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COMMENTARY

MAKING PRINCIPLISM PRACTICAL: A COMMENTARY ON GORDON, RAUPRICH, AND VOLLMANN

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In their article in this issue, John-Stewart Gordon, Oliver Rauprich, and Jochen Vollmann examine the justifiability and practicality of principlist theory. The authors show a solid grasp of the theoretical foundations of principlism, and they make an original contribution to literature on the use of case studies in the four-principle approach. I substantially agree with the authors' conclusions and the path taken to reach those conclusions. Nonetheless, I will raise questions that need more attention than they receive in this article. One problem is whether their analysis is applicable only to principlism or is applicable more broadly to other areas of practical ethics. Another problem concerns whