was devastating to the family. The skilled-nursing facility charged $700 a day for its patients. At that rate, an extended stay would be devastating to the finances of the Johnson children.

Fortunately, at this point, a Hillhaven nurse made a suggestion that really saved the situation: that they get their mother out of the HMO and back on regular Medicare, a government-funded health service program for the elderly. The regular Medicare program would cover at least 89 percent of the bill. That was exactly what they did subsequently. The move cost the Johnson family a total of $6,202, but gave
Belva Johnson a chance to stay in the facility and made the significant progress mentioned above possible.

Diseases in old age usually wreak havoc in the lives of the elderly. Chronic conditions are often the results, and they require long-term rehabilitative care. However, when patients are hit with this kind of desperation, they quickly find their HMOs backing away from them, according to George Anders. HMOs, in maneuvering to curtail cost, usually find ways to dictate shorter hospital stays, or to refuse the tests that are necessary, or sometimes just discontinue payments for medical bills. In a recent article printed in The Coast News, a woman agonized over the behavior of her mother's health insurance company: "This is no longer about helping her to recover from her injuries. This is a waiting game. They wait to respond to request of payment. ... [T]hey wait because the odds [statistics, in their favor] that my 85-year-old mom won't live long enough to be reimbursed for her medical bills, for her rehab, for her nursing care, ..." George Anders has this assessment of managed care companies with respect to the care of the elderly, indicating that they "sometimes neglect the most important element in handling terminal illness: compassion."

In caring for the poor, the managed-care companies do not seem to fare well either. George Anders has documented many incidents to demonstrate this. HMO statistics cited by George Anders confirm:

Medicaid HMOs failed to provide adequate prenatal care for as many as 45 percent of women who gave birth in 1993. That rate was nearly four times worse than HMOs reported for their regular commercial members. Adults and children often didn't get the

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64 Ibid., 174.
66 Health against Wealth, 186.
regular checkups that are a mainstay of good managed care; 15 percent of one Medicaid HMO's enrollees in the Dayton area hadn't seen a doctor in three years.\textsuperscript{67}

Medicaid is a government health care program for the indigent. In an effort to reduce cost, some states have contracted HMOs to run these programs. George Anders is not the only critic who believes that managed-care organizations provide substandard care to the poor. Rothman offers a similar observation, "If special managed care programs are initiated that serve only the poor, they are very likely to provide substandard treatment."\textsuperscript{68}

The aforementioned stories are illustrative of the ethical implications of the "managed care" movement forged by the necessity of economics. Like medical technology, the wave of the new economics of medicine (cost containment) washes ashore some new ethical issues, along with many old ones that demand more thorough attention. This wave is in many ways as powerful — if not more so — as technology in shaping the discipline of biomedical ethics. For one thing, it has much broader implications. Medical technology affects only those who need it, but the new economics in medicine affects everyone: the old and the young, the rich and the poor. It raises the fundamental question of what kind of physician-patient relationship we should accept. Is the relationship basically a contractual one driven by marketplace and legal principles? If it is, then procedures or methods derived from broad-based statistics in caring for patients may be considered adequate. Those patients being mistreated, who happen to fall in the outlying area of statistics, are just out of luck. In the view of the marketplace, elderly or poor patients who prove to be economic drains of society may deserve substandard treatments. It also raises the question which asks what the proper goal of medicine should be. Should the health of

\textsuperscript{67} Ibid., 196.
patients be the only goal of any medical transaction between physicians and patients? Is it ethical if it is mixed with profit motivation? There is the issue of distributive justice of health care, which raises the concern of distributing health care resources to the poor. If distributive justice of health care is desirable, should its achievement be left to the tempos of the marketplace? These questions also form the backdrop of biomedical ethics as the field continues to take shape. The two approaches we are comparing here will have a lot to say in many of these areas.

1.4 Methods and Approaches

As we have seen in previous sections, technology and economics have ushered biomedical ethics into a new era. Interestingly, in matters of philosophical discourse and reflection, it is the theologians who first arrived on the scene. As a matter of fact, prior to the birth of biomedical ethics, Joseph Fletcher, an Episcopal theologian, in his pioneering work of 1954, *Morals and Medicine*, was already touching on many subject areas that foreboded their significance a couple of decades later. Among the topics he chose were sterilization, contraception, artificial insemination, truthfulness and euthanasia. Albert Jonsen hails the pervasive theme of the book - the patient's right and interest - as "the harbinger of the future bioethics." Subsequent to that, we see participation from many quarters of society: the philosophers, the lawyers, the government, etc. Many scholars attempt to wrestle with the ethical implications of the new medicine. Together they bring in a variety of methods and approaches. Some of them enjoy great vogue and have received prominence, like the principlist approach. In what follows, we shall attempt to give a brief tour of the landscape of methods and approaches. However, it is almost

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68 *Beginning Count*, 165.
69 *Birth*, 43.
impossible to be exhaustive in this matter. Therefore, we shall satisfy ourselves by confining our discussions to the major ones.

1.4.1 Theological Methods

The early participation of the theologians in the field was impressive. Although their participation lacked the maturity of full-grown ethical theories, it did give a crude representation of various ethical approaches that preoccupy the field later on. Besides Joseph Fletcher, Albert Jonsen names two other theologians who contributed significantly in the bioethics discourse early on: Paul Ramsey and Richard McCormick. The three theologians "presided over the creation of bioethics," according to Jonsen. Fletcher's allegiance to the patients in many of the ethical issues he dealt with (contraceptives, artificial insemination, euthanasia, etc.) represents a significant departure from traditional medical ethics. He champions the concepts of human freedom and control: "Choice and responsibility are the very heart of ethics and the sine qua non of a man's moral status." Thus he never really has anything negative to say about science and technology, which he views as channels of expansion for human freedom and control. His second book on biomedical ethics - The Ethics of Genetic Control: Ending Reproductive Roulette - amplifies these themes. He later identifies himself as an "act-utilitarian," who sees morality as a collection of acts of informed calculation for the overall well-being of society. His famous essay "Humanhood" is an embodiment of this philosophy, where he defines a "person" to consist of "minimum intelligence, self-awareness, self-control, a sense of time - of futurity and of the past, the capability to relate to others, concern for others, communication, control of existence, curiosity, changeability, balance of rationality
and feeling, idiosyncrasy, and neocortical function."  This profile obviously excludes the fetuses, the retarded, the moribund, and perhaps the senile from humanhood. In this manner, we see that his allegiance to the patients is not so much a philosophy generated from compassion for the sick and the weak, but rather a logical deduction from his passion for human freedom and control. The guiding post for that freedom and control is social utility, in whose name he not only defends abortion, sterilization, and contraception, but also genetic screening, eugenics, human cloning, euthanasia and infanticide.  

Although speaking as a theologian, Fletcher is more a front runner of bioethicists who would espouse utilitarian principles as solutions for biomedical ethics. These later bioethicists include John Harris, R. M. Hare, Jim Rachel, Peter Singer, etc. Invariably, as the first principle of biomedical ethics they adopt in some form the general theory of utilitarianism of John S. Mill and Bentham. The general theory of utilitarianism, stated by Mill, is recited as follows:

The creed which accepts as the foundation of morals, utility, or the Greatest Happiness Principle, holds that actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness. By happiness is intended pleasure, and the absence of pain; by unhappiness, pain and the privation of pleasure. 

As a matter of fact, John Harris, a utilitarian bioethicist, actually follows in the footstep of Joseph Fletcher, in defining the notion of "person" in utilitarian terms - self-consciousness, being able to value his/her own life, etc. - in order to eliminate moral qualms about infanticide, since infants lack those qualities and are therefore not classified as "persons."

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70 Ibid., 46.
71 Ibid., 46.
73 See a discussion on Harris' utilitarianism in The Elimination of Morality, 18-9.
The second theologian who, at an early stage, entered into the field of bioethics, is Paul Ramsey. Ramsey comes from the Methodist tradition, and proclaims himself a Christian ethicist. Throughout his career, it is claimed that he does not hesitate "to invoke ultimate appeal to scripture or theology and to warrants such as righteousness, faithfulness, canons of loyalty, the awesome sanctity of a human life, humankind in the image of God, ... hesed (steadfast covenant love), agape (or charity), ... as these standards are understood in the religions of our culture, Judaism and Christianity."74 Although he considers himself a Christian ethicist, this aspect of his thinking is rarely visible in his writings. He chooses to argue for his positions in terms that can be understood by religious skeptics. His interest in biomedical ethics encompasses five areas: research with human subjects, care of the dying, the definition of death, organ transplantation and the allocation of scarce resources. His major work, The Patient as Person, was published in 1970, and Jonsen hails it as "the first truly modern study of the new ethics of science and medicine."75 Ramsey, along with Fletcher, is considered an "externalist" of biomedical ethics, a term designated by Daniel Callahan to describe a view of biomedical ethics as morality engendered not from within the profession, but by the wider moral standards of society. The Hippocratic tradition is considered largely an "internalist" view in medical ethics. Thus leading the break from the Hippocratic tradition, Ramsey holds that "medical ethics is consonant with the ethics of a wider human community ... the moral requirements governing the relationship of a physician to patients and researcher to subjects are only a special case of the moral

74 Birth, 48.
75 Ibid., 50.
requirements between man and man." Many later bioethicists resonate with him and this concept in their approaches to biomedical ethics.

Ramsey's most significant contributions to biomedical ethics are perhaps his thoughts on the concept of covenants and on the care of the dying patient. Following Karl Barth, he envisions the human community as governed by the covenant between God and human; on account of that primordial covenant, human beings are covenanted with each other. The most notable mark of the relationship is the loyalty or fidelity each human being is to bestow upon another, as a promise of the covenant. Ramsey's bioethics are largely an outcome of this concept, as he seeks to determine "actions and abstentions that come from adherence to covenant, to ask the meaning of the sanctity of life, to articulate the requirements of steadfast faithfulness in which some decision must be made about how to show respect for, protect, preserve, and honor the life of fellow man." His ethics of care for the dying patient is a natural outcome of the covenanted fidelity to the patient. When the doctor ceases to be able to overcome the illness that is claiming the life of the patient, it is his/her duty to continue caring for the dying patient in covenanted fidelity. These two lines of thought have wielded significant impact on bioethicists who hold convictions in covenantal ethics. Subsequently these themes are picked up and expanded by William F. May in his formulation of the Medical Covenant, a subject of the present dissertation.

The third theologian who has entered the scene in early biomedical ethics, mentioned by Albert Jonsen, is Richard A. McCormick. He is a Roman Catholic theologian and a member of the Society of Jesus. He is a strong adherent to the

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76 Ibid.
Catholic moral tradition, while maintaining an openness to revision where he thinks it is necessary. Father McCormick brings with him the Catholic conviction in the natural law thesis that moral agreement can be achieved through reasons which are comprehensible to people with normal reasoning capacity. He engages in discussion of abortion, contraception, human experimentation, and care of the dying patient. Central to his positions in all these issues are concept of "proportionism" and teleology that guide the ethicist through a set of basic values. This set of basic values includes "the tendency to preserve life; the tendency to mate and raise children; the tendency to seek out other men and obtain their approval - friendship," etc.

McCormick considers himself a "moderate teleologist," by which he means that "other elements than consequences function in moral rightness and wrongness," for the moral agent. These elements, for McCormick himself, share "a notion of ultimate good ... that is non-temporal, unlimited, and unquantifiable." These elements are conceptions of human dignity and human rights that are not amenable to consequentialist calculation, but are transcendent ends guiding the order and choice of the basic values for the individual. The concept of "proportionism" is a way to balance or order the conflicting claims of the basic values in order to achieve those transcendent ends. It requires that the moral agents weigh the relative importance, the relative urgency - thus being "proportionate" in reasoning - of the conflicting values. Which ones are more pressing in the situation? Which ones will achieve the overall good in attaining those transcendent ends? There is a significant similarity between McCormick's method of "proportionism" and Ross' "prima facie" duties, and perhaps with Rawls' "reflective equilibrium." 

method of proportionate reasoning and Ross's method of weighing "prima facie" duties," commented Tubbs.\textsuperscript{80} With his method of "proportionism" and transcendent teleology, McCormick has weaved what Jonsen labeled a "middle course"\textsuperscript{81} in the fledgling field of bioethics, between Joseph Fletcher's liberal situationist view and Ramsey's conservative theological stand. These are the front-runners of biomedical ethics, who have responded to the challenge of the new medicine with philosophical insight, theological acumen and, what's more, an unflinching optimism for the amelioration of humanity.

1.4.2 The Principlist Approach

But the field took a sharp turn in the middle of the 1970s, as the U.S. Government was compelled - so to speak - to examine the ethics of biomedicine, by surging technology and the revelation of the dubious practices of some medical research programs run by public agencies. In 1966, Dr. Henry Beecher published an article titled "Ethics and Clinical Research," in which he identified twenty-two such research projects with dubious ethical practices.\textsuperscript{82} In one of the public hearings on the pressing need for guidance in biomedical ethics, Senator Edward Kennedy remarked:\textsuperscript{83}

\begin{quote}
Scientists may stand on the threshold of being able to recreate man. Under what conditions should genetic manipulation of our population be allowed or neurological or pharmacological modification of behavior permitted? What constitutes death? Who should have access to life-saving equipment in short supply? Should society expose some to harm for the benefit of others?
\end{quote}

This series of questions and many others like it posed by government officials lays open the public nature of many bioethical issues. Subsequently the U.S. Government

\textsuperscript{79} Ibid., 100.
\textsuperscript{80} Ibid., 50.
\textsuperscript{81} Birth, 53.
\textsuperscript{82} Henry Beecher, "Ethics and Clinical Research," in Bioethics, an Anthology, 421-8.
\textsuperscript{83} Ibid., 95.
entered the scene of bioethics by way of several prominent national commissions created to study certain pressing ethical issues, and appointed by Presidents of the United States. These commissions and the reports produced from them proved to be extremely influential in shifting the course of bioethics. The most notable of these is The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1974-1978. Those sworn in as eleven members of the Commission included "three physicians, two biomedical researchers, three lawyers, one public member, and one other ethicist..." According to Senator Kennedy, the charge of the Commission was to "focus the most creative minds in the nation on complex moral, ethical and religious problems and will help clarify them both for society as a whole and for the individual investigator. The commission is designed to help us find the critical balance required to satisfy society's demands for advancement of knowledge while abiding by (the rights) of its individual members." The specific goal of the Commission was to identify ethical principles governing fetal-research or research with human subjects.

In fulfilling the mandate of the Commission, a new way of approaching ethics began. According to Albert Jonsen, one of the commissioners, "The commissioners listened to their advisors, and to the public which addressed them by word and letter; they listened to each other and, in so doing, became colleagues. The debates were long, tortuous, and often contentious, but the duty to formulate recommendations pushed debate toward closure. In this new way, a public moral discourse began to evolve..." In this long, laborious process out comes the well-known Belmont report, named after the conference center that staged the final preparation. The report

84 Birth, 99.
85 Ibid.
identifies three basic principles as "among those generally accepted in our cultural tradition, that are particularly relevant to the ethics of research involving human subjects: the principles of respect for persons, beneficence and justice.\textsuperscript{87} The significance of the report cannot be overstated, for the future of bioethics has been largely dominated by approaches closely related to these principles. The Four-Principle Approach (splitting the principle of beneficence into two: beneficence and nonmaleficence) by Beauchamp and Childress is a prime example of this method, which is subsequently and disparagingly dubbed "principlism" by some critics. The method begins with several of these aforementioned principles, believed to be garnered from "common morality," and applies them deductively to specific clinical situations. Specification schemes, as in the approach of Beauchamp and Childress, are employed to balance principles in conflict. The significance of this method lies not only in the few principles it clusters as the pillars of wisdom and morality in bioethical deliberations, but also in its posture as a public ethic. By clustering around principles, the method avoids the appearance of endorsing a particular moral theory or a particular moral or religious tradition. Such endorsement in the formulation of public policies is seen as detrimental in a culturally diverse society.

The prominence of the principlist approach is acknowledged by many. For example, Jonsen in his reminiscence of bioethics history ruminated, "The Belmont Report... had a broad impact. It became the classic principlist statement, not only for the ethics of human experimentation but for bioethical reflection in general.\textsuperscript{88} DuBose, Hamel and O'Connell made a similar observation, "Since its emergence some thirty years ago, bioethics in the United States has employed several

\textsuperscript{86} Ibid., 101.
\textsuperscript{87} Ibid., 103.
methodologies. Principlism - the use of moral principles to address issues and resolve case quandaries - has come to dominate (emphasis mine)." Other principlist versions named by the same authors were those of "Robert Veatch in *A Theory of Medical Ethics* (1981) and H. Tristram Englehardt, Jr., in *The Foundations of Bioethics* (1986)." Thus, *The Belmont Report* has accomplished two major shifts in the method of biomedical ethics. First it provides the field with a way of doing ethics - principlism - detached from a major moral theory, like utilitarianism or Kantianism, and shunning religious traditions. Of course, this detachment is only superficial. As we will show in later chapters, the driving force of these principles as the principlist seeks to apply them still comes to reasoning based on an assortment of these major moral theories. Second, it redirects the course of bioethics to the public arena from the private, enclosed tower of academia. The theological reflections typical in early biomedical ethics faded away, and it eventually gave way to the force of secularization of an ethics whose nature is increasingly public.

The Four-Principle Approach of Beauchamp and Childress is a form of principlism and is most influential. It is a subject under scrutiny in this dissertation, and therefore will not receive extensive treatment in this chapter. Suffice it to say that it has expanded *The Belmont Report*'s three principles into four (the principle of nonmaleficence added) and has broadened its scope from treating human subjects in research to cover bioethics in general.

### 1.4.3 The Casuistic Approach

Casuistry as an ethical method has a long history. But as a method of moral inquiry it went into disrepute in the mid-seventeenth century, for educated lay people

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88 In the Foreword for *A Matter of Principles?* xv.
and scholars alike believed at the time that moral judgments could be securely grounded on or derived from universal principles.\textsuperscript{91} However, beginning sometime in the mid-twentieth century, there has been a surge of revived interest in the method.

Where principlism is a deductive approach to bioethical reasoning, casuistry is an inductive method which starts from concrete situations and cases to arrive at specific maxims or principles. The former is described as a top-down approach, whereas the latter is bottom-up. The casuists move from clear-cut, known paradigm cases to difficult, esoteric situations. By analogous reasoning, they apply solutions of known cases to new ones. The casuists are more likely to concentrate on the particularities of each case than to make an immediate appeal to theory, rule or principle. In this process, the casuists seek to gradually map the entire ethical terrain. Toulman and Jonsen are perhaps the best advocates of casuistry in contemporary bioethics. Together, they coauthored the book, \textit{The Abuse of Casuistry - A History of Moral Reasoning}, in which they argue that moral beliefs and reasoning in reality do not follow the pattern of deductive method, but are formed from experience, wisdom and prudence garnered from actual cases. There are six noteworthy steps involved in the casuistic method, namely 1) paradigm and analogy, 2) maxims, 3) circumstances, 4) probability, 5) cumulative arguments, and 6) resolution.\textsuperscript{92}

\subsection*{1.4.4 A Systematic Theory}

Another reaction to the "dominance" of the principlist approach is one which attempts to present a more systematic account of biomedical ethics. In introducing their moral theory for biomedical ethics, Gert, Culver and Clouser name their book in

\textsuperscript{90} Ibid.
particular: *Bioethics, A Return to Fundamentals.* The title subtly reflects the concern of the authors over a fledgling field characterized by a fragmentation of principles, rules or theories. With their work, they intend to bring forth a systematic approach with an integrated moral theory of bioethics. In the preface, they bring out their concern immediately as they muse soberly over the state of the field:

> Our concern is provoked by numerous observations of the state of the field, chief among which is the tendency on the part of many to regard each area of applied ethics as an entity unto itself; that is, as independent of a general account of morality. Few, if any, systematic attempts are made to relate the applied ethics to a general account of morality.\(^9\)

In their work they offer some very salient criticisms of the current state of theoretical biomedical ethics. In their view, most bioethics theories in vogue today offer "no systematic investigation of the different approaches, no attempt to discover or validate the foundations of these approaches, and no detailed attempt to relate these approaches to the systematic solving of medical ethics problems."\(^9\)

In contrast, Gert, Clover and Clouser attempt to present a systematic account of biomedical ethics. They view morality as a public system in which the "considered moral judgments" are those commonly formed by everyone. "It is a complex system known to all to whom it applies..." assert the authors.\(^9\) A theory of morality is a systematic account that tries to explain the way this moral system is embedded in society. The task of moral theory is then not to invent such a moral system, but to explicate what already exists. As they see it, this complex, public moral system consists of four main components: moral rules, moral ideals, relevant moral features, relevant moral features,

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\(^9\) Ibid., 251-7.


\(^9\) Ibid.

\(^9\) Ibid., 5.
and a detailed procedure for dealing with conflicts. They consider that the chief purpose of morality is to minimize the evils or harm done to individuals and society. Best known of the system is their set of moral rules. Ten simple rules of behavior analogous to the Ten Commandments are presented: (1) Don't kill, (2) Don't cause pain, (3) Don't disable, (4) Don't deprive of freedom, (5) Don't deprive of pleasure, (6) Don't deceive, (7) Keep your promises, (8) Don't cheat, (9) Obey the law, and (10) Do your duty. The authors also claim to have discovered "major relevant moral features" with which some of the conflicts in the moral rules may be settled. The major relevant moral features consider further what kinds of harm is inflicted upon whom, the duration of the harm, the relationship of the persons involved, the benefits incurred, alternative actions available, etc. These considerations help rank the moral rules applicable in each particular situation and thus help resolve some of the conflicts generated. The authors admit, however, that not all conflicts may be resolved in this manner. Medical ethics is then a particular application of this public moral system.

1.4.5 Other Methods

Other reactions to the principlist approach include what Rosemarie Tong terms as the "Bioethics of Care," whose chief proponent remains Dr. Eric Cassel. He views that the chief aim of the medical enterprise is not only "to cure the patient of a particular disease but to heal the patient - that is, to make the patient whole again." These care-focused bioethicists, however, are different from what later emerged as the care-focused feminist approach derived from the care-focus philosophy of

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96 Ibid.
97 Ibid., 52.
98 Ibid., 37-8.
Gilligan. This strand of the bioethics of care relies on "the understanding of care that emerged earlier in human history," but not on the quality culturally identified as "feminine." Of course, the feminist approach to care-focussed bioethics also has emerged as one major alternative to non-feminist approaches. Rosemarie Tong lists three major publications of this strand of bioethics of care: Susan Sherwin's *No Longer Patient*, Mary Mahowald's *Women and Children in Health Care*, and Susan Wolf's collection, *Feminism & Bioethics*.

Other approaches to bioethics must include a description, however brief, of what is known as virtue ethics. Virtue-based ethics, alternatively known as character ethics, emphasizes the agents who make the decisions or perform the actions. It is a philosophical tradition following Plato and Aristotle, who put a preeminent position on the virtue of the moral agents. Virtue is defined as "a disposition to act or a habit of acting in accordance with moral principles, obligations, or ideals." Therefore a virtuous person performing a moral act is not just following the rules or principles. She must also experience the right emotion, like sympathy, love or regret, desiring the performance of such an action, besides having the right motive. Well known contemporary representatives of virtue-based bioethics are Gregory Pence, Alasdair MacIntyre.

There are still many other forms of bioethical approaches or theories, which we will not exhaust here, like rights-based theory or community-based theory. Rights-based theory is often considered as being in the same vein as liberal individualism, following the tradition of Thomas Hobbes. A right is a justified claim

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100 Ibid., 72.
101 Ibid., 93.
or entitlement. Proponents often resort to the language of rights to bolster or advance moral or political ideals. Community-based theory views "everything fundamental in ethics as deriving from communal values, the common good, social goals, traditional practices, and the cooperative virtues." Therefore, social conventions, cultural traditions, and communal solidarity play very important roles in this type of theory.

Concluding Discussion

The foregoing discussions represent a brief description of the technological, economical and philosophical contexts that give rise to the birth and shape of contemporary biomedical ethics. As one may have already noted, the voices of biomedical ethics are many, and consensus is far from visible. Thus Jonsen in exploring the question of whether bioethics is a discipline, notes the fact that part of the history of bioethics is mired in a search for theory. However, the very dim conclusion that Jonsen has to offer is that "[b]ioethics has no dominant methodology, no master theory." Meilaender also observes, "Questions of method and of substance have been intertwined in the debates about the nature of bioethics." Although some form of the principlist approach seems to dominate, it does so not without significant criticisms from many quarters of bioethics. Unfortunately for the fledgling discipline of bioethics, there are no methodological standards or evaluative criteria that help the ethicists or the laymen sort through the maze of theories.

Yet technology moves blazingly ahead and the wheel of economics continues in its merciless course, as we have seen in this chapter. The pressing needs and questions of bioethics do not seem to allow us the luxury of a respite. For many of

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102 Principles of Biomedical Ethics, 63.
103 Ibid., 77.
104 Birth, 345.
105 Body, Soul, and Bioethics, 2.
the sick patients and their families, their fates or those of their loved ones, human values and destinies are at stake. The real life stories in this chapter are not cited without purpose, for we wish to show that bioethics is not just about theories or philosophical abstraction. The entire "discipline," if we can call it that, is in the very thick of human life. When Mrs. Lamona Adam rushed into the emergency room, baby in her arms, crying, "Help my baby! Help my baby!" it is bioethics' agonized cry.

Thus we hope that this perusal of bioethics' scientific, economic and philosophical backdrops will help us recognize the serious nature of the discipline (using the term loosely). Leon Kass, in an apt comment about the state of bioethics, states: "We must return to what animated the enterprise, the fears, the hopes, the repugnances, the moral concern, and above all, the recognition that beneath the distinctive issues of bioethics lie the deepest matters of our humanity." In commenting on bioethics as a discipline, Callahan expresses a similar conviction, "In defining issues, bioethics would need...the ability to...get into people's ethical agonies." Bioethics is called upon to address serious concerns, not merely to think about them. Therefore its success or failure lies in its ability to meet, in some measure, these concerns. In the search of method and approach, this must be one of the chief yardsticks of excellence. Thus, in resonance with Leon Kass, Mailaender states curtly, "...what really counts is whether a method opens bioethical reflection to these 'deepest matters of our humanity.'" Therefore, in sorting through the current maze of bioethics theories, perhaps key questions to be asked are: how well does the theory or approach or method help the common person solve his or her moral

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106 Cited in Body, Soul, and Bioethics, 36.
107 Cited in Birth, 325.
dilemma in the midst of dire medical predicament? How well does it respect the very sick patient's wholeness that upholds him or her as a member of the human community?

Since the onset of managed care, the goal of the medical profession in the U.S. has been tempered with a business motive: profit. Patients' health and well-being are no longer the pure aim of many health organizations, as in the past with the fee-for-service environment. As our real-life stories demonstrate, this mixed goal often accounts for many mishaps that caused our patients much agony. The goal of an organization ultimately represents its philosophical outlook, which often translates into practices that reflect such an outlook. Patients benefit or suffer because of the philosophical outlook embedded in the institutional goal of the health care organization that covers them. For-profit managed care organizations are a good example. Perhaps we can learn from the managed care phenomenon. Saving cost and generating profit is a good goal, but is it the ultimate goal when it conflicts with the human side of the matter? Is the really sick patient just a data point outlying from the overall statistical picture of correct medical procedure, or is he or she a human being whose uniqueness may sometimes require differentiated treatments? In examining any theories, methods or systems of approach that purport to deal with the serious concerns of bioethics, we suggest that their perceived goal for the medical profession is likewise important. Often flowing from this goal is a series of practices or procedures that do the patients good or harm. Is their stated goal in resonance or recognition of the "deepest matter of humanity?" Therefore, in sorting through this maze of bioethics theories, methods or approach, a second key element to look at is their purported goal for the medical profession.
There is yet a third element we can glean from the socio-economic context of American medicine. Recall the testimony of Dr. Peeno against the managed care industry to which she was fortunate (or misfortunate) enough to have twice belonged. She quit her managed-care job because of the blatant disregard of the human dimensions of the patients that was required of her in order for her to do her job well. Her testimony resonates in our hearts because it reveals another vital aspect of bioethics. To repeat, she said, "The whole system is organized to keep you from thinking about the human dimensions of what you do. As a medical director, you are distanced from the consequence of your action. It's just numbers and claims that people talk about." Bear in mind that she is not a bioethicist. By profession, she is a medical doctor, and we have no idea of her religious or cultural background. But that testimony strikes a responsive chord in the heart of common people. The gist of her testimony is this: in order to be concerned about the human dimensions of medicine, one is ill-fitted if positioned at a distance from the patients, or if patients' individuality is hidden in statistical average.

In order to sort through the variegate bioethical theories, methods and approaches, we may do well to heed her advice. If "the deepest matter of our humanity" is important to bioethics, the success of any bioethical theories, methods or approaches must address this concern well. The third element as unveiled by Dr. Peeno, which can help us assess them, amounts to what the bioethicists call the physician-patient relationship. Is the physician-patient relationship a distanced one as in business or is it a more intimate one which concerns fellow members of the same human community? Dr. Peeno, with first-hand experience, believes it makes a difference, and we agree. As Dr. Peeno is keenly aware, the framework with which
an approach posits the physician-patient relationship to a large extent predetermines the concerns of that relationship.

It is not within the scope of this dissertation to sort through all the bioethical theories, methods and approaches, but we shall attempt to examine two out of this maze. Throughout this examination, we are setting to answer this question: Is the Medical Covenant of William F. May a corrective vision to bioethics as manifested by the dominant Four-Principle Approach of Beauchamp and Childress? The keys unveiled by this study of the socio-economic contexts of American medicine will be very valuable, and in the absence of standard evaluative measures, will serve as yardsticks for that examination. For a true vision for bioethics must include, besides other things, a deep concern for the sick and their families in human terms that they can understand.
Chapter 2

The Four-Principle Approach
Introduction

The modern discipline of biomedical ethics is born of the necessities of its time. The rapid advances of medical technologies, the emergence of the global socio-economic environment, the convergence and clash of diverse cultures and traditions in America, all of these have a part in forming and molding what we see in the field of biomedical ethics today. The story of scholarship in biomedical ethics reflects much of the character and development of its macro-environments, and Daniel Callahan eagerly characterizes its history into two distinctive periods: "renaissance" and "enlightenment." This characterization, however accurate it may be, is insightful of biomedical ethics' cultural dependence.

Many scholars recognize the theological beginning of modern biomedical ethics. However, the drive for formulation of public policy in an increasingly pluralistic society inevitably causes a shift toward a more humanistic framework. Many theorists have responded to this call (see Chapter one). Of this group, Beauchamp and Childress' Four-Principle Approach is believed to have captured the widest acceptance. The Four-Principle Approach is characteristic of the cultural and philosophical backdrops that nurture it. As the postmodern age challenges the reign of science as the only sure path to knowledge, the Four-Principle Approach also rejects the supremacy of any single ethical theory that governs human behaviors in a consistent and systematic manner, particularly those in biomedical ethics. Regarding this point, Beauchamp and Childress frankly admit a "constrained skepticism" about this kind of claim from ethical theorists and "are doubtful that such a unified

foundation for ethics is discoverable.\textsuperscript{109} The complexity of moral life and the inevitable conflicts embedded in the competing ethical theories lead to their conviction that no single, supreme ethical theory is "ultimately defensible (or at least has been adequately defended)."\textsuperscript{110} When applied to real-life moral dilemmas.

Therefore, the Four-Principle Approach does not claim to be an ethical approach unified by a single theory. It has frankly abandoned that approach as inadequate to meet the moral challenges of post-modern medicine, made acute by the advances of medical technology in a pluralistic society. However, it would be inaccurate to characterize the Four-Principle Approach as a complete rejection of theoretical ethics. Their rejection concerns only the supremacy of any one single theory. They readily acknowledge the many strengths (as well as the weaknesses) across diverse ethical theories and traditions. As a matter of fact, in searching for an adequate and practical solution to biomedical moral dilemmas, Beauchamp and Childress have recognized a so-called "convergence" of mid-level principles that are more or less common among diverse ethical frameworks. They find that differences among ethical theories are overstated. In a given situation, it is their claim that different theories produce roughly similar action guides and similar descriptions for different roles of characters in ethics. Hence, no matter which ethical theory that one starts with, they conclude: "It is possible from several of these standpoints to defend roughly the same principles, obligations, rights, responsibilities, and virtues."\textsuperscript{111} They term this phenomenon as "convergence across theories."

Thus, despite their differences, various ethical theories do exhibit substantial degree of convergence in mid-level principles. The Four-Principle Approach starts

\textsuperscript{109}Principles of Biomedical Ethics, 106.
\textsuperscript{110}Practical Reasoning in Bioethics, 32.
with these principles, which, as the name implies, number four in total: 1. Respect for autonomy, 2. Nonmaleficence, 3. Beneficence, and 4. Justice. The following pages will first expound on the theoretical framework of the Four-Principle Approach based on the fourth (and latest) edition of their text, *Principles of Biomedical Ethics*. The first edition of the text was published in 1979, and the fourth edition was issued in 1994. In the fourth edition, they have spent considerably more space in explicating their method, added new sections about different theories, and added new sections about virtues in professional ethics to compliment their emphasis on principles. Despite these substantial changes over the different editions, however, characteristic perspectives have been retained on major issues, according to the authors.¹¹²

In this chapter, descriptions of each principle and the relevant issues will follow. Although the Four-Principle Approach is largely a principle-based system, as mentioned, recognizing the place and role of virtues and the issue of the physician-patient relationship in a comprehensive ethical theory, Beauchamp and Childress have devoted considerable space to both subjects. Likewise, these subjects will be summarized here in no less important fashion.

2.1 A Principle-Based, Common Morality System

2.1.1 Three Models for Moral Justification

Beauchamp and Childress distinguish three generic models for moral justification: deductivism, inductivism and coherentism.¹¹³ Traditional ethical theories usually take the deductive (e.g. Kantianism) or the inductive (e.g. casuistry) method. A deductive method is a top-down approach, where moral judgments are

¹¹¹ *Principles of Biomedical Ethics*, 110.
¹¹² Ibid., vii.
justified by pre-existing normative precepts that cover the judgment. The task of moral justification is then to find inference from a normative precept (which is more general) that supports or covers the judgment (which is more specific) together with the relevant facts of the situation. It is an application of a general principle or theory to a particular case, hence the adjective "deductive." The judgment for a particular case is deduced from a universal or general theory or principle. However, this model is too simplistic to capture the essence of the complex process of moral reasoning and justification, which, in the view of Beauchamp and Childress, involves a dialectic relationship between experiential judgment and covering precepts. Experiential judgment arises from real life situations and as such can inform and ameliorate the covering norms by further specification of the norms. Another problem with the deductive model is the potential infinite regress of justification for any judgments. It is conceivable that there be a demand for continuous justification after one is presented. A final flaw with the covering-precept model is that it presupposes that only one correct normative theory exists, while there are a host of competitive moral theories that have been developed and defended on their own merits.

Inductivism is a bottom-up justification method, in contrast to the deductive method. Moral justification can be induced from individual cases to form and develop generalized norms and rules. In this scenario, a tradition of moral values can be the starting point, and, with an agreed set of procedures, the development of moral frontiers can be envisioned and realized in new circumstances and experiences. Many Oriental philosophies are developed with this method. A notable one is

113 Ibid., 14-23.
Confucianism. Although Confucius is credited with being the originator of his school of thought and philosophy, he frankly admitted that he merely was an assiduous student of ancient sages and traditions. However, he did acknowledge the fact that he had a way to generalize or synthesize what he had learned, to adapting to or meet the moral demands of changing situations.

However, Beauchamp and Childress see an inherent flaw with pure inductivism. If some moral principles stand completely outside the starting set of moral values or traditions, it is difficult, if not impossible, for an inductive method to reach it. They cite the example of human rights. We often invoke the common notion of human rights to criticize or expose the inadequacies of traditions. In these cases, inductivism will be powerless to justify such moral criticisms. Thus, inductive moral theories need to be "buttressed by an account of the proper role of rules and principles in adjudicating disputes and constraining particular judgment."\(^{114}\)

The third and favored moral justification model for Beauchamp and Childress is what they call "coherentism." Moral justifications for this model go in either direction, top-down or bottom-up, thus in a dialectic fashion. The starting point for this model is what they call a set of "considered judgments" selected from the moral traditions of the society. This should be a set of moral values or convictions in which we have the highest confidence. Accompanying this set of "considered judgments" is a set of agreed procedures to prune, adjust, or criticize the "considered judgments" in order to reach a state of coherency with regard to our common moral sense, principles and all of the "considered judgments." Resultant action-guides are further tested for incoherence. If incoherence is detected, principles, rules or "considered

\(^{114}\) Ibid., 19.
judgments" are all liable to revision. In this way, even the cherished "considered judgments" are open to criticisms and changes. This state of coherency within the model is what Rawls referred to as "reflective equilibrium."

Therefore, coherentism is distinguished from deductivism, which holds that ethical theories are sufficiently complete for applications to moral problems. Coherentism believes that actual moral experience can inform and may at times demand revision of fixed ethical theories. Furthermore, coherentism is distinguished from inductivism, which holds that moral justifications only come from cherished traditions or proven cases. Coherentism recognizes the role of principles and rules, which can adjudicate with respect to our moral judgments.

At this point, what coherentism needs is a set of procedures to adjudicate between principles and moral experiences. This set of procedures in the formulation of Beauchamp and Childress consists of several components. These components include what they call "specification," "balancing," and a set of "common morality" principles.

2.1.2 Specification

Since Beauchamp and Childress regard the process of moral justifications as two-way, or dialectical, moral theories can form our action guides, and moral experience can inform and enrich our moral theories. A crucial procedure that will allow this to happen is "specification." Furthermore, bare theories or principles in their unspecified state are often abstract and empty of specific content. In this state, theories or principles are often indeterminate when it comes to real-life dilemmas. For example, let's consider the principle of nonmaleficence. Nonmaleficence is the principle that we ought not to inflict harm or evil on others. Unspecified, the

115 Cited in Principles of Biomedical Ethics, 20.
principle is indeterminate in a situation of self-defense, or in a case of war. Is killing in self-defense or in a battlefield morally wrong, violating the principle of nonmaleficence? The principle of nonmaleficence needs further specification to have morally-determinate content for these two cases of real-life experience. Theories, principles or norms are therefore only fixed temporarily, and are subject to further specification to allow for new circumstances. They cannot be fixed permanently, because, as Richardson puts it, "the complexity of the moral phenomena always outruns our ability to capture them in general norms."\textsuperscript{116}

Therefore, there are two functions for specification. The first is to give specific content to abstract, indeterminate moral principles so that they may be applicable to more specific, real life experiences. The second function of specification is to steer them through more complex moral problems that may involve apparent conflicts between two or more moral norms.

Specification is thus a process of moral deliberation among different norms once given the facts of the situation. The test of justified specification is coherence in the resulting ethical system. This method does not preclude outright the possibility of dogmatic, biased, or irrational ways of specification. The test of overall coherence in the resulting ethical system is admittedly the only constraint that safeguards such abuse. But specification will not solve all the problems that arise out of conflict among norms. Some conflicts are very obstinate and will not be specified away, and these problems must appeal to a second component of the Four-Principle Approach, namely balancing.

\textsuperscript{116} Cited in \textit{Principles of Biomedical Ethics}, 30.
2.1.3 Balancing

The act of balancing conjures up a metaphor of different weights moving up and down along a scale. This is exactly what is supposed to happen when Beauchamp and Childress talk about "balancing" in their system. The need for balancing occurs when two or more principles or norms conflict in a real-life situation, and when the resulting problem will not be specified away. In other words, this is a genuine conflict situation among norms. Then the system calls on the moral agents to assign appropriate weights to the norms in conflicts so as to produce what Ross called "the greatest balance"\(^{117}\) of right over wrong. In this process, less weighty principles can then be overridden. Rationality or good reasoning must be provided in order for the act of balancing or overriding to be justified. In the Four-Principle Approach, Beauchamp and Childress consider no moral principles or rules as absolute. They are nevertheless "prima facie" obligations that they are morally binding and "must be fulfilled unless [they] conflict on a particular occasion."\(^{118}\) Thus any principles or rules can be subjected to balancing in conflict occasions.

Balancing determines the relative weight among norms, whereas specification clarifies their scope and meaning. According to Beauchamp and Childress, balancing often eventuates in specification. The two components do not compete with each other but work complimentarily to augment the coherence of the ethical system. Beauchamp and Childress, however, admit of the vagueness and the reliance on intuition as to what constitutes coherence -- the required test of acceptable balancing and specification. "In all these cases some intuitive judgments and some

\(^{117}\) Cited in *Principles of Biomedical Ethics*, 33.

\(^{118}\) *Principles of Biomedical Ethics*, 33.
subjective weightings are unavoidable, just as they are everywhere in life when we must balance competing goods.\textsuperscript{119} Are there any morally conflicting circumstances where our intuition for balancing and specification would fail? Beauchamp and Childress frankly admit: "...in some circumstances we will not be able to determine which moral norm is overriding."\textsuperscript{120} Can this reliance on intuition and subjectiveness be reduced? Five rules have been offered in their book in this regard:

1. Better reasons can be offered to act on the overriding norm than on the infringed norm.
2. The moral objective justifying the infringement has a realistic prospect of achievement.
3. No morally preferable alternative actions can be substituted.
4. The form of infringement selected is the least possible, commensurate with achieving the primary goal of the action.
5. The agent seeks to minimize the negative effects of the infringement.\textsuperscript{121}

2.1.4 Common Morality and Mid-Level Principles

A third element of the Four-Principle Approach is Beauchamp and Childress' concept of "common morality." "A common-morality theory takes its basic premises directly from the morality shared in common by the members of a society."\textsuperscript{122} This basis can be a shared tradition or a set of common-sense values recognized as norms in the community. This is what Rawls referred to as the "considered judgments" mentioned earlier, and this set of "considered judgments" forms the starting point of a common-morality theory. Although an ethical theory begins with a set of common moral values, this is not to say that the theory is just a systematization of the common sense judgments and nothing more. A common morality theory armed with the scheme of interpretation, specification and balancing, constrained by the notion of coherence, according to Beauchamp and Childress, is capable of clarifying, expanding, and correcting that set of values.

\textsuperscript{119} Ibid., 36.
\textsuperscript{120} Ibid., 37.
\textsuperscript{121} Ibid., 34.
\textsuperscript{122} Ibid., 100.
It is also incorrect to say that all customary viewpoints in a society will automatically qualify for inclusion in the domain of common morality. It is important to distinguish a customary morality from "common morality". Common morality "is a pretheoretic moral point of view that transcends merely local customs and attitudes." An example given by Beauchamp and Childress is the belief in the universality of basic human rights. A filter functioning for the "common morality" is the universality of the standards considered. Therefore, a common morality, constructed in this fashion, is pluralistic in character.

While the Four-Principle Approach begins with a set of common morality, it is also principle-based. Although there are wide disagreements in ethical theories, the disagreements are often centered at the level of moral justification. As we have already noticed, Beauchamp and Childress find these diverse theories converging readily at mid-level principles. They observe that, "Differences between types of theory are exaggerated... Many different theories lead to similar action-guides... It is possible from several of these standpoints to defend roughly the same principles, obligations, rights, responsibilities and virtues." This convergence is "common in normative theories that provide frameworks of principles and rule." They argue, henceforth, the differences among ethical theories, though extant, are not nearly as significant or relevant to the construction of a practical ethical system that relies on mid-level principles and rules. Thus the Four-Principle Approach begins with four clusters of principles, believed to be founded in common morality: 1. Respect for autonomy, 2. Nonmaleficence, 3. Beneficence, and 4. Justice. Each of these principles will be summarized in later sections.

123 Ibid.
124 Ibid., 110.
One can see immediately that the four principles stated in this manner are void of specific content, and hence, the importance of the scheme of interpretation, specification and balancing is also clear. The four principles, according to Beauchamp and Childress, have their source at common morality, which means they are cherished common sense principles which find universality across theories and diversity of traditions. However, in the formulation of Beauchamp and Childress, they are not absolute principles, and there is not a lexical order that prioritizes them. They are what Beauchamp and Childress would depict as "prima facie" principles, which mean that, in ordinary circumstances, the principles are binding, and do dictate a judgment of right and wrong on certain actions. However, they are subject to revisions or to being overridden if in conflict with another principle in a particular circumstance. This is the act of balancing described earlier. The key is to provide acceptable justification. The moral agent must provide justification that withstands the test of coherence in the overall system. Although the Four-Principle Approach heavily relies on principles, it does not exclude categories that utilize the concepts of rights, emotions or virtues. The system in fact tries to incorporate them in a supplementary manner. These other concepts can be useful at times in formulating a certain moral argument, but the role they play in this system is not as central as that of principles. The role of rules appears to be a subordinating one in the Four-Principle Approach. After the scope has been specified for a certain principle in a particular situation, a set of rules will often result that forms action-guides for the moral agents. Therefore it is helpful to think of rules as being at a supporting level for the principles.

125 Ibid.
2.2 Respect for Autonomy

2.2.1 The Concept of Autonomy

The word "autonomy" literally means self ("autos") rule ("nomos"). It was a Greek word originally referring to the self-rule of Hellenic city-states. Applying that concept to a person means that a person should be entitled to freedom of self-rule or self-governance. He or she is to act upon or to choose his or her own will, free from any controlling interference or from any external limitations that prevent meaningful decisions. A theory of autonomy usually includes three elements: 1) intentionality, 2) understanding and 3) absence of controlling influences. An autonomous action or choice should be intentional, with a sufficient degree of understanding of what the choice entails, and is free to a sufficient degree from external controls. Understanding of an action or a choice and freedom from external controls need not be total or absolute. People's actions or choices can still be autonomous if sufficient degrees of these two elements exist.

2.2.2 The Principle of Respect for Autonomy

The principle of respect for autonomy is therefore to treat persons in a way enabling their autonomous actions or choices. Disrespect for persons' autonomy would then involve actions or attitudes that diminish, ignore, or demean their autonomy and consequently deny them minimal stature as persons. Stated in its negative form, the principle of respect for autonomy is this: "Autonomous actions should not be subjected to controlling constraints by others." Beauchamp and Childress acknowledge two sources for this principle: Emmanuel Kant and John S. Mill. Mill's position requires not just compliance with the negative form of the principle, but also an active strengthening of autonomous expression for others.
Kant's categorical imperative requires respectful treatment of persons as ends rather than as means to ends. Treating persons as ends and not as means also entails a positive notion of fostering their capacity as agents. Both perspectives thus appear to dictate a fairly strong positive element for the principle of respect for autonomy.

As Childress expounds the principle of respect for autonomy in *Practical Reasoning in Bioethics*, we need to distinguish it from "the principle of autonomy." "The principle of autonomy" presupposes an ideal of personal autonomy. It is a belief that we ought to be autonomous persons and make autonomous choices. However, "the principle of respect for autonomy" makes no such presupposition. Thus a competent person may choose to surrender his or her autonomous decision-making (first-order decision) to others (professional experts or family members). The principle of respect for autonomy will respect that autonomous choice, termed as second-order decision by Childress, whereas "the principle of autonomy" will lament that decision, because it renders the person less autonomous.

The scope of the principle of respect for autonomy only covers persons who are autonomous. Nonautonomous persons, like infants, or mentally retarded persons, are not treated the same way as normal, autonomous persons. Therefore, interpretation or determination of whether a person is autonomous becomes a major preoccupation in application of this principle, an occupation which Beauchamp and Childress belabor extensively in his book, and which we will also summarize in the latter part of this section.

126 *Practical Reasoning in Bioethics*, 60-61.
From the viewpoint of those believing the ethics of a profession to be internally derived, the Hippocratic Oath is clearly beneficence-oriented. The physician's primary duty and obligation are toward the benefit of the sick from the perspective of medicine. Other duties like truthfulness or respect for competent patients' autonomous choice are not mentioned in the Oath. The earlier versions of the Medical Ethics of the American Medical Association still follow this tradition. Only in later versions, do some constraints on paternalism appears, like the following: "A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of law."127 The concept of patients' autonomy is a rather novel phenomenon brought on by many factors, including the emphasis on patient's rights in a consumer society, the altered legal atmosphere concerning the proliferation of malpractice, the skyrocketing cost of health care, and the frontier-breaking technological advances in medicine. The traditional monopoly of the medical profession in terms of medical knowledge and ethical judgments is seen to be breaking down rapidly in this socio-economic context. The autonomous model of medicine requires physicians to "take the values and beliefs of the patient to be the primary moral consideration in determining the physician's moral responsibilities of patient care,"128 even if they conflict with those of the physicians.

Both in the nature of the medical profession and in its ethical traditions, there is a tendency for physicians to limit or diminish a patient's autonomy using their position and authority. The weakened physical and psychological states of the

127 The statement appears in the 1980 version of the Principles of Medical Ethics of AMA, quoted in Who Should Decide, James F. Childress (New York: Oxford University Press, 1982), 42.
patient brought on by illnesses, encourage the perpetuation of such a dependency. Thus this principle, though prima facie, takes on preponderant proportions in applications of the Four-Principle Approach of biomedical ethics.

2.2.3 Interpreting Respect for Autonomy

2.2.3.1 Informed Consent

The application of this principle, according to Beauchamp and Childress, mostly hovers around the issue of informed consent. If the patient is to be an autonomous agent in his or her own medical care, he or she must give consent to the treatment, and the consent must be an informed decision. Thus informed consent becomes the "basic paradigm" of autonomy in health care. But the issue of informed consent becomes fairly complex if one considers the various factors that may exert undue influences on the patient, like the changeable psychology of the patient, the urgency of the illness, the manipulative power of some physicians, the complexity of some medical diagnoses, the vagueness of some prognoses, and the uncertainty of alternative treatments.

2.2.3.2 Types of Consent

There are various forms of "consent." Besides "express consent," where consent is given expressly or directly, there is "tacit consent." "Tacit consent" is consent given passively by omission. For example, if a teacher asks his class if it is okay to move the time of lecture to an hour earlier, the class may give "tacit consent" by a uniform lack of objection. However, "implied" or "implicit" consent is inferred from actions of the patient. If a patient checks into a hospital for physical examination, from this action an implicit consent to all the ordinary procedures for a routine health check-up can be inferred. "Presumed" consent is inferred from what
we know about the patient's past actions. In the issue of organ procurement, policies of implicit or presumed consent have often been adopted, (by several nations, and several states in the United States.\textsuperscript{130}) The moral rationale is that when the decedents have not registered their opposition, there is implicit or presumed consent. That is presumptuous, because the decedents may have not been aware of the laws. This form of consent is sometimes useful in determining patient's autonomous choice when obtaining express consent is not possible. However, it also leaves room for danger and abuse, since fictional consent can be easily constructed under these categories of consents.

Another factor that could give rise to difficulties in determining the validity of a patient's consent is that his or her consent to certain things can change over time. People's beliefs and preferences undergo modifications and evolve. Thus prior consent may conflict with current consent. Beauchamp and Childress have given one example that demonstrates the complexity of this kind of situation:

In one case a twenty-eight-year-old man decided to terminate chronic renal dialysis because of his restricted life-style and the burdens on his family. He had diabetes, was legally blind, and could not walk because of progressive neuropathy. His wife and physician agreed to provide medication to relieve his pain and agreed not to put him back on dialysis even if he requested this action under the influence of pain or other bodily changes as he died. While dying in the hospital, the patient awoke complaining of pain and asked to be put back on dialysis. The patient's wife and physician decided to act on the patient's earlier request not to intervene, and he died four hours later.\textsuperscript{131}

However, in their judgment, Beauchamp and Childress think that at least the wife and physician should have put the patient back on dialysis to reconfirm his prior request or to see whether he had changed his mind.

\textsuperscript{129} Principles of Biomedical Ethics, 128.
\textsuperscript{130} Ibid., 129.
\textsuperscript{131} Ibid., 130.
2.2.3.3 Competence

Judging whether a certain decision is autonomous or not often involves determining whether the person is competent. But we must distinguish the concept of competence from that of autonomy. According to Beauchamp and Childress, competence is the ability to perform a task. It is a task-specific concept. Rarely is a person incompetent in every sphere of life. When the concept of competence is invoked in determination of the autonomy of a patient, we are referring to the patient's ability to make sound medical decisions relevant to his or her own health care. The premise that the concept of autonomy is related to that of competence assumes that an autonomous decision is necessarily one made by a competent person, though competence is not sufficient to guarantee the autonomy of a decision. As we noted above, the autonomous consent of a patient to proposed treatments must also be one that is informed. The notion of informed consent contains several elements of which competence is but one consideration.

2.2.3.4 Elements of Informed Consent

Beauchamp and Childress have listed five elements of informed consent, considered to be favored by disciplines across many fields, namely: legal, regulatory, philosophical, medical and psychological. Adding a couple of their own, the authors have concluded with the following list:

I. Threshold Elements (Preconditions)
   1. Competence (to understand and decide)
   2. Voluntariness (in deciding)
II. Information Elements
   3. Disclosure (of material information)
   4. Recommendation (of a plan)
   5. Understanding (of 3 and 4)
III. Consent Elements

132 Ibid., 145.
133 Ibid., 145-6.
For space considerations, we will not go into the details of these various elements. Beauchamp and Childress have covered them extensively, particularly the element of "disclosure," which involves several competing legal standards. \(^{134}\)

### 2.3 Nonmaleficence

#### 2.3.1 The Concept of Nonmaleficence

The principle of nonmaleficence occupies a prominent role in the tradition of the Hippocratic Oath, expressed in the well-known maxim *Primum non nocere* or "Above all (or first) do no harm." It asserts unequivocally the physician's obligation not to inflict any harm on his or her patients intentionally. The principle has been a powerful rule of ethics, which has operated throughout many centuries to govern the conduct of physicians, and its dominance has only been challenged in recent decades by conflicts with the rising importance of the perspective on patients' autonomy. But the principle occupies an important position in the Four-Principle Approach, and is prima facie binding unless overridden by a competing principle. It will then be subject to the requirements and to the scheme of balancing in this system.

#### 2.3.1.1 The Distinction between Nonmaleficence and Beneficence

In order to explicate the principle further, Beauchamp and Childress suggest that one must distinguish it from the principle of beneficence. In the publication of *The Belmont Report*, the principle of nonmaleficence is collapsed with that of beneficence, but the authors choose to distinguish them, I think with a couple of

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\(^{134}\) Three legal standards are competing here: the professional practice standard, the reasonable person standard, and the subjective standard. The tendency is moving toward the reasonable person standard, although, according to Beauchamp and Childress, only 25% of jurisdictions in the U.S. have adopted this standard. The rest of them still mostly adhere to the more traditional professional practice standard. See *Principles of Biomedical Ethics*, 146-150.
good reasons. First of all, the obligation of the principle of nonmaleficence is in general more stringent than that of beneficence. Secondly, in case of conflicts between the two, the obligation of nonmaleficence is also typically overriding. It is not difficult to understand that, since beneficence is generally considered something that is praiseworthy but not obligatory (though this is not necessarily always the case.)

Adapting from the scheme of Frankena, Beauchamp and Childress distinguish the two principles in the following way: 135

Nonmaleficence
One ought not to: 1) inflict evil or harm.

Beneficence
One ought to: 2) prevent evil or harm,
3) remove evil or harm,
4) do or promote good.

Although Frankena claimed there is a priority in the order of the list, Beauchamp and Childress do not think it is sustainable.

2.3.2 Traditional Distinctions and Rules Governing Nonmaleficence

To further specify the principle of nonmaleficence, the medical profession sometimes relies on several traditional distinctions and rules governing decisions for treatment or nontreatment. These traditional distinctions were developed through religious traditions, philosophical discourses, professional codes or the law, and may be at times helpful. However, four of them, in the opinion of Beauchamp and Childress, are not tenable and are "morally dangerous" 136 if maintained. Therefore, according to the authors, the distinctions thus maintained in the four guidelines should be collapsed. The four guidelines are 1) withholding vs. withdrawing treatments, 2) ordinary vs. extraordinary treatment, 3) sustenance technologies vs.

135 Ibid., 192.
medical technologies, and 4) intended effects vs. merely foreseen effects. To replace these distinctions, the authors suggest one of their own, that between optional and obligatory treatments. One can see that the four distinctions are very much at the heart of the debates in some quarters of biomedical ethics. Depending on one's perspective, the resulting positions in any of the four distinctions could differ greatly. It will be interesting and instructive to understand the arguments of the authors in collapsing these distinctions. However, the authors do not want to do away with all traditional distinctions in specifying the principle of nonmaleficence. There is at least one distinction that the authors in some way still maintain some interest in defending - that is the difference between killing and letting die. In what follows, we will summarize the arguments of the authors in collapsing the four distinctions, present a summary of the authors' proposed distinction (optional and obligatory treatment) and delve into how the authors assess the significance of the distinction between killing and letting die.

2.3.2.1 Withholding vs. Withdrawing Treatments

The cases involved in this distinction are usually treatments involving life-sustaining operations. Doctors and family members normally feel justified in withholding such operations, but not in withdrawing them once initiated. The philosophical debates about this distinction mostly center on the distinction between acts of omission and commission. People feel that withholding treatments are acts of omission (e.g. not starting a respirator) and that such acts are less culpable if the outcome is the death of the patient. However, withdrawing treatments (e.g. stopping

136 Ibid., 196.
a respirator) are acts of commission, and somehow, people have a stronger sense of responsibility and guilt if the outcome is the patient's death.

However, according to Beauchamp and Childress, such a distinction is untenable and even dangerous, because it sometimes leads to over- or under-treatment of the patient, depending on the circumstances. First of all, both withholding and withdrawing treatment can cause the death of a patient. The difference people feel about culpability is not sustainable when distinguishing between acts of omission and commission. It is just as wrong if by omission a death results, particularly when an obligation to act is present. Secondly, the distinction can lead to over-treatment in some cases. The doctor or family members may feel reluctant to withdraw life-sustaining treatments when they are no longer beneficial to the patient, and in other situations the doctor or family members may feel reluctant to start life-sustaining treatments, because they worry they cannot stop them once started. The distinction thus maintained could really affect the objectivity of treatment decisions. In this way, patients' welfare can be unduly compromised. Therefore, Beauchamp and Childress conclude: "The distinction between withholding and withdrawing is morally irrelevant... Decisions about beginning or ending treatment should be based on considerations of the patient's rights and welfare, and therefore, on the benefits and burdens of the treatment as judged by a patient or surrogate."137

2.3.2.2 Ordinary vs. Extraordinary Treatments

The distinction between ordinary and extraordinary treatments has a long and prominent history in legal, religious and medical traditions. What is regarded

137 Ibid., 199.
ordinary or extraordinary concerns whether the treatment is considered "usual" or "unusual," "customary" or "uncustomary." Recently, criteria have been proposed for the distinction between ordinary and extraordinary treatment, such as whether the treatment is simple or complex, natural or artificial, noninvasive or highly invasive, inexpensive or expensive, and routine or heroic. But it is not clear why the distinction is morally relevant if a complex, artificial, expensive or invasive treatment is in accord with the patient's best interest, just as one that is simple, natural, inexpensive or noninvasive, might also be in the patient's best interest. The key consideration, according to Beauchamp and Childress, should be whether the treatment would result in benefits for the patient relative to the burden it may cause. For example, treating pneumonia with antibiotics is standard, simple and relatively inexpensive, but could be "morally optional"\(^{138}\) for someone who is inflicted with cancer or AIDS and who is irreversibly and imminently dying.

Therefore, according to the authors: "The principal consideration is whether a treatment is beneficial or burdensome, not its form.... If no reasonable hope of benefit exist, then any expense, pain, or other inconvenience is excessive, and it is sometimes obligatory not to treat."\(^{139}\)

### 2.3.2.3 Sustenance Technologies vs. Medical Technologies

Sustenance technologies are here referring to those technologies that supply nutrition and hydration using needles, tubes, catheters, and the like, whereas medical technologies refer to medical life-sustaining treatment, such as respirators and dialysis machines. In recent years, debates have been widespread about the legitimacy of distinguishing between the two in forgoing life-sustaining treatments.

\(^{138}\) Ibid., 201.
\(^{139}\) Ibid., 202.
Some argue that sustenance technologies are non-medical, and that they should always be provided, because they believe that these technologies provide the basic and fundamental needs of nourishment and fluids. It is "a routine nursing care" and is "a fundamental matter of human dignity, not an option for medical judgment." In fact, such was the sentiment and expression of a controversial rule once proposed by the U.S. Department of Health and Human Services for treatment of disabled newborns.\(^{140}\)

Another argument proposing that sustenance technologies should never be optional draws on the symbolic significance of such treatments. Most people generally find it intuitively appalling to have to "starve" someone to death. Provision of nutrition and hydration symbolizes a society of care and compassion. They believe feeding the hungry with food and water is a rudimentary healing gesture, and is the obligation of a communal society. The third argument is the wedge or slippery slope argument. The idea is that policies of not providing medically administered nutrition and hydration may lead to adverse consequences such that the society will not be able to limit the practices only to legitimate cases.

However, Beauchamp and Childress have rebuffed all of these arguments as unsustainable by reason. First of all, some medically administered treatments of nutrition and hydration themselves involve risk, harm, discomfort and indignity. There are cases where the patients vehemently rejected the treatment, and where physical restraints are required to prevent patients from removing the lines and tubes. Evidence also indicates that some patients die more comfortably without such treatments. Therefore, for some patients, the burden of medically administered

\(^{140}\) Cited in *Principles of Biomedical Ethics*. See endnote 32 in chapter 4.
nutrition and hydration can outweigh the benefit, and these patients should not be deprived of the right to refuse treatment. Secondly, the obligation to care for the patients should rest on the patient's interests and benefits, not on some symbolic meaning for the larger society. The slippery slope argument can be a legitimate one, for it is uncertain whether the lines that distinguish the legitimate cases can be drawn clearly. However, Beauchamp and Childress contend, "no evidence exists that the protection of these patients requires that MN&H (Medically administered nutrition and hydration) be provided in all circumstances or that the emotions underlying the symbol of providing nutrition and hydration are either necessary or sufficient to avert social disaster." Therefore the authors conclude that "it is sometimes legitimate to remove MN&H," and they further list three conditions that pave the way to rejecting MN&H.141

2.3.2.4 Intended Effects vs. Merely Foreseen Effects

This is the traditional rule of double effect (RDE), which claims that a single action may have two foreseen effects, one good and the other harmful, and is not morally wrong if the harmful effect is merely foreseen but not intended. The example often cited to clarify the use of RDE is a patient experiencing terrible pain and suffering. The physician may administer some toxic analgesia, which will relieve the pain and suffering readily, but at considerable risk of hastening the death of the patient. Under the RDE, the physician who administers the pain reliever is not guilty of maleficence, as long as his intention is to relieve pain and not to hasten death.

141 "(1) The procedures are highly unlikely to improve nutritional and fluid levels. (2) The procedures will improve nutritional and fluid levels, but the patient will not benefit (for example, in cases of anencephaly or permanent vegetative state). (3) The procedures will improve nutritional and fluid levels and the patient will benefit, but the burdens of MN&H outweigh the benefits." Principles of Biomedical Ethics, 206.
Therefore, the RDE makes a distinction between intended effects and merely foreseen effects.

However, Beauchamp and Childress argue for a model of intentionality based on what is willed rather than what is wanted. In this model, intentional actions and effects include any action and effect willed in accordance with a plan, which may result in tolerated (undesired) as well as wanted effects. Thus the distinction collapses under this conception. A person who knowingly and voluntarily acts to bring about certain effects brings about them intentionally, even if it includes an effect that is not desired. The effect is intended, although the person did not desire it.142

2.3.3 Optional Treatments and Obligatory Treatments

In rejecting these leading distinctions about forgoing life-sustaining treatment, Beauchamp and Childress propose to replace them with the distinction between optional and obligatory treatments. The distinction hinges on the classification of cases according to the following categories:

I. Obligatory to Treat (Wrong Not to Treat)
II. Optional Whether to Treat
   A. Neutral (Neither Required nor Prohibited)
   B. Supererogatory (Surpassing Obligation)
III. Obligatory Not to Treat (Wrong to Treat)

Furthermore, the authors provide a couple of leading conditions by which omitting treatment would be justified. We will summarize them below.

142 Perhaps in this formulation, Beauchamp and Childress have clarified the distinction between intention and motive. Any actions and effects produced according to a set of plans are intended, but producing certain effects may or may not be the motive for the intended actions. If the traditional distinction of the RDE is allowed to reformulate itself according to this new wording (intention vs. motive), it is not so sure that Beauchamp and Childress have successfully collapsed the distinction as they think they did. Nevertheless, Beauchamp and Childress did acknowledge this possibility. See Principles of Biomedical Ethics, 210.
The first such condition is when treatment offers no benefit to the patient because it is pointless or futile. An example for which this is true is when the patient is dead, but still on a respirator. The patient is not harmed by the cessation of the respirator and will not benefit by its continued operation. However, the term "futility" is controversial, particularly in some religious traditions where the patient is not considered dead by the recognized criteria of the health-care institution. Should futility refer only to an impossibility of benefit from treatment, or should it allow an interpretation of probabilities based on a balance of probable benefits and burdens? This is a value-laden judgment and it is often difficult to find agreement. But "the upshot is that a pointless or futile treatment, in the sense of a treatment that has no chance of being efficacious, is morally optional but that other putatively futile treatments are often not optional."\textsuperscript{143}

Another condition for which treatment is not obligatory is when the burden of treatment outweighs the benefits. Here Beauchamp and Childress allow the calculus of burdens and benefits to be determinative of the moral status of treatment. The patient in this condition needs not be terminally ill, according to the authors. "Medical treatment for those not terminally ill is sometimes optional, although it could prolong life for an indefinite period and the patient is incompetent and has left no advance directive," asserted the authors. Here we can see how the authors specified the principle of nonmaleficence to limit its scope: "The principle of nonmaleficence does not imply the maintenance of biological life, nor does it require the initiation or continuation of treatment without regard to the patient's pain, suffering, and discomfort."\textsuperscript{144} Their interpretation and specification of the principle

\textsuperscript{143} Ibid., 214.
\textsuperscript{144} Ibid., 214.
of nonmaleficence center very much around the notion of quality-of-life judgment; that judgment not only carries a strong notion of value, but also the notion that the value is predominately a calculus of benefits and burdens in the utilitarian perspective. Thus the authors admit: "Our arguments thus far give considerable weight to quality-of-life judgments in determining whether treatments are optional or obligatory. When quality of life is sufficiently low that an intervention produces more harm than benefit for the patient, it is justifiable to withhold or to withdraw treatment."\footnote{Ibid., 215.}

2.3.4 Killing and Letting Die

This is a category of traditional distinction in biomedical ethics that Beauchamp and Childress seek to reformulate, but they stop short of a full-scale rejection. Again, they want to formulate this distinction with categories such as "benefit-burden" and "obligatory-optional." First of all, they contend that the "killing and letting die" distinction is vague in that they are not mutually exclusive concepts. It is therefore ambivalent to claim moral justification for one category (i.e. letting die) over the other (killing). There are instances of letting die that are clearly linked with the intention to kill, and one would have no moral qualms in classifying those as instances of killing. There are also instances of killing with merciful motive that one should not condemn outright as murder.\footnote{For examples that illustrate and clarify these contention, refer to Principles of Biomedical Ethics, 221-5.} Both forms of causation of death are intentional, and their moral significance lies in the motive of the agents who cause the death and not in their forms. "Nothing about either killing or allowing to
die entails judgments about actual wrongness or rightness, or about the beneficence or nonmaleficence of the action," asserted Beauchamp and Childress.\textsuperscript{147}

Based on this argument, Beauchamp and Childress would favor a discussion of the matter which abandons the language of "killing." Now, the matter of discussion is not "killing" or "letting die," but that of "forgoing treatment so that the patient dies" or "assistance in (the patient's) dying."\textsuperscript{148} Formulated in this way, Beauchamp and Childress have skillfully shifted the spotlight of the center stage from the physicians, the family members or the surrogate to the patients. The chief moral agent of the moment and the decision is the patient, not any other personnel. All others are there just to assist the patient in accomplishing his or her wish. Thus, Beauchamp and Childress are able to assert:

If competent patients have a legal and moral right to refuse treatment that involves health professionals in implementing their decision and bringing about their deaths, we have a reason to suppose they have a similar right to request the assistance of willing physicians to help them control the conditions under which they die.\textsuperscript{149}

Deploying the metaphor of "machine" for human life, Beauchamp and Childress continue their argument: if it is the patient's right to refuse treatment and to stop a machine that sustains his or her life, it seems logical that the same right should extend to stopping the "machine" of the patient, that is indeed the body of his or her life. Machine, after all, should be able to be switched on or off by people without provoking any moral outrages. The chief purpose of machine is its utility. When the machine outruns its utility, of course, it can be disposed of by the autonomous choice of the owner without any moral qualms. In this line of utilitarian argument, Beauchamp and Childress seem successfully (at least apparently) to have argued

\textsuperscript{147} Ibid., 225.
\textsuperscript{148} Ibid., 226.
\textsuperscript{149} Ibid.
away any vestige of the inherent wrongness of active voluntary euthanasia that may still linger in people's minds.

Another line of argument for voluntary active euthanasia that Beauchamp and Childress employ is a liberal one. This argument centers on the right of the individual person who requests assistance so that he can die. According to Beauchamp and Childress, "causing a person's death is wrong because of a harm or loss to the person killed, not because of losses that others encounter." What this argument entails is significant, for Beauchamp and Childress go on to state:

If a person desires death rather than life's more typical goods and projects, then causing that person's death at his or her autonomous request does not either harm or wrong the person.... To the contrary, not to help such person in their dying will frustrate their plans and cause them a loss, thereby harming them. It can also bring them indignity and despair.\(^{151}\) (Italics mine)

This declaration, I believe, is tantamount to proclaiming the right of the patient to active voluntary euthanasia. The authors admit, though, that it might still harm others or society, as their wishes or interests may be set back by the death of the person.

Therefore, we see that it is some combination of a utilitarian and liberal outlook that helps Beauchamp and Childress justify their stand on voluntary active euthanasia. But interestingly, Beauchamp and Childress stop short of endorsing a practice of voluntary active euthanasia in public policy. The problem of a publicly endorsed practice of voluntary active euthanasia is its potential abuse. It is the slippery slope argument that prevents Beauchamp and Childress from going all the way. Because of society's inability to monitor the practice of voluntary active euthanasia, the risk of more people being harmed by such a public policy is too great to assume.

\(^{150}\) Ibid., 236.
\(^{151}\) Ibid.
2.4 Beneficence

2.4.1 The Concept of Beneficence

As distinguished from the concept of nonmaleficence, beneficence refers to actions done to benefit others and not just to an avoidance of harm to them. It involves positive actions to help others, and in this sense is more difficult as a moral requirement. Many people would agree that while nonmaleficence is obligatory, beneficence most often is just an ideal. In many cases, we would not fault people for failing to act beneficently, while violation of nonmaleficence will certainly provoke anger and indignation. Therefore general obligation for beneficence is difficult to establish.

However, obligation for beneficence can arise out of a special social arrangement or relationship. As parents, we have special obligations of beneficence toward our children; similarly, by agreeing to assume the positions of teacher or physician and the like, a special obligation of beneficence toward students or patients is also established. Thus the principle of beneficence in biomedical ethics rests on the special arrangement and relationship between the medical profession and the public it serves. Promoting the health and welfare of patients is the internally-assumed goal of medicine. The Hippocratic Oath and the American Medical Association all affirm this purpose as a goal worthy of pursuit.

2.4.1.1 Justification of Obligation of Beneficence

There are many different accounts of justification for the principle of beneficence. Beauchamp and Childress choose to defend it with what they call "a reciprocity-based account." Notably, utilitarians believe that the principle of utility dictates or implies the principle of beneficence. Deontological ethicists like Kant
and Ross believe that the principle of beneficence is central to their system of ethics. David Hume argues that the principle of beneficence is engendered from the fabric of social interactions: "All our obligations to do good to society seem to imply something reciprocal. I receive the benefits of society, and therefore ought to promote its interests." We may take it for granted, but the fabric of society sustains our social needs and promotes our psychological health as communal beings, not to mention the economical convenience and prosperity that we enjoy in general as a team member of that collective entity. Beauchamp and Childress think that the principle of beneficence in biomedical ethics rests on this reciprocity belief. This belief of reciprocity is good because it will result in the promotion of general welfare for society - a utilitarian motive. As we shall see, William May is also a strong proponent of a reciprocity basis for medical ethics, although there is a significant philosophical difference between both reciprocity accounts. May's reciprocity account is an expression of gratitude rather than utility.

The Hippocratic Oath and the American Medical Association, in contrast, have been less moved by this reciprocity ethics. Traditionally, they view the profession as an independent, self-sufficient philanthropist, acting on the lofty impulse of to benefit humankind. As May, Beauchamp and Childress have consistently pointed out, this posture that the profession assumes is a pretentious one and gravely inaccurate. In reality, the health care professionals, like many others, are deeply indebted to society.\textsuperscript{152}

\footnote{\textsuperscript{152} See Chapter 3, Section 3.3.3.1, subheading Indebtedness, of this dissertation, for details of the indebtedness of the health care professional to society.}
2.4.2 Paternalism

One of the major issues in biomedical ethics is the priority between the principle of respect for autonomy and the principle of beneficence. In some instances of health care situations, the two principles may come into conflict. A well-known example would be what ethicists refer to as Dax's Case, which we will have an occasion to explore in greater detail in Chapter four. Dax is the name of burn victim Donald Cowart, who after the burn incident, changed his name from Donald to Dax. Donald Cowart was a twenty-seven-year old at the time of the accident. He and his father parked their car near a leaky propane storage tank, which exploded upon ignition of the car. His father died instantly, but Donald suffered a 97-degree burn, and was rushed to the hospital. In the hospital, he consistently refused the treatment to which the doctors, with equal insistence, subjected him. Donald wanted to die rather than go through the treatment. This is a classical example that illustrates potently the potential conflicts embedded in the two principles. The doctors, believing that they were acting for the beneficence of the patient, insisted that he goes through the treatment. When the doctors refused to acquiesce to his wish to die, Donald Cowart accused them of paternalism. Therefore, to further specify the principle of beneficence and to balance it with the principle of respect for autonomy, often boil down to resolutions related to paternalism.

The term “paternalism” originates from the political realm, where the principle and practice of paternal administration or governance of a people or community is similar to a father’s relationship with his children. There are two distinctive features of paternalism. One is the paternalist’s claim of acting beneficially, and the other is that the paternalist usually makes all or some of
decisions for the people or person to whom he is administering in relation to their welfare. In the biomedical context, Beauchamp and Childress define paternalism to be "intentional nonacquiescence or intervention in another person's preferences, desires, or action with the intention of either avoiding harm to or benefiting the person."\(^{153}\) It is interesting to note the slight difference in the definition of paternalism which Beauchamp and McCullough offer: "Paternalism is 1) the intentional limitation of the autonomy of one person by another, 2) where the person who limits autonomy appeals exclusively to grounds of beneficence for the person whose autonomy is limited."\(^{154}\) In Beauchamp and McCullough's definition, the essence of paternalism is preserved, but the emphasis on the person's autonomy is particularly prominent. The difference in the definitions results in a slight difference of scope when applying the concept, which will be commented upon later at an appropriate place.

There are two basic premises in the antipaternalist's argument. The first is that paternalist rules violate individual's rights and that they inevitably will lead to widespread, unacceptable limitations of liberty. The second stems from skepticism that the physician knows the best interests of patients better than the patients and their families themselves. As Beauchamp and McCullough pointed out, it is rare to find a pure paternalist in biomedical ethics who defends paternalistic behaviors based on patients' benefit alone. Many paternalists are equally concerned about the sweeping scope that some form of pure paternalism might take, and about its detrimental effects on human rights and society. According to this more limited perspective, paternalism is justifiable on these conditions: the first is that the risk or

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\(^{153}\) *Principles of Biomedical Ethics*, 274.

\(^{154}\) *Medical Ethics - The Moral Responsibilities of Physicians*, 84.
harm prevented is greater than the risk or harm caused by interference with the person's liberty. The second is that the treatment is universally justified under relevantly similar situations involving any other persons. The third is that the paternalistic action has a high probability of success. The fourth is that the action contemplated is the least autonomy-restrictive alternative. If these conditions are met, we have a good case of strong but minor paternalism that is justifiable. A good example is given by Beauchamp and Childress as reported by Mary Silva:

After receiving his preoperative medicine, C, a 23-year-old male athlete scheduled for a hernia repair, states that he does not want the side rails up. C is of clear mind and understands why the rule is required; however, C does not feel the rule should apply to him because he is not the least bit drowsy from the preoperative medication and he has no intention of falling out of bed.... The nurse responsible for C's care puts the side rails up. Her justification is as follows: C is not drowsy because he has just received the preoperative medication, and its effects have not occurred. Furthermore, if he follows the typical pattern of patients receiving this medication in this dosage, he will become drowsy very quickly. A drowsy patient is at risk for a fall. Since there is no family at the hospital to remain with the patient, and since the nurses on the unit are exceptionally busy, no one can constantly stay with C to monitor his level of alertness. Under these circumstances the patient must be protected from the potential harm of a fall, despite the fact that he does not want this protection.... The nurse restricted this autonomous patient's liberty based on ... protection of the patient from potential harm... and not as hedge against liability or for protection from criticism.

This is what Beauchamp and Childress call minor, strong paternalism and is justifiable according to the criteria given above.

In contrast to strong paternalism, where justification appeals to the patient's benefit alone, there is weak paternalism. Weak paternalism justifies its conducts based on some diminished autonomy of the patient. Therefore the justification of this limited form of paternalism also boils down to determination of the patient's competence or autonomous status, which was discussed above under the heading of The Principle of Respect for Autonomy. As noticed earlier, the difference in the definitions of paternalism by Beauchamp and McCullough, and Beauchamp and Childress will lead to a difference in scope when applying the concept of
Beauchamp and McCullough do not consider that weak paternalism is really paternalistic when the patient's autonomy is diminished, and are skeptical that the label of weak paternalism is even appropriate. However, Beauchamp and Childress, retaining the classification, acknowledge that "It is therefore doubtful that weak paternalism as a moral position can be distinguished from antipaternalism," because "no substantial autonomy exists" in the case of weak paternalism. Beauchamp and Childress further distinguish between soft and hard paternalism. If the values used to assess harms and benefits also belong to the patients, the paternalism which overrides the wish of the patient is considered soft; otherwise the paternalism is hard.

2.5 Justice

2.5.1 The Concept of Justice

The concept of justice as rights due to a person and as a fair distribution of social goods is a western concept. Only in recent decades have the Chinese demonstrated the assimilation of these western ideas to some degree, through the appearance of student protests (e.g. The Tinonman Square Demonstration) and the like. To the majority of the Chinese population, this western concept of justice is still very alien to the core of their understanding of ethics and morality. However, according to Beauchamp and Childress, "one who has a valid claim based in justice has a right, and therefore is due something." "An injustice therefore involves a wrongful act or omission that denies people benefits to which they have a right or fails to distribute burdens fairly." The source of this concept is attributed to Aristotle: "equals must be treated equally, and unequals must be treated unequally."

155 Principles of Biomedical Ethics, 282.
This is considered the "formal" principle of justice, and one obvious problem of the "formal" principle of justice is that it is void of content.

The attempt to fill in the content of this "formal" principle of justice is made through the "material" principles of justice. The "material" principles of justice further specify the relevant characteristics, which are also called "the relevant properties" for equal treatments. An example given by Beauchamp and Childress is the principle of need, which states that justice is a distribution scheme based on fundamental needs. Therefore, "fundamental need" is the relevant property of the material principle of justice based on need in this framework. This material principle of need thus further clarifies the "formal" principle of justice. However there is great ambiguity about which material principle to use in identifying relevant properties that persons must have in order to qualify for a particular distribution. For example, does being a resident or a citizen of a country qualify as a relevant property for health care services? Or is gender a relevant property in some distribution processes? These are some of the questions that beg answers in establishing public policies for distributive justice.

Henceforth, many theories of justice exist. There are utilitarian theories that emphasize maximizing public utility, libertarian theories that stress rights to social and economic liberty, communitarian theories that center on the traditions of a community, and egalitarian theories that demand equal access to the basic goods in life. A prominent spokesman for the egalitarian theory of justice is John Rawls, who interprets justice as fairness. He sees that justice a group of rational agents blinded by a "veil of ignorance," who are unaware of their abilities, social status, position or

156 Ibid., 327.
lotteries in life. This group of people would then agree on and choose principles of justice that allot to everyone the minimum level of life's primary goods. As they are unaware of what social mishaps or vicissitudes might befall them, the tendency will be to choose principles that will maximize that minimum level of goods in order to protect themselves in possible damaging situations. This contractarian theory of justice as equal opportunity and fairness found its proponent in biomedical ethics in Norman Daniels, whose arguments form the basis of an egalitarian distributive justice espoused by our authors, Beauchamp and Childress.

Based on a Rawlsian contractarian principle of "fair equality of opportunity," Daniels argues for a just health care system in which each member of society, regardless of wealth or position, would have equal access to a decent minimum level of health care. This proposal of a decent minimum health care service, according to Beauchamp and Childress, has "engendered wide support for egalitarianism" and its brand of justice. Justice in fair-opportunity attempts to eliminate unjust forms of distribution based on the lotteries of life, like IQ, gender, wealth or position that one cannot have great control of. Beauchamp and Childress assert: "Properties distributed by the lotteries of social and biological life are not grounds for morally acceptable discrimination between persons if they are not properties that people have a fair chance to acquire or overcome."157

This fair-opportunity rule of justice points to many inherent flaws of the current health care system in the U.S., which is operated on the libertarian justice of free market principles. The primary barrier to adequate health services in the U.S. system is lack of insurance or inadequate insurance coverage. The general estimate

157 Ibid., 342.
is that there are roughly 37 million U.S. citizens (one in seven) who do not have health insurance of any kind. Over sixty percent of the U.S. population has insurance supplied by their employers. Another twenty-five percent has either private health insurance or some form of publicly supported health insurance programs like Medicaid, Medicare, and the like. Many people without health insurance are employed, but by small companies that offer no health insurance benefits, or that offer no health insurance coverage to part time employees and/or their dependents. Other U.S. citizens, who fall into this category of the uninsured, are those that are uninsurable due to poor health or risky preexisting medical conditions. And then there are those who, though they have some form of health insurance, are underinsured. Exclusionary clauses employed by health insurance companies seek to exclude coverage for certain diseases, injuries and pre-existing conditions.

As one can see, many parts of the U.S. health system are flawed. Workers with small companies, part-time employees, unemployed persons, widows, widowers, and divorcees are left without health insurance. Many proposals that seek to correct these ills appeal to virtues of charity, compassion and good will toward the sick and the uninsured portion of the society, but these efforts are ultimately inadequate and fail to meet the health care needs of many citizens and residents in that category.

2.5.2 The Right to a Decent Minimum of Health Care

It is this sense of social injustice of the current health care system in the U.S. that propels Beauchamp and Childress to argue for a "right" to a decent minimum health care for all members of U.S. society. Two arguments have been put forth to defend such a stand. The first argument is from the standpoint of collective social
Beauchamp and Childress perceive that threats to health of the members of a society are "relevantly similar to threats presented by crime, fire, and polluted environments." These latter social threats are mainly handled by collective efforts through government actions and policies. If that is the case, why not handle threats to health in the same way? Their second argument is from the standpoint of "fair opportunity," which as a concept of justice has been discussed previously. A just society should act to counteract some injustices in life caused by the misfortune of the social and biological lotteries, so as to allow its members a fair opportunity to partake of social goods.

However, the more difficult problem is how to specify the scope and limits of a right to health care. What entails a decent minimum of health care? This is more of a question that can only be answered through the political process. Here the authors frankly admit that it is a "major problem confronting health policy in the U.S. today," and "has proved difficult to explicate and implement."

### 2.6 Professional-Patient Relationship

Discussions of the professional-patient relationship are framed by Beauchamp and Childress in terms of rules and virtues subordinate to or as specifications of the four principles presented above. Therefore, in the scheme of the Four-Principle Approach, the virtues of a professional-patient relationship occupy a role similar to rules that are derived from the four principles or as further specifications from them. In their discussion of one of the virtues of the professional-patient relationship, "fidelity," Beauchamp and Childress assert: "Few today would agree that fidelity is the fundamental moral norm, but many would accept it as an

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158 Ibid., 351.
essential norm.... Obligations of fidelity are best understood as norms that specify the moral principles discussed in previous chapters, especially respect for autonomy, justice, and utility."\textsuperscript{159} (Italics mine) Other virtues of the professional-patient relationship are treated similarly. This is a very significant outlook of the Four-Principle Approach.

The virtues or rules that further specify the four principles discussed by Beauchamp and Childress include veracity, privacy, confidentiality, and fidelity. They will be briefly summarized in the following sections.

\textbf{2.6.1 Veracity}

Three arguments are listed for the obligation of veracity. First of all, veracity is based on respect owed to others. Respect for persons demands that we communicate with them truthfully. Truthful communication is a must if our interactions involve consent. Second, veracity has to do with the obligation of promise keeping. In the biomedical context, many instances of the professional-patient relationship can be identified by a specific, though at times implicit, contract or promise. Truthful interaction and cooperation are necessary to accomplish the task at hand as stipulated by the contract or promise. Third, the professional-patient relationship is a fiduciary one based on trust. Adherence to rules of veracity is essential to foster a trusting relationship and maintain an image of trustworthiness for the profession. These three justifications, with the possible exception of the first, have a strong utilitarian outlook. According to such an outlook, we should maintain the obligation of veracity because of the benefits to the profession or the relationship it would bring, not because of its fundamental goodness or inherent moral quality. Even with the first justification that we should be truthful as a demonstration of

\textsuperscript{159} Ibid., 430.
respect owed to others, (which is more of a libertarian justification), the authors still have directed our attention to the benefits that veracity would bring to a consent situation.

It is interesting to note that traditionally, the virtue of veracity hardly occupied any place of importance in the ethics of the medical profession. Withholding a diagnosis of cancer or deceiving the patient about imminent death were commonplace. However, the trend is shifting in favor of the virtue of veracity. According to statistics cited by Beauchamp and Childress, in 1961, 88% of the physicians surveyed indicated that they had sought to avoid disclosing a diagnosis of cancer to a patient, but by 1979, 98% of those surveyed reported for a policy of telling the truth to cancer patients.160

2.6.2 Privacy

The boundaries of privacy do not appear to be well defined, although the concept itself seems to be clear. A loss of privacy occurs if others use a form of access to a person trespassing in zones of intimacy, secrecy, anonymity, seclusion, or solitude. Privacy also covers objects intimately associated with the person as well as the person's relationship with friends, lovers, spouses, physicians and others. Privacy consists of domains of life that can be rightfully claimed as personal, and intrusion into them requires the permission of the owner. There are many justifications for the right to privacy, but the primary one, according to Beauchamp and Childress, is one based on the principle of respect for autonomy. We are respecting a person if we respect his or her autonomous wish not to be intruded in things personal. A person must have a right to authorize or deny access to these spheres of his or her life in order to be an autonomous person.
Although a proper professional-patient relationship normally demands that we respect the privacy of the patient, it is occasionally justifiable to override obligations to respect privacy in order to protect other moral objectives. Beauchamp and Childress have given a couple of examples to illustrate this. One example is the compulsory screening for HIV and the other is mandatory treatment and detention of patients with tuberculosis. Because of the infectious nature of these diseases, under proper procedures and carefully monitored guidelines, these intrusive actions may be necessary to protect public health, or just to protect the health interest of certain third parties.

2.6.3 Confidentiality

Confidentiality is different from privacy. Confidentiality is violated when a person deliberately discloses information entrusted to him in confidence to someone else without permission. In contrast, a person commits intrusion of privacy when he enters the record room of a hospital and starts browsing the data of a certain patient without authorization. Traditionally rules of confidentiality have been common in codes of medical ethics. The American Medical Association and the World Medical Association both have rules of confidentiality affirming the obligation of secrecy.

There are three arguments in support of the rules of confidentiality. The first one is a consequentialist argument in that the consequences of breaches of confidentiality are so negative or detrimental to the professional-patient relationship that it is good to maintain the prima facie obligation of confidentiality. Without such protection, patient will be reluctant to disclose relevant information for treatment purposes. The second argument is from the principle of respect for autonomy, similar to the justification for the right of privacy. The third argument is fidelity-

160 Ibid., 398.
Based. Because of the disclosure of sensitive and private information of the patient in medical practice, a failure to maintain confidentiality constitutes a failure of fidelity to the patient. That will have a detrimental effect on the professional-patient relationship.

Given the understanding of the importance of maintaining confidentiality with patient information, like the obligation of privacy, there are situations where breaches of confidentiality are warranted. Examples are child abuse situations, where the law requires mandatory reporting, HIV infections, Tuberculosis, etc. 161

2.6.4 Fidelity

Although some ethicists believe that fidelity is a fundamental moral norm to a fiduciary relationship like that between physicians and patients (e.g. Paul Ramsey 162), Beauchamp and Childress place it at the level of a rule derived from the four principles they espouse in their system of biomedical ethics. However, Beauchamp and Childress readily acknowledge, however, that a professional-patient relationship is a fiduciary one founded on trust and confidence placed in the professional by the patient. By accepting such a relationship, the professional is assuming the position of trustee of the patient's health and welfare, and is committing herself to a significant degree of loyalty to the patient in that regard. According to the authors, that loyalty entails two essential aspects: 1) The professional surrenders his/her own interests to those of the patient in conflicts, and 2) the patient's interests take priority over others' interests.

But the rules of biomedical ethics are never that straightforward. Like all other rules or principles in the Four-Principle Approach, the rule of fidelity is also

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161 Please refer to the text for a more comprehensive treatment of circumstances where breaches of confidentiality are morally justified. Principles of Biomedical Ethics, 424-9.
prima facie, subject to being overridden given sufficient reasons in conflict situations. Fidelity to the patient can be subject to many serious situations involving conflict of interests. One area that is filled with these potential conflicts is third-party interest.

The U.S. medical system, in particular, relies heavily on third party payment of the cost of treatments, like health insurance companies. These third parties can sometimes impose legitimate conditions in diagnostic and therapeutic procedures for the patients, which could be potentially in conflict with the interests of the patients themselves. The HMOs mentioned in Chapter One are well known for doing that. These conditions are often imposed through efforts to standardize care for all insured and to reduce cost. Thus the physician is obligated to work within these guidelines and maintains fidelity with the patient to best meet the patient's interest and welfare.

Occasionally, this may mean that the professional needs to put in efforts to change or challenge these institutional constraints if they seriously threaten the vital interests of the patient. Many HMOs, in an effort to reduce costs, keep 10 to 30% of the physician's income; its return at the end of the year is dependent on the financial well-being of the organizations. This is a constraint intended to encourage physicians to be cost conscious in their treatment of patients.

Another area that spells potential conflicts of interest is physician's self-referral to physician owned facilities. According to Beauchamp and Childress, "10% of physicians in the U.S. (40% in Florida) who are involved in direct patient care have an investment interest in a health care business to which they may refer patients for services."AMA has now recognized the need for a stricter rule for self-referral

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162 That is the central theme in *The Patient as Person* by Paul Ramsey.
163 *Principles of Biomedical Ethics*, 439.
as demanded by physician's fidelity to patient. Beauchamp and Childress agree, stating emphatically, "Avoidance of self-referral should not be considered an option, but rather a firm obligation of fidelity and a necessary condition of moral integrity."164

2.7 Virtues and Ideals in Professional Life

2.7.1 The Role of Virtues in the Profession

Although principles and rules are central in importance in the Four-Principle Approach, Beauchamp and Childress do acknowledge a role for virtues and ideals in professional life. They recognize the difference between mere "adherence to principles and rules," and the "reliable character, moral good sense, and emotional responsiveness"165 that mark a virtuous person. In a very broad sense, character comprises a set of stable traits internal to that person that enables him or her to make moral decisions. According to Beauchamp and Childress, "all normal persons have the capacity to cultivate the traits that are centrally important in morality."166

In the view of Beauchamp and Childress, virtues in professional life are tied to institutional and social expectations of the role of the professional. Each profession has a history or tradition that sustains and encourages the cultivation of the virtues appropriate to the role. When the role of the profession shifts, the virtues appropriate to that role also shift. One interesting example is the nursing profession. In the traditional model, when the nurse was largely considered a helper or "handmaiden" of the physician, passive virtues of obedience and submission were encouraged. However, in the contemporary model, the nurse is considered to assume

164 Ibid., 440.
165 Ibid., 462.
166 Ibid., 463.
an advocacy role for the patient; prominent virtues including respect for autonomy, justice, persistence and courage are on the agenda for cultivation.

### 2.7.2 Four Focal Virtues

Among many others, Beauchamp and Childress espouse four focal virtues that they believe will be the central character traits that form a virtuous professional in medicine. They are, namely, compassion, discernment, trustworthiness, and integrity. These four are chosen for obvious reasons. Compassion, a trait of genuine concern for others' misfortunes, pains or sufferings is what the profession is all about. To care for the sick requires a parallel emotional response as well as professional expertise. "The emotional tone displayed in the interaction is part of the assistance rendered," observed Beauchamp and Childress. Although emotional involvement may sometimes reach an extreme and cloud objective professional judgment, more often it "appropriately motivates and expresses good character," and does have "a role in ethics alongside impartial reason and dispassionate judgment," affirmed Beauchamp and Childress.167

The virtue of discernment is also chosen by the authors for an understandable reason. Discernment speaks of sensitive insight and acute judgment for critical endeavors. An excellent health care professional requires the mark of discernment, for the tasks that he or she is involved with often demand critical judgments and decisive actions. Forms of caring delivered by the professional require, in the words of the authors, "discerning insights into what is at stake, what counts the most, and what needs to be done."168

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167 Ibid., 468.
168 Ibid., 469.
Trustworthiness is another virtue indispensable in the health care professional. Trust is having confidence in another person's reliability, moral character and ability to perform certain tasks. "Such trust is often the most important ingredient in our choice of one physician rather than another," rightly observed Beauchamp and Childress.¹⁶⁹ Often the patients are entrusting an important part of their life to the physicians, namely, their health, which may at times involve judgments of life and death. Trustworthiness, technically and morally, is therefore a minimum quality of character trait that physicians must possess in order to respond proportionately to the level of trust that society has placed in the profession.

Integrity is a character trait similar to that of trustworthiness and is chosen for a similar reason, except that integrity encompasses a much broader moral horizon. Besides the reliability that is included in trustworthiness, it means moral uprightness, and integration of a life that forms a compatible whole. In the usage of Beauchamp and Childress, however, as the authors acknowledge, it takes on a narrower meaning: "moral integrity means fidelity in adherence to moral norms."¹⁷⁰ The utility of the virtue of integrity is in its "being faithful to moral values and standing up in their defense when they are threatened or under attack."¹⁷¹

### 2.7.3 Moral Excellence

Beauchamp and Childress recognize the tendency of principle-based, common morality ethical systems to gyrate toward a moral minimum. It will be regrettable if a moral minimum is what we strive for, because such a model of morality is "uninspiring and devoid of moral challenge." Therefore, the authors

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¹⁶⁹ Ibid.
¹⁷⁰ Here we see again how the authors subjugate virtues to principles or norms. We will contend in later chapters that such view of virtues is basically a utilitarian view. Ibid., 471.
¹⁷¹ Ibid.
finish off their book on the Four-Principle Approach with a discussion of moral ideals and excellence. There are four reasons why they want to incorporate the concept of moral excellence in a principle-based, common morality ethical system. First of all, the authors recognize an undue imbalance in contemporary ethical theory focusing on the minimums of moral obligations. Moral minimums hardly comprise the whole picture of ethics and morality. If moral minimums are the expectation, we will inevitably lead a mediocre moral life. Though valuable, such an outlook is hardly worthy of our highest moral aspirations. Secondly, the authors wish to "overcome a certain skepticism in contemporary ethical theory about high ideals in the moral life." The cumulative impact of such skepticism leads to a belief that moral ideals are but one of life’s major endeavors; they are first of all optional and therefore no more worthwhile or valuable than hobbies, recreation, and other projects that are also beneficial to the agents involved or to society. Thirdly, the motivation for including moral ideal and excellence in their system arises out of a belief in the need for comprehensiveness in an ethical theory or system. Comprehensiveness is, after all, a criterion for measuring the soundness and practicality of an ethical theory, proposed by the authors. Finally, a model of moral excellence reveals a goal of morality worthy of our aspirations. It gives direction to our moral pursuit.

Beauchamp and Childress have identified a model of moral excellence in an example provided by an English country doctor named John Sassall. Sassall's moral ideal was devoted service to a poor and needy community, and he pursued that faithfully and incessantly in his life in a deprived village located in a remote region

\[172\] Ibid., 490.
of Northern England. Sassall was willing to give up his social life and served among poor villagers who had very little to pay him for his services. He himself grew as a moral person as he came to understand the villagers more and learned how to care for them as whole human beings. A deep trust developed between him and the villagers even under the most difficult and trying circumstances. Beauchamp and Childress have extracted four elements from this real life story to serve as a model of excellence for health care professionals.

First, John Sassall was faithful to a moral ideal that guided his medical services. Second he was properly motivated (by a genuine concern for the poor villagers.) Third, he possessed an exceptional moral character which allowed him to carry out his supererogatory ideal. Fourth, he was a person of great moral integrity, which enabled him to weather distracting conflicts, personal desires or trying circumstances. These four components, Beauchamp and Childress believe, "appear to be sufficient conditions of moral excellence." Beauchamp and Childress also go on to describe what it takes to become a saint and hero, and the difference between the two, in the remainder of their book. Interesting though these topics are, we will not summarize here since they are nevertheless less germane to our purpose.

Summary

In the short space of a chapter, we have run through a quick tour of the Four-Principle Approach of Beauchamp and Childress. Most readers will likely be impressed with the comprehensiveness in terms of procedures given and the practicality of the system devised. We believe these qualities have undoubtedly contributed to the widespread acceptance of the system in the field of biomedical

\[173\] Ibid., 495.
ethics. It indicates an important consideration of any theories or systems in ethics or morality, which is the need to be comprehensive enough (in term of procedures) to handle the wide varieties and complexity of moral conflicts in real life situations. Another consideration is the level of practicality. A theory or system must come down to a certain level of practicality in order to find widespread acceptance.

In this brief perusal of the Four-Principle Approach, we also see that, despite the claim of "common morality," the chief tenets are still those of major philosophical traditions, Kantianism, utilitarianism, or contractarism. The combination of these views dominates the so-called justifications of many rules, specifications and balancing in the system, as we have attempted to point out some of them in the discussions. This is the central feature, or the driving mechanism, of the so-called "principle-based and common morality" system. We will analyze this phenomenon more thoroughly ("unpacking") as we present our comparisons of the system with that of William F. May in later chapters.
Chapter 3

The Medical Covenant
Introduction

In order to understand the concept of the Medical Covenant, one must begin with May's views on the various tasks of the physicians and the plight of the patients. According to May’s own testimony, he served as an observer for one year at the teaching hospital of Cornell Medical College in New York City, and for a weekend as a boarder with the profoundly retarded at the Caswell Center in Kinston, North Carolina.174 Throughout his publications, he acknowledges his indebtedness to these kinds of opportunities, which have been many, that have benefited him with a first-hand look at the tasks of physicians and the plight of patients. In this manner, the Medical Covenant, though a theological concept rooted in Scripture, is brewed with a great sense of realism. Not only does May demonstrate that in-depth knowledge of the health care system in the U.S., but he also displays that rare gift of sensitivity which deepened his understanding of the various crises that the patients face. It is through this unique combination of May's talents that the Medical Covenant finds its sharpest focus and most comprehensive and holistic expressions.

May views the tasks of the physician in five symbolic images, of which the symbol of covenant is central. The other four images are that of the parent, the fighter, the technician and the teacher. The physician performs her duties in and out of the patients' rooms largely in the robes of these four images, for each image embodies some aspects of the functions and duties of the physician. They are images familiar enough to the average Americans about their doctors or to the physicians themselves about their profession in the American context. As we will discover, the images are deeply entrenched in American culture. Therefore, May reveals no great

secret, as he discusses these roles of the physician in his book *The Physician's Covenant*, published 1985. Some of the tensions or conflicts embedded in these roles relative to each other already appear much in public debates, which in part helped shape the discipline of biomedical ethics. However, May's great contribution to the medical profession in ethical discourse is his critical assessment of these four roles, and how each of them can be discharged properly and in a balanced fashion if guided by the central symbolic image of the covenant. Therefore it is not May's thesis to reject or diminish the importance of the roles that these four images represent of the physician's tasks. He readily acknowledges their significance, but the Medical Covenant will serve as a central guide of ethics, without which the four images would run unbridled into territories characterized by imprudence or extremes.

In what follows, May's understanding and criticisms of the physician's tasks symbolized by the four images will be presented. A brief sketch of how the Medical Covenant will correct or guide each particular image will also be given. However, the central idea of the Medical Covenant will only be presented later at the end of this chapter, as it is difficult to appreciate its corrective functions without prior knowledge of the various roles of the physician in general and May's understanding of them in particular. Although May views the function of the Medical Covenant as central to biomedical ethics, it is fostered as a response based on his understanding of the current American context of the medical profession and biomedical ethical theories and practices. The Medical Covenant does not seek to replace any ethical theories that have already found their places in the discipline. The Medical Covenant conceived by May, as we will come to understand, is not an ethical theory. Rather it is an image that clarifies the motivation and provides the framework, the direction
and the limits of the physician/patient relationship, within which biomedical ethical decisions are made.

3.1 The Tasks of Physician

3.1.1 The Parent Image

The major thrust of the parental image is the caring and nurturing functions of the physician. There is an old Chinese adage about the physician: "The heart of the healer is that of the parents." Perhaps, in today's more bureaucratic hospital settings, this image has lost much of its original familial ambience. But the term "family doctor" identifies the physician with providing primary health care to the family. She also knows that an illness is not only an individual mishap, but one that could shake the whole family, and as a physician she needs to respond properly to that. She takes care of the family health-wise.

Another strength of the image as seen by May is that care and nurturing dispensed by the parent to his children almost always are acts of self-expenditure, either emotionally or materially. When the parent cares, he gives a part of himself. I can recall the doctor who delivered my third child. He was called in to the hospital abruptly in the early morning. He performed professionally, but the cheerfulness and loving-kindness he displayed in his performance despite the awkward hour spoke of this self-expending parental virtue. Here May also distinguishes the nature of parental care from that of a philanthropist. The doctor who cares and nurture as a philanthropist does so condescendingly. He cares out of a surplus of resources. His identity is not at stake. "Parental expenditure, however, is always in some degree self-expenditure."175 He gives part of himself.

175 The Physician's Covenant, 39.
But not all acts of the parent are of an exemplary nature. The parent
overreaches his boundary if he treats his children as mere objects of obedience.
Some professional, carrying this image to the extreme, may override a competent
patient against his or her wishes as if the patient were in truth a child, with little
mental capacity, incapable of choosing for his or her own good. The behavior is
labeled "paternalism" by ethicists. This kind of experience with the medical
profession is by no means infrequent. I recall a young dentist whom I was seeing for
my dental ailment several years ago. In all his earnestness he tried to impose a cure
for me in which heavy surgery and financial expenditure were involved. He hinted at
the possibility of losing my teeth quickly if I did not acquiesce to the proposed
treatment. His imposing tactic alerted me to a probable case of paternalism. I went
to a different dentist instead, where I received counseling about an alternative
treatment, that was simpler and less expensive. It has been more than five years
now, and my teeth that gave me the problem are still intact thanks to the alternative
treatment. The kind of behaviors exhibited by my first dentist, while they may be
well intended, inflict upon sound patients a loss of stature and freedom. "Forthwith,
the parental image deteriorates into paternalism," laments May.\textsuperscript{176}

Although the parental image breeds paternalistic tendencies, the antipaternal
camp also can be guilty of diminishing the patients. The apparent respect for
autonomy can actually mask inaction or apathy on the part of the physicians, if they
don't participate sufficiently in guiding their patients' decision processes. If we don't
bother to judge patients' decisions or actions on the pretense of patient autonomy, we
are saying that they or their actions don't matter. In the recent economic revolt of the

\textsuperscript{176} Ibid., 42.
American medical profession, the managed care movement (see Chapter one), led by a surge of HMOs and PPOs aiming to cut the cost of medicine, has created an environment in which antipaternalistic behaviors can happen. Under pressure to limit medical costs per patient, physicians may just undertreat the patient. There is only a fine line between paternal vice and antipaternal sin. In the contemporary market of the medical profession, the antipaternal sentiment coupled with demand for economic efficiency often pushes the professionals to antipaternalistic extremes, producing what May calls a "minimalist ethics."\textsuperscript{177}

The advance of technology, the ever-growing bureaucratization of the medical profession, and economic pressure are ushering in an era of impersonal medical practice. We are witnessing in our generation the disappearing of some of the strengths of the parental image of healers. Although the image has its shortcomings, it reminds us of an indispensable function of the healing profession, that is self-expending care and nurture. Only in accomplishing of that function can we say the healer has fulfilled a part of her call. But how does she balance paternal and antipaternal tendencies, both of which can be detrimental to patients if carried to an extreme? How can she maintain that fine balance of good parenting in the midst of economic and bureaucratic pressures from her own profession? This is where May espouses the virtue of a central, more fundamental image for the physicians, the covenant, which will be discussed in more detail in later sections. For the time being, a brief sketch will suffice.

Central to the concept of the Medical Covenant is a feature called covenant fidelity, which always seeks the well-being and best interest of the other party in the

\textsuperscript{177} Ibid., 52
covenant. It takes solemnly into account the covenanted partner as a person also created by God. This particular outlook serves as a central vision for the physician-patient relationship in the midst of competing paternal or antipaternal impulses. Regardless of economic pressures, the physician who exhibits the trait of covenant fidelity will act in the best interest of her patient. The transaction between the physician and the patient, asserted May, "requires the ... virtue of fidelity. A sustained ... commitment to the ... well-being of the patient distinguishes the professional exchange from a market-place transaction."178

3.1.2 The Fighter Image

One of the more popular images of the medical profession is the fighter image. Terminal patients are hailed for their terrific courage to fight for life. When we fall ill, we say that we have lost the battle to the germs. Medical research organizations capitalize on this powerful image to raise funds for the continuous "fight" against many dreaded diseases. The fighter image of the healing profession is so deeply entrenched in our culture that it needs not be explained or elaborated upon for common citizens. To a large extent, we believe, this fighting stance against death and disease is for the good of humanity and should be affirmed. Undoubtedly, it has motivated technological progress of medicine, helped eliminated much suffering for humankind and helped increased the human life span in general.

May summons the writings and spirit of Camus to illustrate the image of the fighter against death in the medical profession. In his *Letters to a German Friend*, Camus cited Obermann, who poignantly illustrated the spirit of that fight: "Man is mortal. That may be; but let us die resisting; and if our lot is complete annihilation,

let us not behave in such a way that it seems justice!"179 Of course, Camus was citing Obermann to illustrate the spirit of fighting against the death and destruction of Nazism that was about to envelop humanity. Contemporary medical teams, however, also fight death and suffering in the hospital wards with that level of tenacity, and the spectacular success of modern medical technology has undoubtedly contributed to some transient victories. Although, in the end, death is ultimate and universal, our fight against it in many hospital wards also seems ultimate, relentless and universal. May observes: "In the Middle Ages, respect for the natural impulse of self-preservation led to the prohibition against suicide; in recent times, a piety toward the machine argues for the endless prolongation of life."180

The fighter symbol, according to May, actually "presupposes a specific religious reflex before the threat of death."181 It is an answer to one of the deep-seated religious reactions toward death's destructive and sacral power. This reaction takes two forms in our contemporary society. One views the terror of death as the absolute evil. Life then appears absolutely sacred in this mirror. Ultimately, this religious reaction sanctions an unconditional fight against death. The second abhors suffering as the absolute evil. Henceforth, quality of life becomes more sacred than life itself, which actually gives sanction to mercy killing that eliminates suffering by eliminating the sufferer. Both of these forms are more religious than we may think. In viewing life or quality of life as absolute, both revere a creaturely good in place of the creator. We may be deceiving ourselves if we think we can discuss the matter of death and suffering in a non-religious way.

180 The Physician's Covenant, 65.
181 Ibid., 67.
May offers his criticism of the fighter symbol from a religious perspective: "Monotheism permits the believer to recognize only God as sacred, creatures as good but not God; they derive from God. Life is a fundamental good, but not absolute; quality of life is to be prized, but not above all else." However, this pure theistic approach, though acceptable, still falls short of dealing with the evils of life in their full implications. In this regard, May is not hesitant to offer his Christian view: "In a Christian setting, these evils appear real, but not ultimate... They cannot be ignored because the passion of Jesus itself narratively insists that suffering and death cannot be avoided, eliminated, or repressed. At the same time, the account of his dying (and resurrection) also exposes the ultimate impotence of suffering and death to separate men and women from God." Therefore, men and women can deal with death and suffering in an unperturbed manner, fighting them as we can, but accepting them in our befallen predicaments as we approach our limits.

What does the covenant symbol offer in response to the criticism of the fighter symbol? In brief, the covenant symbol would not embrace life or quality of life as the ultimate goal of the medical profession. Instead, the health of the patients in a holistic fashion would be upheld as a proper aim. This includes the mental health of the patients as they face their ultimate ends. As we lose our battles against terminal illnesses, this goal of the Medical Covenant enables the doctor to switch from a fighting stance to one that is geared to caring for the dying patients. "Although the progressive impoverishment of the patient does not in and of itself humiliate, the event of dying does humiliate if the zeal of others gratuitously

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182 Ibid., 69.
183 Ibid., 70.
prolongs it.\textsuperscript{184} The medical profession should not define its goal as fighting death at any cost. The overall health and condition of a person in the dying moment demand our attention, not just the battle against terminal illness.

The covenant concept, views the covenanted partner as a full person, created by God. Covenant fidelity to the patient as a person mandates that healing professionals make providing care the ultimate goal. In this light, maximal medical maneuver is not necessarily optimal care during the final passage of the patient. Physicians should subordinate the operation of life-prolonging machines to the welfare of the patient. The central question is whether it is optimal care. The distinction between starting and stopping machines and between ordinary and heroic measures fades away as we allow the covenant mandate to guide holistic medical practice.

In this manner, covenant fidelity of the physician to the patient would justify allowing death, because fighting death is no longer the ultimate aim. In the last moments of a patient's life, the imperative to give care is to assist the patient to die well. Joseph Fletcher designated this as passive euthanasia, and he labeled mercy killing active euthanasia.\textsuperscript{185} But the mandate of the physician's covenant does not extend to yield active euthanasia. To kill a patient because of intolerable suffering is to abandon him or her, to disown him or her from the community in which the covenanted fidelity to its member is the imperative to give care. May believes it is the inadequacy of this care to the dying members of our community that leads them to seek "voluntary" active euthanasia. How voluntary is that if we consider the fact that it is the community who fails in the first place our communal commitment to our

\textsuperscript{184} Ibid., 73.
members in the most needy moments of their lives? Before we nod our heads and give sanction to this so-called "voluntary" active euthanasia, it is incumbent upon us to re-examine our fidelity to our covenanted members of our society.

3.1.3 The Technician Image

As a computer professional takes pride in the elegance of his software code and the mathematician in the succinctness of his equations, the physician draws immense satisfaction from the excellence of his technical performance. Ethicists and philosophers may be embroiled in lengthy debates over difficult medical quandaries, but the fact is that the physician faces the challenge of technical performance everyday. Excellent technical performance thus becomes the center of her ethical experience. Utilitarianism and Kantian ethics, neglecting this aspect of professional ethics, both miss the interior aspiration of the professional who finds meaning and satisfaction in performance. In either case, philosophers relegate technical performance to a secondary, subordinate level. They fail to reckon with the moral force that the meaning of the act fades in significance relative to the beauty or the form of the act itself.

According to May, Hemingway voices the technical commitment of the modern professional. The emphasis is on the aesthetic, stylish, procedural or codal performance. The professional prizes performance above the interior meanings or the moral value of the act. There are some strengths in this professional image. First of all, the patient needs a physician who takes pride in her performance and does her job well. Secondly, a professional guild that upholds technical performance will generate to a degree some self-regulatory function. Physicians are not inclined to extend referral to some colleagues whose performance is in question. Thirdly, an
emphasis in technical performance tends to shield the physician with an emotional
distance from her patients. At times the physician needs some emotional distance to
perform her duties with sound judgment and objectivity. She needs to be able to
withdraw expertise with freedom if her services no longer provide benefit.
Nevertheless, this virtue can also turn into a vice if one carries it to extreme.

May's criticisms of this symbol are twofold. First of all, the physician's
emphasis on technical performance may estrange her from the patient. The codal
ideal of performance filters out the personal, "not merely the patient as person but the
physician as person." Secondly, the physician, in pursuit of excellence of
performance, may over-emphasize the technical side of the healer's art. There is a
further component to be spoken of in the wholeness of the process of healing. The
healer "not only must attempt to cure disease but must address the illness of which
the disease forms but a part...The fully rounded work of healing reconnects the
patient with the world and recovers his or her self-control and self-confidence." Again covenant fidelity to the patient will provide the needed correction to the
technician symbol. The physician's covenant not only demands that the physician
treats the patient as person, but it also demands that the patient be treated wholly.

3.1.4 The Teacher Image

None of the images discussed above serve the function of teaching
adequately, which is actually required of the physician toward the patient in many
illness situations. Research shows that proper instructions from the physician
actually enhance rates of compliance from the patient. According to the same

186 The Physician's Covenant, 98.
187 Ibid., 104-5.
study, compliance rates also improve as the physician includes the family in her classroom. In the U.S., the rates of death due to heart attack and stroke have receded dramatically recently. It is believed the improvement is due to changes in diet, especially reduced salt intake, regular exercise, reductions in weight, drug compliance for control of hypertension, and other preventive measures. This improvement further reinforces the idea that the function of teaching occupies an importance place in the healing profession.

However, the medical profession hardly conjures up the teacher image in its own vision. "Neither medical school education nor residency training programs prepare physicians adequately for teaching," asserts May. The economic structure of medicine in the U.S. further discourages the physician from teaching her patient. The third party payment system recompenses the physician for concrete services to the sick, not for teaching the patients how to maintain good health.

According to May, the covenant image of the physician mandates teaching as part of her healing activities. The physicians have the overall responsibility for the patients to nurture and maintain good health, which includes the "delicate business of transforming their patients' habits." May has listed several areas in which teaching would yield positive benefits for the patients: acute care medicine, preventive medicine and rehabilitative and chronic care. However, even in terminal care where teaching seems unneeded, the teaching physician may be more predisposed to disseminate the crushing truth to her patient in a more tactful way.

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189 The Physician's Covenant, 155.
190 Ibid., 147.
191 Ibid., 150.
3.2 Moral Agents in Biomedical Ethics

A deeper appreciation of the Medical Covenant must also entail an understanding of the nature and identity of the major moral agents involved. This includes the physician as professional, the patient as person, and the medical institutions as collective moral agents. Moralists or philosophers in biomedical ethics concentrate on solving medical dilemmas and quandaries. They are seeking answers to the question "what should we do?" Ethical theories formulated with this premise alone fail to do justice to the diversity and complexity of all the major components that beg the moral questions we face in medicine today. By concentrating on quandaries alone, these moralists unwittingly diminish the scope of ethics. For any system of ethics, to be complete, must ultimately address a second question "whom shall we be?" A computer programmed correctly will be able to spit out all the right answers to any medical quandaries and hard cases according to whatever ethical theory we program into the machine. But the machine fails to be a moral agent, who can exercise free moral choice within a range of possibilities, who sees values when no practical solutions exist, whose being is impacted, shaped or altered by whatever decisions he or she makes.

The concept of covenant forces us to reckon with the being of the moral agents. Covenant is a relationship among moral agents, who exercise free moral choice, and whose beings will be impacted or shaped by the content of the covenant. As May demonstrates, the Sinai covenant of Scripture was one that sought to shape and alter the being of Israel. Therefore, it is not surprising that May, throughout his works, relentlessly comes back to this subject of moral agents. Three major players
in the venture of biomedical ethics really draw his attention: the physician as professional, the patient as person and medical institutions as collective moral entities. In the discussion below, we shall gain an appreciation of how May understands them, and how he thinks the Medical Covenant can assist them in being who they need to be.

3.2.1 The Physician as Professional

There are two important aspects that pertain to the nature of a professional. The practitioner of a profession professes something on behalf of her clients. She is offering her technical expertise on behalf of her clients based on some tradition of learning, and further, she vows to be morally accountable to the clients and the public she serves. Therefore when she opens up her office and is ready to receive clients, she is handing over her technical expertise to an implicit form of public trust. Her knowledge and skills no longer remain a private property, but a public entity that bears with it the rewards and responsibilities of any civic endeavor.

The professional, in a religious sense, professes a calling, one which defines her fundamental commitment and is only limited by the nature and boundary of her works. Since the physician is working to maintain or recover the general well-being of her patient, the scope of this endeavor forms her commitment and limits. Without this commitment, in May's words, "the practitioner is merely a careerist; in old religious language, he or she has no calling."\(^{192}\)

The Hippocratic Oath and the American Medical Association's (AMA) code of ethics\(^{193}\) express to some degree this sense of calling, although not quite to the satisfaction of May. The Hippocratic Oath contains three sections: first, duties to

\(^{192}\)Testing the Medical Covenant, 57.
patients; second, obligations to the physician's teacher and his family, and third, an oath to the gods of faithful adherence to the above two. Both May and Ludwig Edelstein agree about the codal character of the first section and the covenantal character of the second, though May offers a different reason for calling the second set of obligations covenantal. May has also offered an interesting discussion on the differences in character between code and covenant, which we will defer until later when we come to the concept of the Medical Covenant itself. The AMA's code of ethics adopted in 1847 and the one adopted in 1957 both manifest this codal ideal of duties toward the patient in terms of technical proficiency. However May's major criticism of both the Hippocratic Oath and the AMA code of ethics is their lack of an element of indebtedness to the public and the patient in their visioning of the physician as a professional. As such, in the Hippocratic Oath fashion, the physician is indebted only to the gods and to her teacher as she performs her work. In the AMA codes, even this last trace of indebtedness has disappeared as the modern doctors assume the posture of philanthropists serving humankind. In both the 1847 and 1957 AMA codes, there is mention of the indebtedness of patients and the public to physicians and the medical profession, but nothing is articulated to the opposite effect. Thus the codes offer "the picture of a relatively self-sufficient monad, who out of the nobility and generosity of his disposition and the gratuitously accepted conscience of his profession, has taken upon himself the noble life of service," asserts May. The conceit of philanthropy reaches its pinnacle (and has not subsided)

193 For both documents, please refer to the appendix section of Principles of Biomedical Ethics by Beauchamp and Childress, first edition.
194 According to May, Edelstein's classification was based on the Pythagorean convention of conducting the student by oath into the "family" of the teacher, thus a covenant. However, May points out, "the fact of indebtedness constitutes the chief reason for using the term "covenant." The Physician's Covenant, 110.
in the 1847 AMA code which begins one of its opening sections with the following: "[Physicians] should study, also, in their deportment so as to unite tenderness with firmness, and condescension with authority, as to inspire the minds of their patients with gratitude, respect, and confidence."\textsuperscript{196}

This is of course too presumptuous a posture for the physician as a true professional. The physician is in fact greatly indebted to the patients, the community at large, and the educational system that nurtured her. Consider the social investment in the training of our doctors. Consider those public monies that pour into medical schools, teaching hospitals and research, in the midst of a society that is gravely in need in many diverse areas. This indebtedness to the community that supports medical education is substantial. Further, in view of the fact that many more qualified candidates apply for medical school than are accepted, the medical student's indebtedness for privileges of training cannot be presumptuously dismissed. Furthermore, the physician is indebted to the patient, who is willing to offer himself as a subject for experimentation, or as teaching material in a teaching hospital, not to mention the extraordinary fee paid for services. Finally, the physician needs the patient in order to be who she is, as much as the teacher needs the student to define and shape his identity. In order to understand this point, we only need to think of the sentiment of a retired professional, who experiences a sense of lost identity upon retirement, when he no longer interacts with his clients.

We will see May's emphasis on the feature of indebtedness within the covenant concept, which again he draws from the Sinai covenant of Scripture, whose preamble states the indebtedness of Israel to her God, who brought the Israelites out

\textsuperscript{195} Ibid., 112-113.
\textsuperscript{196} Ibid., 113.
of Egypt and slavery. The motivation of our covenantal relationship with each other is this indebtedness to the transcendent God.

In some misfortune in life, the patient falls prey to disease and illness, but his presence continues to challenge the character of the physician as professional. May has listed three distinctive qualities that mark the medical professional as a covenanted partner in the physician/patient relationship. The first of these is the virtue of prudence, which is an intellectual mark of attentiveness and discernment. Since the physician's performance is both artful and technical, it behooves her to be attentive to the patient as a whole and discern what will serve his well-being and best interest. The second of these is the virtue of fidelity, which is a moral mark of love and loyalty. The professional interaction between the physician and the patient should be above and beyond what is required of the marketplace. The virtue of fidelity elevates the physician to the demand of her calling, and is an essential quality for a covenantal relationship.

The third is the virtue of public spiritedness, which is an organizational mark of civic responsibilities and communal ties. Not uncommonly, the physician serves her patient in a team setting. She needs to be able to work in concert with others for the benefit of the patient, and often she is called upon to be the leader of the health care team. In that case, she needs to orchestrate the entire healing effort with attentiveness toward not only the patient, but also the subordinates under her leadership. The virtue of public spiritedness also calls for a civic responsibility to distribute health care service to all members of society, independent of their ability to pay. Granted this need of the community will not be met by merely the effort of the

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197 Testing the Medical Covenant, 60-79.
professional alone. But May sees "the obligation to distribute professional services (justly) as both a public and a professional responsibility." The civic responsibility of the professional also requires her to control the quality of the care produced and distributed. Professional self-regulation and discipline is one minimal means to ensure quality control. The referral system of the medical profession in the U.S. currently is not a very effective way to screen out or ostracize non-performing colleagues. Given the shortage of physicians in the U.S., the non-performing physicians can always find a community where their mediocrity of service is needed and endured. The AMA needs to devise more effective measures to strengthen this covenantal requirement of the profession.

All these virtues of the physician as professional – prudence, fidelity to patient and public spiritedness – call for nothing less than a covenantal relationship between her and the patient. And only the indebtedness of a covenantal relationship, as May offers, can capture the proper motivation for interactions between the physician and the patient.

3.2.2 The Patient as Person

The patient as person is a major component of May's ethical approach to medicine, and this may be a result of the legacy of Ramsey's theological contribution to medical ethics. In introducing his book *The Patient's Ordeals*, May openly acknowledges, "This book attempts to reactivate an earlier moral tradition: it seeks to reckon with the moral problems which the patient and the patient's family face." Other than Ramsey and May, very few moralists or philosophers place any kind of

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198 Ibid., 76.
199 Paul Ramsey, one of the early contributors to medical ethics, published *The Patient as Person* in 1970 (New Haven and London: Yale University Press)
emphasis on the ethics of the patient and his family. They mainly approach medical ethics from the side of the doctor. Without a deeper understanding of the plight of the patient and his family, the talk of respect for the patient's autonomy and consent ultimately sounds hollow and seems devoid of substantial content. This is where one appreciates May's sensitivity and the wholeness of covenantal ethics. In May's career, as mentioned before, he has spent considerable time in the field observing the quandaries of doctors as well as the crises of patients. These experiences enable May to achieve a degree of depth and wholeness in his medical ethics that truly distinguishes him from his contemporaries.

Following the zeal of enlightenment into the post-modern era, contemporary medical ethics attempts to rid itself of the element of religious traditions, which is deemed to be divisive and troublesome in a pluralistic society. The need for public policies in the area of medicine provides a further impetus for consigning the religious element to relative oblivion. These social and philosophical factors account in large part for the rise of a rationalistic approach to medical ethics that exalts reason and some universal principles as the sole guiding forces. But, contemporary experiences in our society "reek of religions," May protests.201 "The crises that patients face often trouble them religiously," May states matter-of-factly.202 It is therefore not surprising that May voices his discontent with the contemporary rationalistic approach to medical ethics, which, devoid of religious content, necessarily misses a central facet of the patient's ordeal and healing process.

202 The Patient's Ordeal, 2.
3.2.2.1 The Patient's Body and Identity

May's understanding of the patient stems from the Judeo-Christian tradition that affirms the body as real. This theological background coupled with his sensitivity for the patient in crises probably led to his conviction that the body is the identity of the patient. In May's words, "A person not only has a body; she is her body." Because of this particular theological perspective, in arguing for organized giving of bodily organs versus routine salvaging, May asserts that even in death, "the body commands the respect of identity." This identification of the patient with his body makes the idea of routine salvaging even for good medical cause objectionable.

Roaming through institutions for the mentally retarded, cancer hospitals and medical clinics, really brought out May's sense and sensibility for the well-being of the patient, which has ultimately enabled him to bring the Medical Covenant into sharper focus. In providing care for the health of the patient, the physician must support the patient in whole, body and person. And everywhere in medical institutions dealing with serious or terminal illness, health crises assault not only the body but also the person. Health crises assault identity, and confront the patient with the question what to do and, more profoundly with the question who he shall be after the crisis. The case of a burned victim, Don Cowart, poignantly illustrates this point for May. After an explosion that burned two third of his own body and killed his father, Don Cowart declared to a farmer who first saw him: "I am a dead man. I can't live." The fire burned his face, his eyes, his ears, his hands and his feet. Don was effectively no longer the same man, and he changed his name to Dax. Even after the

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204 Ibid., 40.
205 The Patient's Ordeal, Ch. 1.
doctors partially restored some functions of his body, there was not much the surgeon could do to restore his physical appearance. "The surgeon must accept that what delights him as a technical result may still be a horror to his patient," conceded John D. Constable, M.D. Dax was left ultimately with the agony of dealing with the consequences.

3.2.2.2 Life vs. Quality of Life

Upheavals like that experienced by Dax certainly force us to rethink the identity of the patient as he goes through them. They also exert new pressure to reconsider the issue of life versus quality of life. In this debate, the pro-lifer take the position that life is an absolute good and rejects any reason for terminating life. Dax, in this case, actually invoked the defense of quality of life to plead with his mother and his doctors to let him die. But the terminology of "life" and "quality of life", according to May, fails to adequately convey the impact upon the patient in upheavals like that faced by Dax. The defense of quality of life only affects life's quality, which seems relatively unimportant compared to the defense of life itself. But Dax's case and many others like his illustrate that the issue is much more profound than what the term "quality of life" seemingly implies. For Dax, it is not just the quality of life that is at stake. It is a rebirth of a new identity with charred flesh and scorched bone. It is a reconstruction of a new life with partially restored functions and a mutilated psyche. For the old Don Cowart is no longer, and the new Dax must begin. In order to properly appreciate the trauma patients like Dax have gone through and will face subsequent to their crises, May suggests a shift of terminology to that of "rebirth and reconstruction," which is exactly what the

207 Ibid., 21-24.
patients will encounter and what our healing profession and ethicists often fail to address.

3.2.2.3 Paternalism vs. Autonomy

Understanding the identity trauma of a patient going through a crisis also helps May rethink the debate between paternalism and respect for the patient's autonomy. When Dax's caregivers refused to heed his pleas to be allowed to die, he accused them of paternalism. Paternalism justifies intervention or manipulation bypassing the freedom of another adult on the grounds that it is for his or her well-being, or that the harm done is trivial relative to the good that it achieves. As discussed in the section on The Parent Image, the well intention of the helping professional can lapse into paternalism if carried to an extreme. But trauma patients like Dax, in order to face the reconstruction of life well, needs more than just liberty. He needs someone or a community that is willing to assist him to face that dark future. Without that commitment, respect for the patient's autonomy will simply dwindle to hollow ideology or to what May calls "a minimalist ethics" that mocks the lofty appearance of our health care system.

3.2.2.4 A Crisis of Community

In May's words, the body of the patient is "more important to his identity, than words to a poet." May is not expounding a theological position, but rather making a descriptive observation based on a deeper understanding of the patient's world and inner reality. Some theologians may question the validity or wisdom of equating the body with the identity of a person, but for the patient, it seems to be the only truth that matters or is valid to him for that period of his life. Another reason why health crises assault a patient's sense of identity is that they also threaten his
familial and communal ties. For the patient in health crisis, the disease not only threatens his body, but also his psyche with the dreaded separation from his community and familiar surroundings. It also assaults his family members with the same separation. Thus, both the inner and outer worlds that define who the patient is are shattered. However, as May grimly points out, "Ironically, the very apparatus by which the community ministers to his physical need isolates him further. The modern hospital segregates the sick and the dying from their normal human resources." 208

Contemporary cultures have a tendency not only to institutionalize the sick, but also to shroud them with the desolation of non-communication between themselves, the doctors and their nearest kin, particularly when we choose evasion as a means to talk about their real conditions. However, according to May, "Isolated by evasions and lies, the patient is driven out of the community before his time. We have forced upon him a premature burial." 209 May is not suggesting that we should bombard the patient with direct grim discussion of his dismal condition. That kind of bluntness is not called for in a delicate situation like that faced by a patient suffering from terminal or serious illness. But truth can be revealed with what May calls "indirection," which is a discreet and genuine method of disclosure without the rough edges of blunt talk. 210

For the patient, when disease strikes, it strikes as a crisis of the flesh, but to a certain degree, it may also strike as a crisis of community. Covenantal ethics demands that we treat the person as a whole, body and soul. This wholeness also

209 Ibid., 484.
210 For examples, please refer to "The Sacral Power of Death in Contemporary Experiences," 484-487.
includes his communal ties. The community who maintains covenantal fidelity to the patient must work to provide care and preserve ties with him as a person.

3.2.2.5 The Ethics of the Elderly and the Sick

As John Yoder finds in amazement, "the New Testament addressed the subordinate person in the social order as a moral agent." There were no precedent for this in Hellenistic thought, he argues. However, the ethics of the elderly and the sick has been consistently neglected by contemporary moralists and ethicists. In May's view, we unwittingly signal their exclusion from our community if we only talk about the ethics of the caregivers but not of the care-receivers. Covenantal ethics demands that we care about the person as a whole and who he becomes, even for the least or the marginal among our community. Motivated by the wholeness of covenantal care, May attends to the ethics of the elderly and the sick in no meager proportion. He has devoted a couple of papers to this subject and touches upon it from time to time in other writings.

As May has provided the medical professionals with a list of virtues, he has also furnished a list for the elderly and the sick. The list for the elderly includes many virtues, of which courage comes first. Perhaps that is what the elderly need most, courage to face their declining years or the onset of serious illness. When we are young and well, we can confront adversities with strength and vitality, and overcome them with our resolve for actions and doing. But old age and serious illness present us with a different test. It is a test of a different nature, one that can only be answered ultimately by who we are, when no amount of action will prevail.

211 Cited by May in "Who Care for the Elderly," The Hastings Center Report (December, 1982), 36.
212 May's papers devoted to this subject include "Who Care for the Elderly," "The Virtues and Vices of the Elderly." A section is devoted to the ethics of the sick and dying in Testing the Medical Covenant, 46-47.
Therefore, courage, hopefully will be a mark of the aged who have faced a good number of vicissitudes in life.

If old age is a period marked by challenges not to be solved by mere activities, humility looms large as a needed virtue. Old age and disease assualt our dignity as persons. As May criticizes caregivers in the U.S. for condescension in their pursuit of the philanthropic ideal, care-receivers need the virtue of humility just as much as they do. Only a sense of humility can ease the pains of being humbled by the problems of old age.

Patience is the next virtue that May lists, not because of the diminished vitality level that normally besets the elderly, but because an appreciation for the deeper purpose in life often requires it. May continues to list many other virtues: simplicity, benignity, integrity, prudence, wisdom, nonchalance, courtesy and, finally, hilarity. Valuable as it is, space does not allow me to summarize May's elaboration on them. For that purpose, one is encouraged to refer to his paper "The Virtues and Vices of the Elderly." To complete the picture, it will not do if the Medical Covenant goes without a list of virtues for the very sick and dying. May identifies five key virtues for them to face the very calamity of their lives: patience, courage, prudence benevolence and hope. They are very similar to those for the elderly. They are also the key virtues for families and caregivers. The very sick or dying patients need to have patience in dealing with the catastrophic event that has befallen them. Going through diagnoses and enduring hospital visits require it. They need to have the courage, the kind of forbearance to face the truth about their deteriorating health, and then they need the prudence, the wisdom, to discern what is

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213 Testing the Medical Covenant, 46-7.
needed and what is not for proper treatments or refusal of treatments. Benevolence and hope are hopefully there as the patients finally withdraw from the earth scene, as friends and relatives are bidding farewells. "Hope rests upon nothing in our own hands or in the doctor's hands but rather casts us, whether we live or die, in God's hands. Such hope rests in that final openhanded equanimity that would uphold all thousand of the living and the dying," contemplates May.\textsuperscript{214}

The patient's plight occupies an important position in medical ethics. Only in appreciating the patient as a person can we comprehend the significance or the full force of the Medical Covenant as a moral mandate. It is with this deep-seated conviction May formulates the Medical Covenant as an answer to the health care problems and issues of the U.S.

\textbf{3.2.3 Medical Institutions as Collective Moral Agents}

A comprehensive approach to medical ethics cannot neglect the institutions, (the hospitals, the medical schools, etc.) as collective moral agents. They are collective moral agents because morally they do have a distinctive purpose or mission that charters their existence, and their existence and operation do affect to a very large extent people's moral lives. Thus it is not surprising to find a good portion of May's works devoted to the ethics of medical institutions. Again, as in the understanding of the patient's predicament, May's apprentice experience in the medical institutions mentioned earlier really emerges as a great asset for his insights into institutional ethics in medicine. The various medical institutions May's work touches upon are the hospital, the university, the total institution, the American Medical Association, and to a lesser extent, the hospice and neighborhood health clinics. However, we only need to concentrate on the major ones in this discussion.

\textsuperscript{214} Ibid., 47.
Besides being morally clear about their distinctive purpose, large institutions have three structural characteristics. They are 1) hierarchical; 2) dependent on regular procedures and standards; and 3) official and impersonal. May's observations of medical institutions come in three areas. First of all, because of their public nature, large institutions do have secondary responsibilities toward the public more than they are willing to admit. Since they employ a good number of workers, decisions or policies on the institutional level affect a lot of people. Although serving primarily a distinctive corporate mission, the institution must try to understand its place within the larger framework of society as a whole and its common good. For the health institution, health care is but only one common good among many in the society. It also must seek to understand that in serving its community, it is indebted to the community which "charters its life, grants it protection, and endows its enterprises with a public significance to which it must respond."216

Secondly, because of its hierarchical structure, the institution tends to subordinate its workers into subservient roles. It only looks at its employees in terms of efficiency. After the normal shift hours, the employee fades into a non-entity and is perceived to have no bearing on the corporation whatsoever. This perspective takes shape as the pressures meeting the primary goals of the institution mount. That is understandable, but this attitude misses many of the secondary responsibilities demanded of quasi-public institutions, of which the medical institution is one. Yet another type of employer tries to act on behalf of the employee benevolently and paternalistically. This is done in the name of the welfare of the employees. But none of these perspectives are desirable and are inherent of a hierarchical institutional

\[215\] The Physician's Covenant, 170.
\[216\] Ibid., 176.
structure. The best kind of employer seems to be one who will take the well-being of the workers into account while serving the primary purpose of the institution.

Men and women come to serve in an institution because together they can achieve some purpose greater than themselves. It is also because they need community for support, correction and encouragement. When the institutional community functions properly, men and women find fulfillment of their talents and also learn to be better professionals among themselves. That will requires an institution to forgo some of its hierarchical atmosphere and to stress the collegial aspect of the institutional life.

Thirdly, the institution's emphasis on the office at the expense of the person creates for the professional conflicts of duties to the patients, to oneself, and to one's colleagues. As discussed above, the physician should reckon with not only the disease but also with the patient as person. Accustomed to the demands of official duties, she may also diminish her own personal life. Neglected children or a resentful spouse may be the cost of a successful career. The collegial relationship with coworkers may also begin to strain when an atmosphere of competition fills the office.

3.2.3.1 The Hospital and the Total Institution

The hospital and the total institution in general bear the type of criticisms May levels at the institution above. Although recognizing the values and resources of the large-scale hospital, May thinks that reforms are in order, particularly to allow for less structural conflicts and to alleviate bureaucratic burdens. We are, perhaps, moving toward a so-called "duplex social organization" where smaller, more informal organizations deliver health services supplementing large-scale hospitals.
The hospice and the neighborhood health clinic are two examples. The hospice can, sometimes, care for the dying better than the hospital, because it addresses the needs of the dying person's family and community. The neighborhood health clinic can also in a way deliver more efficient and localized services that suit the particulars of the neighborhood. Other movements May mentions are the holistic health care movement and organized efforts at self-care. These are worthy experiments that supplement the services of large-scale hospitals.

Modern day hospitals, and total institutions to a degree, in their relentless fight against death, somehow have become "its instrument and symbol," observes May ironically.\(^{217}\) Somehow, our management of the problems of old age, illness and mental disturbance is largely by segregation. We sequester cancer patients into cancer wards, the retarded into institutions for the mentally retarded, the elderly into convalescent homes. We tend to remove these afflicted population groups from our sight, because this is an easy solution, and they eventually and literally disappear in these institutions as they die. Thus hospitals and total institutions have acquired the image of the devourer, a symbol of death in traditional societies, explains May. But the people do not have many alternatives today, because there are too few intermediate solutions before institutionalization.

The ways in which we care for our elderly people receive similar criticisms from May. We institutionalize the elderly in what May calls "Geriatric Barracks," whose architectural designs and treatment of the elderly really mocks the word "Homes." May urges more sensitive reflection in designing these "homes" for the elderly. Three basic body functions of the elderly should be considered, as the body

is the center of control, enjoyment and self-revelation in a person's world. Here we see May's concept of body (that constitutes the identity of the person) is at work. Covenantal ethics causes us to be sensitive to this part of our patient or the aged. May also cares about how our elderly people conduct themselves. The list of virtues for the elderly is our attention and respect paid to this often neglected group of people.

3.2.3.2 The University

May has written a couple of essays concerning the university in its role as a teaching institution of medicine, medical ethics and theology. May's criticisms of the university are constructive and actually provide his readers with an overview of his approach to medical ethics. Perhaps this is natural to him because the university is more akin to his vocation as an educator or teacher. His criticisms of the university must be seen in light of his understanding of the tasks of medical professionals in the field. In that manner, his suggested corrections for the university strike one with a great sense of realism and relevance. That is the hallmark of an accomplished applied ethicist whose field experience cries out with corrective insights in a discipline which has been too well and too long dominated by theoreticians.

As mentioned in a previous section, a professional, declares himself "to be morally accountable for his expertise." That has been the traditional expectation of the medical doctor as spelled out in the Hippocratic Oath: "In purity and holiness I will guard my life and my art." However, the university in training professionals, long ago abdicated responsibility for promoting moral reflection and nurture. It opts

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for the more concrete task of developing a technician. As a result, the moral substance of the profession gets obscured, and the professional is reduced to only a trader of a specific set of knowledge or skills.

In May's mind, in order to train people who can live up to the high calling of the profession, the university needs to recover or strengthen three aspects of its vocation. First, it must not satisfy itself with preoccupation in descriptive scholarship alone. The importance of descriptive scholarship is not to be downplayed, particularly in a field where scientific pursuits and technological advances are the bulk of its work. However, the university should also strive to stimulate or cultivate critical intelligence in its training program. The university threatens the professions, and society for that matter, with moral poverty as technicians shun critical thinking.

Second, the university exists for the betterment of civic life. It has the responsibility to instill in the trainees a sense of self larger than the individual. Knowledge and skills have a public component such that exploitation of them for private opportunity will eventually diminish the profession. Finally, the medical professional needs to be a good teacher. She heals as well as transforms, in some way, the being or habits of her patient. To train a professional, who will be able to answer competently the full spectrum of her calling demands that the university must at least reassess its role in these three areas.

3.3 The Medical Covenant

3.3.1 The Hippocratic Oath and The American Medical Association Codes of Ethics

As discussed above, the classic understanding of the ethics of physicians is embodied in the Hippocratic Oath, whose primary focus is the obligation of
physicians to provide medical care to patients and to protect them from harm. It also evinces a covenantal obligation of the physician to her teacher and the teacher's family. Interestingly, the Oath alludes to religious entities for authority. The Oath is made solemn by a swearing to the gods and goddesses by the physician. The American Medical Association Principles of Medical Ethics adopted in 1957 covers a wider scope. As stated in its preamble, it encompasses "standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public."\(^{219}\)

May's criticisms of both attempts to regulate the conduct and ethics of the medical profession are directed at their codal characters and the philanthropic posture that they presume for the physician. First of all, there are positive things about a code. As May understands it, "a code shapes human behavior in a fashion somewhat similar to habits and rules," which are categorical and universal to those who happen to fall within its scope. A code is ahistorical in the sense that it does not derive its authority from particular, external events. Its power stems from inherent rationality or reason within the code or the profession itself. From this perspective, the norms of medicine are generated from within the practice. Furthermore, a code not only directs content of actions, but also governs their forms. It is concerned not only with what is done, but also with how it is done. A code in this sense encourages technical excellence. Finally, a code of conduct also tends to lessen personal involvement of the physician with the patient, which is needed occasionally if the physician is to provide objective, emotionally free medical judgment for her patient.

\(^{219}\) *Principles of Biomedical Ethics*, first edition, appendix II, 282.
However, the positive aspects of such a code can also turn negative. Since both the Hippocratic Oath and the AMA code posit the physician and patient relationship without a prior historical event, they espouse a relationship that is technical and is, henceforth, without ties. When a code becomes the central characteristic of a relationship, it eschews emotional involvement and discourages bonding. As with the bullfighter in the Hemingway novel, there comes a time when the engagement between the bull and the fighter will be over. What is left with the spectators or the parties involved is only the beauty or excellence of the performance. Undoubtedly in May's mind, codal ethics can foster technical excellence in this sense. Both the Hippocratic Oath and the AMA Codes of Ethics appeal to the ideal of philanthropy as motivation for their lofty ethics. However, as we have already pointed out, this is not satisfactory to May. Codal ethics exalt technical excellence but neglect the whole person. Philanthropy misrepresents the reality of the medical profession's indebtedness to the public. Its condescension can quickly degenerate into paternalism. A codal relationship between the physician and the patient cannot answer the deeper challenges faced by the profession as we have discussed in previous sections. The various tasks of the physician as embedded in the four images, the implications of the physician as professional, the patient as person and medical institutions as collective moral agents – all these aspects point to the need for a drastically different paradigm to serve as the guiding force for biomedical ethics. For May, that paradigm or that central image is the covenant of Scripture.

3.3.2 The Biblical Covenant

May sees corrections for these flaws through the biblical concept of covenant. Speaking as a Christian ethicist, May never hides the origin or source of this concept.
The concept of covenant that he has in mind comes from Scripture. He acknowledges this whenever he expounds the concept. The biblical covenant that May often alludes to is the Mt. Sinai covenant that God established with his people Israel through his servant Moses. This biblical concept of covenant forms the backbone of the relationship between God and his subjects, and permeates Scripture as a relationship framework among people. There are four essential elements in this biblical concept of covenant. The first is a gift, bestowed to the people of Israel by God in a historical event culminated in the exodus of the Israelites from the slavery and government of the Egyptians. The gift established the indebtedness of the Israelites to their God Yahweh, and henceforth their ties to this transcendent being. The Israelites received this gift from their God Yahweh not only as individuals but as a nation as well. That is why the Sinai covenant is in a strict sense a communal covenant, a covenant of the nation with her God. The second element is the exchange of promises. God promises his blessings for the Israelites, and the Israelites promise to keep his commandments. They are in essence promises of fidelity between God to Israel and vice versa. It is demonstrated through the history of Israel that God never abandoned his people, even though Israel broken the promise of the covenant numerous times. May also alludes to the "new covenant" of Jesus Christ to further expound the nature of self-expending love as an essential feature of covenant fidelity. God’s fidelity to humankind is accomplished and demonstrated through the death and suffering of Jesus Christ on the cross. The third element is the shaping of the subsequent life in response to the gift and the promissory event.

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221 *The Physician's Covenant*, 127.
commandments are given to the Israelites to help shape their spiritual and moral lives, and therefore help them to remain faithful to the covenant. It is a covenant that transforms whoever succumbs to it and obeys its commands. The fourth is those rituals that symbolize the covenant and the foundational events that gave rise to it (the festivals, the dietary laws, and the Sabbath). This element also has a transforming effect through religious or ritual channels. In all, the covenant of God with Israel attends to the wholeness of the person and the nation as a community. It cares about how the Israelites conduct their lives in terms of what they should or should not do. It also cares about who they are going to be. The commandments and the rituals are put in place to accomplish this.

This is in a nutshell what the biblical covenant is all about. May draws avidly from its essential features and principles and applies them to the problems and issues of biomedical ethics. The Sinai covenant is not the only part of Scripture that May refers as a source of inspiration for the Medical Covenant. He draws from many other passages as well as he sees fit. For example, he alludes to God's covenant with Noah for human responsibility to nonhuman creation. He refers to "the covenant in Christ" or "the new covenant" to explicate the concept of self-expending love.

3.3.3 The Formulation of the Medical Covenant

3.3.3.1 The Essential Features of the Medical Covenant

In formulating the Medical Covenant, May draws from his understanding of and insights into the tasks of the physician, the physician as professional, the patient as person and the medical institutions as collective moral agents. In order to correct or balance the tensions or excessive impulses of the images (identified previously)

222 Ibid., 126.
223 Ibid., 127.
that govern the ethics and performance of the physician and her profession, May believes that several essential features of the Medical Covenant are necessary. These features are gleaned from the principles of the Sinai covenant mentioned above.

**Indebtedness**

The conceit of philanthropy embedded in the Hippocratic Oath and the AMA Codes of Ethics can be greatly corrected through a covenantal relationship between the physician and patient. May argues that the service of the medical profession to the public is in fact a reciprocal act, responding to the considerable debts it has acquired to the community. We have already seen in a previous section how the physician in many ways is a product of the community and the public she seeks to serve. A covenantal ethics will help the physician acknowledge this indebtedness to the patient and society that have nurtured and sustained her professional self and her profession. The indebtedness to the transcendent and to our fellow human beings in our community is the motivating force of the Medical Covenant. This sense of indebtedness enables the physician as a professional to dispense her services with prudence, fidelity and public-spiritedness, along with a deep sense of humility. While the philanthropic impulse enables us to dispense surplus resources for the benefit of others, the sense of indebtedness helps the physician to give self-expending love to her patient for his well-being as befit the image of a parent.

**Covenant Fidelity**

Covenant fidelity is another feature that May draws upon to build his case for the Medical Covenant between the physician and the patient. While traditional medical ethics prescribes an ethic of code and philanthropy, American culture and its market forces gradually fashion out one of contract, which is just a prevalent
response of a pluralistic society that has given way to consumerism. There are positive things about a contractual relationship between the physician and the patient. First of all it emphasizes informed consent rather than blind trust between the contracted partners. In this sense, a contractual relationship encourages respect for the dignity of the patient, which can be neglected in a more condescending philanthropic posture, a parenting or paternalistic relationship. Secondly, a contract can be legally enforced, because of its explicit contents. It spells out what is required and expected of the contracted transaction. It protects the underlying self-interest of each party.

Although the notion of contract does provide some corrections to the ethics of code and philanthropy, it is deficient in many areas and in some instances, has introduced some vices. Like code and philanthropy, it suppresses the idea of gift in the transaction. The contracted parties come together for a mutual exchange of goods and services motivated by self-interest. There need not be any prior historical event of gifts that marks the beginning of relationship. This mode of operation reduces professional obligation to self-interested minimalism, as May has often pointed out. The contractor only acts to fulfill the letter of the contract, and nothing beyond. And in other cases, the contractual physician, in protecting himself (self-interest) against mal-practice lawsuits, may opt to overtreat the patient, a form of maximalistic ethics. Therefore, contractual ethics, as driven by self-interest, may err on both extremes, depending on the circumstances.

May puts forth a very interesting comparison of a contractual and covenantal ethics. First of all, a contract is external to the parties involved, whereas

covenant is internal. The fulfillment of a contract is measured and discharged by the outward performance of duties dictated by the contract. Recognizing a prior gratuitous act from one party to the other, covenant draws upon a deeper, personal tie that aims to nourish or even transform the persons involved. This deeper, personal tie which stems from a prior gratuitous act is what May calls covenant fidelity. Covenant fidelity is manifested in a promise or pledge of loyalty to the other party, a promise attendant to the well-being and best interest of the partner in the covenant. Therefore, while contract aims to dispense a duty, covenant moves to complete a person. Contractual ethics relies on external restraints (e.g. laws) to keep people within moral limits. Covenant appeals to the internal commitment and aspirations of the covenanted parties for a more fulfilling and complete relationship.

Contractual ethics assumes an equal and balanced posture between the two parties regardless of the real situation. But in real life, a physician is in a much more powerful and knowledgeable position than the patient is. The patient's knowledge of his own illness and the options open to him is rather limited. The fact that the patient is seriously ill further traumatizes his psyche and lowers his self-esteem. Covenant fidelity, however, would oblige the stronger one to accept some responsibilities for the more vulnerable. This is manifest in the covenant between God and his people Israel. When Israel sinned or broke their covenant, God was the one who acted to bring them back. Covenant fidelity means that God, being the stronger and more powerful party of the covenant, often takes on more responsibility in the covenant. However, in human relationships, this doesn't mean that the stronger or more powerful party must deal out benevolent behaviors paternalistically, for the covenant
recognizes the other party involved as a person, one who is endowed with stature and freedom equal to that of ourselves.

Therefore, there are at least three characteristics that pertain to the trait of fidelity in a covenant relationship. It seeks the well-being and best interest of the covenanted partner. It also means steadfastness and loyalty in sustaining the relationship, and when the covenant partner is in a weaker position, covenant fidelity extorts the stronger one to take on more responsibilities, to the extent that it won't diminish the partner as a person.

In this light, we can see that many ills or tensions of the four images of the physician can be corrected. Covenant fidelity can balance the paternalistic and antipaternalistic tendency of the parent image. Because of covenant fidelity, the parent can work to protect and nourish the child to his benefit, but leave him enough room for his identity to form and flourish. Covenant fidelity can also show the inadequacy of the technician image in pursuing technical excellence alone and neglecting other aspects of the patient, because in a covenant relationship, we are dealing with a person, not an object.

Communal Ties

Another important feature of the covenant concept that finds important application in the Medical Covenant is the idea of communal ties. In understanding the crisis of the patient as he faces terminal illness or traumatic experiences, May sees the importance of communal ties to the patient all too well. When critical illness strikes, it is not only an assault of the flesh, but it is also a crisis of community. However, insensitive to this plight of the patient, the modern solution to his predicament is often one of isolation. As mentioned earlier, we segregate the sick
and the aged in hospitals and institutions, and sometimes subject these most needy member of our community to the additional trauma of abandonment. The call of the medical profession fashioned from the covenantal perspective would urge us to correct this ill of our current medical practice. It calls for more intermediate solutions between total institutions and family care. As May notes, the hospice movement and neighborhood health clinics are fresh experiments that are heading in this direction.

The concept of community embedded in the Medical Covenant also helps May formulate the scope of the Medical Covenant, as we will discuss in a later section.

Wholeness of the Person and Transformation of the Self

The Sinai covenant addresses the wholeness of the person. The commandments touched on all aspects of a person's life: relationship with his God, neighbor, marriage partner, parents and the self. The rituals so mandated are to form and mold the person of his spirituality and his communal ties. One aspect of the promise of fidelity of God to his people is that he takes it as his responsibility to mold and transform his people to their fullest potential. These two ingredients have direct applications in the Medical Covenant. It challenges us to ask the question: what is the goal of medicine, hence, the Medical Covenant? May readily furnishes an answer resonant with this feature of the Medical Covenant as we shall see below.

3.3.3.2 The Goal of the Medical Covenant

In exploring the different images that pertain to the tasks of the physician, we can see the complexities of her goal. In the parent image, the task of caring looms large, but in so doing it may neglect the patient as a full autonomous person. The
fighter image deems fighting disease as the ultimate task of the physician, but there comes a time when fighting must cease and assisting the patient facing his death becomes the priority. The technician image may help the physician hone the excellence of her skills, but is probably insufficient in addressing the patient's emotional well-being. Furthermore, a good physician must be a good teacher to her patient, as she may need to transform some habits of her patient. Thus by themselves none of these images could adequately or fully define the healer's task.

May selects the image of the covenant as an encompassing concept that can aid the physician in properly accomplishing all her tasks. Covenant fidelity motivated by a sense of indebtedness to the patient, society and the transcendent can properly guide the physician between parentalism and patient autonomy. The sense of indebtedness avoids the conceit of philanthropy for the physician. Fidelity to her profession helps the physician motivated to sharpen her technical skills and maintain her technical performance, but fidelity to her patient keeps her in a healthy emotional proximity to the patient with whom she works. Fidelity to her patient requires the doctor to stay close to her death bed and provide care, if fighting the disease becomes futile.

In order to fulfill all these tasks well, May believes the goal of the Medical Covenant is not just to fight disease or death or suffering, though some of the images may narrowly focus on some of these functions. May broadly defines the goal of the Medical Covenant to be "pursuit of health," and, "let it be noted, the extension of a healing care in the midst of disintegrating health." The healer's task is to make the patient whole again, physically and emotionally. Only goal defined with this

\[225 \text{ The Physician's Covenant, 130.}\]
broadness is resonant with the goal of the primary covenant of Scripture. As mentioned previously, the Sinai covenant cares about Israel as whole. The commandments of the Sinai covenant touched upon all aspects of Israel's life: God, neighbor, parents, and self. The rituals would further act to mold a person's spiritual being, transforming him to be the person who he is meant to be.

3.3.3.3 The Scope of the Medical Covenant

We can see how the Medical Covenant addresses the scope of health care in the U.S. by posing two questions. The first question it poses on current health care services is how universal is health care coverage for American residents? The second question is how comprehensive is that coverage? Although there is much to be proud of in the U.S. health care system, the answers to both questions show that our health care system is seriously flawed. At any given time, it excludes more than one out of seven Americans (about forty million people) from health care insurance; it leaves another one out of seven underinsured. When we exclude individuals from health care, we are saying to them that they don't belong to the community. May invokes the primary covenant of humankind with the transcendent God as a mandate for universal health care coverage. "The God who is the creative, nurturant, and donative source of all beings establishes the primary covenant. Loyalty to such a God requires loyalty to all of his creatures." In this sense, covenant fidelity to all fellow human beings mandates some form of universal, basic health care. This is what May calls the external catholicity of the Medical Covenant. Thus to maintain or establish proper communal ties is a basic ingredient of the Medical Covenant and

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226 Testing the Medical Covenant, 100.
227 The Physician's Covenant, 137.
such ties extort us not to abandon some portion of our community from basic medical care.

Besides commanding some kind of universal health coverage for the public, the *internal catholicity* of the Medical Covenant demands that we meet the need of the whole person, body and soul. The criticism has been made that the U.S. health system is largely an acute care glutton but a preventive medicine anemic. We also fail very much to follow through comprehensively with rehabilitative, long-term, and terminal care. Although society must bear the main responsibility for distributive justice in health care, the individual professional does also share some of that responsibility.

**Summary**

To summarize, the Medical Covenant formulated by May takes its roots from Scripture. Although there are many covenants scattered throughout Scripture, the one in Sinai formed between God Yahweh and his people Israel forms the primary model for May. Essential features gleaned from the Sinai model that have clear applications in the Medical Covenant include the sense of indebtedness, fidelity of the covenanted partners, the transforming element of the subsequent life by the covenant, the wholeness with which we are to treat our covenanted partner, and finally the communal ties engendered by the covenant. Any one of these features, standing alone by itself probably does not constitute a covenantal relationship, but with a cluster of these features, a strong covenantal relationship is indicated. This list does not pretend to exhaust all important features of the covenant concept, but it represents those that are relevant to biomedical ethics. Understanding the various tasks of the physician, May has also delineated the goal of the Medical Covenant,
which he believes to be the pursuit of health, not just fighting death or suffering, though this could be an important component. Finally the scope of the Medical Covenant constitutes what May calls the external and internal catholicity. The external catholicity requires us to pursue universal, basic medical coverage, because everyone is included in the primary covenant with God. This communal tie says that we have basic responsibilities in treating our community members in need. Internal catholicity requires us to pursue comprehensive coverage, treating the patient as whole.

Given this formulation of the Medical Covenant, we gain a much better understanding of why and how May treats many subjects and issues in biomedical ethics. We have already seen how May applies the features of the Medical Covenant to correct and balance the tensions and conflicts inherent in the physician's tasks. The external catholicity of the covenant urges May to look beyond ethical issues alone. He is one of the rare biomedical ethicists who wields a comprehensive approach to this discipline. Biomedical ethics does not just call for solutions to medical quandaries and dilemmas alone. Beyond that, biomedical issues reflect who we are as moral agents, the physician as professional, the patient as person, and the medical institution as collective moral agent. In all these dimensions, May labors to offer his insight from a covenantal perspective. The virtues of the physician as professional require prudence, fidelity to the patient, and public-spiritedness. We can now see that all these resonate well with the internal and external catholicity of the covenant concept. One needs to be on the side of the patient during his crisis to understand why his body is his identity. May does not stop at sympathizing with the patient. He offers his insights and criticisms for the elderly and their conduct and
ethics. His list of the virtues and vices for the elderly is one spoken with love and covenant fidelity to them. Medical institutions must take seriously their secondary civic responsibilities to the public and to their employees as a team and a community, because May views them as quasi-public institutions. Covenantal ethics is ultimately a communal ethics. The university's task is not just to produce medical technicians, but professionals who do their jobs well, who are capable of critical moral reflection and who can teach, for there is a transforming element of the patient inherent in the Medical Covenant.
Chapter 4

Comparison, Part I: Euthanasia and Assisted Suicide
Introduction

No sooner had interests in biomedical ethics been revived in the 1960s and 1970s than the discipline was besieged by a plurality of philosophical approaches. As discussed previously (Chapter One), many different voices have since clamored down the respectable hallway of academic biomedical ethics. The scholarly circle of biomedical ethics has been filled with Kantian or deontological principles, utilitarian or consequentialist terminology, Aristotelian notions of virtue ethics, or the Catholic tradition of natural law, etc. There is the contractarian model of Robert Veatch, the communitarian framework of Michael Sandel, the casuistic method of Albert Jonsen, not to mention the recent arrival of feminist voices in biomedical ethics. It is difficult to exhaust one’s list. For the readers and users of biomedical ethics, there is a genuine need to sort out these positions objectively. This calls for efforts that will illuminate the options offered and account for the salient and the less salient features of each vantage point relative to other viewpoints. It calls for analyses that will identify their sources of inspiration and elucidate their underlying logic. Besides providing the benefit of elucidation, this type of efforts will also enhance mutual learning across philosophical traditions and moral viewpoints. Such are the tasks considered primary for the comparison and clarification project of bioethical theories or approaches.

There have been several such efforts in the past. The Ph.D. dissertation of Virginia Sharpe, *How the Liberal Ideal Fails as a Foundation for Medical Ethics or Medical Ethics “In a Different Voice,”* examines the deontological liberalism of Engelhardt and the contractarian approach of Veatch in contrast with the teleological
theory of Pellegrino and Thomasma in medical ethics.\textsuperscript{228} There is another effort by James B. Tubbs, Jr., \textit{Recent Theological Approaches in Medical Ethics: McCormick, Ramsey, Hauerwas, and Gustafson}, also a Ph.D. dissertation.\textsuperscript{229} Tubbs' work compares the four prominent moralists in their respective theological perspectives in medical ethics. There is yet another effort provided by Rosemarie Tong. It offers an interesting comparison not only of feminist and non-feminist approaches, but also of the various strands of feminist medical ethics.\textsuperscript{230} Though none of the authors cited above claim a neutral vantage position in their comparisons (nor am I suggesting that they needs to), they contribute significantly to the clarification project of the maze of biomedical ethics methodologies. This dissertation, in undertaking a comparison between the Four-Principle Approach and the Medical Covenant of William F. May, follows in their footsteps and seeks to make a similar contribution.

As stated in the Introduction, we are to juxtapose the Medical Covenant with the Four-Principle Approach of Beauchamp and Childress, it being the most popular and principal biomedical ethical method of the day. Recall the method of comparison which we conceived and outlined in the beginning. For the first part of comparison, we choose the topics of euthanasia and assisted suicide, which are the subject of this chapter.

Perhaps a word about the method of comparison for the first four topics (the first two parts) is in order. The third part of comparison pertains to a study of method, whose nature is entirely different from the first two. We will describe how

\textsuperscript{228} Virginia A. Sharpe \textit{How the Liberal Ideal Fails as a Foundation for Medical Ethics or Medical Ethics \textit{In a Different Voice},} a Ph.D. dissertation, 1991.


we will proceed with that in Chapter 6. In the meantime, we will concentrate on the method of comparison for the first two parts.

In the Introduction we said that we would follow Childress' model for comparison. In defending his approach, he has provided an interesting comparison of "principlism" with the theory-based approach of Clouser and Gert and the casuistry-based approach of Jonsen and Toulmin, using a practical issue of human fetal tissue transplantation research for discussion. In this discussion, he compares the resulting position of each approach, the logic and the rules or principles used to arrive at the position. He also discusses the nuances and implications of the resulting position. His method, though informal, illustrates our idea of "unpacking." Therefore, adapted from Childress, a format of comparison can be devised and is described below:

1. First of all an introductory section for the topic will be presented, noting some historical development, issues of contention, etc.

2. Secondly, a case will be selected and presented, if feasible, for the topic under discussion, noting the fact that not all topics will be amenable to discussions confined to a single case (like health care reform). The authors may or may not have chosen a case within which to confine their discussions. Therefore, this section may or may not be present, depending on the topic. If present, this would be a historical narrative of what happened in the case, based on existing documents.

3. Thirdly, the resulting positions respective to the two approaches in regard to the identified issues for the topic will be stated. This will result in two sections being presented, one for Beauchamp and Childress and the other for William May.
4. The final section will present the comparison, with a brief sub-section re-stating the respective positions. The respective methods or principles used to reach the resulting positions will then be analyzed. What is the logic used? What rules or philosophical concepts have been applied? What are the options offered by the two sides? This is the "unpacking" process. These questions will guide the comparison of the two approaches.

With the comparison of the first two parts structured this way, it is believed that the corrective features of the Medical Covenant to the Four-Principle Approach, if any, will be magnified. What we gain in the first two parts of comparison will help us greatly in the comparison of method.

4.1 Euthanasia - The Morality of Killing and Letting Die

Both May and Beauchamp and Childress have discussed extensively issues pertaining to euthanasia, and it has been a central topic for years in the debate forum of biomedical ethics. The topic of euthanasia is chosen for comparison partly for this reason. The positions on various issues of euthanasia are clear and well-documented on both sides. This fact should serve us very well in the comparison process and will be very illuminating. Another reason for choosing this topic is the breadth of issues it encompasses: the distinction between killing and letting die, the conflict between paternalism and patient's autonomy, the tension between acute and chronic care, just to name a few. The topic is also illuminating because of the seriousness of its nature. It is ethics not of trivial morality but of decisions that involve life and death. Perhaps that is why the topic of euthanasia has always generated such heat in the biomedical forum whenever it is debated. There is something inherent in the topic that is akin to our identity and being. The debate in euthanasia goes to "the issue of
one's core identity - both for the person suffering through such an event and those who help that person heal," observes May.231

Ancient sages have often brooded over the meaning of death in their writings. Many were resigned to the reality of its presence. Fann Jong-Ian, an outstanding Chinese statesman in the Sung Dynasty (c. 1200 A.D.), made this comment about death when he was approaching the end of his life: “Even the sages of our past could not avoid life and death. They had no control of what comes after they died. They came from nothing and returned to a state of nothingness... Since there is nothing we can do [about the events of life and death], let our hearts not be troubled and accept them as they come.”232 This probably characterizes the serene attitude of many ancient Chinese philosophers toward the reality of their own death. Few really thought that they had control over the time or the manner of their own death. Though suicide is known to have existed as a means of ending one’s life in China for various reasons. But the fact that killing can be a means to end the sufferings of impending death did not appear to have entered their thoughts. The Chinese were generally taught that matters of life and death are fates bequeathed by heavenly authorities, whatever they are.

Christian teaching about divine authority over life and death also seems to have asserted great influence in determining the general attitude about euthanasia and suicide in the West – that is, until recently. In tracing the history of euthanasia, Jonsen cites the early Christian saint, Thomas Aquinas: “Suicide is the most serious of sins because one cannot repent of it.”233 Euthanasia may not be a form of suicide technically, but one can feel the moral reprobation this teaching spilling over,

231 Testing the Medical Covenant, 44.
232 Yau-Phei Huang, Life Philosophy of Fann Jong-Ian, Taiwan: Yan-Chih Book Co., LTD., 312.
because both are forms of ending lives artificially in challenge of divine authority. In fact, in the early debates about euthanasia, several theologians appealed to the concept of the divine in defense of the sacredness of life. The Protestant theologian, Paul Ramsey, did not hesitate to bring in the notion of God in defending his positions on various issues concerning the edges of life: “The value of human life is ultimately grounded in the value God is placing on it.” Richard A. McCormick, a theologian of the Catholic tradition, states, “Life is sacred because of its origin and destiny, because of the value God puts on it.” Pope John Paul II, in his “Declaration of the Sacred Congregation for the Doctrine of the Faith” in 1980, expressed this reliance on divine authority in formulating the Catholic church’s stand:

We must firmly state once again that no one and nothing can, in any way, authorize the killing of an innocent human being, whether the latter be a fetus or embryo, or a child or an adult or an elderly person, or someone incurably ill or someone who is dying. In addition, no one may ask for such a death-dealing action for oneself or for another for whom one is responsible, nor may one explicitly or implicitly consent to such an action... For such an action is a violation of divine law...

But the Catholic teaching does include a distinction between extraordinary and ordinary means of treatment for the terminally ill. Pope John Paul II in the same document cited above, clarified, “It is always licit to be content with the ordinary remedies which medical science can supply. Therefore, no one may be obliged to submit to a type of cure which, though already in use, is not without risks or is excessively burdensome.” Thus risks or excessive burdens to the patients and their families characterizes the notion of extraordinary means of treatments.

233 Birth, 262.
237 Ibid. 654.
However, Beauchamp and Childress and May do not dwell on these terminologies. Beauchamp and Childress' position on euthanasia is understandably not a religious account. Obviously, the notion of a transcendent or divine authority does not play a role in the formulation of their position. The Medical Covenant of May, though of Christian origin, is also wary of invoking the authority of the divine in defending its position. One may surmise that May deliberately forgoes that option, because he wants to gain a wider hearing from his secular audience, as he often does in ethical discourse.

According to Beauchamp, euthanasia can be classified into the following categories: passive or active, voluntary, involuntary and nonvoluntary euthanasia. Passive euthanasia involves cases of allowing to die without human interventions except for palliative care, where active euthanasia is done involving deliberate actions of the physicians or a third party in terminating the patient's life. Euthanasia becomes voluntary when the patient requests it, and it becomes nonvoluntary when the patient is mentally incompetent to make an informed choice. And rarely do people defend involuntary euthanasia where it is performed against the patient's expressed wish. When the patient requests assistance from the physician to terminate his own life, where the patient is the chief agent of causing his own death, it is termed assisted suicide. In Intending Death: The Ethics of Assisted Suicide and Euthanasia, Beauchamp distinguishes four major subtypes of euthanasia formed by a combination of the above-mentioned categories: 1) voluntary passive euthanasia, 2) nonvoluntary passive euthanasia, 3) voluntary active euthanasia, and 4) nonvoluntary

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active euthanasia. William May does not delve into the difference between voluntary and nonvoluntary euthanasia as Beauchamp and Childress do, although he does allow for their plausibility. His focus is rather on the distinction between the active and passive categories. Naturally our comparison will reflect the same focus, where both sides overlap as far as their attentions are concerned.

As we may have already noticed, euthanasia is a complex topic with many sub-issues. Besides the four major subtypes of euthanasia that we mentioned, it involves distinctions between withholding and withdrawing life-sustaining treatment, extraordinary and ordinary treatment, artificial feeding and life-sustaining medical technologies, etc. Beauchamp and Childress do provide detailed discussions of these sub-issues. However, interesting enough, William May prefers to speak on a more macro level and the finer distinctions between these treatments – it would seem – he'd rather leave for the policy or procedure makers for biomedical ethics. Of course, this represents his interest being mainly in the philosophical or conceptual realm of biomedical ethics. Our point here is that although euthanasia is a topic of central importance in the philosophical schemes of both Beauchamp and Childress and May, their level of attention varies considerably with each sub-issue.

Discussion of active and passive voluntary euthanasia often results in debate on the distinction between killing and letting die. The issue has been the center of debate about euthanasia for decades. Once the debate gets past this distinction issue, then we have to wrestle with the morality of ending a patient’s life, whether by active (killing) or passive (letting die) means. Although euthanasia may branch out to many sub-issues, the central one is the morality of ending a patient’s life with or

239 Ibid.
240 Principles of Biomedical Ethics, 196-211.
without his or her consent or request. As mentioned, almost no one defends the position of involuntary euthanasia; active means of ending a patient's life entail only voluntary and nonvoluntary euthanasia. Thus our comparison of Beauchamp and Childress and May's positions on euthanasia will focus on these two points: 1) the distinction between killing and letting die, and 2) the morality of ending a patient's life, whether by active or passive means.

4.1.1 Beauchamp & Childress' Position on Active Voluntary Euthanasia

It should be of interest to note that in the US public forum, there is a general, faint yet detectable abhorrence toward killing as a means to end a patient's life, even if the patient is already in the final phase of his existence with an incurable disease, suffering great pains. While some consensus has been reached concerning the legitimacy of some decisions to forgo treatments by both physicians and patients, a diversity of views exists on the morality of ending the life of patients by a second party. The distinction between killing and letting die exists particularly in the United States courts of law. While judges often condone passive euthanasia in defense of a patient's autonomy, they have never allowed active voluntary euthanasia (AVE). The case in point is Dr. Jack Kevorkian with his suicide machine. He has successfully dodged all prosecutions in the US courts of law except in the last case where he had lethally injected Youk, a 52-year-old patient suffering from Lou Gehrig's disease. Youk sought Kevorkian's help to end his life and suffering and, as a result of the injection by Kevorkian, he died on Sept. 17, 1998. All of Kevorkian's cases (except the one of Youk), were cases of assisted suicide where the patients were the agents administering their own death. However, in the Youk case, in defiance of the US courts, Dr. Jack Kevorkian recorded on video the process where
he as a doctor administered a lethal injection into his patient that caused his patient's death. This action effectively changed the nature of his undertaking from assisted suicide to active voluntary euthanasia (AVE). Even though the euthanasia was performed upon the request of his patient and the patient's family, in a stinging lecture to Dr. Kevorkian County Circuit Judge Jessica Cooper handed him a jail sentence of 10 to 25 years.242

Although never sympathetic to Dr. Kevorkian's method of assisted suicide (or AVE in Youk's case) involving his patients, Beauchamp and Childress nevertheless challenge this traditional distinction between killing and letting die. The logic of this distinction appears spurious if not outright erroneous to Beauchamp and Childress. Recall from our discussion of the Four-Principle Approach in Chapter Two that they argue that neither killing nor letting die necessarily entails moral judgment of right or wrong of either type of action. They contend that neither do they convey the beneficence or maleficence of the action per se. The case of a newborn with Down syndrome in need of an operation to correct a tracheoesophageal fistula is cited to illustrate their point. The parents and the physicians did not believe the operation was in the infant's best interest and thus let the infant die, forgoing the operation. This case provoked a public outcry, because in the public opinion, by omission of the operation (letting die), the parents and the physician killed the infant.243 Here we can see killing and letting die, indeed, are not mutually exclusive as moral concepts. "...some particular instance of letting die... may be worse than some particular instance of killing," assert Beauchamp and Childress matter-of-factly.244 Beauchamp

241 See Intending Death, 14.
243 See endnote 66 in Principles of Biomedical Ethics, 254.
244 Principles of Biomedical Ethics, 225.
and Childress correctly note that motive and intention are more relevant in determining the morality of these acts than their normal classifications. Therefore Beauchamp and Childress come to the conclusion that "it would be absurd to accept all cases of letting die as morally justified, and it is no less absurd to view all forms of killing...as unjustified."245 Actually Beauchamp and Childress prefer to collapse the distinction between killing and letting die, but stop short of recommending it for fear of the resulting slippery slope if it is adopted as public policy.

However, if killing may not be wrong per se, what actually makes it wrong when it is wrong? Beauchamp and Childress attempt to provide an explanation for why we view killing as morally wrong when it is so. In their account, "causing a person's death is wrong because of a harm or loss to the person killed, not because of losses that others encounter."246 It is wrong because the person killed suffers a setback in his or her interests in life, which, in this case, are completely annihilated. In Beauchamp and Childress' rather utilitarian terminology, the person loses "the capacity to plan and choose a future, together with a deprivation of expectable goods."247 Beauchamp and Childress also acknowledge that the morality of killing may also have a communitarian component that it is wrong when it threatens social stability or causes harmful consequences to society. Therefore, the morality of killing in Beauchamp and Childress' account is pretty much equated with the utility of the act to the person involved and the society as a whole.

With a utility account of the morality of killing or causing death, Beauchamp and Childress are ready to advance their view on the morality of voluntary active euthanasia. Since a utility account does not see any intrinsic wrong in the act of

245 Ibid.
246 Ibid., 236.
killing, it is simply a logical consequence to state that "if a person desires death rather than life's more typical goods and projects, then causing that person's death at his or her autonomous request does not either harm or wrong the person." Having tamed the traditional sting of morality against voluntary active euthanasia with an argument of utility, Beauchamp and Childress wield its force powerfully again with their deeply entrenched belief in Kantian, American liberal individualism. They further advance this concept as in fact a right of the dying patients. If patients have rights (legal and moral) to refuse treatments thus resulting in their own death with involvement from health professionals, patients have similar rights to request the assistance of willing physicians for active euthanasia or suicide. "If a right exists to stop a machine that sustains life, through an arrangement involving mutual agreement with a physician, why is there not the same right to stop the machine that is one's life by an arrangement with a physician?" Such arguments hold particular appeal for the American people who are the products of strong utilitarian and liberal upbringings in their culture.

However, such an act may still cause instability in society if adopted as a practice, according to Beauchamp and Childress. Therefore, Beauchamp and Childress, despite their endorsement in concept of voluntary active euthanasia for competent patients, do not recommend it for public policy. The reason, as mentioned before, is the fear of a slippery slope that will lead to abuse.

If there is nothing intrinsically wrong with the act of killing, the slippery slope now posed as a problem by Beauchamp and Childress would disappear shortly if a better management or monitoring/enforcement scheme is available to secure or

247 Ibid.
248 Ibid.
level the slope, so to speak. As a matter of fact, Beauchamp and Childress do argue in that direction: "Our apparent success in managing many cases of treatment omission that qualify as forms of passive euthanasia in health care institutions and the courts is an encouraging sign that abuses are containable, although only a weak body of data exists." They further note an inconsistency in our public policy if we do not hold the slippery slope to be a problem in allowing passive euthanasia but somehow holding out against active voluntary euthanasia.

4.1.2 William May's Position on Active Voluntary Euthanasia

Whereas Beauchamp and Childress' position on active voluntary euthanasia relies on the demolition of the distinction between killing and letting die, May's position depends on it. May frankly admits of the theistic tradition as his source of inspiration, which holds that neither life nor quality of life are absolute goods. They are fundamental goods that human beings should aspire to, but are not something divine in themselves. This perspective allows May to have a much more "relaxed" position with regard to AVE than some of the absolutists in both camps that uphold life or quality of life as something inviolable. Thus, May can foresee some rare or exceptional cases where it is allowable to have AVE, and other cases that call for a patient's "decorous response" in courage and endurance instead of seeking a quick exit by employing AVE. However, the exceptional cases where AVE is permissible should be extremely rare – so rare that collectively they don't make a good case for public policy.

However, the area of agreement on this issue between May and Beauchamp and Childress stops here. May does argue that a line should be drawn between

249 Ibid., 226.
250 Ibid., 235.
killing and letting die. There are two reasons he takes for this position. First, society often needs a line drawn between two practices, despite the existence of exceptions. "A particular fifteen-year-old adolescent may be more mature than the average seventeen-year-old, but that does not of itself invalidate a line somewhere, usually sixteen, specifying an age requirement for a driver's license," argues May. Indeed the proponents of obliterating the line between killing and letting die often rely on fictitious or exceptional cases for their arguments. The now classic example given by James Rachels in 1975 is the case of a six-year-old cousin of Smith and Jones, both of whom stand to gain a large sum of money if anything should happen to their cousin. The story goes as follow:

One evening while the child is taking his bath, Smith sneaks into the bathroom and drowns the child, and then arranges things so that it will look like an accident. In the second [case], Jones also stands to gain if anything should happen to his 6-year-old cousin. Like Smith, Jones sneaks in planning to drown the child in his bath. However, just as he enters the bathroom Jones sees the child slip and hit his head, and fall face down in the water. Jones is delighted; he stands by, ready to push the child's head back under if it is necessary, but it is not necessary.... Now Smith killed the child, whereas Jones "merely" let the child die. That is the only difference between them. Did either man behave better, from a moral point of view? If the distinction between killing and letting die were in itself a morally important matter, one should say that Jones's behavior was less reprehensible than Smith's. But does one really want to say that? Then James Rachels, like many others who follow him, goes on to conclude that the distinction between killing and letting die is morally irrelevant. However, these fictitious or exceptional cases only point to another important factor for moral relevance: the underlying motive of the agents performing the acts. In fact Winston Nesbitt in his article, "Is Killing No Worse Than Letting Die?" points out the same flaw of the Rachels argument. The actions of both Smith and Jones are equally morally reprehensible, because, like Smith, "Jones ... was [also] fully prepared to kill

251 Testing the Medical Covenant, 16.
his nephew, and would have done so had it proved necessary." In this case, the motives of the actions of killing and letting die are the same and at fault. Only the actions differ. Therefore Rachels' example does not argue for the general obliteration of the distinction, and it certainly does not argue for obliteration of the distinction if the motives for either actions are not morally unacceptable. That is, if the motives for killing or letting die are both morally acceptable, the distinction between killing and letting die may still have other ethical relevance. As a matter of fact, May proceeds to argue in this manner.

The second reason May gives for maintaining the line is that "nature has already drawn a line between a death that nature brings about ... and a death that we wreak on ourselves or others." This is a distinction of agency that the other camp that opts for its obliteration chooses to ignore. This distinction underlies the traditional prohibition against AVE and the acceptance of passive euthanasia, marking the significance between human and natural agency. According to May, this distinction has ethical relevance. We may accept the motives of both types of actions being compassion, but ignoring the boundary of agency, contends May, reduces all options to human control. There is something to be said about the person who aims at having control over everything. Psychoanalysts have long recognized that "the person who insists in controlling everyone and everything is, in fact, out of control."255

Despite their reservations about public policy, Beauchamp and Childress are sympathetic to the cause of AVE. This cannot be said of William May. Observing that the proponents of AVE usually focus their arguments on five areas, May offers

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253 Nesbitt's article is collected in Bioethics, an Anthology, 232.
254 Testing the Medical Covenant, 17.
an insightful disputation of each of them. It will do well for us to summarize them here.

First of all, a strong trump for the euthanasianists is the idea of respecting for the patient's autonomy. We saw it in display as we discussed Beauchamp and Childress' position. As we recall, Beauchamp and Childress ask poignantly in their defense for their position: "If a right exists to stop a machine that sustains life, through an arrangement involving mutual agreement with a physician, why is there not the same right to stop the machine that is one's life by an arrangement with a physician?" (italics mine) They'd like to cast the issue in the absolute sense of a right. Any restriction on that right will be viewed as an encroachment on human liberty.

May, however, offers three reasons why such "absolutization of autonomy" is not warranted. First, we are not just individuals, but also parts of a whole. We belong to a human society in which we can express ourselves and flourish. Not only that, "society has an interest in us not simply when we harm others but also when we [apparently] harm ourselves." AVE proponents may not consider euthanasia an act of harm, but its detrimental nature and the irrevocability of the act are sufficient reasons for a caring society to air its concerns. Secondly, acceding to a person's wish whatever it is does not necessarily reflect respect. Respecting a patient's autonomy regardless of the outcome, rather, may undermine an ethics of care based also on a deep respect for the person. Thirdly, competent patients' requests for euthanasia may not be as autonomous as they appear to be: "The decision and plea to be killed is

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255 Ibid., 43.
257 Testing the Medical Covenant, 26.
hardly an unforced decision if the terms and conditions under which we deliver care for the dying is already woefully mistargeted, inadequate, or downright neglectful," asserts May.258 In other words, society and family members may have created the conditions or pressures that, unwittingly, coerced the decision for euthanasia by patients.

The second reason cited in defense of AVE is compassion toward the dying. But as May observes, in some cases, it is "a huge irony" or "hypocrisy" to claim compassion for killing the patients when we have long neglected their care. In the blunt talk of May, "a country has not earned the moral option to kill for mercy in good conscience if it hasn't already sustained and supported life with compassion and mercy."259 To support this frank argument, he cites the embarrassing statistic that over 40 million U.S. citizens lack health insurance. According to his source, the U.S. is the only industrialized country other than South Africa that denies a major portion of its citizens minimum health care. This social condition may have created the pressure under which many aged or poor people succumb to a desire for euthanasia.

May also cites a 1991 New England Journal of Medicine editorial where it was reported that 90% of suicide victims suffered from depression. Another study, also cited by May, showed that 3 of 45 terminally ill patients had considered suicide, and all of them suffered from clinical depression.260 However, primary physicians often fail to diagnose minor and major clinical depression (the failure rate ranges from 45 to 90 percent according to one study261). Many doctors recognize a major problem in the care of the dying is the undertreatment of pain. All these statistics

258 Ibid., 26.
259 Ibid., 28.
260 See footnote 20, Testing the Medical Covenant, 34.
261 See footnote 21, Testing the Medical Covenant, 34.
reveal the underlying inadequacy of our system of care for the dying. According to May, our medical covenant with the sick, weak and the dying members of our community is to provide care. Only until we fulfill these obligations to a substantial degree can we appeal to AVE as our last resort with a clear conscience.

The third argument for AVE usually considers the burdens of the care and treatment of the dying for family members and society. The calculus of the burdens of care and the quality of life remaining for the dying patients usually speaks for the expediency and exigency of AVE. This utilitarian measure of cost and benefit often acts as an added pressure for the patients to request AVE. For others, this argument also secures the moral appearance that we are not acting on the impulse of liberal individualism but as a part of the whole.

It is admirable that the patient would consider these factors and act to spare society or his family members the sacrifices that his illness unfortunately may have obliged. However, if society or family members adopt these arguments to encourage AVE, it reflects a medical relationship between society and its constituents that is essentially contractual. For a calculus of cost and benefit only redounds to a contractual relationship. The patient is truly and fully a part of a covenanted community not only when he is willing to make sacrifices for others but also when he is willing to accept them from others. A covenanted community always gives ways to an expression of mutual give and take. May also points out that a patient’s attempting to relieve his burdened caregivers through his own death suggests that his society is “insufficiently supporting its caregivers or failing to provide them with adequate respite from their labors.”

262 Ibid., 35.
The fourth argument for AVE appeals to the private nature of dying. In this view, dying is a process pertaining to the patient and his doctor alone. May contends that public investment in and support of the medical profession and medical resources make euthanasia a proper subject for the public domain. Moreover, the threat of abuse (slippery slope) also properly places that process under public scrutiny.

The fifth argument for active euthanasia exalts the merit of human control. The pro-euthanasia movement seeks to control the suffering process of dying through science and technology by eliminating the sufferer. Similarly, the anti-euthanasianists seek to control human mortality through an unconditional, relentless fight against death, also under the auspices of science and technology. Both forms of control opt for a solution-oriented answer to our problems. But some pragmatic problems of our lives, particularly those of dying and suffering, defy that mindset and call for a different type of response. This set of problems often exhibits an obstinate resistance or lack of amenability to technological solutions. By virtue of their nature, they cut right to the core of our identities and reveal who we are according to our responses to them.

According to May, this set of problems, like serious illness and dying, calls for "decorous response" rather than control. "Decorous response" in May's mind presupposes a set of virtues that defines the inner being of a person. May identifies five key virtues for people facing the very calamity of their lives: patience, courage, prudence, benevolence, and hope (see Chapter Three, Section 3.2.3.5: The Ethics for the Elderly and the Sick). The patient needs to have patience in dealing with the catastrophic event that has befallen him, in going through diagnoses and
lengthy hospital visits and enduring whatever sufferings or pains accompany his latest fate. By courage, May does not mean that of the more active mode of confronting or attacking evils. He means the passive kind that enables a person to face with forbearance a difficult situation that has refused to be amenable to quick solutions.

May equates prudence with the virtue of discernment. As diagnoses and prognoses reveal the obstinate nature of his illness and the stark future, the competent patient needs the discernment to distinguish what is needful, helpful, intrusive or irrelevant in his own situation. He then needs to summon his courage to decide for or against further treatments. If the illness has progressed to the point that it has wrecked havoc on his capacity for discernment, he needs to rely on his caregivers to exercise discernment on his behalf to stop irrelevant treatments and endure with him in the last moments of his life as friends, lovers or attendant strangers. Therefore benevolence and hope are a couple of virtues for the dying and his family and friends, particularly during the moment of bidding farewell. However, May does not see an absolute stand against AVE. He can, in his own words, "imagine rare circumstances in which I hope I would have the courage to kill for mercy - when the patient is irreversibly beyond human care, terminal, and in extreme and unabatable pain."^263

4.1.3 A Comparison

4.1.3.1 A Summary of Positions

To summarize, May fashions his stand on AVE from a very different perspective than Beauchamp and Childress. As we have already seen, Beauchamp and Childress believe that the distinction between killing and letting die is morally
irrelevant. And from their utility concept of harm (as a setback in a person's interests in participating in the goods of life) they deduce a general stand that is in favor of allowing AVE, but stop short of suggesting it for public policy for fear of the slippery slope and public abuse.

May, on the other hand, recognizes a distinction between killing and letting die as a distinction in moral agency (that between nature and human); he further recognizes practical need in society and public policy to draw a line between them. Therefore May favors allowing to die but argues against AVE in general. He disputes the five arguments for AVE, and his arguments can be summarized as an ethics of care motivated by the community's covenant fidelity to her members. The logic of his arguments will be analyzed in further detail in the next section. However, May recognizes the existence of exceptional cases that may at times call for the courage to kill for mercy.

4.1.3.2 The Logic or Philosophy of Their Respective Arguments

Despite their similar stands against public policy for AVE, their main positions on the topic and the underlying logic or philosophy are very different. Though not disclosed directly, implicit in Beauchamp and Childress' arguments is a combination of utilitarian and Kantian logic, as we attempt to point out whenever possible in presenting their position. Beauchamp and Childress do acknowledge the source of their principles as Kantian or Utilitarian, whatever the case, at the outset. However, in the main body of their arguments, this important point seems to be glossed over and Beauchamp and Childress have a tendency to present their arguments as pure reasons, as if they were independent of any philosophical

263 Ibid., 48.
traditions. (Examples will be given in the section below.) That tendency certainly has something to do with their conviction that their system begins with a set of principles that constitute, in their mind, "common morality." We will pick up this point again in Chapter Six in a comparison of Beauchamp and Childress' and May's methods. For now, we will attempt to establish that the underlying belief and philosophy of Beauchamp and Childress on euthanasia is a combination of utilitarian and liberal individualistic principles. This is what we will do in the section below.

In contrast, May appeals at the outset to the theistic tradition that has shaped his philosophy. That theistic tradition is clearly Christian and May makes no attempts to hide it. May, however, never appeals to the authority of his Christian tradition for his position, and he chooses to debate whatever issues and argue for his beliefs on the basis of philosophy and logic. Therefore, while Beauchamp and Childress' stand on AVE is an ethics of utility and liberal individualism (a point to be established below), May develops his ethics of care as a response to the covenant relationship that he perceives to be inherent between the patient and his physician. The source of that covenant concept is Judaic-Christian by May's own admission.264

We will consider three key concepts of Beauchamp and Childress' position on euthanasia, the collapse of the distinction between killing and letting die, their concept of wrong in causing death and how they establish the right of AVE for the patient. As mentioned in our presentation above, their plan is to obliterate the distinction between killing and letting die as far as morality is concerned. Since killing is not necessarily wrong, it is warranted that readers reexamine why we view killing as wrong, when it is wrong. It is at this juncture that Beauchamp and

264 May refers to the Christian-Judaic concept of the covenant in many instances as his source. See Chapter Three of this dissertation, Section 3.3.2 The Biblical Covenant, footnote 47.
Childress provide their account of the wrongfulness of killing, which supposedly explains when killing is and is not wrong. Beauchamp and Childress then close their line of arguments with the "right" language – i.e. that AVE is a right of the competent patient. Thus the three concepts delineated here are keys to their arguments for AVE.

If killing is perceived to be intrinsically wrong, then AVE is defeated right before the debate starts. Therefore it is paramount for Beauchamp and Childress to dislodge that entrenched thinking. As noted above, the American public and legal system seem to have a faint but detectable abhorrence toward AVE, but allow actions of letting die for terminal patients. Beauchamp and Childress' first task is then to loosen that ingrained belief. The argument they propose for the obliteration of the distinction is supported basically by citing cases where letting die is morally worse than or equivalent to killing (e.g. the Down syndrome newborn). Those instances of letting die are morally worse than killing because of the underlying motives of the agents involved. As Beauchamp and Childress state, "Some particular instance of killing may be worse than some particular instance of allowing to die; but some particular instance of letting die also may be worse than some particular instance of killing." Thus they conclude: "Nothing about either killing or allowing to die entails judgments about actual wrongness or rightness, or about the beneficence or nonmaleficence of the action."\(^{265}\)

If one is not predisposed to the plausibility of AVE, the shallowness of this argument is very obvious. May correctly points out that a few exceptional cases do not argue for obliteration of the line drawn between the two actions. As society often

\(^{265}\) Both quotes from *Principles of Biomedical Ethics*, 225.
needs to draw a line somewhere in things that it attempts to regulate, (e.g. the age of eligibility for driver license as given by May), exceptions should neither deter its efforts for nor speak against the value of a line. Beauchamp and Childress' argument also overlooks the area of moral agency, which May discernibly points out. The agency in an act of killing is human, whereas the agency in an act of letting die is nature. Some moralists also make the same mistake of arguing for the obliteration of the distinction: If the end result is death anyway, what does it matter by which route? This disregard for moral agency and preoccupation with the end result of an act display the inclination of the consequentialist mindset of the utilitarian, where the end result of cost and benefit is the sole determinant of the morality of an act.

The concept of wrong in causing death is also vital in Beauchamp and Childress' argument that killing does not necessarily wrong the patient in an act of AVE. Conventional wisdom has people immediately understand killing as an act of harm to another person or to oneself. Beauchamp and Childress' strategy is to dislodge that entrenched, traditional belief in order to advance the plausibility of AVE. Therefore the concept of wrong in causing death is vital in their line of argumentation. Beauchamp and Childress present the view that "causing a person's death is wrong because of a harm or loss to the person killed, not because of losses that others encounter." Furthermore a harm is defined in their scheme as a setback in a person's interests in life. In Beauchamp and Childress' logic, harm is to be measured by a calculus of interests and setbacks in life, a clearly utilitarian philosophy. For as John S. Mill declared in his essay, "Utilitarianism," "The creed

\[\text{266 For example, Allen Buchanan argues to do away the distinction. He says in his essay, "Intending Death: The Structure of the Problem and Proposed Solutions," "In either case we take it on ourselves to decide when to end our lives, and either we have a right to make such a decision or we do not." In Intending Death, 36.}\]
which accepts as the foundation of morals, Utility, or the Greatest Happiness Principle, holds that actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness.\textsuperscript{267} Thus Beauchamp and Childress are able to conclude: "If a person desires death rather than life's more typical goods and projects, then causing that person's death at his or her autonomous request does not either harm or wrong the person."\textsuperscript{268}

This utility account of harm or wrong in causing death is by no means "common morality" or universal. It contrasts starkly with that of the Judaic-Christian concept that there is an intrinsic wrong in causing death in another person, because every human being is created in the image of God according to the Hebrew Scripture.\textsuperscript{269} In the Buddhist tradition, the wrong of causing death applies even to animals, simply because "the heaven has the virtue of being fond of procreation," which includes the animal kingdom. This is the reason for the widespread Buddhist practice of not killing even the smallest among the animals. The coy fishpond that one finds in most Buddhist temples is not a piece of creative landscape architecture, but a symbol of this firm belief. The fishpond is also called a pond of "let-live," or allowing to live. Fishes caught are supposed to be released in the pond as a symbolic act of this belief. Neither of these two accounts refers to a utilitarian calculus of the interests and setback of the person's "typical goods and projects" in life for the establishment of wrong in causing death in another person. Both of them refer to some intrinsic nature of life inherent in the act of creation that upholds the value of life in itself. Nevertheless, there is some merit to Beauchamp and Childress' utility

\textsuperscript{268} Principles of Biomedical ethics, 236.
account of wrong in causing death in another person. This utility account is certainly a reason why it is wrong to cause another person's death, but it is not a complete account nor does the account furnish an ultimate reason why killing is wrong, as the Judaic-Christian and the Buddhist traditions may testify. Beauchamp and Childress, somehow, regrettably, flinch from interacting with these long-established traditions and choose to opt out with a quick exit:

Those who believe it is sometimes morally acceptable to let people die but not to take active steps to help them die must therefore give a different account of the wrongfulness of killing persons than the one we have suggested. The burden of justification, then, seems to rest on those who would refuse assistance to those who wish to die, rather than on those who would help them. (Italics mine)

It is not clear why the burden of justification seems to rest on those who give a different account of the wrongfulness of killing persons. Given the long history of some of those other accounts (the Judaic-Christian or the Buddhist), it is perplexing why Beauchamp and Childress think that their utility account has established an a priori position.

Perhaps Beauchamp and Childress dismiss these other accounts outright as mainly religious accounts, and do not regard them as appropriate participants in the academic debates of biomedical ethics. However, it is not clear that this academician's aversion to the insights of religious traditions is warranted, particularly in the realm of biomedical ethics. As May aptly points out, in the realms of life and death and the ethics that concern them, secular society "reeks of religion, and those who want contact with the modern world will need to acknowledge this fact."271 When confronted with vicissitudes of a magnitude that approaches the edges of life,

269 In Scripture, the wrong of causing death in others is instructed to Noah, in this manner: "Whoever sheds man's blood, By man his blood shall be shed, For in the image of God He made man" Gen. 9: 6, NASB.
270 Principles of Biomedical Ethics, 236.
common people, modern or ancient, often respond and think religiously. Confucius, an avowed humanist, when asked about life after death by one of his disciples, refused to traverse into the unknown with an evasive answer: We do not yet know enough about life. How do we presume to know about death (or life after death)? However, when Confucius was really sick one day (to the point of almost dying), he responded to his disciple (who urged him to pray about it) that he had already prayed about his sickness for a long time. Religious sentiments often flow in the scenes of life and death and in the ethics that concerns them. When we exclude religious insights from our philosophical discourses on biomedical ethics, we risk missing a big part of the picture.

Another key concept in Beauchamp and Childress' line of argumentation in advancing the plausibility of AVE is that it is the right of an autonomous individual. They invoke the argument that "if competent patients have a legal and moral right to refuse treatment that involves health professionals in implementing their decision and bringing about their deaths, we have a reason to suppose they have a similar right to request the assistance of willing physicians to help them control the conditions under which they die." And "If a right exists to stop a machine that sustains life, through an arrangement involving mutual agreement with a physician, why is there not the same right to stop the machine that is one's life by an arrangement with a physician?" (Italics mine) The invocation of rights to defend an ethical concept resonates loudly with modern day liberal individualism, which historically has developed under the influences of Kant, John S. Mill and John

Locke. Kant was interested in developing a community whose mark is respect for the person. The Kantian imperative of never treating another person as a means to an end upholds the individual as an inviolable entity who possesses some intrinsic set of rights in life. Beauchamp and Childress' invocation of the language of rights in defense of AVE is but an expansion or derivation of this Kantian logic, originally argued for political freedom for the individual from state censure. "Kant's delineation of the ideal state... [is] a system that protects the freedom and rights of everyone..."275 Of course it is unclear if Kant would endorse this right to AVE as a part of the inviolable set of human rights as Beauchamp and Childress attempt to apply to biomedical ethics.

Beauchamp and Childress' invocation of a liberal individualistic ideal in advancing AVE also smacks of the Millian concept of human liberty. In Mill's classical treatment of individual freedom for the minority, On Liberty, he forthrightly admits that his arguments are basically utilitarian.276 In like manner, Beauchamp and Childress justify the right to AVE on the grounds of utility - if the patient does not wish to participate in the goods and projects of life, AVE or not should be entirely of his own choosing, so long as it does not harm the common goods of society.

As it is impossible to over-emphasize, May's philosophy underlying his arguments against AVE in general is distinctive from that of Beauchamp and Childress. His perspective can be characterized as an ethics of care motivated by his perceived covenant of the community (health care professionals, family members and society) with the patient. First of all, the patient is part of the community. By

274 Both quotes appear in Principles of Biomedical Ethics, 226.
virtue of this fact, an "inclusive covenant" exists between him and his community, according to May. The revelation of this covenant is in Hebrew scriptures. May cites as his model the great covenant delivered at Mt. Sinai to the Israelites. And he concludes, "For Christians, God's covenant with Israel structurally prefigures the inclusive covenant that will spread across the whole of humankind in God's Son (Jesus Christ)."277

All the essential elements from this covenant as delineated in Chapter 3 figure prominently in May's argument against AVE. The first element that May starts out with is our communal tie with the patient. Although the patient is an individual, he is also a part of the community. The community has a legitimate concern for the well-being of the patient, because of the inclusive covenant for humankind. The second element is the covenant fidelity that fosters May's ethics of care toward the dying patient. The community should be more committed to chronic or palliative care for the patient, as resorting to AVE by the patient and health care professional often reflects not our mercy but the inadequacy of our care. Community commitment in providing these forms of care is an expression of this covenant fidelity to the patient, even if it may entail some amount of sacrifice to the common goods. A community that is dedicated to the well-being of its members affirms this sacrificial give and take as called for by the covenant. The inclusive covenant also upholds the wholeness of the patient as a person as its goal. Public endorsement of AVE undermines the integrity of the inner person who may be challenged to exhibit the virtues of humility, courage and prudence in facing the calamity. The quick exit provided by AVE betrays this more wholesome goal of the covenant for the patient,

277 Testing the Medical Covenant, 53.
as if the problems and mishaps in life can always be dealt with by a solution-oriented mindset. Indebtedness to the patient and society as a whole motivates the physician and the community to adopt such an ethics of care, as we are all co-sojourners in life graced by and indebted to the love of God.

This covenental ethics of care contrasts sharply with Beauchamp and Childress’ utilitarian ideals where moral acts in life must germinate from a calculus of the common goods or a contractual compliance of human rights. May does not dispute the usefulness of these concepts, but the Medical Covenant of William May based on biblical traditions definitely opens up a wider moral horizon and challenges us with a deeper biomedical ethics.

4.2 Assisted Suicide - Paternalism and Patient's Autonomy

Some people may consider assisted suicide a form of euthanasia, but as has been mentioned, there are some major differences between the two. First of all, as clearly stated by Beauchamp, the distinction is in the final agency of death: "In assisted suicide, ... the person whose death is brought about must be the final cause of death, ... whereas in 'voluntary active euthanasia' the final cause of one person's death must be another person's action." Second, although some of the issues of euthanasia and assisted suicide overlap, one of the noted tensions in cases of assisted suicide is paternalism and patient's autonomy. This tension arises as physician and patient posit diverging views about what benefits the patient. In our comparison of the Four-Principle Approach and the Medical Covenant on assisted suicide, our interest will center on the issue of paternalism and patient's autonomy, not only

278 Intending Death, 4.
because this issue often occupies a central position in assisted suicide, but also because it has become an important topic in biomedical ethics debates.

The conflict between paternalism and respect for patient's autonomy in the practice of medicine is a contemporary phenomenon, rising to public attention only in the last couple of decades. This is not to say that the conflict never existed prior to that. But as a major issue in medical ethics capturing public interest, it is a recent phenomenon. Beauchamp and McCullough\(^ {279} \) have a very apt description of the conflict. They see the conflict as one between the beneficence model and the autonomy model of medical practice. The beneficence model views the benefits or best interests of the patient purely from the perspective of medicine, whereas the autonomy model recognizes the values and beliefs of the patient as primary in medical consideration. Paternalism therefore characterizes actions that intervene in or limit patient's choices of medical decisions, appealing to the benefits or best interests of the patient judged from the perspective of the physician. Childress defines it as "a refusal to accept or to acquiesce in another person's wishes, choices, and actions for that person's own benefit."\(^ {280} \) But as Beauchamp and McCullough dexterously weigh the conflict, it is whose perspective on the patient's benefit that is the central issue. For the proponents of the autonomy model, whenever there is a conflict between the physician's and the patient's perception of patient benefits, the fundamental responsibility of the physician is to respect and facilitate the patient's self-determination in decisions that affect his own medical fate.

The Hippocratic tradition, with a long history of dominance over the practice of medicine in the West, actually belongs to the former of the two models. In its

\(^{279}\) See Medical Ethics - The Responsibilities of Physician, Chapter 2.
\(^{280}\) Childress, Who Should Decide, 13.
language or code of ethics, it emphasizes the professional's skill and judgment and rarely mentions respect for the patient's values and beliefs. Thus Childress thinks that the Hippocratic Oath "tends to be paternalistic." The AMA's code of ethics, in a similar fashion, traditionally places more emphasis on the profession's perspective on what will benefit the patient. Only in the 1980 revision has the patient's perspective been included as a consideration in the normal practice of the physician: "A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of law."

And a later report of the ethics committee of AMA acknowledges: "The medical profession is no longer perceived as the sole guardian of the public health, and consequently the traditional paternalism of the profession is in conflict with society." Thus another underlying current in the conflict of paternalism vs. patient's autonomy is the challenge that the ethics of the profession is no longer to be considered only as internally generated. The profession must also recognize external moral norms of the community it attempts to serve.

In this section, the comparison of Beauchamp and Childress' and May's positions on this issue shall begin with a real case: Dax's Case. Dax's Case is a case of assisted suicide requested by the patient but persistently rejected by his caretakers. His caretakers persistently take a view of beneficence for the patient that is polemically opposed to that of the patient himself. Therefore, this is also a classical case of the tension between paternalism and patient's autonomy. After the presentation of Dax's case, Beauchamp and Childress' and May's respective positions on Dax's case will be summarized.

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281 Both quotes cited by Childress in *Who Should Decide*, 42.
4.2.1 Dax's Case

Dax's case is one of the most well documented cases of conflict between doctor and patient. It is also an excellent case to illustrate some of the issues pertaining to assisted suicide. Dax is the adopted name of burn victim Donald Cowart, who, in a natural gas explosion accident that occurred in 1973, incurred a third degree burn over two-thirds of his body that left him totally blind and permanently disfigured. But an instant before, he had been a 27-year-old veteran pilot of the Vietnam War, who had walked freely and was an excellent athlete. The accident killed his father, who died on his way to the hospital.

When the accident happened, Dax, as he recalled, did not want to go to the hospital at all. He asked for a gun from the first man on the scene (a farmer), saying that he was a dead man who no longer could live. However, the rescue team rushed him to the hospital anyway and started treatments right away. He told them that he didn't want them to try anything, but they went ahead with the treatments despite his refusal. He was subjected to painful daily treatments of skin grafts, several surgeries, and painful daily 'tubbings' and dressing changes.\(^{282}\) However, he was adamant and persistent in his desire not to be treated, even though he recognized the consequences of refusing treatment, which include the possibility of death.

The hospital psychiatrist interviewed him in April of 1974 because of his staunch refusal to undergo further corrective surgeries and his request to be released from the hospital and to be allowed to die. He was found competent, rational and of a sound mind by the psychiatrist. He abhorred the excruciating pain of the treatments that he received and lamented his loss of independence. By his own calculation, even if, by a slim chance, he could recover some degree of independence, he would
have to adjust to a complete change of interests in life. He did not think it was worth to try. Therefore, through his attorney, he requested a court order for his release from the hospital, which he did eventually receive.

But the twist of the story is that after he received his release from the hospital, Dax did not commit suicide as he said he would. He changed his mind and continued to receive treatment, and 11 years later, in 1984, it was reported that he was doing well: he had married, finished law school and become an attorney for patient's rights. However, he still refused to vindicate the doctors who had insisted on treating him against his wishes 11 years before. In his view, the decision to force him into receiving treatment was "morally unjustifiable paternalism then and now, because 'the ends do not justifies the means.'"

4.2.2 Beauchamp & Childress' Position on Dax's Case

The twist of Dax's case really makes the analysis of paternalism vs. patient's autonomy interesting, though logically perplexing. The discrepancy between Dax being glad to be alive but ungrateful for his doctors' previous, unrelenting and heroic efforts to save him seems contrary to common sense. However, both Beauchamp and Childress and May have written essays supporting Dax's curious position, many years after the accident and after most of the consequences have been made known and have unfolded in the public eye. Therefore the study and the comparison of Beauchamp and Childress' and May's positions on this case will be illuminating in our study of paternalism vs. patient's autonomy.

First of all, there is no doubt in both Beauchamp and Childress' minds that Dax's story represents a case of paternalism of the medical profession intruding upon

282 Practical Reasoning in Bioethics, 140.
283 Ibid., 130.
the patient's own values and priorities in life. Both Beauchamp and Childress have written separately on the subject and expressed this opinion. But it is in the essay of Childress and Campbell that their position and logic have been greatly illuminated. Therefore in this discussion, we will rely on this essay more than their others writings, recognizing there may be some finer differences between Beauchamp and Childress themselves regarding this issue. But these differences are more germane to the finer details and the technical aspects of the definition and concept of paternalism and should be immaterial in representing both Beauchamp and Childress' views on this matter.

In brief, Childress believes that Dax's case actually represents a case of active, hard and impure paternalism committed by the medical rescue team against the burn victim then known as Donald Cowart. Childress distinguishes between active and passive paternalism. Active paternalism is intervention contrary to a patient's expressed wishes and choices of treatment, whereas passive paternalism is nonacquiescence to a patient's expressed wishes and choices. Passive paternalism is only the refusal to carry out a patient's own desire or plan of treatment. However, active paternalism is an active imposition of the doctor's plan of treatment upon the patient against his wishes. In Dax's case, against the patient's wish, the rescue team insisted upon continued treatments which included, among other corrective surgeries, the painful procedure of daily tubbing in a Hubbard tank that helps prevent infection and removes dead skin and crusts. It is a clear case of active paternalism, according

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284 For Beauchamp, he has written about it in Beauchamp and McCullough, Medical Ethics - The Responsibilities of Physician, Chapter 4. For Childress, he has written about it with Claudia Campbell in Practical Reasoning in Bioethics, Chapter 7.

285 For example, Childress distinguishes between strong and weak paternalism, whereas Beauchamp argues that weak paternalism is technically not paternalism at all. Weak paternalism is defined by
to Childress. The paternalism committed against Donald Cowart is also considered *hard* in Childress' terminology. It is a case of *hard* paternalism, because "his clinicians, his mother, and other relevant parties, such as the family attorney, often...[would] appeal to values (such as religious salvation) and rankings of values (such as the priority of life over quality of life) that were alien to Dax himself." But the paternalism is *impure*, because in justifying the paternalism, the clinicians invoked in addition to the consideration of Dax's own welfare the harms and burdens that others (his mother, etc.) may incur. Pure paternalism justifies itself only on the grounds of the patient's own welfare.

However, according to Beauchamp and Childress, some paternalism is justifiable. In their well-known text, *Principles of Biomedical Ethics*, they have fashioned a model according to which some paternalistic behaviors are justified. A slightly modified version of the model reappears in *Practical Reasoning in Bioethics* and includes four criteria for justification: 1) the patient is incompetent to make medical decisions; 2) the patient is at serious risk or in great harm; 3) the intervention would probably be effective and its positive results would probably outweigh the negative results; 4) the intervention is the least autonomy-restrictive alternative. But Dax's case fails to meet even the first criterion. The psychiatrist who was summoned to evaluate Donald Cowart testified that he was competent.

Childress has also evaluated two other lines of defense for paternalism in Dax's Case: time and community. The time element is usually invoked to defend acts of paternalism, particularly by health care professionals in emergency situations.

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Childress as nonacquiescence to patient's wishes and choices, when it is judged that the patient is nonautonomous.

286 *Practical Reasoning in Bioethics*, 124. For a definition of hard and soft paternalism, see Chapter 2, Section 2.4.2 Paternalism of this dissertation.
Time is needed to determine whether the patient is autonomous, whether his decision is in line with his normal philosophy and outlook on life, and that his medical decision is not one formed under duress. During the time that all these questions remain unanswered, paternalistic interventions are justified, so argue many health care professionals. Childress does recognize the legitimacy of this argument. As a matter of fact, he cites John S. Mill's example of justifying the temporary restraint of a person attempting to cross a dangerous bridge, just to make sure the person is acting autonomously. This kind of act has its legitimate place in ethics and is only responsible. Therefore, in Dax's Case, it was legitimate for the emergency rescue team to ignore Cowart's repeated requests for nontreatment, when he was brought in the hospital. However, when Cowart persisted in his pleas for nontreatment ten months into the case after the accident, and when the psychiatrist affirmed his competency and the authenticity of his decision, the time element does not provide any grounds for the paternalism committed against Cowart as Childress sees it.

But then does the fact that Dax Cowart is alive and well now, leading a productive life ratify the paternalistic interventions against him committed many years ago? As we already mentioned, Dax's own position is that it does not. He refuses to say thanks to the clinicians who saved him against his wishes, even though he admits that he is glad to be alive; he maintains ungratefully that "...the ends do not justify the means." This discrepancy is good enough to affirm the logic for Childress, as far as he sees it, for he also proclaims, "... it is insufficient to appeal to future ratification as a basis for continuing treatment against a competent patient's

Ibid., 125.
wishes in the present... An appeal to future ratification is insufficient to justify paternalistic interventions...\(^\text{288}\)

Another line of defense for paternalistic intervention usually appeals to community concerns, because respect for the person seems to be a morality that often leads to decisions with a one-sided emphasis on the individual. In Dax's case, should he have considered the concerns of his mother, his attorney, his friends and his rescue team? Don't they have a genuine concern for his well-being and his life? Do the concerns of the community for the patient have a claim on his life, enough to justify paternalistic interventions to save him from a suicidal decision, even against his wishes? According to Childress, such an expression of community, though essential and important, is nevertheless insufficient to justify overriding respect for the person. "... it is important to insist that a true community, involving equals, cannot exist without respect for persons and that such respect requires procedures to protect rights as well as needs."

There are two main philosophical arguments for antipaternalism, according to Beauchamp and McCullough. The first one is that even with limited paternalism, there is potential for "widespread limitation of liberty that inevitably leads to serious adverse consequences." A second reason argues that the physician does not necessarily know better than the patient what is in the patient's best interest. Therefore, their ideas can resonate with those of John S. Mill: "Only harm caused to another, not harm caused to oneself, provides a valid ground of intervention with a person's autonomous choices and actions." In this manner, Beauchamp and McCullough probably express well the underlying sentiment for such obstinate and

\(^{288}\) Ibid., 130.
determined attachment to the principle of respect for the patient's autonomy. In Dax's case, even proven benefits for the patient 11 years later, in the mind of Beauchamp and Childress as well as that of Dax, did not vindicate the doctors' paternalistic interventions. For Beauchamp and Childress, the principle of respect for the person is the bulwark of individual liberty. Violation of this principle has led to adverse social and political consequences in the past. To the anti-paternalists, the principle carries with it symbolic significance of a magnitude equal to that of human destiny.

4.2.3 William May's Position on the Dax Case

While Beauchamp and Childress approach Dax's case from the vantage point of a staunch liberal outlook, May provides a fresh angle anchored on the Medical Covenant of care. Interestingly enough May's approach does carve out a third alternative between the dilemma of paternalism and patient's autonomy.

From May's covenantal outlook, he sees flaws in both camps: the paternalists and the anti-paternalists. The paternalists justify intervention, manipulation or bypassing the freedom of a competent adult on the grounds that they know better than the patient involved. Thus the paternalists commit the sins of the over-bearing in blatant disrespect of the person. However, the anti-paternalists may mask their indifference toward the patient's plight with a noble claim of respect for the patient's autonomy. As May observes, "Anti-paternalists often lapse into the sins of the under-bearing." It is an easy, intellectual cop-out which allows them to distance themselves from the patient's dilemma.

Covenant fidelity toward the patient, his well-being and his wholeness would enable a physician to restrain his paternalistic tendency to prescribe mere physical
beneficence for his patient. What is it that lies in the way between the physician's and the patient's view of beneficence in this conflict? The physician or moralist who recognizes covenant fidelity would eschew a quick, textbook type, intellectual solution, as it often brushes aside the differences and obscures the deeper ethical question at hand. Covenant fidelity toward the patient demands that the physician or moralist takes a step back and attempts to understand in a deeper and more personal way the dilemma confronting the patient. In Dax's case, William May decidedly has taken his readers onto a different route, which unfolds into a different vista that will enable the readers to have a better grasp of the conflict.

First of all, May employs a narrative format starting with the story of the accident. He then guides his readers in vivid detail through the traumas befallen Donald Cowart – those caused by the accident itself and those by subsequent life-saving treatments. When the readers are engaged by the details of the suffering that Cowart endured, we are placed at a much closer vantage point to the psychology and emotions of his plea for nontreatment. Conventional wisdom may view the conflict between Dax and his doctors as a manifestation of the tension between life vs. quality of life. However, it is at this point that we can understand why May would view that the issue confronting Cowart as more than that. Cowart's plea of "let me die" is not merely a cry that deplores the perceived miserable way of life in the future, or an act that shuns the bleak prospect of an impoverished existence. The juxtaposition of life vs. quality of life by some moralists of Dax's dilemma cannot do justice to what had happened to the person Donald Cowart. The brief narration of the event by William May in *The Patient's Ordeal* reveals just such shallowness:

Dax himself goes to the heart of the event in an interview eleven years after the explosion and fire that killed his father and severely burned two thirds of his own body, including his face, his eyes, his ears, his hands, and his feet, leaving charred flesh and scorched
bone where, an instant before, a 27-year-old man had walked freely. This young, recently discharged jet pilot and veteran of Viet Nam had excelled as a golfer, surfer, football player, runner, and rodeo cowboy. The first man on the scene, a farmer, exclaimed, "O my God!" and Donald Cowart said, "Go help my father," and then asked the farmer for a gun: "Don't you see, I am a dead man. I can't live."

Don Cowart's laconic self-appraisal exposes the shallowness of all efforts to interpret catastrophe by appeal to the notion of "quality of life." The fires have not merely scorched his quality of life, shadowed the margins of his life; the explosion has immolated him. The Don Cowart that was has died.

After the explosion, Donald Cowart eventually changes his name to Dax.289

May goes on to describe in considerable detail the subsequent treatments that Cowart was subjected to, the painful daily tubbing, the corrective surgeries, and the horror of disfigurement. May points out that the final reconstruction of the severely burned face, perhaps a technical achievement for the doctors, may still remain a horror to the patient. Only in such narration or similar language can the readers even begin to comprehend the underlying trauma of the burned victim. Only in this frame of mind can we begin to understand why the victim perceives the catastrophe to be annihilating.

If May understands it correctly, the catastrophe had destroyed the former self of Donald Cowart. The name change from Donald to Dax, though serving a practical function - Dax is much easier to write and say after the mishap - symbolizes just such a change. Catastrophe of this magnitude always attacks our identities. No one can hope to survive such a calamity with his or her identity remaining intact. May therefore rightfully asserts, "That upheaval calls for rites of passage and a new life."290

Thus in cases of allowing to die or assisted suicide, the conventional formulation of the debate as that between life and quality of life distorts the picture,
according to May. For catastrophe victims similar to Dax, the issue is more than merely a deterioration of his quality of life.

To thrust the debate into a more accurate and level framework, May proposes a shift in terminology for discussion from "life vs. quality of life" to life/death/rebirth. What catastrophe victims like Dax are facing is not just a degrading quality of life but a rebirth of a new identity. The terminology of "life vs. quality of life" slants the argument in favor of the pro-lifers, because "life" naturally sounds more important than mere "quality of life," but the new terminology of rebirth properly expresses the impact of such an annihilating accident on the core self. The path of recovery for such accident victims is frequently a renewal and reconstruction of a destroyed self from the ground up.

This shifting of terminology has great implications for health care ethics, as May insightfully observes. The terminology of rebirth/reconstruction alerts the health care community to the importance of rehabilitation and chronic care. This vocabulary further espouses a team concept of relevant health care workers that includes not only the physicians, but the nurses, social workers, therapist, psychiatrist, pastor, minister and the like. The new terminology accounts more fully and accurately for the task of recovery for the patient and his community, of which physical reconstruction is only the beginning. The rebirth/reconstruction of an individual self takes the expertise, care and cooperation of all these disciplines in the community.

In this manner, May cracks open and sheds light onto the traditional impasse between paternalism and patient's autonomy. Ada Cowart, Dax's mother, in her reflections on the case, made this comment: "Looking back over the last ten years, I
think I made the right decision [not to let Dax die]... Now that he's married, enjoying life and his business, I know it's right now.\textsuperscript{291} So she approves of the paternalistic interventions done to Dax, her son, for his benefit. On the other hand, as already mentioned, Dax refuses to give retrospective ratification to what the doctors did to him against his wishes. Each side claims to be right ten or eleven years after the accident. The impasse is still unresolved given the full disclosure of subsequent events years later. The crack of light wedged open by May's covenantal outlook calls for a third position. It is covenantal because it takes the fidelity of a covenanted partner to recognize freedom as the necessary precondition of moral decision, thereby refusing to leave the patient at the mercy of the paternalist. Covenant fidelity also recognizes the beneficence and importance of treatments, rehabilitation and chronic care that supports the rebirth or reconstruction of the patient's self. The fidelity of the Medical Covenant calls for community actions that refuse also to abandon the patient to underbearing sins of anti-paternalistic behaviors.

May's position recognizes that the kind of choice confronting catastrophe victims like Dax often consists of two decisions. First, obviously, it is a decision responding to quandary. Should I accept medical treatments as prescribed by the medical staff and struggle to live an impaired existence? The second decision, perhaps less obvious, but equally important if not more, is a decision about whether to make good on the first decision. If the patient is to accept medical treatments, he needs the will and the desire to deal with whatever consequences there may be in order to make good on his first decision. The second is a resoluteness that enables the patient to face the harshness of life that comes out of his first decision. Without a

\textsuperscript{291} Quoted by Childress in \textit{Practical Reasoning in Bioethics}, 129.
clear and positive prospect of the second, the patient will just shrink from the first. The anti-paternalist is right about the first decision, that it is entirely the choice of an autonomous patient. As May readily accedes, "No paternalist can force him down the road." But by simply emphasizing the resolution of the quandary, the paternalist is neglecting the second decision that the patient must face, perhaps, in the starkness of a barren future. The Medical Covenant of William May recognizes the connection between these two decisions, and he calls for the care and support of the community to strengthen the resolve of the patient to face the prospect of his future, however stark. "The community can and must assist in countless ways," May advises. Only with such relentless fidelity toward the patient entrenched in a covenantal relationship can the autonomous patient choose to accept the treatments freely.

### 4.2.4 A Comparison

#### 4.2.4.1 A Summary of Positions

According to Beauchamp and Childress, Dax's case is definitely a case of active, hard and impure paternalism, where the doctors and the rescue team imposed treatments upon Mr. Cowart against his expressed wish for non-treatment and to die. A key factor in Beauchamp and Childress' determination is that Mr. Cowart was judged competent by a psychiatrist ten months after the accident. After winning the court release to go home, Mr. Cowart, however, changed his mind and continued treatments. In spite of the fact that he is leading a productive life today, Mr. Cowart insists that what the doctors and the rescue team did to him was wrong, and he refuses to ratify the morality of their acts. Beauchamp and Childress agree with Mr. Cowart: "An appeal to future ratification is insufficient to justify paternalistic

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292 *The Patient's Ordeal*, 35.
interventions." In Dax's Case, his caregivers often refer to the concerns of his mother and the people in his community to justify their paternalistic interventions. Beauchamp and Childress, though recognizing the importance of community concerns in medical decisions for the individual, believe that they nevertheless do not have sufficient warrant to override the respect for persons.

May agrees with Beauchamp and Childress that Dax's is a case of paternalism. However, he does not just throw up his hands and satisfy himself with that intellectual position. The covenantal perspective of the Medical Covenant enables him to see through the corresponding pitfalls of both the paternalists and the anti-paternalists. He contends that the polemic between the two camps is shallowly cast into that between life vs. quality of life. He sees the true situation befalling the catastrophe victim more as one of life, death and rebirth. The recasting of the polemic enables one to see the importance of an ethics of care in cases similar to that of Dax. Affirming the stand of patient's autonomy in this case - no one can force Dax down the road of recovery but himself - May, however, believes that community presence and commitment in the ethics of care will help the victim sustain his decision to survive better, and thereby may enable the victim to opt for the decision in the first place.

4.2.4.2 The Logic or Philosophy of Their Respective Arguments

In Dax's Case, there is no dispute between May and Beauchamp and Childress regarding whether it is a case of paternalism. Both sides readily acknowledge the paternalistic behaviors of the doctors and the rescue team in treating Mr. Cowart against his wishes. However, the logic or philosophy that underlies both camps bespeaks very distinctive approaches to the problems.
Two philosophical arguments are usually given by Beauchamp and Childress in support of their stand against paternalism. The first one is a utilitarian argument of socio-political welfare for society. They believe that even limited paternalistic rules in principle "allow widespread limitation of liberty that inevitably leads to serious adverse consequences if paternalistic principles are institutionalized." The second reason springs from their skepticism regarding the idea that doctors know the best interests of the patient better than the patient does himself.

However, in Dax's Case, Beauchamp and Childress' denouncement of paternalism seem to spring more from the sentiment of the first argument than the second. In Dax's Case, the best interest for Mr. Cowart as seen by the doctors, the rescue team, and his mother at the time of the accident are definitely vindicated by the subsequent productive life he is leading eleven years after the event. Even though Dax disputes the rightfulness of the interventions which his health care team had intruded upon him, he never disputes the fact that the outcome did turn out better for him. He readily admits that he is glad to be alive, except that he refuses to be grateful. "The ends do not justify the means," he contends. That argument actually implies what he is enjoying now in his life is a better outcome than the one he sought during the time of the accident and of his recovery. Therefore, with the benefit of hindsight, it now appears that the health care team and Dax's mother did know the best interest for Mr. Cowart. Thus the second argument does not, in retrospect, apply in Dax's case. Knowing this, Beauchamp and Childress center their argument against paternalism mostly on the ground of socio-political utility. In fending off paternalistic community concerns that may undermine individual self-determination,

293 Beauchamp and McCullough, 99.
Childress warns, "But the turn toward community, as important and essential as it is, may become tyrannical if it is not limited by respect for persons." This sense of respect for persons rests on the belief that individual liberty is essential for the greater common goods of society, that it is the ultimate bulwark against social and political tyranny. This line of logic smacks of the Millian utilitarian argument for individual liberty. For Mill argues unapologetically, "It is proper to state that I forgo any advantage which could be derived to my argument from the idea of abstract right, as a thing independent of utility. I regard utility as the ultimate appeal on all ethical questions; but it must be utility in the largest sense, grounded on the permanent interests of man as a progressive being." Despite the fact that Mill sometimes does express his appreciation for individual liberty based on its own intrinsic value, his motivation, his fervor and the power of his persuasion for the tenet ultimately lie in its social and political utility as his own admission indicates. Resonating with a similar utilitarian passion, Childress cites Trilling in defense of his anti-paternalistic stand: "Some paradox of our nature leads us, when once we have made our fellow men the objects of our enlightened interest, to go on to make them the objects of our pity, then of our wisdom, ultimately of our coercion."

Understanding the utilitarian zeal behind Beauchamp and Childress' defense of the principle of respect for patient's autonomy is not to say they totally disregard the intrinsic value that the principle bears by itself. But if we are to understand why this principle holds so much water in the Four Principle Approach of moral deliberation, we must reckon with the force of this social-utility passion for individual liberty.

295 Both quotes in Practical Reasoning in Bioethics, 133.
For May, both the paternalists and anti-paternalists fail to take the whole person into account. For the paternalists, their idea of patient's beneficence is shallow because they fail to understand what the catastrophe victim is going through. In Dax's Case, their idea of beneficence is more accurate than that sought by Mr. Cowart himself (as has been proven eleven years later retrospectively), but their shallow understanding of Mr. Cowart's trauma undermines their ability to persuade him to go down the path of recovery. May's proposal of a terminology shift from "life vs. quality of life" to "life/death/rebirth" illustrates this shallowness. The debate that casts itself in terms of "life vs. quality of life" does not accurately capture the essence and impact of the trauma on the victim. What catastrophe victims like Mr. Cowart undergo is more annihilating and destructive than perceived by the paternalists. Even though the patient may accede to the values and beneficent programs that the paternalists prescribe, the patient's ability to sustain and succeed in the program is so hopelessly impaired. Many patients may just throw up their hands and opt for an easy exit. The sin of the paternalists is, therefore, the over-bearing imposition of their idea of good and beneficence on the patient without a parallel commitment to bolstering and supporting the patient's will and ability to cope with the reconstruction of his self and life after the recovery. The beneficence of the physicians may be good, but it is a love too warm and suffocating when it ignores the beneficiary's ability to sustain its fruitfulness. The flaw of the anti-paternalists is essentially the same, although occurring on the side of the under-bearing. In like manner, they neglect the impact of the trauma on the patient's core self, and leave him to an ideal (of respect for persons) too cold and abstract to sustain a fruitful life.
In either case, the outcome for the patient is death: in the former, a psychological death, and in the latter, physical.

None of these outcomes are satisfactory in a covenantal outlook. Covenant fidelity to the patient demands that we look deeper into the dilemma and problem. Covenant fidelity to the patient as a person would not be satisfied by imposing a beneficent recovery program on the patient but abandoning him to his own device to cope with the rebirth and reconstruction of self after the recovery; nor would it be satisfied with a mere fulfillment of an abstract principle of respect for persons, while leaving the patient with the only option of death because of a bleak and hopeless future. Covenant fidelity to the patient calls for a commitment to an ethics of care from the health care community toward the victim. As in May's logic for his stand on euthanasia, only indebtedness to the patient, the community and to the transcendent can motivate such a commitment. Needless to say, the element of transformation embedded in the Medical Covenant must have played a key role in May's insight of the analogy of rebirth. The wholeness concept in the Medical Covenant, as always, entails for May a deeper ethics of care as the only satisfying treatment for the patient. Genuine respect for persons not only avoids treating patients as means but also treats them as whole and as ends in themselves.
Chapter 5

Comparison, Part II: Health Care Reform and Physician-Patient Relationship
Introduction

This chapter covers the next two topics in our comparison of Beauchamp and Childress and May, namely, health care reform and the physician-patient relationship. This part compares topics with broader social and professional implications. Both topics selected fit this description well. Health care reform is a case study of the U.S. medical system, which we have given considerable space in Chapter One. The physician-patient relationship underscores the philosophy of the medical profession.

For health care reform, both sides seem to agree that the current system is unjust in terms of the distribution of health care to the American public, where a significant segment of society is not included, and is therefore urgently in need of reform. However, as often is the case, the agreement stops here. The underlying reasons given for their respective assessments are vastly different, and hence their approaches for improvement or reform are likewise distinctive from each other. Childress readily notes this problem among ethicists and philosophers in his essay, "Rights to Health Care in a Democratic Society": "there is a consensus that our current system - or nonsystem - is flawed and needs to be reformed. This consensus has not, however, translated into concerted, unified action for a particular solution, largely because of different perceptions of the fundamental flaw(s)." Thus, Beauchamp and Childress choose to defend their position for universal access to health care in the language of "right," whereas May espouses a position for health care reform from the consideration of a covenant between a nation and its people. The following section will summarize their respective positions on this topic and
examine their underlying logic and philosophy as we did for the previous two selected topics of comparison.

Subsequent to the topic of health care reform, we will proceed to compare, in like manner, their respective stands on the relationship between physician and patient. Needless to say, their perspectives on this issue are very much reflective of their philosophies on biomedical ethics in general. In the philosophical system of Beauchamp and Childress, the four principles are raised to an exalted level, and they are central to the authors’ thinking in all matters in biomedical ethics. The physician and patient relationship, though essential, is viewed as only one facet of the discipline and must therefore be subsumed by the guidance of the four principles. Therefore, in the Four-Principle Approach, the physician-patient relationship is reduced to a level of rules on veracity, keeping confidentiality, respecting privacy, or keeping fidelity, etc. However, as we have understood it, that is not nearly the perspective of May. The physician-patient relationship occupies a central position in the Medical Covenant. Covenant fidelity of the more knowledgeable or powerful ones toward the weaker ones is the driving force of the ethics in May's system. May grounds such ethics by virtue of the covenant relationship that he perceives to exist between the physician and the patient. In this section, we will highlight this differences of emphasis between the two perspectives and seek to understand their respective logic and philosophy.

5.1 Health Care Reform in the United States

5.1.1 The Case of the United States Medical System

Since we have covered this subject at some length in Chapter One, we will be brief here. The U.S. medical system has undergone major changes in recent decades.
These changes are responses to some specific ills of the system as perceived by the American public, one of which is the so-called "professional dominance" of the profession and the other being the escalating cost of medicine.

The medical profession in the U.S. has traditionally, perhaps as recently as two to three decades ago, enjoyed significant autonomy and power over its own practice. Despite the fact that the profession was basically a fee-for-service health care system driven by free market principles, it wielded considerable "professional dominance" over the subjects and the market forces that it was trying to serve. According to the analysis of Donald W. Light, one of the key factors abetting this dominance was the traditional, sacred trust placed in doctors by American society. The medical doctors practically enjoyed carte blanche to do what they thought best. They had the power to set their own fees and extensive legal and administrative power to define and carry out professional work without competition, and to shape the organization and economics of medicine. Unchecked professional dominance certainly was a factor in the problem of rising health care costs in the U.S. According to Light, Medical expenditures in the U.S. were $650 billion in 1990, amounting to 12% of the nation's GNP. Other estimates reach 14%. However, in the last three decades, the concern over escalating health care costs has driven a silent buyer revolt within the profession. As revealed in Chapter One, the revolt is termed the "managed care" movement.

298 Ibid., 73.
299 Ibid., 74.
300 Childress' number is at 13%, Practical Reasoning in Bioethics, 237; May's number is at 14%, Testing the Medical Covenant, 101.
In the 1970s and 1980s, responding to the "crisis" of escalating medical costs announced by President Richard Nixon and many other leaders, the U.S. government, market forces, and big corporations joined ranks in giving shape to networks of health maintenance organizations (HMOs) bent on efficiency and cost-effectiveness. In 1976, there were 175 HMOs with 6 million members. By 1987, there were 650 HMOs with about 29 million members. Aiming to reduce health care costs, HMOs keep annual visits per person down to 3.8 and hospital inpatient bed-days down to 438 per thousand enrollees, well below the figures for autonomous, traditional care.\footnote{Testing the Medical Covenant, 77.} Another form of health care that seeks to control cost comes in the name of preferred provider organizations (PPO). All PPOs essentially consist of groups of providers who agree to give services at a discount. Employers then structure benefits to encourage employees to use them. For example, they offer to pay all of the fees for PPO providers but only 80 percent of fees from other doctors. PPOs became significant by the mid-1980s, and by 1988 they had 20 million enrollees.

All these turbulent changes led to a paradigm shift for the economics and ethos of the profession: from traditional care to managed care. Managed care medicine became a buzzword for a network of health care organizations (e.g. HMOs, PPOs, etc.) aiming at cost efficiency. This shift may not have all been for the good. According to Scott Rae and Paul Cox, "There is little doubt that managed care has delivered on its central promise, to control health care costs, but many wonder if the price for such cost containment has been the quality of medical care."\footnote{Bioethics, A Christian Approach in a Pluralistic Age, 256.} In Chapter One we saw many examples that raise exactly the kinds of concerns documented by
George Anders, a Wall Street Journal correspondent. Many biomedical ethicists seem to agree with them. Beauchamp and Childress and May are definitely among them. For one thing, both Beauchamp and Childress and May lament the fact that despite the potential for cost containment in managed care, one still finds approximately 37-40 million Americans without health insurance coverage. 15-20 million more are only insured parts of the year, and up to another 40 million are underinsured. This is inevitable, because universal coverage has never been a part of the agenda of managed care medicine. As Beauchamp and Childress regrettably observe, "Insurers often appeal to actuarial fairness in defending their decisions, while neglecting social justice." As a result, insurers often exclude certain illnesses, treatments, or existing conditions from coverage. They refuse coverage for people in certain life styles or specific occupations that are considered at risks. The AIDS crisis has presented dramatic examples of these problems and raises some serious questions about their underwriting practices.

Under-coverage or unjust distribution of health care, depending on one's perspective, is not the only ill that plagues the current U.S. medical system. Managed care may be able to achieve some kind of cost-containment, but it has also brought on other undesirable effects that reduce the quality (according to some) of health care in the United States. For older folks, there may well be nostalgia for a system that provided their families with physicians of lifetime care. In the bygone era of traditional medicine, except in rare cases of relocation, many patients stayed with their physicians for life. In that environment, a very personal, intimate relationship develops between the patient and physician. However, in the cost-

303 Practical Reasoning in Bioethics, 237 and Testing the Medical Covenant, 100.
304 Principles of Biomedical Ethics, 349.
conscious environment of "managed-care," that kind of relationship is nearly impossible. HMOs, in a concerted effort to drive costs down, offer one kind of contract to physicians known as capitation, which allocates to the doctor a fixed payment each month to cover all the medical needs of the patient. If during a particular month, the patient needs less medical care than is covered, the physician keeps the surplus. On the other hand, in any particular month, if the patient's needs exceed that allocation, the physician must swallow the deficit in reimbursement of cost. In this scheme, both the patient and the physician are at the losing ends. According to the source of Scott Rae and Paul Cox, a physician's income has decreased roughly 30% in the past few years.\(^\text{305}\) The average time allotted for a routine office visit is now roughly five minutes, according to HMO guidelines.\(^\text{306}\)

Another factor that discourages the nurturing of the physician-patient relationship is that, under managed care, patients cannot be sure if they can see the same doctor again as they change jobs or HMOs. The set of doctors contracted to each HMO can be and is in fact different. The patients don't have the same doctor when they are in the office or when they enter the hospital. There is no guarantee that continuity of the physician-patient relationship will be maintained. One can see the difficulties in sustaining a physician-patient relationship on a more personal level under these kinds of circumstances.

Another quality setback forged by managed care medicine is what many ethicists term "under-treatment" of patients or illnesses. Scott Rae and Paul Cox have correctly identified the problem as "conflicts of interest" between the physicians and patients created by the concern of managed care to drive health costs down at

\(^\text{305}\) Bioethics, A Christian Approach in a Pluralistic Age, 254.
\(^\text{306}\) Ibid.
whatever price. "Managed care, in its attempts to contain costs, provides a temptation for physicians to limit care based on financial incentives to the physician," observe Rae and Cox.\textsuperscript{307} Under a fixed payment scenario, the physicians' tendency is to order fewer tests and spend less time on diagnoses or prognoses for the patients. Common complaints about managed care medicine include discharging newborns, new mothers, or patients from the hospital sooner than is appropriate, and long waiting periods for patients whose illnesses require a particular medical procedure. According to Rae and Cox, there may be even a subtle suggestion from some HMOs that "all physicians who contract with them participate in physician-assisted suicide with their patients who request it," because "it avoids the high costs of end-of-life treatments and care..."\textsuperscript{308} Some of these problems even require the passage of federal law for correction.\textsuperscript{309}

Managed care medicine may have corrected the problem of over-treatment under traditional care. Over-treatment occurs when physicians order more tests for the patients than are needed, or recommend expensive medical procedures without sufficient warrants. Over-treatments simply resulted in financial rewards for the physicians in that system. Furthermore, under traditional care, the health care insurers rarely questioned the physician’s recommendations, which was a major factor that led to the skyrocketing cost of medicine in the United States. However, fueled by the desire for cost-containment, managed care medicine is now leading to an opposite set of problems, namely, under-treatment of patients and illnesses.

Another difficulty that physicians are facing is the balance between the needs of an individual patient and those of a group of patients. Faced with the challenge of

\textsuperscript{307} Ibid., 274.

\textsuperscript{308}Bioethics, a Christian Approach in a Pluralistic Age, 280.
distributing dwindling medical resources, many physicians begin to find their professional ethics training not equal to the task.

Nevertheless, the revelation of the problems brought on by managed care medicine must not be interpreted as an effort to thwart or discredit the movement of reform. The cost of health care in the United States is indeed too high. At 12 to 14% GNP, it is reported that the cost of health care in the United States is higher than that of any other developed nation in the West. The system does need radical reform, particularly in the cost area, and managed care medicine is one answer to that need. On this both Beauchamp and Childress and May agree. However, exposing the problems that one form of reform brings certainly helps put the challenges or tasks facing the project of bioethics in sharper focus.

5.1.2 Beauchamp & Childress' Position on Health Care Reform in the United States

Beauchamp and Childress believe that the current medical system of managed care arrangement in the United States neglects many issues of social justice in distributing health care services. Though it has the potential to reduce health care costs, it may accomplish that at the expense, they fear, of the patient's health plan choices. The picture of health plan choices looks rather grim to Childress: "This new world of corporate managed care threatens choice in several interconnected ways - employers limit health plans; health plans limit physicians and hospitals, and employees are limited in their ability to protect their interests or find other employment..." To Childress this limitation seriously threatens access to adequate health care considering the statistics on uninsured Americans cited above, and for

309 Ibid., 273.
310 Testing the Medical Covenant, 101; Practical Reasoning in Bioethics, 237.
311 Practical Reasoning in Bioethics, 262.
those who are insured through plans offered by their employer, "84% of employers who offer health insurance to their employees offer only one plan and some of these plans offer a limited choice of providers."\textsuperscript{312} Beauchamp and Childress also see the problem of under-treatment in managed care as looming large and ominous, as Childress states, "... in many managed care programs, there is a temptation to shift risks or to neglect the needs of chronically ill populations in order to limit costs."\textsuperscript{313}

One may wonder if the mere fact that the system is becoming less costly (assuming that managed care can achieve that) will solve the problem of access. Childress' answer is a resounding "no":

\begin{quote}
In conclusion, managed care will perhaps (though not certainly) reduce the societal costs of health care. Such a reduction, if it actually occurs, will not be accompanied by increased access to health care because there is a lack of societal commitment to use any possible savings to bring others into health care... Without a societal perception of and commitment to resolve the problem of access, a less costly system will still remain an unjust system. The fact that it is less costly in no way diminishes its injustice (italics mine).\textsuperscript{314}
\end{quote}

Thus Beauchamp and Childress' solution to these ills of the current system is reform. Although they recognize the many ills of the system, the single most stressing problem that draws their attention is the problem of access. They embrace a platform for health care reform that advocates government-funded universal access to health care. Although they are less definite about the scope of universal health care, they espouse a concept called "a decent minimum," and they leave it to the politicians or the American public to determine what that "decent minimum" constitutes. "The common good is a basic point of reference for public deliberation about how to establish the decent minimum," offer Beauchamp and Childress.\textsuperscript{315}

\begin{footnotesize}
\textsuperscript{312} Ibid., 261.
\textsuperscript{313} Ibid., 261.
\textsuperscript{314} Ibid., 262.
\textsuperscript{315} Principles of Biomedical Ethics, 356.
\end{footnotesize}
In advocating their position, Beauchamp and Childress defend the "right" to a decent minimum of health care. They argue from two perspectives. The first line of argument is from the perspective of collective social protection. Using the analogy of crime, fire and environmental protection from the government, they contend that citizens are entitled to basic protection from health threats also. Particularly, environmental protection is a form of health protection. Therefore, Beauchamp and Childress believe the analogy can carry over to collective actions of protection for health care. This line of argument appeals to coherence of public policy, as Beauchamp and Childress assert, "If government has an obligation to provide one type of essential service, then it must have an obligation to provide another."316

However, it doesn't take a trained philosopher to recognize the thinness of this argument. Beauchamp and Childress admit that "some relevant dissimilarities between health care and many other public programs exist."317 A direct comparison of health care with other services that the government provides for its citizens may not be warranted. For example, health care service usually can be secured by citizens on an individual basis and it is generally within their ability to do so, whereas fire, environmental or police protections are not as amenable to individual access. Beauchamp and Childress therefore try to bolster the line of argument with additional premises. According to them, it is society's right to expect a decent return on the investment it has made in the education and training of physicians, the funding of biomedical research, etc. Although the government does provide some types of health protection in some public health measures, the citizens' investment in the medical system by way of taxation goes beyond public health. Thus, Beauchamp and

316 Ibid., 351.
317 Ibid.
Childress think that citizens can have a legitimate expectation for protection to extend beyond public health measures. But it remains questionable if collective investment could result in a direct obligation of society to provide a basic level of health care to each individual citizen. That seems to depend on the level and purpose of investment involved. Beauchamp and Childress ultimately recognize the frailty of this line of argument, and propose the second line to buttress their position.

The second line of argument appeals to what they call "the fair-opportunity" rule. From this perspective, the justice of social institutions is measured by their ability to counteract the lack of opportunity or misfortunes that befall their members that are not within their control. Diseases or health threats normally are beyond human control to some extent and therefore fit into this kind of category. Some diseases are debilitating to the point that the patient is rendered incapable of participating in normal competition in life. Thus justice means that government has the responsibility to help individuals to recover or restore their abilities from these kinds of debilitating events not within their control, so that all individuals can have a fair chance to participate in the normal opportunities in life. Fairly allocating health care resources as a means of insuring equal access is deemed the obligation of society under this fair-opportunity rule.

However, misfortune in life can be regarded as "unfair," or merely "unfortunate," according to H. Tristram Engelhardt, Jr. If viewed as the latter, it may be more appropriate for society to amend the situation through charity or through other voluntary means, instead of by forced government programs. Hence, in either

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line of argument, Beauchamp and Childress are presented with difficulties in establishing a moral "right" to equal access to health care.

In somewhat of a conceding tone, Beauchamp and Childress finally attempt to gain support for a governmental program that may give universal health access through an appeal to the compassion of society: "Even if the arguments we have presented for a moral right to health care are rejected on the ground that justice does not support this right, a legal right or entitlement to health care can be supported on a different moral basis such as compassion and beneficence." They deplore the callousness of the conscience of the American public that is willing to tolerate the desperation of a segment of society in need of a basic level of health care. In this mode of reasoning, the central issue in health care reform in the U.S. is no longer justice, but beneficence. The enlistment of governmental involvement in distributing health care services is only a matter of expediency. As a matter of fact, Beauchamp and Childress do see the government operating in this role: "One attractive argument for a legal right to health care appeals to the role of governmental coordination in effecting charitable goals." Consequently, one must distinguish such a right as legal or political rather than moral. The right established in this manner is not formed on a firm moral basis but on a political basis or a basis of expediency.

5.1.3 William May's Position on Health Care Reform in the United States

Likewise, May sees that our current medical system is very much flawed in its failure to provide universal access. May presents similar statistics on uninsured and underinsured people in the United States to support his claim. However, in contrast to Beauchamp and Childress, May is more explicit in his demands regarding the level of

319 Principles of Biomedical Ethics, 353-4.
320 Ibid.
health care that the United States government should provide for its people. He sees that our current system "does not offer enough primary, preventive, home, and long-term care, and it woefully neglects mental health coverage." Therefore the bywords of the Medical Covenant in universal access are "comprehensive coverage." Our system is irrationally tilted toward acute care. In May's words, we are "acute-care gluttons and preventive-care anemics." May sees universal and comprehensive coverage as logically intertwined. When we fail in comprehensive coverage, we leave out from our community classes of people afflicted with certain health problems, like those in need of long-term care or the mentally ill. Thus May's basic position on health care reform is universal access and comprehensive coverage.

Society should provide for universal access and comprehensive coverage because, May believes, health care is a fundamental good. He views it as a necessity of life. In that sense, it is not merely "unfortunate" that one is forced to do without health care. Health care has everything to do with the promise that holds for a person's future. Without universal health care, the future flourishing of a segment of society is doomed, and we fail the camaraderie in our community if we simply look askance at the situation and call it "unfortunate." May likens it with the situation where the mother is anxious for the good health of her baby. The baby is not a stranger to the mother. She has a deep, abiding concern for his or her flourishing and development to the fullest. Likewise, the community that we are in, contrary to popular thinking, does not consist of merely strangers. We have an abiding fellowship that cares about one another's well-being and flourishing. "Healthy

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321 Testing the Medical Covenant, 101.
322 Ibid.
children, and therefore health care, are part of a nation's covenant with its future," asserts May.\footnote{Testing of the Medical Covenant, 103.}

May further cites the preamble of the U.S. Constitution to demonstrate this communitarian heritage. The first words in the Constitution declare unswervingly: "We, the people." That spirit of a people living in a shared community, in a shared hope for the future was tested and affirmed through the ordeal of the American Civil War, notes May. The American people could not and should not survive half slave and half free. May warns the American people that they could not stand "half sick and half well, half protected and half uninsured."\footnote{Ibid., 104.}

As mentioned above, in order to have truly universal access, the system must also be comprehensive. By being comprehensive, May means that the system must offer primary, preventive, and some long-term care as well as acute care. Leaving out these options, universal access becomes meaningless to certain classes of people afflicted with these health care needs. Not only that, the system must be high quality and responsive to choice. Health care is too important a good to tolerate sloppiness or mediocrity in our system. Therefore, reform must take care to maintain all the good qualities of our current system, providing professionals a good medical education, and an encouraging environment for research and diligent work. Furthermore we need to protect the integrity of professional judgment, and a better scheme for holding our professionals accountable and weeding out unethical and incompetent practitioners. May supports a system that provides the patient some kind of choice and freedom in selecting doctors and health care plans. Needless to say, this kind of system is likely to be very costly to implement. How should this system be financed? As May sees
it, the cost of this kind of system should be spread across the board, fairly, to the entire community. "A fair sharing of benefits and burdens would draw the community together and tie the generations to one another," advises May.\textsuperscript{325}

But May understands that health care is not the only fundamental good. It is one of the many, like defending the nation, housing and education for the children. Thus May urges prudence in resource allocation. However, if we are already spending 12 to 14% GNP on health care, that seems to give us enough room to distribute the nation's health care needs among others.

Finally May recognizes health care as a public good. It is a public good because of the huge social investment in medical education, medical research, and the infrastructure that enables and sustains the functioning of the good: "[P]atients who allow young residents to practice on their bodies as they learn their art, community chest drives, foundation gifts, corporate grants, municipal taxes, bonds floated to build hospitals - all these social supports refute the notion that health care is exclusively a private skill or a commodity up for grabs by the highest bidder."\textsuperscript{326} As a public good, then, the members of the community share both its benefits and responsibilities. As a public good, the professionals are indebted to the society that made them who they are today. May also notices that many professionals do feel this indebtedness, as he observes, "thousands of young professionals want to give back, even as they have received."\textsuperscript{327} But we need a system that will provide the channels and that will help them make good on their profession as a calling and not just a job.

\textsuperscript{325} Ibid., 105.
\textsuperscript{326} Ibid., 108.
\textsuperscript{327} Ibid.
5.1.4 A Comparison

5.1.4.1 A Summary of Positions

Beauchamp and Childress advocate universal access to health care and a level of coverage that meets what they term a "decent minimum." They attempt to establish this position by a moral right to health care using two lines of argument. The first is based on an analogy of collective social services. Analogous to crime, fire and environmental protections, health care should be in the same category and demands similar government protection. The second appeals to the rule of fair opportunity. Diseases, injuries and health threats rob people of opportunity to a fair share in life. The responsibility of a democratic government is to help defray the effects of these mishaps and to guarantee its people a fair chance in the competition for life's normal goods. However, diseases, injuries and health threats, undesirable as they are, can be viewed as "unfortunate" rather than "unfair." It is not entirely convincing that a moral right to health care can be established on the grounds of justice. Recognizing this weakness, Beauchamp and Childress are willing to settle for a political right to health care, where the right is based on the compassion of society, and government involvement is based on expediency. As to what constitutes decent minimum coverage, they think it appropriate that this be decided in the political arena.

In contrast, William May has a surer footing on this matter and appears less ambivalent than Beauchamp and Childress regarding the grounds of his argument. May also opts for universal access to health care, but he recognizes that universal access is meaningless without comprehensive coverage. If society continues to
neglect preventive, long-term care and care for the mentally ill, a segment of society will be cruelly excluded from the sharing and enjoyment of the common good. May does not appeal to the principle of justice for his position. Rather he sees it as the nation's covenant with her people. Analogous to a mother's love and concern for her child's future flourishing, the nation has a similar obligation toward its people.

5.1.4.2 The Logic and Philosophy of their Respective Arguments

Both lines of argument of Beauchamp and Childress draw on the egalitarian theory of John Rawls, which understands justice as fairness. What constitutes fairness in the Rawlsian concept are norms or principles of cooperation or distribution agreed upon by free and equal persons entering a social contract. These persons are equal in the sense that they are all situated in what Rawls calls an "original position," where no one knows in advance their abilities, social status, or their allotments in life. They are all behind a "veil of ignorance," so to speak, when they deliberate on the terms of this contract. A social contract agreed upon in this way is thus considered to be the fairest of all, according to Rawls and his adherents. Everyone situated in the original position without knowing anything about his/her future will assume the worst case scenario and negotiate for his/her share of the common good in that manner. Everyone will then receive a minimum fair share of the common good regardless of their status, abilities, or lottery in life. It is a Rawlsian conviction that a "fairness of opportunity" will be the outcome of such a contract.

Norman Daniels extends the Rawlsian concept of justice to health care, being one of the common goods. He argues for "a just health care system based centrally on a Rawlsian principle of 'fair equality of opportunity.'" The fair opportunity rule

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328 See Principles of Biomedical Ethics, Chapter 2.
329 Principles of Biomedical Ethics, 340.
stipulates that "no persons should be granted social benefits on the basis of undeserved advantageous properties (because no persons are responsible for having these properties) and that no persons should be denied social benefits on the basis of undeserved disadvantageous properties (because they also are not responsible for these properties)."\(^{330}\) Such a rule seeks to compensate for the discriminating effects of the social and natural lotteries of life.

This Rawlsian contractarian approach to social justice imagines that a group of strangers sitting behind a "veil of ignorance" in an original position, exercising pure reason, will agree to the principle of fair opportunity and the difference principle.\(^{331}\) In Norman Daniels' application of these two principles to health care, universal access to a decent minimum coverage will be guaranteed to everyone in society. As mentioned previously, even as Beauchamp and Childress invoke this line of argument, they are not convinced of the force of its moral persuasion themselves. Imagine a group of strangers coming together to decide on the principles of distributive justice in a third world country, where starvation of a segment of the society is a normal experience, and where, to that segment of society, survival is still a daily struggle. In that setting, universal access to health care will not be high on the agenda. Fair distribution of food that insures daily survival of everyone involved will dominate the chief agenda of that society. Health threats or diseases of life will very likely be considered as only "unfortunate." In other words, the morality of distributive justice of health care is very difficult to establish in a contractarian framework, and is community dependent. Beauchamp and Childress concede this weakness in this line of argument: "In light of this problem of a criterion of

\(^{330}\) Ibid., 341-2.
unfairness, the implications of the Rawlsian approach and the demands of the fair-
opportunity rule remain uncertain in biomedical ethics and health policy." They admit that "no bright lines distinguish the unfair and the unfortunate."

One of the factors that contributes to this ambiguity of a contractarian approach on distributive justice of health care, we believe, is the assumption that the imaginative group of people who come together for the determination of a proper social contract is a group of strangers. This is the basic assumption of a social contract theory, be it of Hobbes, or of Rawls. In the original formulation of Hobbes, he assumes a hostile "state of nature," in which everyone is an enemy. In Hobbes' words:

> Hereby it is manifest, that during the time men live without a common power to keep them all in awe, they are in that condition which is called war; and such a war, as is of every man, against every man... Whatsoever therefore is consequent to a time of war, where every man is enemy to every man.333

In the assumption of Rawls, the group of people is also made up of strangers. Behind that "veil of ignorance," they don't even know their own identities, let alone those of their neighbors. The only things that Rawls assumes for this group of people are rationality and self-interest. Rawls posits that a group of people whose members are of a sound rational mind, who are equipped with self-interest, and who do not know their lots in life, will choose the two principles he envisions for just distribution of the common good of society. However, if the people in this group are strangers to each other, there are no moral grounds for them to reach the agreement alleged in the social contract. Agreement may be reached for political expedience that protects self-

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331 The difference principle is a principle to strive to maximize everyone's minimum share of life's common good.
332 Principles of Biomedical Ethics, 345.
interest, but this is hardly a solid ground for morality. An interest in fairness presupposes a minimum concern for others over and beyond our own self-interests. In the bliss of ignorance, for self-preservation, we may agree to some principle of justice as fairness to others. But the sense of fairness that we enact in that circumstance is only political, and a mere pretense to morality. Once the situation changes, there is no guarantee that self-interest will continue to direct that we adhere to whatever we had agreed to. This is one important factor that explains the feebleness of Beauchamp and Childress' attempt to establish a moral right to health care, a project which they seem to abandon in a later publication.

In *Practical Reasoning in Bioethics* by Childress, published in 1997, three years after the latest edition (fourth) of *Principles of Biomedical Ethics*, Childress seems to adjust his stand, now arguing at the outset only for a political right to health care in a democratic society like the United States. Beauchamp and Childress do allude to the political right to health care as a last resort of things in *Principles for Biomedical Ethics*, but Childress' later adjustment makes the political agenda central in his thesis. The title of his essay is very telling of this shift: "Rights to Health Care in a Democratic Society." Although he never admits openly of this shift, it is obvious in this essay that he has centered his argument on a legal-political right to health care rather than on a moral right. Alerting his readers to the difference between a moral and political right, he has this to say:

In short, arguments for a political-legal right to health care do not stand or fall on whether there is a moral right to health care;... We ought to adopt and implement a political-legal right to health care, even if arguments for a moral right to health care are not fully convincing. 334 (Italics his)

334 *Practical Reasoning in Bioethics*, 243.
This shift of strategy may in itself reflect a shift in Rawls' philosophical position regarding his "theory of justice." Subsequent to Rawls' publication of his famous work *A Theory of Justice* in 1971, serious, substantive criticisms were mounted from all sides. There are a couple of criticisms coming from the communitarian camp that Rawls' theory of justice has never seemed to be able to surmount. Since Beauchamp and Childress' notion of justice draws heavily from Rawls (and his adherent Daniels), it will be beneficial for us to recap briefly the communitarian criticisms here.

First of all, according to the communitarians, a group of people behind the "veil of ignorance," stripped of all forms of knowledge including self, beliefs, social attachments, etc. quickly becomes a group of people of non-identity. Each member becomes identical to every other in the group. The significance of this, according to Paul Kelly, is that "in so far as any representative individual can cognitively recognize the force of the two principles, then the whole idea of the contract becomes redundant."335 Another criticism is that if the subjects in the original position are precluded from any form of self-knowledge, how can they be said to be engaging in rational discussion or bargaining? What comes out of that contract is not a contract but a "discovery, coming to awareness, or gaining recognition," of the liberal persuasion of justice, in the terms of Paul Kelly. There is no choice involved, because the subjects are stripped of all grounds for individuating perspectives. Yet another devastating blow to the Rawlsian contract, recognized by the communitarians, is the question of motivation: "why should real people in full knowledge of their identities acknowledge the purchase of such a radically abstract

moral identity and therefore acknowledge whatever principles are chosen behind the 'veil of ignorance'?" 336 The communitarians are relentless, when they probe still further. Paul Kelly thus acknowledges: "This motivation problem remains even if we abandon the 'original position' altogether, for we will still be faced with the requirement to show why we should adopt the impartial perspective and accord it priority over the personal perspective."337

Paul Kelly believes that these communitarian criticisms may have caused some of Rawls' revisions of his position. Rawls' new book, Political Liberalism "accommodates many of the substantive communitarian charges," observed Paul Kelly.338 One important revision in the subsequent account is Rawls' conception of his theory as political rather than metaphysical. If the scheme of an original position and a veil of ignorance render the contract morally invalid, we may have to live with the plurality of our society and attempt to achieve some version of justice politically. Childress' position on health care reform mirrors such a change.

As a matter of fact, the current state of the collective political leadership on this issue in the United States reflects just such a difficulty as encountered by Rawls or Beauchamp and Childress. Politically there is a consensus that our current medical system needs reform. There is even agreement regarding what is wrong with our system. There is little dispute that universal access and some kind of basic health coverage are the goals of reform. However, in the plurality of perspectives on health care reform, there is a conspicuous absence of a clear, moral mandate. Subsequently there is no consensus on how to achieve reform or on who will be the bearers of the cost of reform, because these questions are intricately connected with the diverse

336 Ibid., 231, Paul Kelly is rephrasing the communitarian critique.
337 Ibid. Again, Paul Kelly is rephrasing the communitarian critique.
perspectives on why and what is wrong with our health care system. For example, the report, *Securing Access to Health Care*, published by President Clinton's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, in stark contrast to Beauchamp and Childress, consistently avoids the language of rights and argues only for a societal obligation to provide equitable access to health care.\(^{339}\) Avoiding the language of rights, the Commission is acknowledging that such a societal obligation can be fulfilled in many ways, perhaps most reasonably at the discretion of different segments of society, according to their senses of beneficence and abilities. Thus Childress concludes in his essay, "Rights to Health Care in a Democratic Society": "A more just health care system awaits a vigorous moral, social and political commitment - whose appearance is, sadly, nowhere in sight - to establish a general political-legal right to health care."\(^{340}\) The failure of Beauchamp and Childress, and their counterparts in the political sphere for biomedical ethics, to champion a moral mandate for just health care, must account for the bleak outlook.

In stark contrast, William May approaches the same problem of our society, the inhumanity of our market-driven health care system, by a different route. The route he takes is definitely not through the "noisy gong or clanging cymbal" typical of the political arena, where power makes rights or a pseudo representation of morality. He affirms with Beauchamp and Childress that our health care system needs reform, perhaps drastic reform. He is unequivocal regarding the content and scope of the reform needed. In his view, our health care system must provide for universal access and comprehensive coverage, and he is not willing to sacrifice quality for them.

\(^{338}\) Ibid., 232.

\(^{339}\) *Practical Reasoning in Bioethics*, 240; also see endnote 7 of Chapter 13 of the book.
The route by which he takes us to that goal is one that calls for a "return to our foundation as a people." The founders of the American Constitution had this vision in mind. The founding of the American federation rested on a national covenant of a people free and equal, united and toiling for the future and the common good of the community. This is a far cry from the contractarian assumption of the people being strangers, happening to be in casual acquaintance or drawn together for mere political expedience. In the setting of strangers with diverse perspectives, it is inevitable that the morality of certain right claims will always be suspects and our obligations to other human beings unconvincing. No wonder a political route to justifying right to health care sounds so feeble even in the ears of its own proponents.

The Medical Covenant of May repudiates the notion that we are a nation of strangers. As noted in Chapter 3, one of the essential features of the Medical Covenant is its affirmation of community among the people. As members of the community, it hurts us to see certain segments of society excluded from health care. As members of the community, we ought to be outraged morally to see some people flourish while other wither for lack of medical help. The national covenant that the founding fathers of the United States envisioned stipulates that we are all in this community together. Excluding a certain segment of the community from health care only means that we are abandoning them.

This sense of community is by no means confined only to the expressions of the American forefathers. The heart of the Chinese people has resonated powerfully and vibrantly to this sentiment in her philosophies and folk literature throughout the centuries. One of the disciples of Confucius, Mr. Sima, one day lamented that while

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340 Ibid., 262.
341 Testing the Medical Covenant, 126.
many of his peers found great pleasure and enjoyment in the company of their siblings, he was the only one who had not been blessed with a brother. Zixia, another disciple of Confucius, thus said to him, "If a gentleman is reverent and avoids error, if he is courteous in his dealings with others and observes the obligations of ritual, then all within the Four Seas are his brothers. Why should a gentleman be distressed at not having brothers?" \(^{342}\) "All men are brothers within the Four Seas" thus becomes a common adage in Chinese literature for more than two thousand years. Pearl S. Buck, the noted Nobel winner in literature, once translated a Chinese folk epic into English, *Shui Hu Chuan*, meaning, *The Stories of the Shui-Hu-Lake Heroes*. The novel is a Robin-Hood-like story about a band of bandits, outcasts, losers or wanted-criminals who banded together to challenge oppressive authorities and the abusive rich upper class for the relief of the common folks. The epic story took place about 100 years before Robin Hood in the Sung Dynasty of China. Buck discerningly and thoughtfully translated the title of the book as "All Men Are Brothers," which is the true spirit that permeates the original story.

These traditions cited are not religious traditions. The Confucian tradition is a recognized humanistic philosophical tradition, which prefers not to address spiritual or religious matters. It is not that Confucius denied the existence of those realms. He just didn't think he knew very much about them. On the other hand, *All Men Are Brothers* is a classic Chinese folk novel, whose popularity in China rivals that of Robin Hood in the West. The point is that it doesn't require a religious person who recognizes a transcendent creator to affirm the brotherhood of humankind. The

\(^{342}\) *The Analect*, 44-5. At the time of Confucius, which was 550 BC, the extent of the earth was thought to be confined by the Four Seas.
contractarian assumption of the state of nature inhabited by strangers is by no means self-evident and so far still remains an unsupported hypothesis.

Now, Zixia's reply to Mr. Sima is very instructional indeed. For he believes there is some kind of bond among humankind and that the bond or tie carries with it some ethical implication. Zixia expressed it in terms of reverence and fidelity to truth (avoiding errors), and courtesy and respect for the rituals. He was in effect saying to Mr. Sima: You can reap the benefit of that tie now and continually enjoy it; it is already there for you. But the reciprocal responsibilities underlying the benefit are expressions of reverence and fidelity to truth, and courtesy and respect for the rituals.

The Medical Covenant of May says similar things. "A covenantal ethic, above all else, defines the moral life responsively," May asserts emphatically. Whereas the responsive elements are expressed by the Confucian tradition as reverence and fidelity to truth, and courtesy and respect for the rituals, they are expressed as covenant fidelity and love in the Medical Covenant. Our love and covenant fidelity for our fellow human beings would not allow us to leave a segment of society without adequate health benefits. If we see them as essential to our own flourishing and well-being, they are essential to the flourishing and well-being of all in the community. The essence of covenant fidelity to our fellow human beings is still the rote saying of the bible, "Love your neighbor as your self."

Bear in mind that another important element in the Medical Covenant is that our covenant fidelity to our fellow human beings is motivated not by charity but by a sense of indebtedness, both to the community as a whole and to the transcendent who first loved us. That is why under the Medical Covenant that we do not have the option of seeing as merely unfortunate the desperation of our fellow man without
adequate health coverage. Perhaps it is not unfair either. The Medical Covenant probably will not put it in either category. It is somewhere in between. The Medical Covenant explicitly does not have the motivation problem of the contractarian enterprise. It is the Christian story that we, the sinful human beings, have experienced the unconditional love of God undeservedly that motivates us to love one another, regardless of justice. Indebtedness to the transcendent and the community and covenant fidelity are the moral motivating forces.

In the contractarian setting envisioned by Rawls and Daniels, the principles of justice are to be elicited from a group of abstract persons, stripped of all self-knowledge including their stations in life and community attachments, behind a "veil of ignorance." Respecting the Kantian or the liberal ideal that the individual is sacred, free and equal, the bargaining or negotiation scheme thus formed only appeals to their self-interest and rationality. As the communitarians point out, persons abstracted in this manner are, unfortunately, no longer full persons, and a contract made in this fashion is only an outcome of manipulation and not valid. In other words, "the veil of ignorance" thing is just a trick, so that the persons involved will choose John Rawls' principles of justice unwittingly. However, as the communitarians rightly observe, people tricked to make decisions this way will disown the decisions later on. It is interesting that a theory that begins with such deep respect for the Kantian ideal ends up in such great violation of the person, although in an abstract way. The second categorical imperative of Kant stipulates that we should never use a person as a means to any ends. Rawls' early theory of justice manipulates his imaginative group of people to an admirable social end.
By comparison, the Medical Covenant of May appeals to the full person in the community. The Medical Covenant demands that we treat the person as whole. This is another essential feature of the Medical Covenant as delineated in Chapter Three. Only by refusing to treat the person in a fragmented fashion do we truly respect the person. Only in this manner can we hope to treat illness, not just disease. Interestingly, May also finds an application of this in exhorting the American people to health care reform. Acceding to the insight of the contractarians, that human actions are largely driven by self-interest, May, being ever optimistic, nevertheless, recognizes another side of human nature. Pleading to both sides of human nature, May entreats the American people:

It [health care reform] will surely require a broad appeal to self-interest. But it will also need to appeal to what Lincoln called "the better angels of our nature," those angels that Tocqueville must have discerned when he wrote that a "covenant exists...between all the citizens of a democracy when they all feel themselves subject to the same weakness and the same dangers; their interests as well as their compassion makes it a rule with them to lend one another assistance when required." May makes his appeal to the potential of the full person. In his own words about Dax, if we recall from the previous chapter, "No one can force him down the road of recovery." No one could force or even manipulate the American people down the road of health care reform. To be free moral agents, people must be free to make morally wrong decisions, including decisions about health care reform. Of course, self-interest may have something to do with it. Who knows if one day we ourselves may need universal and comprehensive health care? We may as well be honest about it. May is realistic enough to acknowledge the role of self-interest in this enterprise. But as Robin Gill is also prepared to claim, "self-regarding interest, in whatever guise it appears, is inadequate as an exclusive basis of moral behavior," May

343 Ibid., 126.
344 Moral Leadership in the Postmodern World, 44.
appeals to the full person. By appealing also to the better side of human nature, and reminding them of their national heritage, (not stripping it off like Rawls), May points to an alternative way that the American public may be inspired to reach for the higher ground of a covenantal love for their fellow citizens, as envisioned by their forefathers in grounding the United States as a *community* by a national covenant.

### 5.2 The Physician-Patient Relationship

In the topics we have discussed so far, we have seen, to a degree, some appearance of convergence between Beauchamp and Childress and May's positions. In euthanasia, despite the fact that Beauchamp and Childress and May hold different positions on AVE, they both express concern regarding the slippery slope problem that would arise if AVE were to become a publicly endorsed policy. In the issue of assisted suicide, they both agree that paternalism against a competent patient's wish is not justified. In health care reform, the agreement between both camps is even more apparent. Both sides opt for universal access and both express a need for reform in the scope of coverage of the current health system in the U.S. Only through deeper analyses of their arguments and logic did we unravel the extent of differences between the two perspectives. However, on the issue of the physician-patient relationship, the apparent convergence of the two camps is at best illusory. On the issue of the physician-patient relationship lies the deepest, most central difference that demarcates the two philosophical approaches to biomedical ethics. The significance and implications of that difference is far-reaching. It touches on broader, meta-ethical issues like what grounds morality, the scope of ethical inquiry, etc. These issues, though interesting, are not within the scope of this study.
Therefore we will not be able to resolve the difference here, but we will certainly take note of it. The following will present our comparison of the two parties on the subject at hand in the manner that we have previously prescribed.

5.2.1 Beauchamp and Childress' Position on the Physician-Patient Relationship

The physician-patient relationship in Beauchamp and Childress' Four-Principle Approach does not occupy a very central position. They position it as a cluster of sub-issues a couple of levels down from the four principles that they espouse for their system, and they express their position on this topic in terms of several rules that govern this relationship. Needless to say, they believe these rules are derivable from the four principles. In the scheme of the Four-Principle Approach, these rules "further specify these principles in treating problems of veracity, privacy, confidentiality, and fidelity"345 that form the core of the physician-patient relationship. In this sense, they are arguing that because we have the four principles we should adhere to these rules or we should develop this type of physician-patient relationship. Therefore it is clear that in the Four-Principle Approach of biomedical ethics, the physician-patient relationship is subsumed under the category of principles.

In what follows, we shall explicate Beauchamp and Childress' "further specifications" of the four principles in the rules of veracity, privacy, confidentiality and fidelity between the physician and the patient.

5.2.1.1 Veracity

Traditional Hippocratic medicine does not place much emphasis on the physician's veracity toward the patient. Interestingly, the Hippocratic Oath has a

345 Principles of Biomedical Ethics, 395.
provision for confidentiality, but there is no mention of veracity. It is actually surprising to contemporary readers to find that physician deceptions to patients were commonplace a couple of generations ago. The prevailing attitude on the subject was epitomized by Dumas' heroine in *Camille* who declared, "When God said that lying was a sin, he made an exception for doctors, and he gave them permission to lie as many times a day as they saw patients." Thus, veracity became one of the major issues that Joseph Fletcher attended to in his pioneering work on medical ethics, *Moral and Medicine*, written in the 1950s. In the modern practice of medicine, Beauchamp and Childress note the fact that up until 1980 the American Medical Association neglected to mention the obligation of veracity in its codes of ethics.

Beauchamp and Childress argue for veracity as a rule for physician-patient relations for three reasons. The first is based on "respect owed to others." This is clearly a derivation from the principle of respect for autonomy, a Kantian principle that refuses to treat other human beings as means but as ends themselves. But Beauchamp and Childress are never pure Kantian followers. Even under this first reason, they bolster their argument with some sense of consequentialism. Veracity is essential for the rule of disclosure and consent. Authentic patient consent is grounded on truthful communication.

The second reason Beauchamp and Childress offer is an obligation of fidelity and promise keeping. This argument is contractarian in essence. Beauchamp and Childress argue that an implicit contract exists in a medical context between the physician and patient: "By entering into a relationship in therapy or research, the

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346 Cited by Joseph Fletcher, in *Moral and Medicine*, 34.
347 *Principles of Biomedical Ethics*, 396.
patient or subject enters into a contract, thereby gaining a right to the truth regarding diagnosis, prognosis, procedures, and the like, just as the professional gains a right to truthful disclosures from patients and subjects.\textsuperscript{348}

The third reason is more utilitarian in nature. Beauchamp and Childress believe that fruitful interaction between physician and patient depends on building a relationship of trust. Truthful communication is indispensable in fostering a trusting relationship.

But traditional justification for physician deceptions to the patients often rests on a notion of "benevolent deception." Benevolent deception is a claim that truthful disclosure of patients' conditions is often in some way harmful to the patients, such as when it causes patient anxiety, leading the patient to depression or to commit suicide. Beauchamp and Childress regard such a claim with suspicion, although they don't wish to throw out the argument entirely. Like most of the principles and rules in their system, the rule of veracity is "prima facie binding," and not absolute. Thus they "accept benevolent deception in a narrow range of cases, but its use will be infrequently justified."\textsuperscript{349} However, what that "narrow range of cases" entails they do not specify.

Does the patient have a right not to know about the true condition of his own ailment? Beauchamp and Childress ultimately confirm patient's right not to know based on the principle of respect for autonomy. But they express reservation about the claim that most patients do not want to know their incurable or hopeless conditions despite the fact that they say they do. "Claims about what patients genuinely want are inherently dubious when they contradict the patients' own

\textsuperscript{348} Ibid.
\textsuperscript{349} Ibid., 399.
reports," assert Beauchamp and Childress.\textsuperscript{350} Nevertheless, Beauchamp and Childress recognize the importance of sensitivity to social practices, and they leave it open as the physician may contemplate the how's of dispensing truthful communication subject to patients' cultural preferences.

5.2.1.2 Privacy

The concept of privacy can be expressed as inaccessibility by others to some spheres rightfully pertaining to the person himself or herself. These spheres may include information, zones of intimacy, secrecy, anonymity, seclusion or solitude. They also extend to "bodily products and objects intimately associated with the person, as well as to a person's intimate relationships with friends, lovers, spouses, physicians, and others."\textsuperscript{351}

Beauchamp and Childress believe that the primary justification of the right to privacy rests on the principle of respect for autonomy. Beauchamp and Childress follow Joel Feinberg in ascribing a "region of sovereignty" to the person and hence a right to protect it by limiting access.\textsuperscript{352} Nevertheless, Beauchamp and Childress take note of an interesting objection to this justification of the right to privacy, against which their defense seems to be less than persuasive. Since Beauchamp and Childress' justification of the right to privacy is based on the respect of autonomy, does that mean, so raises the objection, that a nonautonomous person does not have the right to privacy? But according to common understanding, a nonautonomous person still has the right to privacy. Beauchamp and Childress concede that "it seems intuitively correct to say that it is a violation of privacy, not merely a tasteless act of negligence, to leave a comatose person undraped on a cart in the hospital

\textsuperscript{350} Ibid., 400.
\textsuperscript{351} Ibid., 408.
However, to such criticism, Beauchamp and Childress suggest that one response is to "emphasize a broader conception of respect for persons that includes both respect for their autonomy and respect for their dignity." Another possibility suggested by Beauchamp and Childress is to assume the nonautonomous person's prior wish against needless exposure before he or she becomes nonautonomous.

Beauchamp and Childress discuss quite extensively the application of the concept of privacy in public policy. The two areas of interest are compulsory or voluntary screening for HIV and TB. However, these details, though interesting, are not germane to our comparison of Beauchamp and Childress and May's concepts and positions on the physician-patient relationship. We are more interested in their philosophical arguments and logic. Therefore, for the details of these discussions, the readers are encouraged to consult their work directly.\(^\text{354}\)

**5.2.1.3 Confidentiality**

The concept of confidentiality is similar to that of privacy. The difference is given a clear illustration by Beauchamp and Childress, which we are going to recap here. An infringement of a person's confidentiality occurs when another person fails to protect information confided in him or discloses it deliberately to a third party. However, violation of privacy occurs in the case of a person without authorization entering a hospital record room thereby gaining access to patient information.

As mentioned before, the Hippocratic Oath contains a prohibition against infringement of confidentiality: "What I may see or hear in the course of the treatment or even outside of the treatment... I will keep to myself holding such

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\(^{352}\) Ibid.

\(^{353}\) Ibid., 411.

\(^{354}\) Please refer to sections contained in pages 412-418 in *Principles of Biomedical Ethics*. 
Correspondingly, the AMA codes of ethics and the World Medical Association all have established some kind of rules or safeguards for confidentiality of patient information. Protecting confidentiality for the patient has a long-standing history in the medical profession.

Beauchamp and Childress defend the rule of confidentiality on three grounds. Typical of their defense for the right of privacy and rule of truthfulness, these reasons are a mixture of the Kantian principle of respect for person and consequentialist arguments. The first offered by Beauchamp and Childress is a consequentialist argument. If patients could not trust physicians to maintain secrecy on some of the information provided, they would not disclose full information about themselves. This may be detrimental to the treatment process. The second aligns respect for autonomy with the right of privacy. Breaches of confidentiality are considered violations of privacy and personal integrity. The third argues from the viewpoint of fidelity. The physician-patient relationship is seen as an execution of an implicit contract, where fidelity to the contract requires keeping certain information confidential. These are arguments similar to those discussed previously with regard to the rules for privacy and truth telling, and thus will not be elaborated here.

The application of this rule encounters difficulty primarily in dealing with AIDS patients, where confidentiality may be infringed in disclosing the condition of the patient to his or her sexual partners. But the protection of third parties involved seems to demand such disclosure. Beauchamp and Childress believe that there are circumstances in which the patient is not entitled to the protection of confidential

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355 Principles of Biomedical Ethics, 1st. ed., Appendix II.
information. These circumstances include AIDS, child abuse, or a serious intent to murder or to cause great harm to someone. Legal or moral obligation exists to divulge pertinent information if serious dangers are present to third parties.

5.2.1.4 Fidelity

Consistent with other rules of the physician-patient relationship discussed above, Beauchamp and Childress also view fidelity as a rule that further specifies their four principles of biomedical ethics. They observe that two models exist in our common understanding of the nature of fidelity. One relies on the notion that fidelity is more of a disposition to be true to one's word. However, as important as this sense of fidelity is, they prefer the second model that relies more on the values of loyalty and trust. Beauchamp and Childress observe that the physician-patient relationship, unlike those formed in business or in the market place, is a "fiduciary relationship," where one party entrusts something of value to another. In the case of medicine, the patient is putting her well-being or her health into the hands of physician. In this setting, Beauchamp and Childress note that "abandonment [of the patient] is a breach of fidelity [on the part of the physician], an infidelity amounting to disloyalty."356

Unlike the other rules in the physician-patient relationship, the justification for the rule of fidelity is not elaborated on by Beauchamp and Childress. They gloss over its justification with only a few statements:

Obligations of fidelity are best understood as norms that specify the moral principles discussed in previous chapters, especially respect for autonomy, justice and utility. These principles justify the obligation to act in good faith to keep vows and promises, fulfill agreements, and maintain relationships and fiduciary responsibilities. 357
In their endnote, they cite Rawls' contention that "the principle of fidelity' is only a special case of the principle of fairness applied to social practices of promising."\(^{358}\) They also cite Charles Fried as he "grounded the obligation of promise-keeping in respect for autonomy."\(^{359}\) However, Beauchamp and Childress fail to present the arguments themselves. It is unclear to the readers in what fashion or to what extent one should adopt Rawls' and Fried's arguments in supporting Beauchamp and Childress' contention. Nevertheless, Beauchamp and Childress conclude, "obligations of fidelity are present... whenever the physician establishes a relationship with the patient."\(^{360}\)

Beauchamp and Childress explicate what fidelity means in the physician-patient relationship in terms of loyalty. Beauchamp and Childress note the traditional concept of loyalty as giving the patient's interests priority over the self-interest of the professional and over others' interest. However, the modern practice of medicine is beset with settings of divided or conflicting loyalties. Conflicting or divided loyalties occur when "fidelity to patients, subjects, or clients conflicts with allegiance to colleagues, institutions, funding agencies, corporations, or the state."\(^{361}\) Although the rule of fidelity to the patient is "prima facie" binding, it is not absolute in any of those settings. In their book Beauchamp and Childress explicate in considerable detail the order of loyalties in cases of conflict with third parties, institutions, and other settings.\(^{362}\)

\(^{358}\) See endnote 75 of Chapter 7 in *Principles of Biomedical Ethics*, 457.

\(^{359}\) See the same endnote.

\(^{360}\) Ibid., 430.

\(^{361}\) Ibid., 431.

\(^{362}\) Ibid., 432-52.
5.2.2 William May's Position on Physician-Patient Relationship

The approach of William May to this issue is decidedly different from that of Beauchamp and Childress from the very outset. For certain May did not write with the Four-Principle Approach in the foreground of his thoughts. It so happens that these two powerful philosophical currents converge upon the shore of humanity in the area of biomedical ethics with innate intensity and energy. But they do not mix. The very nature, the properties and the character of each current prevent them from mixing. In fact each tells of a distinctive journey that it has traveled, and each from a distinctive origin is shaped accordingly. They may converge on the same shore, but their characters remain intact and distinct, true to their origins.

The topic of the physician-patient relationship is most reflective of that difference in character. Whereas Beauchamp and Childress view the relationship as something derivable from their four principles, May envisions the relationship as central in the Medical Covenant. In his introduction to the book *The Physician's Covenant*, he has made clear that centrality. In that book, May introduces five images, each of which in some way describes a task of the physicians: parent, technician, fighter, covenanter and teacher. We have summarized these images in Chapter Three. May pictures all of these types of relationships existing to a certain degree between the healer and the patient. But as we may recall, May names the image of covenant central to them all: "Its [the book's] center of gravity rests in the image of the healer as covenanter, the central inclusive image for the whole."363 The centrality of the covenant between the healer and the patient does not dismiss the other images. "Correspondingly, the covenantal image accommodates in
principle for the healer's activities; it warrants them all" (emphasis mine), declares May.364

The main source of inspiration for the Medical Covenant of May is the Christian Scripture. However, this is not the only source of inspiration for a covenantal relationship in a professional setting. May also argues for it from a professional standpoint without any religious references. But ultimately it is the Christian Scripture that largely provides May with all the necessary ingredients that formulate the Medical Covenant. The bible describes an inclusive covenant between God and humankind, and by virtue of this covenant, human beings are not strangers to each other who have happened to sojourn here on earth. By that tradition, the history of the human race is a narrative of a covenanted people. For the relevant moral features of such a covenant relationship, May draws heavily from the model of the Sinai covenant between God and the people of Israel. Chapter Three of this dissertation has also provided a glimpse of May's development of these themes. It will not be necessary to repeat them here. It will suffice to briefly recap what these features are for the physician-patient relationship posited in a covenant framework.

There are five features of a covenant framework that May uses repeatedly in his analyses of various issues in a physician-patient relationship. The first one is the sense of indebtedness of the professional to her clients, community and the transcendent. It is this sense of indebtedness that motivates her regard for her profession as a calling and not a job. Interestingly enough, it is this motivating force that is so glaringly absent from other frameworks that seek to build morality solely

363 *The Physician's Covenant*, 23.
364 Ibid.
upon consequences, political agreement, self-interest or some free-market principles. It also helps her to maintain a more humble professional posture that avoids the conceit of philanthropy that is so evident in other mindsets.

The second feature is covenant fidelity that May draws from the Sinai covenant and the example of Jesus Christ. One of the instructions given in the Sinai covenant as summarized by Christ is to "love your neighbor as yourself." The content of covenant fidelity is unequivocally about a persistent expression of this love toward our fellow human beings. Therefore, a covenant framework posits the relationship as one that exists to look after the well-being of others in that covenant.

Whereas contract caters to the expression of individual rights or self-interests, it is in the particular interest of others that covenantal ethics is community oriented. Therefore the third feature of the covenant expresses an unyielding communal tie that binds members of that community together. One of the worst sins from the perspective of covenantal ethics is the exclusion of fellow human beings from the community.

The Sinai covenant for the people of Israel also gives guidance as to the scope of the covenant. The instructions given in the Sinai covenant touch on almost every sphere of life. Analogously, May develops the goal of the Medical Covenant to encompass the whole of the person, not just treatment of the disease. Treating persons as whole is therefore another feature of the covenant. This helps May establish the goal for the Medical Covenant - the wholeness of the patient. The corollary of this goal in medicine entails therefore, in many cases, a process of transformation of the patient in his health habits or certain ways of life. The healer, very often, will be an essential helper to bring that process about.
The above is a quick recap or overview of the essential features embedded in a covenantal relationship. With this understanding, the next question we may ask is what kind of professional will best meet the requirements of the Medical Covenant. To this question, May has a ready answer.

May envisions three qualities for such a professional in the field of medicine. Again, we have elaborated on these in Chapter Three. We will just give a brief description here. The first of these qualities is the virtue of prudence, which is an intellectual mark of technical excellence, attentiveness and discernment. The second is the virtue of fidelity, which is a moral mark of love, compassion and loyalty. The third is the virtue of public spiritedness, which is an organizational mark of civic responsibilities and communal ties. Without further elaboration, one can easily see that all these three marks flow naturally from the nature of a covenantal relationship.

As covenantal as ever, May is also attentive to the ethics of the elderly and the very sick. He has developed a list of virtues for each of them. The lists are quite similar. As we grow old, prior to reaching that terminal point, cultivating some virtues for ourselves may enable us to be better people as we face terminal illness. His list of virtues for the elderly includes courage, humility, patience, simplicity, benignity, integrity, prudence, wisdom, nonchalance, courtesy and finally hilarity. For a detailed discussion of these virtues, one may consult May's paper, "The Virtues and Vices of the Elderly."365 His list of virtues for the very sick includes patience, courage, prudence, benevolence and hope. We offer a brief discussion of them in Chapter Three, Section 3.2.2.5, The Ethics of the Elderly and the Sick.

5.2.3 A Comparison

5.2.3.1 A Summary of Positions

The physician-patient relationship in the Four-Principle Approach is expressed as a cluster of rules derived from the four principles, namely, the rules of veracity, privacy, confidentiality and fidelity. These rules, followed properly, will govern a relationship between the healing professionals and the patients that foster trust and cooperation in the treatment process and protect certain rights of the patients. As they do with most of their principles, Beauchamp and Childress ground these rules in the combination of the Kantian respect for autonomy and the logic of consequentialism. However, these rules are not absolute, and in some conflict situations, particularly those concerning the health and safety of third parties, they can be infringed upon justifiably.

In contrast, the physician-patient relationship is central in the Medical Covenant. The covenant of the physician-patient relationship gives moral "warrants" to all relevant healing activities, in the terminology of May. The source of inspiration for the Medical Covenant is mainly Christian Scripture. The dominant model is the covenant given at Sinai between God and the Israelites. Five features of the Medical Covenant are essential in providing the framework for the physician-patient relationship, namely, indebtedness, covenant fidelity, communal ties, wholeness and transformation. From this framework, May generates three important virtues for the healing professional: prudence, fidelity and public-spiritedness. Lists of virtues for the elderly and the very sick have also been developed by May for their benefit.
5.2.3.2 The Logic or Philosophy of their Respective Arguments

Beauchamp and Childress and May approach this topic in markedly different ways. If there was any illusion of similarity between the two ways of doing biomedical ethics, their perspectives on the physician-patient relationship ought to shatter it. As will be shown, the divergence in their understandings of the relationship represents a total demarcation of two ways of doing biomedical ethics or ethics in general. Sometimes, we suspect that even the authors themselves may not be aware of or appreciate the deep gulf that separates them philosophically. For example, in analyzing Dax's case, Childress includes this comment about the approach of William May: "Even though May and Campbell [Childress' co-author] and I start at different points - narratives and norms, respectively - there is considerable convergence." Likewise, May has the following to say of Beauchamp and Childress' Four-Principle Approach,

This vastly influential book [Principles of Biomedical Ethics, 4th ed.] organizes the discussion of biomedical ethics around four principles...However, Beauchamp and Childress do not wish to deny the importance of the virtues for practitioners ... anymore than I wish, ... to deny the moral importance of principles.

What May says in this quote is true, but by saying no more than that, he may lead one to falsely believe that there are not many irreconcilable differences. However, such is not the case, at least in the eyes of a third party observer or after a careful analysis such as the one that we are undertaking. Ethicist Paul Lauritzen has recently contrasted May's narrative approach with Childress' principlist approach in Dax's case and concludes that their respective works "could not be more different." We concur with the observation of Lauritzen.

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366 Practical Reasoning in Bioethics, 134.
367 Testing the Medical Covenant, footnote 3, 55.
Beauchamp and Childress' perspective on the physician-patient relationship is largely a combination of Kantian individualism and consequentialism. In this view, the final arbiter of morality tends to be the consequence of an act or a posture adopted in the relationship. Even in citing the Kantian argument of respect for autonomy to defend the rules of veracity, privacy, confidentiality and fidelity, Beauchamp and Childress, as noted above, have the tendency to bolster it with a consequential argument. Therefore, the rule of veracity is good and moral because fruitful interaction between physician and patient depends on building a relationship of trust. Their conclusion makes no attempt to conceal this fact. Thus they argue that "obligations of veracity are best understood as specifications of several principles and that conscientious adherence to these specifications is vital for a successful patient-professional relationship" (emphasis mine). This is also true of their arguments for the other rules.

The Medical Covenant, on the other hand, views the ethics of medicine as relationship based. The content and shape of that ethics are determined by the kind of relationship inherent between a physician and a patient. The Medical Covenant, of course, posits that relationship in a covenant framework, for reasons already articulated above and in Chapter Three. In this view, action and its consequence, or simply adherence to duty, are not always sufficient warrants for ethics or morality, although May never wants to deny their places or importance in ethical considerations.

In a consequentialist view of the physician-patient relationship, even in combination with the Kantian respect for autonomy, it is inevitable that the

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369 Principles of Biomedical Ethics, 396.
relationship is predicated on a rule-dominant framework, like that of Beauchamp and Childress. In that framework, the success of the relationship is reduced to following a set of rules, like truth telling, keeping confidentiality, respecting privacy, etc. There is a tendency to formulate these rules into procedures or guidelines so that it will become clear to physician and patient alike what actions are expected of them in what circumstances. In Beauchamp and Childress' discussion of the physician-patient relationship, there are many examples of such guidelines or procedures. As noted in our previous discussion on the topic of health care reform, one persistent assumption of Beauchamp and Childress' moral framework is that we are beset among strangers in a pluralistic society. Therefore, a fruitful physician-patient relationship forged in that setting must rely on rules and procedures. Childress frankly admits of this in *Practical Reasoning of Bioethics*, "If consensus exists in a pluralistic society, it is primarily about rules and procedures, some of which protect the autonomy of agents, their freedom to negotiate their own relationships" (emphasis mine).

Of course there are great values in rules and procedures and they have on important function in the sphere of public policy. May readily and repeatedly concedes this throughout his writings on medical ethics: "...we cannot dismiss the agenda for medical ethics of obligation theorists such as Paul Ramsey and James F. Childress. Their principle-oriented theories have value both philosophically and religiously, and they serve variously a religiously pluralist and secular society

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370 For examples, see the guidelines of AMA's Council on Ethical and Judicial Affairs for infringement on confidentiality. *Principles of Biomedical Ethics*, 427 and the guidelines on justifying conditions for randomized clinical trials, 451.

371 *Practical Reasoning of Bioethics*, 50.
dominated by large organizations in need of generalized standards. May, however, believes the tasks of an ethicist are not only about rules and procedures, but ultimately must concern the moral agents themselves, and the attendant virtues that shape who they will become. The unfortunate effect of a consequential mindset for ethics is that in the maze of rules and procedures, the person is often blocked from sight. In that framework, the moral agent fades into oblivion. The final criteria for good and moral actions are their consequences, and moral agency, as a result, becomes inconsequential.

The significance of the Medical Covenant is the re-coupling of moral actions and their moral agents. The Medical Covenant cries out to re-establish that link in our concepts of morality and ethics. Its claim is that the grounds of ethics emanate from a certain human relationship. The grounds and principles of ethics come from the facts of who we perceive we are in the cosmic setting and who we are in relation to other human beings, the animal kingdom and our environment. The claim of the Medical Covenant is that we are no strange sojourners in this life, happening to travel together. As human beings, we are bound by a tie parochially recognized not only by the Judaic-Christian traditions, but also by wise men and philosophers in the Far East, as mentioned in the previous section. This tie as recognized by William May and inspired by Christian Scripture is the inclusive covenant. The ethics for the physician-patient relationship must be grounded on this relationship.

The outcome of such a relationship framework for ethics produces a set of virtues or qualities by May attendant to the moral agents themselves, instead of a set of rules, or guidelines, or procedures of prescribed actions produced by Beauchamp.

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372 Testing the Medical Covenant, 55-6.
and Childress. This contrast reveals a fundamental difference in their conception of ethics. What is ethics? One (Beauchamp and Childress) holds that it is only actions and their consequences that count and the other (May) holds up the person as also a vital concern of morality.
Chapter 6

Comparison, Part III - Method
Introduction

Methodology occupies such prime importance in scientific inquiries that no touting of its virtue is required. But we believe methodology is equally critical, if not more, in the pursuit of disciplines like philosophy or theology, notwithstanding their imprecise nature. The room for errors is substantial indeed in this enterprise, and can only be curtailed by diligent attention to methods. This is one of the reasons that a comparison of methods is offered. Another reason comes from the "unpacking" process of the previous chapters, where the respective positions of the two approaches have been analyzed. Although we have not exhausted the full range of topics and issues in biomedical ethics in our comparison of the two approaches, in our "unpacking" process, we have come across two distinctive methods of doing biomedical ethics. We have come away with an impression that the method which each side has chosen is not incidental, but is intimately related to their very conception of the task and scope of ethics. This chapter will complete the threefold comparison scheme and attempt to reveal that link, that the method chosen by each respective camp underscores their very understanding of the nature of ethics itself.

An overall impression one gains from reading the materials of both camps is their different methodologies. The impression gains greater credence as we engage in further analysis of their arguments and reasoning for their respective positions on several individual topics and issues. Of course, they differ in their views on many individual issues, to a greater or lesser extent. However, if we were to satisfy ourselves with merely such a reading, we would remain sadly unaware of the undercurrent that drives the contemporary debates of bioethics. Professor Gilbert Meilaender is more than merely perspicacious when he characterizes the
contemporary debate of bioethics as a struggle or quest for method. "Questions of method and of substance have been intertwined in debates about the nature of bioethics," asserts Meilaender.\cite{373} For example, one of the major struggles in the search for method (and one in which we have witnessed a significant shift) in the last two to three decades is the "internalist" and "externalist" struggle. In the "internalist" view, the medical profession is pictured with its internal goals and norms, as represented by the Hippocratic tradition. The goals and ethics of the profession are to be found within and not subject to the application of outside, universal norms. However, the last thirty years or so have witnessed a shift from this method to a more "externalist" view. More and more ethicists have yielded to the necessity to relate biomedical ethics to the wider (or universal) moral standards of society. Both the Four-Principle Approach and the Medical Covenant are "externalist" views, despite the fact that there is nevertheless some overlap between them and the Hippocratic tradition. But as we have seen from the exercises of the previous chapters, there remain significant differences between the two approaches. The essence of their differences can also be expressed in term of differences in method. This we will attempt to explicate in the following sections. Therefore, a summary and an analysis of their respective methods will be presented below, followed by a comparative summary of the analyses.

6.1 Beauchamp and Childress' Method

6.1.1 A Summary of Beauchamp and Childress' Method

We have given a general description of Beauchamp and Childress' method in Chapter Two. Therefore we are going to give just a summary here. Basically Beauchamp and Childress' approach is what they call a "principle-based common

\cite{373} Meilaender, Body, Soul, and Bioethics, 2.
morality" system. They reject the employment of a single, overarching ethical theory to serve as the foundation for a moral system. Instead they begin with four principles, believed to be drawn from common morality: the principle of respect for autonomy, the principle of nonmaleficence, the principle of beneficence and the principle of justice. The principle of respect for autonomy states that patients have the right to self-determination and are not to be subjected to the controlling constraints of others, as long as they also reciprocally respect the autonomy of others. The principle of nonmaleficence states that we are not to inflict harm upon patients intentionally. The principle of beneficence calls upon us to contribute to the well-being of patients. The principle of justice refers to a fair, equitable distribution of health care resources in society. However, none of these principles are absolute; rather they are prima facie binding except in a situation where two or more principles conflict. However, in many real life situations, these four principles are indeterminate and are unable to dictate what constitutes the right action. A scheme of interpretation, specification and balancing is required to produce specific action plans for specific situations. The goal is to reach a state of "reflective equilibrium" that best brings the four principles into coherence. In Principles of Biomedical Ethics, Beauchamp and Childress expend considerable effort addressing real life issues to demonstrate how that specification and balancing scheme works, which results in a guide for biomedical ethics that is highly practical with an abundance of rules and procedures.

6.1.2 An Analysis of Beauchamp and Childress' Method

We will not attempt to analyze Beauchamp and Childress' method comprehensively, because that would take considerable time and space, and a
comprehensive treatment is probably not necessary. Instead we will be selective and concentrate on several salient features of that method that we believe are germane to the purpose of this dissertation. Several features stand out in the Four-Principle Approach: 1. The explicit abandonment of a single, overriding ethical theory. 2. The choice of the so-called "Common Morality," which gives rise to the four principles of the system, and 3. A procedural approach necessitated by the demands of public ethics. These are the central features of the Four-Principle Approach that form the essence of the Beauchamp and Childress' method of biomedical ethics. We will discuss these features in the following sections.

6.1.2.1 The explicit abandonment of a single, overarching ethical theory

One of the most distinctive features of the Four-Principle Approach is its abandonment of a single, overarching ethical theory. Beauchamp and Childress' rejection of such an approach is explicit, and the meaning of their rejection is twofold. First of all, they reject the existence of a first ethical principle that governs our moral life. For example, the utilitarian theory honors such a first principle, namely, an action guide to achieve the greatest good for the greatest number of people. Beauchamp and Childress observe, "[M]any distinct [moral] theories have been developed and ably defended, without a substantial consensus as to which system best meets the tests for a theory."374 This is obvious as Beauchamp and Childress espouse four principles for their system, none of which has an absolute, overriding power over the others. As has been discussed in previous sections, each principle has only prima facie binding power, and reigns in a conflicting situation only upon careful considerations of competing principles based on "experience and

374 Principles of Biomedical Ethics, 17.
sound judgment." No principle has a priori authority over the others before any real situations are known. Furthermore, they refuse to accept or develop a single, foundational ethical theory as a basis of their ethical approach, be it utilitarianism or Kantianism. Failure to have an underlying, integrating ethical theory to serve as its basis has been a major criticism of the Four-Principle Approach by its critics. The ablest critics in this area are H. Danner Clouser and Bernard Gert. However, Beauchamp and Childress dismiss the need for such a foundational theory as unrealistic and irrelevant. They are, in their own words, "skeptical of this enterprise." They demur to the development of an integrated, systematic theory. "We have not attempted a general ethical theory and do not claim that our principles mimic, are analogous to, or substitute for the foundational principles in leading classical theories such as utilitarianism (with its principle of utility) and Kantianism (with its categorical imperative)," defend Beauchamp and Childress. Instead, they see their system as a realistic appraisal of the moral life: "Whereas critics ... rely on an ideal of systematic unity, we see disunity, conflict, and moral ambiguity as pervasive aspects of the moral life. ... [A] theory of morality cannot be faulted for a realistic appraisal of them."

Lacking such a foundational theory, it is inevitable that the Four-Principle Approach suffers from disunity and incoherence, just as its critics assert and as the authors themselves concede. First of all, such disunity manifests itself in the approach's lack of a unifying goal. Surprising as it may be, in such a comprehensive account of biomedical ethics as the Four-Principle Approach, an explicit,

375 Principles of Biomedical Ethics, 107.
376 Clouser and Gert, "A Critique of Principilism."
377 Principles of Biomedical Ethics, 106.
378 Ibid.
overarching or integrating goal is missing. One may note in the beginning of *Principles of Biomedical Ethics* that the objective of the authors is "to provide a framework for moral judgment and decisionmaking" in the field of biomedicine. This may be a good goal in the metaethical sense, as something to which all bioethics theories should aspire. But this can hardly serve as a material goal for an ethics system because it is empty of directional content. However, one can find individual goals for the principle of respect for autonomy, or for the principle of nonmalficience, etc., but not an encompassing one for the whole system. The individual goals for the four principles are clear (see the previous section), but an overall, encompassing goal for the entire system that could thread the four principles together is conspicuously missing. Thus without a central goal, it is unclear how the four goals as prescribed by the four principles cohere, particularly in cases where more than one of these principles applies.

A case in point would be the issue of assisted suicide where both the principles of beneficence and of respect for autonomy are involved as discussed in Dax's case presented in Chapter Four. There is not an integrated theory or a central goal within the Four-Principle Approach that could give the conflicting principles a priority ranking or that could resolve the conflict. The fragmentation or disunity created by these two principles as in the case discussed is apparent. What has resolved the conflict in the case for Beauchamp and Childress is *not* derived from the Four-Principle Approach, but from a utilitarian reasoning for socio-political stability if individual autonomy is upheld and respected. Why is a utility account for socio-political stability important or prioritized in a system for biomedical ethics? As they

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379 Ibid.
380 Ibid., 3.
often do, the authors leave the readers no further clues, perhaps, except as an outcome from their allies of "experience and sound judgment." This is the method of justification for the principles applied in specific cases of conflict that gives rise to the criticism of disunity and incoherence. This disunity Clouser and Gert call "the anthology syndrome," where the Four-Principle Approach is seen as a cluster of unrelated principles.

As for the justification process, Beauchamp and Childress call it "reflective equilibrium," after John Rawls. The process begins with what Rawls calls "considered judgment," or what one thinks is true. "The goal of reflective equilibrium is to match, prune, and adjust considered judgments so that they coincide and are rendered coherent with the premises of theory," explain Beauchamp and Childress. But without an underlying moral theory or a single unifying goal, this process can only degenerate into "intuitive equilibrium," a term coined by Rae and Cox. Clouser and Gert, not coincidentally, also offer the same criticism: "Principlism, in failing to operate within an overall unified moral theory, defaults to eclectic, ad hoc 'theories' which ultimately obfuscate moral foundations and moral reasoning."

From the exercise of our comparison, we can see that these criticisms are not groundless. One more example will suffice to demonstrate this. In the case of distributive justice for health care (Chapter Five), the argument that Beauchamp and Childress follow is the contractarian model of Daniel and Rawls, which utilizes the

381 See Chapter Four, Section 4.2.4.2.
382 Principles of Biomedical Ethics, 107.
384 Ibid., 20-26.
385 Ibid., 21.
386 Bioethics: A Christian Approach in a Pluralistic Age, 75.
concepts of "the original position" and "the veil of ignorance." As we recall, to determine a just distribution of health care, a group of people is put behind "the veil of ignorance," stripped off all knowledge of their talents, background, position, wealth and their status in society, achieving what Rawls would call "the original position." In that situation, the group of people will necessarily agree, the model theorizes, to a distribution scheme that is deemed just by everyone. As commented upon previously, this scheme is manipulative and its operating principle appears in stark contrast to the principle of respect for autonomy, where informed consent is a key element championed for the patients. How the concept of informed consent in the application of the principle of respect for autonomy suddenly yields to the priority of that of the veil of ignorance in the application of the principle of justice is indeed beyond the readers. Why relevant information and knowledge are so important in one instance and so counterproductive in another is a mystery in the Four-Principle Approach. There is no reflection or any objective means of resolution given for this apparent incoherence by the system. One may argue that the veil of ignorance is only an abstract idea and the people in the original position are not real people. But the problem with this argument is that the philosophers who formulate or follow this contractarian model believe in the result of such abstraction. It is their intention and conviction that the result of such abstraction is applicable to real people and society, which is by no means less manipulative. The coexistence of the concepts of informed consent and the veil of ignorance in the system without any rational justification affirms the criticism of Rae and Cox: "In the end, cohering to reflective equilibrium only means cohering to one's own subjective, intuitive grasp of

what one thinks is correct. The incoherent and ad hoc nature of such "reflective equilibrium" in the system must be responsible for the great credence given to the criticisms that the authors have faced.

6.1.2.2 Unmasking the "Common Morality" of the Four-Principle Approach

Another salient feature of the Four-Principle method is its employment of what Beauchamp and Childress call the "common morality." It is important to explain what the term means and how it is used in the system, for it does not coincide with what average people think. Normally people use the term "common morality" in reference to a morality commonly known to and practiced by a majority of the people. But that is customary morality. According to Beauchamp and Childress, "A customary morality ... is not synonymous with the common morality. The latter is a pretheoretic moral point of view that transcends merely local customs and attitudes. Analogous to beliefs in the universality of basic human rights, the principles of the common morality are universal standards." Therefore, "common morality" to Beauchamp and Childress is a set of standards that crosses local boundaries, a set of principles or rules that echoes in common humanity. This is not to say "common morality" is the morality known to and practiced by a majority of the people. It is simply a set of overlapping standards of diverse customary moralities, believed to have universal appeal. The four principles that form the pillars of the Four-Principle Approach are said to be of such "common morality."

As we recall, the method of the Four-Principle Approach is to start with the four principles garnered from "common morality" and subject them to the coherence model of justification, a process of interpretation, specification and balancing, to

388 Bioethics: A Christian Approach in a Pluralistic Age, 76.
reach what is called "reflective equilibrium," as they are used to deal with the problems of biomedical ethics. As Beauchamp and Childress elaborate, "This strategy allows us to rely on the authority of the indispensable principles in the common morality, while incorporating tools to refine and correct its weaknesses and unclarities and to allow for additional specification." Thus, we may wish to note, the four principles provided in the system are merely starting points. Because of the process of interpretation, specification, and balancing, "we will not end with the identical content with which we began," warn Beauchamp and Childress. In other words, after all has been said and done, what we end up with may not be "common morality" at all.

The last point is important, because one of the reasons for the popularity of the Four-Principle Approach may very well be its claim and appearance of having been derived from "common morality." In fact, British medical practitioner and lecturer of medical ethics Raanan Gillon has documented from his own experience just such a phenomenon:

> When I first read Beauchamp and Childress I recognized what I thought a very important framework for medical ethics - a common basis of commitment (admittedly only prima facie, but nonetheless common to all) to a common basis for moral analysis and the elements of a common moral language....As I began to teach using this framework I was impressed by the readiness with which students could agree that the four principles were indeed consistent with the common perspective on medico-moral issues. When I lectured more widely I encountered similar reactions from nurses, other health care workers, medical students, and more recently members of the general public.

Thus, we can see the effect of the claim of "a principle-based, common morality" system, and the importance of understanding that claim.

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389 Principles of Biomedical Ethics, 100.
390 Ibid., 101.
391 Ibid.
"Common Morality": Its Role as Censor

Besides serving as a starting point for the Four-Principle Approach, the role of "common morality" as stipulated by Beauchamp and Childress also serves a second function. "Any theory that eventuates in moral judgments that cannot be brought into reflective equilibrium with pretheoretical commonsense judgments will be considered seriously flawed," assert Beauchamp and Childress. In other words, Beauchamp and Childress believe that "common morality" or "pretheoretical commonsense judgments" also serve as a censor or a check for moral theory development, the Four-Principle Approach included. Any secondary moral principles or rules developed must cohere well with the initial four principles and the "pretheoretical commonsense judgments." But in the last section, we have seen how "reflective equilibrium" can become "intuitive equilibrium," and is largely so according to several critics of the Four-Principle Approach, particularly when an underlying theory or a central goal is missing.

Another reason for "common morality" to fail to work as ordered - that is, to fail to function as a check or censor - is that the moral problems confronting biomedical ethics are in fact an uncommon bunch of ethical issues. The rapid advances of medical technology have pushed biomedical ethics into realms hitherto unreached. The ethical decisions that people are called to make baffle their "pretheoretical commonsense judgments."

It is interesting as well as important to note that Beauchamp and Childress seek a check for their system from the pool of "pretheoretical commonsense judgments." This is important precisely because this ethical system precludes from

the outset the existence of a transcendent source of morality, or refuses to give preeminent position or authority to any source of moral traditions or moral theories. How does a moral system as such build in a safeguard for the soundness of its moral decisions, or how does such a system seek to improve itself? These are relevant questions that a serious moral system must address. By Beauchamp and Childress' own admission, "A good [moral] theory also should have the power to criticize defective beliefs, no matter how widely accepted those beliefs may be," including its own, (I may add). Therefore, it is paramount for a good moral theory or system to have a safeguard for the soundness of decisions that it engenders. In this sense, we understand the purpose and function of "reflective equilibrium," and "pretheoretic commonsense judgments." However, as the discussion shows, neither of them can function effectively in the system as intended. "Reflective equilibrium" in the end becomes rather intuitive. When an integrating moral theory is abandoned and a central goal is missing, in a conflict situation the moral agent simply does not have an objective or transcendent source for guidance, but clings to his own intuitive grasp of rights and wrongs. "Pretheoretical commonsense judgments" would also fail simply because most biomedical decisions are beyond the common calls of life.

"Common Morality": Its Historical and Cultural Root

Such weakness of the Four-Principle Approach is inevitable when it, from the outset, rejects all religious traditions of morality or a single, integrating moral theory as its basis. In this mindset, there is a hidden, albeit simplistic, assumption of modernity that a neutral rationality or pure reason exists to guide the moral life. All the philosophers need to do is to provide a proper framework for it to take its course.

392 Principles of Biomedical Ethics, 46.
The assumption of "pretheoretic commonsense judgments" is just such an example. Beauchamp and Childress believe there exists such a set of neutral, impartial "pretheoretic commonsense judgments," transcending the commonly known religious, cultural or moral traditions, waiting for us to garner its wisdom. But the observation of Alasdair MacIntyre necessarily puts a chill on such optimism. In *After Virtue*, he observes: "The most striking feature of contemporary moral utterance is that so much of it is used to express disagreements; and the most striking feature of the debates in which these disagreements are expressed is their interminable character...There seems to be no rational way of securing moral agreement in our culture." The observation continues:

> It is precisely because there is in our society no established way of deciding between these claims that moral argument appears to be necessarily interminable. From our rival conclusions we can argue back to our rival premises; but when we do arrive at our premises argument ceases and the invocation of one premise against another becomes a matter of pure assertion and counter-assertion. Hence perhaps the slightly shrill tone of so much moral debate.

One does not need to be a moral philosopher to recognize the realism of this observation.

However, one of the characteristics of such moral disagreements observed and offered by MacIntyre is worth noting. He states, "It is easy to see that the different conceptually incommensurable premises of the rival arguments deployed in these debates have a wide variety of historical origins." We often mistakenly abstract our views from the cultural and social milieus that give them shape. Thus from the standpoint of moral philosophy "Kant ceases to be part of the history of Prussia, Hume is no longer a Scotsman," laments MacIntyre. And without

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394 *After Virtue*, 6.
395 Ibid., 8.
396 Ibid., 10.
397 Ibid., 11.
reckoning with the cultural traditions that give them shape, our "pretheorectic commonsense judgments" may assume a false independence and pretense of impartiality. By appealing to such commonsense judgments, there is still no guarantee that we will escape the contemporary moral impasse depicted by MacIntyre. This is, however, not to deny that impartiality in moral thoughts or philosophy can exist, but only to re-assert the significance of the relationship between moral philosophy and its culture and history.

Therefore, another major flaw in the method of the Four-Principle Approach is its seeming neglect and scanty treatment of the cultural and historical milieus that shape the four principles. The four principles abstracted from their historical and cultural development are taken by Beauchamp and Childress to be "universal standards" drawn from "common morality." To be quite truthful, it doesn't take a sociologist to recognize the Western cultural bias embedded in the four principles. Therefore, Rae and Cox make this observation: "For example, to Beauchamp and Childress the principle of autonomy certainly coheres with the ideal of reflective equilibrium. And yet, the principle of autonomy might not cohere with the reflective equilibrium of a person in Chinese society." In fact, Childress himself makes a similar observation:

...[D]uring a 1979 visit to People's Republic of China with an interdisciplinary and interprofessional delegation interested in ethics... members of our delegation asked Chinese policy makers, health care professionals, and others how they handle some of our "problems" such as refusal of treatment. The most common response was: "That's not a problem here. It doesn't exist here." ... [I]t reflected the unimportance of some Western principles and values such as autonomy, privacy (for which there is no Chinese word), and other ingredients of individualism. (Emphasis mine)

398 Bioethics, A Christian Approach in a Pluralistic Age, 77.
399 Priorities in Biomedical Ethics, 105.
Such a significant cultural contrast of the four principles is by no means restricted only to a far away Eastern country. Recent works on biomedical ethics by authors of other nations or cultures, some of them also Western, have begun to surface to rattle the claim of "common morality" of the four principles. One notable essay, written by Henrik R. Wulff, MD, "Against the Four Principles: a Nordic View," offers an interesting treatment of the cultural and historical root of the four principles, and the author contrasts the Four-Principle approach with what he calls the "Nordic moral tradition and the Golden Rule approach." The conclusion of the essay highlights the importance of cultural traditions in biomedical ethics. The author states:

[C]ultural traditions differ and ... consequently, the problems of medical ethics must always be viewed in the perspective of a particular culture... Those who read the international literature on medical ethics must always be conscious of their own cultural background, so that they do not unwittingly import professional norms which do not fit the society which they serve.  

Ian McDonald in one of his latest publications, The Crucible of Christian Morality, laments that the scholarship of Christian ethics has been too long constructed in isolation of the social contexts and ethos that sustained and nourished its development. The history of the scholarship has been largely a reflection of this trend – that is, until recently. In that volume, McDonald offers his astute observation: "The challenge is not only to recognise the inter-disciplinary nature of the subject but to develop a method which accords with the logic of the study of religion, ethics and culture while relating to more specialised interests in the field."  

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400 Besides the Nordic work cited below, there are Buddhist works by R.E. Florida, A Study of Biomedical Ethics from a Buddhist Perspective by S. Taniguchi, and also a book and several articles by P.Ratnakul.
Besides McDonald, several scholars, including Wayne Meeks\textsuperscript{403}, have recognized the inadequacy of ethical approaches that are abstracted out of their social and cultural contexts. Morality and ethical reflections are seldom made in isolation of their social or cultural ethos. This is true of Christian and non-Christian ethics. Few philosophers, let alone the common people, can stand alone, completely neutral of their cultural traditions. Thus Henrik R. Wulff rightly observes, "The moral tradition of any society to a large extent reflects its historical development,"\textsuperscript{404} echoing the same sentiments of McDonald and Meeks. By directing attention to history and cultural traditions, we are not concluding that an objective description of morality, or an objective moral theory, is impossible, or irrelevant, or unworthy of our pursuit. We are not saying any of that. We are just saying that an objective description of morality, or an objective moral theory, if it is to be developed successfully, must seriously take into account of the history or cultural traditions that shape its major components.

Therefore Henrik R. Wulff's essay stands in stark contrast to the Four-Principle Approach in that it displays great sensitivity to morality's connection to its historical and cultural roots. An example would be the treatment of the principle of respect for autonomy. Wulff continues his keen observation:

> The immigrants who came to the United States had very different cultural backgrounds, and many of them had fled from religious, racial and political oppression. It is easy to understand that the resulting pluralistic society would cherish the right to self-determination as the supreme moral principle. Paramount importance is attached to the right of individuals to shape their own lives and to pursue their happiness with a minimum of interference from other individuals and from society. ... It is this aspect of American culture that is reflected by the principle of respect for autonomy, which in the context of this tradition may be defined as respect for the right to self-determination.\textsuperscript{405} (Emphases his.)

\textsuperscript{403} Meeks have devoted at least a couple of volumes in this direction: \textit{The Moral World of the First Christians}, \textit{The Origins of Christian Morality - The First Two Centuries}.

\textsuperscript{404} "Against the Four Principles: a Nordic View," 278.

\textsuperscript{405} Ibid.
In developing what he calls the Nordic view or the Golden Rule approach, Wulff first notes that the Nordic countries (Denmark, Finland, Iceland, Norway and Sweden) are very homogeneous (as opposed to the pluralistic nature of American society). The inhabitants of these countries largely consist of people with similar cultural and religious backgrounds, and one of the characteristics of these countries is of an egalitarian concept of social justice, which gives rise to "the ideal of a democratic welfare state based on mutual obligations." Thus many social institutions, including the university system and the hospital system, receive large grants from the state, which are practically free. Wulff unabashedly attributes the ideal to the Golden Rule as it is formulated in Christian Scripture, the Sermon on the Mount: 'And as ye would that men should do to you, do ye also to them likewise' (Luke iv.31), hence the name of this approach. In this approach of mutual obligation with the Golden Rule serving as the chief paradigm, the American style of respect for autonomy (respect for the right to self-determination) is de-emphasized. Wulff explains: "[T]he right to self-determination...does not exclude paternalistic action grounded on compassion. Individual rights are not belittled, but it is recognized that ethics is much more than the mutual respect of rights." The Golden Rule approach also has implications for the distributive justice of health care that distinguish it from the Four-Principle approach as we have already noted above.

The point of this exercise – going through some component of the Nordic approach to biomedical ethics – is to demonstrate with a concrete case that the so-called "common morality" in the Four-Principle approach is far from what it claims:

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406 Ibid., 280.
407 Ibid., 283.
the principles of the common morality are universal standards.\textsuperscript{408} As we have seen, the principles in the Four-Principle approach are not even universal in the Western world. Some of the four principles, for example, autonomy, are products of their particular historical and cultural milieus and must be understood as such.

"Common Morality": Exclusion of Religious Language

As we have already noted its presence in the passing, another point of interest is Wulff's reference to Christian Scripture as the source of the Nordic view. In his article, Wulff also notes in general the sharp decline of Christian influences in Nordic countries. Nevertheless, that does not diminish the fact that some aspects of their biomedical ethics have retained a strong Christian component. And Wulff is honest enough to report it. Issues of biomedical ethics often deal with health problems that linger around the edges of life, and as William May correctly observes, "Modern culture reeks of religion and those who want contact with the modern world will need to acknowledge this fact."\textsuperscript{409} It is conspicuous that the Four-Principle approach has completely avoided any religious reference. Most common people, however, make a religious turn when they are confronting the forces of life and death. Any ethics system that purports to deal with biomedical issues in our contemporary society but religiously shuns this religious nature of the common people is doubtful as an adequate or comprehensive biomedical ethics system for them. However, the Four-Principle approach claims to provide "a sufficiently comprehensive general framework for biomedical ethics."\textsuperscript{410} Nowhere in its framework does it provide a justification for this academic aversion to the religious

\textsuperscript{408} Principles of Biomedical Ethics, 101.
\textsuperscript{410} Principles of Biomedical Ethics, 46.
element in biomedical ethics, or for why this religious element found in people facing life and death decisions is completely dispensable. Although the content of religious sentiments depend largely on particular religious traditions, to be complete, biomedical ethics do call for some degree of sensitivity toward this general religious expression of the people in their medical crises. Absent this awareness, the completeness and comprehensiveness of the Four-Principle Approach must remain in doubt.

"Common Morality": An Ensemble of Particular Western Philosophical Traditions

Another thing that casts serious doubt upon the masquerade of "common morality" of the Four-Principle Approach is its argumentation method and philosophy. We have examined in detail in the previous two chapters the logic and philosophy behind the positions taken in each topic chosen for comparison. It is clear that in each case a philosophical tradition is somehow chosen to advocate or defend a certain position. For example, the justification for euthanasia is largely founded on an account of utility in the Four-Principle Approach. The advocating for physician assisted suicide is grounded in logic that upholds the Kantian respect for autonomy as supreme. Another example: The principle of justice in the Four-Principle Approach is actually a Rawlsian contractarian concept of justice as fairness. Each of these examples demonstrates a method of ethics of a very particular Western philosophical tradition, which taken separately still commands a ring of controversy of its own even in Western society and Western philosophical or academic circles. But these particular philosophical traditions are masqueraded
behind this façade of "common morality" of "universal" principles, driving the conclusions of biomedical ethics.

With this criticism, we are not saying that ethical reasoning should be purged of all particularity. No one is neutral enough that they could transcend all social, cultural or philosophical traditions to produce ethical positions that are completely objective, void of any subjective or particular influences. But the criticism points to the need to reckon seriously with or be sensitive to the significance of these forces in shaping our moral perspective.

6.1.2.3 Procedures, Rules and "Practical Ethics"

A Prominent feature of the Four-Principle Approach is its reliance on procedures and rules. Many people believe the prominence of the system comes from the apparent universality of the four principles. The Raanan Gillon experience quoted above is an example. There is some merit to that theory, because the four principles are indeed a good starting point, and the indeterminate nature of the principles does fit people well, particularly people with diverse backgrounds and different moral traditions. But another feature that accounts for the approach's popularity has to be its reliance on easy-to-follow procedures and clear-cut rules. This is one area of strength of the system unsurpassed by many other biomedical ethics theories proffered at this time.

One cursory reading of the text, Principles of Biomedical Ethics, will convince the readers of this truth: that the system places great emphasis on procedures and rules. The emphasis is probably only second to that placed on the four principles. An example will suffice to illustrate the point. For the interpretation of the principle of respect for autonomy, it is shown by Beauchamp and Childress
that the concept of informed consent is most relevant in application of the principle. "The basic paradigm of autonomy in health care, politics, and other contexts is express and informed consent," state Beauchamp and Childress. Subsequent to this statement the readers are confronted with "Varieties of consent," which include the definitions of "tacit consent," "implicit or implied consent," "presumed consent," and finally "deemed consent." And then there are the implications of "consents and refusals over time," "autonomous decisions that anticipate periods of incompetence," and "problems about personal identity and continuity." Of course, the readers will find concepts of "competence and autonomous choice" explained. The readers will find lists of "standards of competence," procedures for "operational tests for incompetence," ... and finally a great list of "the element of informed consent." This method is then repeated for other principles throughout the book.

The heavy reliance on procedures and rules has to be related to how Beauchamp and Childress perceive the task of an ethical system or theory in the context of a pluralistic society seeking common grounds for public policy. If people cannot agree on a single moral theory or tradition, the process of formulating public policies becomes a matter of political deliberation. Peaceable coexistence depends on a well-developed set of rules and procedures which everyone subscribes to beforehand. Therefore, as observed by Childress and Siegler, "If consensus exists in a pluralistic society, it is primarily about rules and procedures, some of which protect the autonomy of agents, their freedom to negotiate their own relationships." Such a perception of the task of ethicists in biomedicine has no doubt contributed to the proliferation of procedures and the permeation of the legal tone in the discussions of

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411 Ibid., 128.
412 *Practical Reasoning in Bioethics*, 50.
the four principles by our authors. This probably is true of many authors in the field of bioethics in the U.S. Hence Henrik Wulff's astonishment at "the legalistic nature of the discussions"413 among American bioethicists. The search for a common ground for public policy in biomedicine really drives most, if not all, endeavors in this field in the U.S. today. One of the most obvious consequences of such drive is the obliteration of the lines between what is legal, political and moral. One interesting experience given by Childress himself is his serving on the Human Fetal Tissue Transplantation Research (HFTTR) panel. It was a panel made up of a variety of experts, ethicists included, to "hear testimony, deliberate, and offer recommendations" on the use of federal funds in human fetal tissue transplantation research.414 The main focus of the Panel's discussion was on the connection or linkage between abortion and the use of human fetal tissue in research. After the Panel had issued its findings and recommendations in a report, Childress had an interesting reflection on the "consensus" issue, leading him to pose a philosophical question: "Was the 'consensus' or 'near consensus' reached by the HFTTR Panel an ethical consensus or a political consensus?"415 (Emphasis mine) The answer seems to be provided by one of the panelists, Patricia King: "the HFTTR Panel has perhaps fostered ... 'the illusion that these bodies have achieved consensus at the level of ethical principle... In fact, the consensus usually comes at the level of practice and policy.'"416 Therefore, the Panel has come to agreement as stated in the report that "federally funded HFTTR, within certain safeguards, is 'acceptable public policy,' rather than 'ethically acceptable,'" a phrase which would have been much more

414 Practical Reasoning in Bioethics, 302.
415 Ibid., 320.
416 Ibid.
"intellectually or rhetorically satisfactory" to the majority panelists and Childress himself.\textsuperscript{417} But that must be a trade off if we perceive the task of the ethicist as primarily one that helps form public policy.

It is perhaps in this sense that Beauchamp and Childress view their work as "practical ethics." By this term, "practical ethics," they want to maintain a distinction between their work and "applied ethics." They explain:

\begin{quote}
The term \textit{practical} refers to the use of ethical theory and methods of analysis to examine moral problems, practices, and policies in several areas, including the professions and public policy. Often no straightforward movement from theory or principles to particular judgments is possible in these contexts, although general reasons, principles, and even ideals can play some role in evaluating conduct and establishing policies.\textsuperscript{418} (Emphasis theirs)
\end{quote}

Therefore, practical ethics in biomedicine, at least in the context understood by Beauchamp and Childress, has among its aims a specific mission of forging public policy. This perceived role of the ethicist, of course, has a definite impact on the work of Beauchamp and Childress and the method that they chose for their task. For one thing, it produces an ethical guide with a very detailed set of rules and procedures and a vast amount of information on possible implications and possible situations. Practical ethics, as the term implies, needs be practical. In \textit{Principles of Biomedical Ethics}, Beauchamp and Childress certainly have fulfilled that aim beautifully. Because of the perceived practical nature of the work, it supports a certain aloofness from theorization. Hence comes the absence or near absence of a central theoretical structure that gives rise to so much criticisms from its opponents. Secondly, practical ethics with formulating public policy as its underlying motive naturally lends itself more toward solving the quandaries of biomedical ethics. Its objective is to answer the question of what to do, given a medical dilemma. This

\textsuperscript{417} Ibid., 320-1.
\textsuperscript{418} \textit{Principles of Biomedical Ethics}, 4.
orientation definitely tilts the ethicists toward the Kantian or the utilitarian or the contractarian solutions, as we have demonstrated in the previous two chapters. These traditions, though distinctive in themselves, are rather similar in that they are all oriented toward prescribing moral actions. Action becomes the focal point and the moral agents generally receive less emphasis in these theories. Not surprisingly, in the framework of the Four-Principle Approach, the virtue, motive, and character of the moral agent are important only in so far as they can facilitate action-oriented solutions. Thirdly, practical ethics with the underlying motive of formulating public policy becomes a form of public ethics. Public ethics in the cultural atmosphere of the U.S. naturally precludes religious perspectives from its discussions, because of the plurality of religious traditions and the political separation between religion and state. This non-religious ambience also sits well with the academy, because philosophy and ethics are believed to be non-religious disciplines, where the notion of God no longer transpires moral authority for general humanity. Appealing to religion to resolve moral controversies is considered to be a parochial endeavor suitable only within the confines of particular faith-oriented communities. In introducing his notion of "a secular health care policy," Engelhardt is reminiscent of this cultural development: "The death of God is a metaphor for the beginning of the modern secular age, the age in which appeals to religion fail convincingly to resolve moral controversies." The Four-Principle Approach is a product of its age, where the political conception of the tasks of practical ethics conveniently gives sanction to a non-religious interpretation of the enterprise of biomedical ethics, despite the prevailing religious ethos and sentiments that surround most life and death situations.

419 Engelhardt, 111.
of the common people. However, Englehardt continues prophetically, "Analogously, the death of man can be taken as a metaphor for the post-modern age, when appeals to human nature fail as well." 420 Englehardt contends that "the philosophical attempt to ground morality in human nature or rationality has failed to provide an intellectually justified common moral basis for the cooperation of moral strangers." The Four-Principle Approach does not affirm such a drastic conception of post-modern morality, because it still clings to the hope of the modern project of grounding morality in reason and rationality. Thus Rae and Cox is correct in observing that "Beauchamp and Childress assume a modern 'enlightenment' approach to their perspective, while Englehardt works out his position with the context of a postmodern mentality." 421 But Beauchamp and Childress' de-emphasis in considerations of the moral agents in moral matters is stepping close to Englehardt's postmodern moral concept of "the death of men."

6.2 William May's Method

6.2.1 A Summary of May's Method

It is almost redundant to state: May's method is one of image. As we recall from Chapter Three, he has chosen five images to represent the tasks of the physician, namely, parent, fighter, technician, covenanter and teacher, and for the one that serves as the guiding center for these images he chooses that of the covenanter. For obvious reasons, the parent image highlights the caring aspect of the physician's task. The fighter image emphasizes the fighting spirit or mode of operation against the disease of the patients. The technician image properly focuses on the technical skills required of the physicians. The teacher image helps the

420 Ibid., 112.
421 Bioethics – A Christian Approach in a Pluralistic Society, 56.
readers appreciate the teaching role of the physician, and to help the readers form a correct image of the covenant, he summarizes for us the history of the Sinai covenant drawn from the Bible. The covenant image thus formed provides the framework, which includes the goal (wholeness of patient), the motivation (indebtedness to patient and to God) the promise (covenant fidelity), and the environment (community) of the covenant, to guide and criticize the other images in May's system.

Obviously, May develops the Medical Covenant after the model of the Sinai covenant of the Judaic-Christian tradition. Although he continues to use common language and reasons to justify and establish his system that are accessible to his readers, he makes no attempt to conceal its source. To reach across the religious boundaries that might exist between him and the reader and for illustration purposes, May utilizes in an extensive manner narratives or stories drawn from works of well-known literary figures, like Faulkner, Camus, Eliot, Hemingway and others. Because in some ways, the stories or narratives that they wrote may reflect some common experiences. In this fashion, May has wrought a very interesting, fresh and readable style of ethical discourses.

6.2.2 An Analysis of May's Method

Even if we may not have a very good idea at this point, we probably already have accumulated some sense that the method of May is very distinctive from that of Beauchamp and Childress. As we explore further, we will discover that May's method is very distinctive also from that of the rest of biomedical ethicists and many of the moral philosophers. As a matter of fact, if we peruse the first couple chapters of Beauchamp and Childress' monumental work, Principles of Biomedical Ethics,
where the central topic is the various methods and theories employed in the field, we will find May's kind of approach is conspicuously missing. This phenomenon is not peculiar or unique to Beauchamp and Childress' otherwise comprehensive account of biomedical ethics methods. In Rosemarie Tong's treatment of this subject, May's kind of approach also falls by the wayside of the respectable academy of biomedical ethics. Our mention of this somewhat strange but obscure phenomenon is not an effort to help May's approach gain some kind of entry into the formal Academic circle of biomedical philosophy. As Meilaender observes, the enterprise of biomedical ethics has in the last couple of decades been largely entangled in a struggle for methods. Such ostensible omission or, as Stephen Lemmers puts it, "The marginalization of Religious Voices in Bioethics," could be simply a revelation of such subconscious activity, the exploration of which may help us gain a stronger grasp on the significance of the difference in methods and its implications. Such marginalization is not a unique phenomenon happening only to May's work. It is the general fate of a whole species of theologians doing work in biomedical ethics. Richard A. McCormick probably feels the sting of such marginalization sharply as he gives the following caricature of the plight of theologians in the field:

As we enter neighborhood homes, many of us have been quickened with the peculiar hospitality of a sign that reads: "Beware of dog." There are doubtless many people around who believe that an analogous sign is in place when a theologian is present to discuss the ethical dimensions of biomedicine. Theologians just may bite. Or perhaps worse, they may not. At their worst they are seen as extremely dangerous. At their best, they are harmless, that is, useless. For these reasons they should preferably be out of sight, or at least on a short leash. (Italics mine)

*Out of sight* therefore is the fate of May's work in the respectable academy of biomedical ethics. There could be a couple of reasons for this marginalization. First

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422 This is the title Lammers used in his article collected in *Religion & Medical Ethics: Looking Back, Looking Forward*, edited by Allen Verhey (Grand Rapids: Eerdmans, 1996), 19-43.
of all, May adopts a method unfamiliar to Western, conventional philosophy scholarship, where methods center on logical discourses and abstractions. Secondly, despite May's attempt to argue his case using secular, non-religious language, his source of inspiration, as he openly identifies, is Judaic-Christian. These probably comprise the strongest reasons for the relegating of May's work to particular ethics of a community outside of the general academy of biomedical ethics scholarship. In what follows, we will discuss the significance of May's method in light of these probable reasons. In our analysis, it will become clear that the scope or the task of ethics underlying May's method is different from that of Beauchamp and Childress. This is the fundamental issue that separates the two camps of biomedical philosophy.

6.2.2.1 A Method of Image

May has adopted a method that is very unconventional in the eye of a particular Western philosophical tradition, a tradition largely characterized by methods in logical deduction and abstractions. But May's method is by no means new, for the method of employing images, symbols or icons to convey a certain message or idea is age-old. Chinese culture, literature and philosophy are replete with symbols and imagery. As a matter of fact, imagery dominates the traditional Chinese method of thinking. Dr. Lin Yutang has an interesting description of the Chinese mind, in which the dependence on and the fascination with pictures and images of traditional Chinese thinking are vividly illustrated. Dr. Lin observes, "With the Chinese... concrete imagery always takes the place of abstract terminology.... To say, 'How could I perceive his inner mental processes?' is not so intelligible as 'How could I know what is going on in his mind?", and this in turn is

decidedly less affective than the Chinese 'Am I a tapeworm in his belly?' The love of imagery in expression has a definite impact on the shape of Chinese literature and philosophy. "Chinese thought, therefore, always remains on the periphery of the visible world, and this helps a sense of fact which is the foundation of experience and wisdom," according to Dr. Lin.

William York Tindall on the other hand notes the use of symbols to "present thought and feeling while celebrating or constructing suitable worlds" in the time of Moses. He then identifies a train of symbolic writers from before the time of William Blake to Fitzgerald and T.S. Eliot in our current age. Thus the use of symbols or images as representations of our "thought and feeling" is common to the literary person in the East or West, ancient or modern. In comparison, logical deduction or abstraction as a dominant method to truth is relatively novel in the history of humankind and its exclusive claim to enlightenment or knowledge is only characteristic of the modern obsession. Few scholars, probably with the exception of those engaged in pure sciences, would subscribe to the view that logical method is the only means to a comprehensive description of reality. There is a sense of wholeness in this approach to truth through the use of images, perhaps, because of their ability to maintain what Dr. Lin calls "a sense of fact" amidst the speculations of philosophers. Incidentally, that is also a reason offered by William Y. Tindall to explain Professor Ernst Cassirer's special affection for images and symbols: he is drawn to them because they maintain "at least a toe upon fact." Therefore, in breaking away from the enlightenment obsession for logical abstraction as a

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425 Ibid., 79.
426 Ibid.
dominant form of rationality, May's use of images and symbols is not just literary or decorative.

As with any particular field of endeavor, diverse opinions and theories abound. The interpretation of the phenomenon of symbolic expressions is no exception. The earliest attempt known to the literary world to assess the role of symbol, image, and figurative language, is often attributed to Aristotle, who believed that metaphor is implicit comparison and its use is primarily ornamental. In other words, metaphor is considered not necessary and can be substituted with plainer and more direct language. Of course, the majority of contemporary scholarship on metaphor no longer holds this view. However, residue of this influence is still apparent in some scholars as is evident in their impatience with and criticism of May's approach. In his critical review of Veatch and May, and their approaches using models (or images in May's terminology) in medical ethics, K. Danner Clouser chides, "The models are whimsical gestalts which obscure the crucial moral points that could have been made with clarity and crispness." Here, Clouser appears to be Aristotle's adherent in terms of his opinion on the use of figurative language. He directly challenges Veatch and May: "What is the point of models?" Clouser, who is so much more used to the modern project of logical abstraction in

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428 Ibid., 40.
430 For a good overview, see article "More about Metaphor," by Max Black in Metaphor and Thought, 19-43.
431 Veatch advances a theory of medical ethics using four models: the engineering, the priestly, the collegial, and the contractual. See Veatch, "Models for Ethical Medicine in a Revolutionary Age," Hastings Center Report 2 (June), 5-7.
433 Ibid., 94.
philosophical treatises, protests impatiently that "[moral] point emerges so much more clearly when abstracted from all the rest of the model's conceptual filigree."\(^{434}\)

But despite these misgivings about the use of symbols, models and images, recent literary theories provide assurance that the value placed on them is not misplaced. In literary theory, image is considered a principal part of the structure of symbol. Thus Tindall asserts, "Among symbolic parts the image is principal."\(^{435}\)

For the purpose of discussion, I shall use the image of covenant in May's framework for illustration, interacting with recent literary theories. In the ensuing discussion, the terms image and symbol may be used interchangeably.

**Image and Context**

In literary theory, context is considered important in the formation of symbol and image. May's use of the covenant image draws us to the Biblical history of the Sinai covenant between God Jehovah and his people. The image summoned in this context becomes an image of a condensed history or narrative. The image does not stand alone, for standing alone, it is drawn out of context. Therefore the context serves to limit or expand the scope of the image or symbol. In *The Literary Symbol*, Tindall expounds the importance of the interaction between image and context. He states, "By reciprocal limitation and expansion, image and context, two interacting components of what they create, carry feelings and thoughts at once definite and indefinite. This composite of image and context constitutes that symbol." The Sinai narrative, told of a relationship between Jehovah God and Israel, serves as the context of the physician's covenant that symbolizes the relationship between the physician and patient.

\(^{434}\) Ibid.
\(^{435}\) Tindall, 102.
Image as a Complex of Feeling and Thought

"The literary symbol, ...embodies and offers a complex of feeling and thought," observes Tindall.\textsuperscript{436} For something that combines complex thoughts, ideas, events and emotions, and that does not lend itself to easy description, the literary genius invented the devices of symbol and image. Because of its ability to retain the context that gives rise to it, the symbolic image is very adapted to express complex thoughts, ideas or feelings, particularly things that may not be amenable or suitable to logical abstraction. The wedding ring is a symbol of the love and commitment of a married couple, while at the same time it commemorates the event of the union. Likewise the image of the Sinai covenant reminds us of the faithfulness and commitment of God toward his people in the context of their exodus and liberation from Egypt. The relationship between God and his people was built on a concrete event. That event is an expression of love and faithfulness on the part of God himself, and an expression of immense gratitude to her God of the Israelite people. The subsequent giving of the decalogue to his people as a major part of the covenant itself, embodies God's hope and expectation for the future of the Israelites as to what kind of people they should become. On the other hand, the covenant also embodies the immense gratitude and indebtedness of the Israelites toward their God, which serve as their motivation in being faithful to the covenant. Thus, the image of the Sinai covenant carries all these thoughts, ideas, emotions and the event itself in a commingled piece as a symbol. The Sinai covenant is indeed an image of complex thought and feeling, as Tindall perceptively intimates of something symbolic, and the physician's covenant brought forth by May is to be an imitation of that.

\textsuperscript{436} Tindall, 15.
**Image and Wholeness**

Because the symbolic image embodies its context, it carries an uncanny ability to preserve the essence of things as a whole. Within the limits of the context, the image conveys a sense of integrity. The symbolic image refuses to present things piecemeal. It has a strong resistance to abstracting or shredding things apart. In order to understand the image as a symbol, one needs to understand the whole thought and feeling complex that it carries. In that complex, some parts would be amenable to narration or description, but some would not. Therefore, the literary person sometimes defines the symbol as "a visible sign (image) of something invisible," or that which represents "an intellectual and emotional complex," that defies description by ordinary language. These are the essence of things that are embedded in the context as a whole, immensely felt at the time, but whose impact definitely will be lost in transmission via media other than the symbolic.

The physician's covenant built from the Sinai covenant therefore has a distinct advantage over the principle-based system of Beauchamp and Childress in the sense that it is more whole as an ethics guide for the relationship between physician and patient. As we explain it in Chapter Three, the physician's covenant covers the goal (wholeness of the patient), motivation (gratitude and indebtedness to the transcendent and the patient), essence and promise of the relationship (covenant fidelity), and the scope of the medical enterprise in the realm of ethics. Principles abstracted from moral theories or actual cases lose a significant amount of these things, which are important in ethical considerations, unless complemented by a central theory or significant effort in specification and balancing such as that

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437 Ibid., 5, 103.
438 For development of each of these components, see Chapter Three, Section 3.3.1.
included by Beauchamp and Childress in their system. But as we saw in the last section, the Four-Principle Approach is still lacking something important, namely, a central underlying goal for the medical enterprise as far as ethics is concerned. Instead we see distinctive goals espoused by each of the four principles, which sometimes compete with each other. The physician's covenant complemented by four other images (parent, fighter, technician and teacher) illuminates the essential task of the physician as a whole. Four vital aspects of the task of the physician are thus in view, yet, guided and criticized by one central image, the covenant. May recognizes that the image, though presenting things in a more holistic fashion, is still not perfect. It sometimes emphasizes the essential at the expense of some non-essential things, which may nevertheless be important. In May's Medical Covenant, the central image, the covenant, serves as a guide and offers the needed criticism for the secondary images.

The Unitive Aspect of Image

Symbol is also regarded as an instrument that brings unity to two hitherto disjointed worlds, the visible and the invisible, the historical and the intellectual, the mundane and the spiritual, etc. Tindall elaborates, "For author and reader the symbol is unitive. ... By uniting the separate it can organize experience into a kind of order and revealing the complex relationships among seemingly divided things, confer peace." We believe this quality of a symbol also contributes to the wholeness of the physician's covenant. There are many aspects of biomedical ethics that seem to be disjointed. How can a teacher's role fit into the task of the physician? For that matter, how do all these seemingly disjointed functions of the physician, the parent,
teacher, fighter and the technician come together? The physician's covenant unites them. The central goal of the Medical Covenant, making the patient whole, connects them. Making the patient whole health-wise entails parent-like love and care, the teacher's transformation of the patient, the fighter's spirit against the disease, and the technical skill of medicine. All these are glued into a whole embodied in the image of the Medical Covenant. Creatively, the Medical Covenant reveals the hitherto invisible interrelationships among them and makes the interrelationships compelling. The Medical Covenant molded after the Sinai covenant also provides a link between the physician, the patient and the transcendent. The motivation for covenant fidelity toward the patient on the part of the physician is her indebtedness to society and the grace of God.

The Creative and Heuristic Aspect of Image

There are other qualities of the symbolic image that we cannot address completely here. But one more is important. The symbol may at times be creative and heuristic. For the receiver or reader of the symbol, its principal function is "organizing his experience and enlarging it."440 For that matter, theorists of symbol even speak of a creative experience. In elaborating on Ernst Cassirer's account of the creative symbol, Tindall states, "The value of the symbol, if we accept this account of it, lies therefore in creating a vision of reality and submitting it to our apprehension. Not only creative but heuristic, it serves to discover the reality it shapes."441 Perhaps nothing can illustrate this better than Tindall's rapt delight in the creativity of symbolic novels:

As tight and reflexive as poems, symbolist novels insinuate their meanings by a concert of elements. Images, allusions, hints, changes of rhythm, and tone - in short, all the

440 Ibid., 15.
441 Ibid., 18.
devices of suggestion - support and sometimes carry the principal burden. "Whatever is felt upon the page without being specifically named there - that, one might say," says Willa Cather, "is created." Presenting themselves, *such creations offer a vision of reality.*

442 (Italics mine)

The creative and heuristic aspects of the image as a symbol work in unison to create new visions or new horizons for the reader or receiver of the symbol. That is important in ethics. For as May sees it, "The task of ethics in the professional setting might be called, at least in part, corrective vision." To May, enabling others to see a new option, a new perspective is a major function of ethics. In that conception of ethics, image as symbol certainly fits the task very well.

6.2.2.2 The Sources of the Medical Covenant

As Beauchamp and Childress cite "common morality" as the source for the four principles of their ethical system, May makes explicit allusions to the Christian Scripture as the source for the Medical Covenant. As such, the Medical Covenant is immediately distinguished from the covenant or Social Contract of Hobbes, Rousseau, or Locke. Despite the use of the terms "contract" and "covenant" interchangeably, the Social Contract tradition really belongs to the contractarian camp of moral or political philosophy, in which Rawls and Veatch are some of the chief contemporary representations.

As it began, the Social Contract tradition did draw its inspiration from the Judaic-Christian concept of the covenant of God with his people. Johannes Althusius, whom Michael Lessnoff identifies as one of the earliest contractarians, conceived the original social contract as a covenant between the rulers and the people, reaffirmed by later generations. But this covenant is based on the primary covenant with God, which set limits to the subsequent covenants of the rulers. This

442 Tindall, 68.
primary covenant Althusius referred to as the "religious covenant": "The debtors in this religious covenant are those who make the promise, or the supreme magistrate of the realm and its ephors together with the entire people. The creditor is God to whom the promise is made."\textsuperscript{444} One of the duties of the ruler drawn from this "religious covenant" is to "plant and nourish the Christian religion as the foundation of his imperium."\textsuperscript{445}

However, the notions of God and "religious covenant" began to fade in the works of subsequent Social Contract theorists like Hobbes, Locke and Rousseau. They are altogether dropped by contemporary contractarians like John Rawls and his followers, in their efforts to develop a moral theory completely independent of the notion of a transcendent being and any religious traditions. In this sense (and others) the Medical Covenant of May is not a contractarian theory, but one may note some interesting resemblance between the Medical Covenant concept and that of the earlier contract theorist, Althusius.

In the article "Code, Covenant, Contract, or Philanthropy," May deals a blow to the fuzzy idea that covenant and contract mean the same thing and rescues the original, biblical concept of covenant from the later contractarians. A contractarian theory of morality, using B.J. Diggs' definition, is "a set of restrictions that it would be reasonable to include in the morality by which [the contractarian moralist] governs himself if almost all were willing to accept these restrictions."\textsuperscript{446} Simply put, it is a rather political concept that agreement by contracted parties constitutes what is moral or required, as in a commercial or legal contract. The chief moral motivation

\textsuperscript{443} The Physician's Covenant, 13.
\textsuperscript{445} Ibid.
\textsuperscript{446} Ibid., 21.
in such contractarian theories is self-interest. The Medical Covenant, on the other hand, draws upon the love and concern for the other party, as exemplified by God who loves his people in Mt. Sinai and also by Jesus Christ in his enactment of the "new covenant." May, who never hesitates to draw from his source and model, explicates:

The term "new covenant" describes the peculiar gift of this self-expending love, its human reception, and promissory ties to it. In laying down his own life, Jesus takes up death itself into the power of donative love. He himself gives and receives in the midst of his own dying and allows others to participate in the selfsame power.447

Thus the Medical Covenant models this self-expending love for others as the essence of morality or what Paul Ramsey terms as "covenant fidelity" to others.

Paul Ramsey, following the theologian Karl Barth, was, according to May, the first person to apply "the term 'covenant fidelity' to the problems of medical ethics in this country [USA] in his impressive and influential The Patient as Person, ..."448 May openly acknowledges his debts to his teacher Paul Ramsey for the concept of ethics in the framework of covenant. However, May regrets that "he [Ramsey] spends only two pages in the preface [of The Patient as Person] acknowledging the theological origins of the notion. Without a firm sense of the religious setting for covenant, ... the moral ideal of fidelity fades before the exigencies of the real world..."449

Therefore the Medical Covenant as applied to contemporary health care ethics has its precursor in Ramsey’s notion of covenant fidelity as "the ruling principle in medical practice."450 However, in Ramsey's desire to reframe his positions in biomedicine within the general framework of secular philosophical

447 The Physician's Covenant, 128.
448 Ibid., see endnote 19, Chapter 4, 199.
449 Ibid., 199.
450 Testing the Medical Covenant, 54.
discussion, the biblical origin of the notion of the covenant and the promise-keeping God fades into the background. This May has decidedly chosen not to do. He explicitly locates the Medical Covenant within the Christian tradition as something valuable offered to secular biomedical ethics.

However, May has never attempted to impose his views in the field as a sectarian Christian ethicist, who thinks that the authority of Scripture or of the Christian tradition alone is enough justification for secular morality. Indeed, May does not appeal to Scriptural authority or the authority of the transcendent to establish the plausibility of his arguments. For instance, May would matter-of-factly point out, “One need not hold to the Christian faith in order to affirm that health care is a fundamental and public good among other such goods.” Many of May’s arguments, like the one above, can be established through the employment of reason and logic, or so he believes. But for May, the corrective vision of the Medical Covenant is to revitalize some of the essential elements that exist among human beings in relationships, particularly in the physician-patient relationship. May attempts to secure this goal by chiefly relying on the use of images and symbols, garnered from well-known literature. As Meilaender has keenly perceived, May "has never taken his faith for granted" in public moral discourses. He has deliberately chosen a path of conversing with the world on some of the vital, ethical issues in biomedicine in a language that is comprehensible to them. True, his views are distinctively of a particular religious tradition, namely, Christianity. He does not see any reason to hide this fact. He does not share the modern illusion of looking at things from a neutral vantage point of reason, as far as philosophical discourse is

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451 Testing, 127
452 For examples, fidelity, indebtedness, etc.
concerned or other endeavors that involve values and judgments. Complete
neutrality is difficult to achieve as long as man himself is moved along in the midst
of cultural and traditional currents. This is not to declare that reason is altogether
bankrupt or impotent. Reason and rationality can still guide or illuminate if we are
willing to understand and reckon with the heritage that shapes or pre-conditions us.
So unlike the sectarian Christian ethicist who chooses to eschew the world, May
persists in reasoning things out with them, but always with the Christian tradition
that has nourished him not too far from view. However, he uses familiar stories from
Faulkner, Joyce, Camus, Conrad, Hemingway or Eliot to bridge the gap. With such a
"fund of historical, literary, and theological allusions,"453 even his opponents at times
find their readings of his work enriching. These stories are scattered throughout his
work, but they are used mainly for illustrative purposes. In The Physician's
Covenant, May draws from the writings of Hemingway and Faulkner to introduce the
Biblical concept of covenant to his secular readers, wherein he states, "Ernest
Hemingway's works illuminate a professional ethic that prizes technique as a shield
against ties. William Faulkner's novels and stories create a bonded world."454 In
Faulkner's novels and stories, May often finds "the ties of marriage and the family,
the bond between the races and the generations, or the primordial tie to the land."455
He then goes on to cite some passages from Faulkner's work to support his claim.
For example, Faulkner's "Delta Autumn" helps him illustrate the covenant mind-set.
The story portrays a boy, Isaac McCaslin, who first learns to hunt and kill a deer
under the tutelage of old Sam Fathers, an Indian. May quotes from this story in

453 Clouser, 89.
454 The Physician's Covenant, 106.
455 Ibid.
The boy makes an unspoken promise to the killed deer:

I slew you; my bearing must not shame your quitting life.  
My conduct forever onward must become your death.  

And this becomes what Faulkner calls the binding moment of the boy's life; he returns to the delta annually to reflect on this sacred event that shapes the rest of his life. This episode May uses to illustrate the concept of the Sinai covenant. May draws the analogy, "From then on, just as the marked Jew, the errant, harassed, and estranged Jew, recovers through ritual renewal the covenant of the exodus and Mt. Sinai, Isaac returns to the Delta every autumn to renew the hunt and to suffer there his own renewal despite the alienation he has subsequently known across a lifetime."  

These stories from well-known literary figures are just one tool May uses to forcefully demonstrates that the concepts of covenantal ethics are not entirely dependent on the authority of the transcendent and can actually be found within our common experiences. 

6.3 A Comparative Summary of the Analyses of Beauchamp and Childress and May's Methods

In previous sections, we have found that analysis of the methods of both camps yields extremely interesting results. For instance, we have discovered that the methods employed by the two camps are not just different, but that they are as different from each other as two persons occupying positions on opposite poles. We find that Beauchamp and Childress, in their utter rejection of a single, overarching ethical theory, suffer from difficulties of fragmentation and incoherence in presenting

456 Ibid., 106-7.  
457 Ibid. 106.
their approach. By mainly relying on the abstraction of principles and the application of deductive logic and reason in approaching ethical issues of biomedicine, they have made the modern, enlightenment assumption that reason, logic and the abstraction of principles constitute sufficient guidance for the moral life. And they believe that their method can be rendered sufficiently neutral and independent from particular historical, cultural or religious traditions. What results is an ethical system that pays scanty attention to historical and cultural development of the four principles and that totally precludes the religious language or sentiments of the subjects it pretends to address. Dr. Wulff disputes the validity of that stance and calls for an approach that pays more attention to its historical, cultural and religious milieus. Notwithstanding the claim of "common morality" as the starting points of their system, we have also shown that the logical arguments that drive their various positions are derived from particular Western philosophical traditions, namely, utilitarianism, Kantianism and contractarianism.

But the Four-Principle Approach has its merits. One great strength of the system is its provision of detailed rules and procedures. This emphasis is exemplary and probably has proven to be extremely helpful to physicians. In this sense, the Four-Principle Approach is a great cookbook type of guide for biomedical ethics. This must be one factor that accounts for its popularity. The heavy reliance on procedures and rules is an outcome of a conception of ethics whose chief enterprise is the formulation of public policy. It is in this sense that Beauchamp and Childress understand their work as "practical ethics." This emphasis explains why the approach is skewed toward prescribing moral actions over urging the development of

458 Ibid.
moral or virtuous characters in the moral agents. It also provides another explanation for the exclusion of religious language from its ethical discourses; that is the American political ambience of separation between religion and state.

Of course, in this conception of "practical ethics," the scope of the ethical task is sharply reduced. It is an ethics for public convenience or political expedience, one that trumpets the enlightenment notion of "death of God," and is quickened by the postmodern notion of "death of man," as Englehardt perceives of ethics in the postmodern era.

In stark contrast, May has deliberately chosen a method of symbolic imagery to present his views in biomedical ethics. It is a method that appears unconventional, particularly in light of the traditional philosophical discourses of deductive logic and abstraction. There are several advantages to this method. First of all, symbolic imagery retains well the context that gives the image shape, and is particularly suitable to carry a complex of thought, idea and feeling. This ability must have contributed to the great sense of wholeness in the Medical Covenant, in contrast to the difficulties of fragmentation and incoherence in the Four-Principle Approach. This advantage in particular is what is missing in the cold, logical abstraction of principles. Of course, logical abstraction of principles has the advantage of clarity that defies the fuzziness of symbolic images. In employing symbols as a method of philosophical discourse, one needs to take time and effort to clarify the contexts, stories and meanings of the symbols. This, fortunately, is what May has done. He uses four other symbolic images to clarify the tasks of the physicians besides the covenant, and he takes time and effort to criticize them. Furthermore, symbolic
imagery has unitive, heuristic and creative values, as it organizes the receiver's experience and enlarges it.

As mentioned in our analysis, this function of symbolic images suits May rather well, for he sees the task of ethics as a corrective vision. The seeing function or the illumination function of ethics is so important to May as to constitute a fundamental difference in his conception of its task, compared to that of Beauchamp and Childress. The purpose of ethical theory is not just to prescribe what to do, eliminating moral quandaries, but to open up "a wider horizon" for its readers.

The source of the Medical Covenant is, needless to repeat, distinctively Judaic-Christian. Unlike Beauchamp and Childress who choose to obscure their particular Western philosophical reasoning with the veil of "common morality," May frequently makes direct allusions to the Christian Scripture as a source, or for examples. This is important as many scholars (McDonald, Meek, Wulff etc.) recognize the influence of our cultures and traditions on our particular outlooks. No one stands completely neutral of his or her cultural and historical heritage. In pursuing philosophical discourses, this impact can be mitigated if we acknowledge this phenomenon and make honest attempts to understand it. In revealing his religious source, May, however, is sensitive enough not to bombard his readers with religious jargon. He chooses to use language that appeals to general readers, and he uses familiar stories from well-known literary figures (Hemingway, Faulkner, etc.) to bridge the gap. For May, his readers will appreciate his honesty and sensitivity and, perhaps, understand his message better, given its roots.

459 Ibid.
However, there is another reason for May to make allusion to the source of the Medical Covenant. One important element of the Medical Covenant is the transcendent, who bestows the initial gifts of life and nurture to all humankind. For covenantal ethics is responsive in nature, where a person's moral motivation for his or her fellow human beings is his or her ultimate indebtedness to the grace of God. It is this ultimate indebtedness to the transcendent that exceeds and transcends all calculation of human gifts and debts, that enables covenant fidelity to our fellow human beings to persist or persevere even with the erosion of fate and time. In choosing a biblical image as his method of biomedical ethics, May is not willing to concede to the enlightenment notion of "death of God" and the post-modern notion of "death of man." Unlike the Four-Principle Approach, the notion of the transcendent and man in the setting of a relationship occupies a chief place in the Medical Covenant.
Conclusion
A Corrective Vision?

We have come toward the end of our journey. It is not a benign journey into the serene countryside where everything that meets the eye seems extremely agreeable. The journey that we have gone through is markedly tumultuous and stirring to the soul, at least for those who retain a deep concern for the plight of the seriously ill and their families. It is a journey into the contemporary forum of biomedical ethics, where issues of life and death are debated and concepts of self and identity challenged. In the journey, we have visited two camps of contemporary biomedical ethics in particular: The Medical Covenant and the Four-Principle Approach. We have chosen four topics with which to compare their respective positions and unpack their arguments and logic. In the last chapter, we have analyzed their methodologies and compared some of their salient features. Let us recall the questions that we asked of ourselves at the outset of our journey: Is the Medical Covenant a corrective vision to bioethics as reflected in the Four-Principle System? If so, in what ways? We may not have exhausted every aspect of their philosophies or dealt with every issue that interests them, but I believe that we have explored sufficiently and that we are in the position to give some credible answers to such questions now.

For readers of this dissertation, even those who have read cursorily, the answer to the first question, we believe, is not shrouded in mystery. The readers probably have already accumulated some sense of direction for the answer to the first question. Is the Medical Covenant a corrective vision to the Four-Principle System? To put it simply, the answer that we'd like to posit is "yes", but as is probably the case with all simple answers in philosophy, it needs clarification and qualifying.
Recall at the outset, we suggested that we would use three key questions to guide our comparison. The three key questions, as a result of our exploration in Chapter One, emerge from a conviction that bioethics arises as a response to human concerns. They are concerns for the seriously ill and their families as they are forced to confront difficult and puzzling ethical dilemmas that result from the advances of science and the harsh reality of economics. Few, if any, professed bioethicists would disagree with this premise, although they may profess mixed directions for the discipline, like forging public policy. Our authors, Beauchamp and Childress, in stating the objective of their work, Principles of Biomedical Ethics, do not seem to object to this premise: "Scientific, technological, and social developments ... challenged many prevalent conceptions of the moral obligations of health professionals and society in meeting the needs of the sick and injured. The objective of this book is to provide a framework for moral judgment and decisionmaking in the wake of these developments."^460 (Italics mine) Likewise, William F. May, in the introduction to his book, The Patient's Ordeal, declares, "This book attempts to reactivate an earlier moral tradition: it seeks to reckon with the moral problems which the patient and the patient's family face."^461 (Italics mine) It is important to remind ourselves of this rudimental conviction, for, in the labyrinth and depth of theoretical abstraction, we oftentimes lose sight of this simple truth.

In this final section of the dissertation, we shall go through the four topics (the first two parts) and summarize the ways in which the Medical Covenant, relative to the Four-Principle approach, illuminates the understanding of, or opens up "a wider horizon" for, those who seem to be caught in the depths of moral dilemmas so

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^460 Principles of Biomedical Ethics, 3.
^461 The Patient's Ordeal, 3.
that they can see clearly alternative visions or options. At the end of that, we shall pose the three key questions identified in Chapter One to assess how these alternative visions or options are indeed "corrective," in the sense of the primary motive of the bioethics enterprise - a resolution to address human concern for the very ill and their families. After that, we will finish with a brief summary of other findings that include those from the comparison of methods and other sthat we happen to encounter along the way.

**Euthanasia**

Under this topic, the "unpacking" process of the previous chapters really helps us see that there are at least three vantage points that the Medical Covenant has opened up for us. Beauchamp and Childress, in the zeal to advance their position for AVE, as we recall, advocate an account of utility to explain why killing is wrong when it is wrong. In Beauchamp and Childress' terms, what is wrong in killing becomes a calculus of the deprivation of the enjoyments of and setback in the participation in the goods of life. AVE becomes justifiable when the patient who requests it no longer has an interest in participating in the goods of life. In that sense, killing is not wrong and occupies no different moral status than letting die. AVE becomes justifiable as long as proper informed consent procedures are followed such that the request is within the patient's autonomous choice.

However, the first vantage angle opened up by the Medical Covenant is the matter of moral agency. In the account of Beauchamp and Childress, the moral agency of the killing act, albeit with a mercy motive, no longer matters, because, as Beauchamp and Childress argue, killing and letting die achieve the same result and practically have the same moral status. The Medical Covenant, however, insists on
the relevance of moral agency. The distinction between killing and letting die is a
distinction of moral agency, where in the former the moral agent is human and the
latter, nature. Nature has reign in matters of life and death. From the time of human
origin until today, this still remains true. Notwithstanding the advancements of
science and the genetic revolution, in those matters human are still not in charge. In
considering euthanasia, the Medical Covenant calls to our mind respect for that line,
drawn between nature and human, which the saneness of humanity has religiously
upheld since the dawn of time.

Secondly, Beauchamp and Childress and their likes, in their rush to justify
AVE, have a tendency to fight suffering at all cost, though that is not explicitly stated
as a goal in the Four-Principle Approach. But that is precisely a weakness of the
Four-Principle Approach. For without a stated goal for the profession of medicine,
the autonomous choice of the patient becomes de facto the goal of the moment,
whatever it is. Hence fighting suffering and/or fighting death at all cost become the
tendency manifested in their approach, because either one could be the tendency of
the seriously ill patient, depending on his/her disposition in the mishap. In contrast,
the Medical Covenant reminds us of the central goal of medicine, whose duty is to
uphold and nourish the wholeness of the patient. Indeed, the terminally ill patient
may be called to face the calamity with fortitude rather than to opt out with a quick
exit. The Medical Covenant eschews neither death nor suffering as absolute evils,
as Christ triumphed over death at the Cross and faced suffering with great fortitude.
With the guidance of this more wholesome goal, the caretakers, the physicians and/or
the family can continue their care for the patient, providing support at the end stage
of his or her life, so that they can face it with similar courage and dignity. For many
terminally ill patients who are also in great pain, the Medical Covenant indeed, holds up an alternate vision.

Thirdly, the dominance of the principle of respect for autonomy in the Four-Principle Approach with regard to euthanasia may obscure the duty of society to provide chronic care. In too readily ceding to the euthanasia request of the autonomous, informed patient, the mercy of the moment may be a consequence of the poor record of chronic care in the community. In other words, the patient may have requested euthanasia due to the cruel prospect of poor chronic care awaiting him or her. Thus, May rightfully asserts, "To put it bluntly, a country has not earned the moral option to kill for mercy in good conscience if it hasn't already sustained and supported life with compassion and mercy." The Medical Covenant, with its promised fidelity to the patient, has unveiled this blind spot for us.

**Assisted Suicide**

In the matter of assisted suicide, the issue may not be entirely one of paternalism versus patient's autonomy, or of life versus quality of life, as the debaters or the Four-Principle Approach would have us believe. Framed in this way the debate quickly reaches an impasse. The Medical Covenant illuminates a third alternative. This alternative calls for understanding from two vantage points. First, the promise of covenant fidelity challenges us to see the patient's plight in a rebirth/reconstruction-of-self framework, whose impact and essence can never be captured in a life-versus-quality-of-life perspective. The case they use in their examination of this topic is Dax's case. According to May, what Mr. Cowart faced was a death of his old self. What Mr. Cowart faced was a rebirth and a reconstruction of self after the calamity, and the loneliness and darkness of that
future. If the healing community sees it more accurately in this light, we may understand why Mr. Cowart so adamantly wanted to kill himself. Secondly, as a community, we may therefore understand the healing task better and rally for an ethics of care that pledges to walk the long recovery path with him. Perhaps, in this way, as May sees it, Mr. Cowart may not be so insistent to die. However, had we only the cold, abstract formulation of the principle of respect for autonomy of the Four-Principle Approach, Mr. Cowart's death wish would have been granted, and his flourishing as a lawyer and a married man eleven years later would have been non-existent. Although the principle of respect for autonomy had been right in this case (as Mr. Cowart insists that it is), it certainly has not been proven good or beneficial (as Mr. Cowart testifies that he is glad to be alive). The promise of fidelity to the patient, to the wholeness of his being, demands more than just being right.

**Health Care Reform**

In the U.S., as most medical practitioners and ethicists would agree, the health care system is in dire need of reform. We may even agree, roughly, on what kind of reform the system needs. There is little dispute that universal access and some kind of basic health coverage are the goals of reform. However, the Four-Principle Approach following a contractarian argument that basically is Rawlsian fails to champion a *moral* mandate for the reform. For centered in that argument is an appeal to self-interest. If people, in the "original position" behind a "veil of ignorance," perceive that they will be the ones in need of universal access and basic health care, they will opt for such reform, so goes the theory. But such a theory of justice does not work in real life, and the U.S. situation is there to prove it. Self-

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462 Testing the Medical Covenant, 28.

463 See Chapter Five, Section 5.1 of this dissertation.
interest continues to operate after the "veil of ignorance" is removed and what was regarded as "unfair" in life in the "original position" will be regarded as merely "unfortunate," particularly for the majority who fare better in life. In their mind such things will probably better be handled through other means like charity rather than a forced government program. Thus, after all the commotion, health care reform of the sort described here is still nowhere in sight.

The Medical Covenant takes its readers on a different route in order to achieve the needed health care reform. The route that May attempts to take the American people on is a return to their foundation as a people. The founding of the American nation rested on a national covenant of a people free and equal, united and toiling for the future and for the common good of the community. In this regard, the Medical Covenant is distinctively communitarian. This is a far cry from the contractarian assumption that people in a city or state are strangers banded together for political tranquility and convenience. The central thesis of the Medical Covenant for health care reform in the U.S. is the rediscovering of our common tie as a people. As members of the community, we ought to be outraged morally to see some people flourish while others wither for lack of medical assistance. The Medical Covenant affords us a vision of communal ties obscured by the contractarian assumption of a society of strangers.

By way of dealing with this topic, the distinction between contract and covenant is again in sharp focus. Contract works with a group of strangers banded together politically for self-interest, whereas covenant assumes a community of people bonded together by moral ties, always, on the lookout to serve the other person's interest. Contract works temporarily as long as self-interest remains mutual.
Therefore its enforcement is political or legal. The promise of covenant, fidelity, however, endures as long as the communal ties exist, and its enforcement is moral. Health care reform pursued from the contractarian perspective ultimately degenerates into a political game, and that's what Childress has conceded. The lack of moral force must account for the fact that various health care reform proposals failed in the U.S. by the year of 1996.\textsuperscript{464} The Medical Covenant reminds Americans of their moral responsibility for the health concerns of the weaker fellow members in the community.

**Physician-patient relationship**

As our exploration goes, the ethics in the physician-patient relationship amounts to a set of rules, veracity, privacy, confidentiality and the like, in the Four-Principle Approach. These rules do not arise from the relationship, but rather they are derived from the four principles. The Medical Covenant, on the other hand, grounds biomedical ethics in the physician-patient relationship. The Medical Covenant envisions the physician-patient relationship as central in biomedical ethics. By virtue of the fact that the physician and patient enter into a healing relationship, they are in association with each other in a covenant. All the features of the Medical Covenant will be at work in that relationship.\textsuperscript{465} The significance of grounding ethics in the relationship is the re-coupling of moral actions and their moral agents. In the rule-oriented mindset, the actions reign supreme. Whether they are moral or not depends on whether the actions comply with the rules. We applaud the decisions or actions as long as they comply with the rules or principles, regardless of their effects on the humans. Mr. Cowart in Dax's case is a case in point. In the Four-Principle

\textsuperscript{464} Testing the Medical Covenant, 116.
\textsuperscript{465} See Chapter Five, Section 5.2.2 of this dissertation.
Approach, as long as the principle of respect for autonomy is satisfied, it is just too bad if Mr. Cowart dies, and his mother’s hope for the flourishing of her son is buried with him. The moral agents and their concerns fade from the scene. In this sense, the patient's decisions or actions serve the rules or the principles. The Medical Covenant in the mind of May is obstinate in his opposition to this. The moral agents - human concerns - are paramount in the bioethical enterprise. They are what give rise to the enterprise in the first place. Rules and principles are supposed to be there to serve human concerns in medicine. The Medical Covenant's promise of fidelity to the patient demands that. Therefore, in contrast to Beauchamp and Childress who are fond of compiling rules and procedures, May is often equally faithful in producing lists of virtues for the physician, the sick or the elderly - the moral agents. The Medical Covenant, by positing centrality for the physician-patient relationship, always has the patients' beings, in term of who they are, in primary focus.

Such is a summary of the reasons why we conclude the Medical Covenant indeed opens a wider horizon for contemporary biomedical ethics, in which the Four-Principle Approach serves as the chief paradigm. In each and every topic that we have examined, the Medical Covenant opens up alternative options and does indeed insist on an ethics that touches on the deeper side of humanity. One need not agree with the source, (although the author of this dissertation does), the Christian bible, that gives the Medical Covenant its inspiration, but the reasons or the arguments with which May chooses to present it are not particularly dependent on sectarian or religious appeals. His references to the bible or bible stories, of course, help illuminate the origins of the thinking and concepts that underlie them, but they are
not absolutely necessary for their acceptance. That is why May sometimes introduces these references at the end of his thesis or presentations. The method (of symbolic imagery) with which he chooses to present the Medical Covenant is very illuminative of this approach. Besides many technical advantages, which we have explored quite briefly in the last chapter, the technique of symbolic imagery is unique in its ability to present a complex of thoughts, ideas, feelings, or principles preserved in its context that appeals to our common experiences. It has the ability to preserve things in their essential whole, which retains a stronger resemblance to our real life encounters. May's frequent use of literary stories from well-known literary figures serves to further strengthen this point. The moral features or ethical concepts of the Medical Covenant are not so esoteric or sectarian after all, but are deeply embedded within the fabric of our cultures, rituals and societies, as many of these literary geniuses have uncovered.

The Test of Relevancy

But to rediscover these concepts embedded in the Medical Covenant, we need to look further than what the principles have abstracted, or what their proponents have staked out as the scope or affair of bioethics. We need to go back to the fundamental element that gives rise to the enterprise: human concerns. If we agree with that, then one of the chief measures of the success of a bioethical theory of approach is this question: how well does the theory or approach address these concerns? It is a question of relevancy. Regardless how neatly, elegantly, coherently, comprehensively or practically the theory or approach is constructed, a successful theory or approach must pass the test of relevancy. Therefore, in order to assess if the Medical Covenant provides a corrective vision to bioethics, relative to
the Four-Principle Approach, the same question or relevancy test applies. Are these alternate options or visions unraveled by the Medical Covenant relevant? Are these alternate options or visions helpful in addressing the human concerns that give rise to bioethics in the first place? In answering this test, we will also use the other two key questions identified in Chapter One to aid our assessment. These two questions can also shed light on the relevancy test.

If we frame the test in this manner, we can again see that the answer to the relevancy question is "yes." Briefly, on the topics of euthanasia and assisted suicide, the Medical Covenant unveils the important duty of chronic care to the suffering or dying patient. If the prospect of chronic care to the patient is not as dismal as she perceives, the patient may not need to request euthanasia or assisted suicide. George Anders has similar insight regarding the "managed care" movement. One of the measures of success for the movement must be its ability to care for the very sick, not just the majority of healthy subscribers. In a cry of compassion, George Anders urges, "Reviewers must gather data on HMO's performance in treating serious diseases. They also should pay close attention to what chronically ill people say about their HMOs."466 Chronic care for the very sick or dying is a relevant issue that proponents of euthanasia are too quick to bypass. In both topics, the Medical Covenant re-focuses for us as the goal of medicine the wholeness of the patient. Death and suffering are not absolute evils. The patient, with help from the ethics of care, may go through them with courage and dignity.

In health care reform, the Medical Covenant reminds us of the fact that we are not strangers who happen to sojourn in this society together. We are fellow

466 Health against Wealth, 258.
members of the community with ties of fellowship or brotherhood. Health care for other less fortunate members of the community is our *moral* concern. All of these are deeper, relevant human concerns that the Medical Covenant is relentless in recovering, and human concerns are what give rise to the bioethics enterprise in the first place.

The second key question that will also illuminate the relevancy issue is this: what is the purported goal of the approach for the medical profession? One of the fundamental issues that surfaces from this comparison is the conception of the ethical task in biomedicine. The principlist approach to ethics has a tendency to screen or abstract out many of these elements of human concern, (the person, motive, virtues or the transcendent), and leaves us with an ethics that is reductionistic and minimalistic at the bidding of the political expediency of "practical ethics." In their attempt to formulate an approach to bioethics that will be instrumental in forming public policy in a pluralistic society, the purported goal for the medical profession is intentionally left unclear or mixed. Sometimes one wonders if the ultimate aim of the Four-Principle Approach is to aid in forming public policy or to aid in the bioethical decisions of the very ill and their families. That ambivalence is a direct consequence of their avoiding the service of a single, overarching ethical theory or moral tradition as a guide in their approach, as has been pointed out in the previous chapter. Therefore, we will not see an overriding goal for medicine specified in the Four-Principle approach. To do so, Beauchamp and Childress will have to commit to some kind of lexical order for their four principles, which they systematically try to avoid. They want to maintain "[t]he latitude to balance principles in cases of conflict
... [leaving] room for compromise, mediation, and negotiation." An overall goal for medicine is perceived by Beauchamp and Childress to work against that. The omission of a specified overall goal for medicine certainly leaves the Four-Principle Approach with great latitude. It also leaves the approach a great amount of indeterminacy in cases of conflict, as beauchamp and Childress' critics are quick to point out. But such becomes an ideal setting for forming public policy, because a certain amount of latitude is needed for compromise and negotiation in the public arena. And that is part of the ethical task conceived by Beauchamp and Childress. Unfortunately, the nature of public policy is to provide a minimum framework for bioethics and an emphasis skewed toward rules, procedures and actions. It is unlikely that the resulting policies will address thoroughly the issues of the moral agents and deeper human concerns. Thus the goals of forming public policies for bioethics and of medicine itself are not entirely identical at times. Failing to specify their priority or allowing them to remain mixed is unfortunately a weakness of the Four-Principle Approach and is seen to weaken the approach's resolve to serve the human concerns of the ill and their families. By upholding an overall goal for the medical profession - the wholeness of the patient, the Medical Covenant is definitely corrective in its attempt to recover the priority of the human aspects. True, we need a practical level of ethics, as May never denies it. But the Medical Covenant simply says that it is not enough and certainly not the entire picture.

The third key question that will aid our relevancy test is: what kind of physician-patient relationship does the approach or theory posit? The reason that this question will help us see whether a bioethical theory or approach addresses human

467 The Principles of Biomedical Ethic, 105.
concerns adequately is obvious. If human concerns are held up as a priority, the relationship will receive primary focus in the approach. As we have an entire section addressing this topic, we probably don't need to elaborate the conclusion here. It will suffice to restate the respective positions on this topic. In the Four-Principle Approach, the physician-patient relationship is seen as a cluster of rules, derived from the four principles. The Medical Covenant views the relationship as central in bioethics. The respective positions of course give us an idea what is the primary focus of the approaches. A rule-oriented mindset like that of the Four-Principle Approach concentrates on actions and their consequences. The Medical Covenant, with its promise of fidelity to the patients, is again corrective on what or who should receive the primary focus in the bioethical enterprise.

Thus the Medical Covenant passes the relevancy test and is deemed a "corrective vision" to the Four-Principle Approach as a dominant paradigm of bioethical methods and theories. Of course, it is corrective in the sense that we believe the chief enterprise of bioethics is tending to the ethical concerns of the very ill and their families. Although many bioethicists or medical professionals would agree with that premise, many may still waver under the pressures of forming public policy in a pluralistic society and/or under the grind of the wheel of economics to reduce costs. Although these two are also admirable goals, patients and their families, the medical profession and society at large need ethical guidance in determining their relative importance. For this task, the Medical Covenant performs beautifully. For with its more wholesome goal, its unflinching promise of fidelity to

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468 For a fuller explanation, the readers are referred to Chapter Six, Section 6.1.2.3 titled Procedures, Rules and "Practical Ethics."
the patients, the Medical Covenant offers not only a wider horizon of bioethical options for them, but also greater hope.

**May’s Difficulties**

Although this dissertation has affirmed to a large extent the corrective function of the Medical Covenant to contemporary bioethics, we do so not unaware of some of the difficulties that it has already encountered. May’s difficulties lie in three categories: 1) method, 2) world-view, 3) practicality.

As mentioned in this chapter, May’s method of image and symbol, though an age-old method, appears nevertheless novel to the modern Western philosophical tradition, which is mainly dependent on logical deduction and abstraction for its discourse. May’s unconventional method, however, seems to alienate some of his colleagues in the field. For example, Joel Feinberg expresses candidly his frustration with May’s symbolic language: “Indeed, both May and Ramsey, ... approach these urgent questions more in the manner of literary critics debating the appropriateness of symbols than as moralists. One wants to remind them forcibly that while they distinguish among symbols and sentiments, there are people out there suffering and dying.”

Feinberg’s frustration with the use of symbolic language is by no means unique. K. Danner Clouser in criticizing Robert Veatch and May’s use of models, (as forms of symbol and image), also appears to be impatient: “The models are whimsical gestalts which obscure the crucial moral points that could have been made with clarity and crispness... Yet it is not really clear in any of the models precisely what the moral failing is. Moral points float about here and there but are lost in the

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469 Feinberg made this remark while discussing the issue of salvaging organs from newly dead bodies for transplanting purpose in “The Mistreatment of Dead Bodies,” The Hastings Center Report, No. 15, vol. 1, 31-37
miscellaneous details of the model.470 For this strand of philosophers and moralists, moral points can only flow out of neat, logical deductions. As we have demonstrated in this chapter, symbolic language has its place in the world of ideas and is able to capture complex thoughts and contexts in a wholeness fashion that sometimes eludes methods of pure logical deduction. Nevertheless, May would face considerable difficulties here, since his readership is likely trained in the modern Western philosophical traditions, which pride themselves on propositional, logical and deductive method of moral discourse.

A second area of difficulty that May would encounter is in terms of worldview. As our comparison has revealed, the chief difference between the Medical Covenant and the Four-Principle Approach lies in their respective world-views. As we have shown consistently, what is behind the Four-Principle Approach is not “common morality,” but a consortium of several Western philosophical world-views, namely, Kantian liberalism, utilitarianism and the Rawlsian contractarianism. All of them, despite their philosophical differences, reject a notion of the transcendent as a chief tenet of their moral systems. Since May is careful enough not to parade the notion of the transcendent up front, the Medical Covenant loses considerable religious motivational strength as it seeks to gain a wider readership. Of course, this may be a calculated trade-off that May is willing to accept as he assumes his current position.

As expected, May’s writings have achieved considerable influence among peers that have a similar world-view. In his article “On William F. May,” Meilaender notes the fact that in the fifteen-year history of The Hastings Center

Report, one of the premier journals in the field. May was the only author singled out twice by figures well known in the world of medical ethics for writings that made a difference. One must note, however, the two well-known figures that conferred this honor on May’s writings are Alexander Morgan Capron and Robert Veatch. Both of them show a certain affinity to a Christian outlook in their own writings. However, his reception among colleagues of other stripes – ethicists who are unsympathetic to the concept of the transcendent – are not as positive. K. Danner Clouser and Joel Feinberg, cited above, are such examples. Sumner B. Twiss, aware of the limitation of May’s source of ethics, which is mainly Christian, has cautioned “The fact is that we live amongst post-modernists, Buddhists, and likely many others who would resist May’s understanding of the unified and engaged self, and this fact suggests that a basic element in May’s moral framework may be too parochial, if he hopes to see his ethic of care more widely applied.” Twiss enters this cautionary note while admitting that he is “frankly attracted to May’s vision and ethic.”471

Henceforth, May’s difficulty lies in the fact that part of the persuasive power of the Medical Covenant also draws from the well where it gains its inspiration – that is the Christian world-view. The factor of faith in the transcendent was paramount as a motivating force in the original Sinai Covenant. The fact that the Israelites saw themselves as sinners in dire need of deliverance also serves as a strong motivating factor for the upkeep of their covenant with God. When May deliberately puts these religious factors aside and replaces them with social ones (e.g. indebtedness to society, etc.), the Medical Covenant automatically loses significant persuasive power, particularly to an audience who does not share the Christian world-view.

A third area of difficulty for May is practicality. For many medical practitioners, this would be the most glaring weakness of the Medical Covenant. Unlike Beauchamp and Childress, who labor to put together pages of rules and procedures for all kinds of anticipated situations, May writes on a conceptual level. For May, it is more important to assemble lists of virtues, for the sick, the elderly, the physician, and the terminal patient. The Medical Covenant may open up many alternative visions, but they are still mostly on a very generic level that does not tell one what to do in a quandary situation. Meilaender makes this observation about May: “If we want cut-and-dried answers we will, of course, sometimes have to turn elsewhere. There can be no doubt that we sometimes need such answers and that May’s greatest strength does not lie in supplying them.”

Ron Hamel also complains, “Though the covenant concentrates on the nature of the interaction between physician and patient, it does virtually nothing to illuminate the contexts of the interaction, particularly the clinical context, its multiple participants, its components, its variability and its dynamic.”

Perhaps that is why May never claims to have constructed a comprehensive system of biomedical ethics. His goal is not to replace, but to provide a corrective vision to what is currently available.

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Other Findings

Besides answering the chief question posed for this dissertation, the journey also affords us glimpses of other findings that are germane to our interest. We find at least four such findings worthy of our notice. We will do no more than just to repeat or summarize them here at the end.

One significant finding pertains to the respective methods Beauchamp and Childless and May employ. The methods they choose to present their views, we discover, are very much indicative of their respective philosophies and conceptions of bioethical tasks. The Four-Principle Approach is conceived not just to do bioethics, but to do bioethics with the forging of public policy in mind. Hence we see a concentration on abstract principles, rules and procedures and a repudiation of a single overarching moral theory or tradition. In the mindset of public policy, actions are what count the most. Thus moral agency fades into the background. The Medical Covenant is interested in centering the bioethical enterprise on the physician-patient relationship, and in recovering all the attendant principles, feelings, contexts, ties, and complexes of thought. Moral agency is important in this scheme. Hence we see May's employment of the covenant image and a comprehensive compilation of lists of virtues.

Another finding is related to the first one. Because of Beauchamp and Childress' interest in forging public policy, the Four-Principle Approach easily succumbs to the vogue of systematically shunning religious concerns. Religious sentiments occupy an important sphere in situations of bioethics, as many common people can testify. Their aversion to this sphere of life without justification is a
puzzle to the readers. The Medical Covenant, being rooted in Christian Scripture, recovers that, and therefore, the notion of the transcendent is paramount in May's approach as the primary giver of the various gifts of life, to which the physicians and patients alike are indebted.

A third finding is a significant one. The "common morality" from which the four principles originate are not so common or universal as Beauchamp and Childress would like us to believe. As our analysis shows, they exhibit great affinity to Western cultural and philosophical traditions, particularly to the historical and social developments confined to the American soil. Another important piece of information really surfaces out of this analysis, or what we call the "unpacking" process. The engine that drives the deliberation process of the Four-Principle Approach is not the four principles of the so-called "common morality," but a consortium of several Western philosophical traditions, namely, Kantian liberalism, Mill's utilitarianism and the Rawlsian contractarianism. When to use which, unfortunately, is not within the grasp of the Four-Principle Approach, but, according to Beauchamp and Childress, is dependent on "experience and sound judgment."

Fourthly, the Four-Principle Approach, despite its shortcomings as outlined throughout this dissertation, is really quite practical and comprehensive in terms of rules and procedures given. This we think must be an important factor that contributes to its popularity. The Approach touches on almost every aspect of the bioethical decision process. What it lacks as contrasted to the Medical Covenant are really issues of depth nature. Its comprehensiveness and practicality are something that the Medical Covenant must aspire to if it is to open a "wider horizon" for its own future.
Selected Bibliography

A. Books

I. Bioethics


Sharpe, Virginia A. *How the Liberal Ideal Fails as a Foundation for Medical Ethics or Medical Ethics "In a Different Voice,"* a Ph.D. dissertation, 1991.


II. Covenantal Social Ethics


III. Covenant Theology


III. Literature


IV. Moral Philosophy

V. New Testament Ethics and Theology

Barth, Karl *Church Dogmatics II* trans. T. H. L. Parker et al., Edinburgh: T & T Clark, 1957a (1946)
________. *Church Dogmatics II*, trans. G Bromiley et al., Edinburgh: T & T Clark, 1957b (1946)


VI. Old Testament Ethics and Theology


B. Articles and Essays

I. Bioethics


Kass, Leon R. "Regarding the End of Medicine and the Pursuit of Health." The Public Interest, 40 (1975)


II. Covenantal Social Ethics


III. Covenantal Theology

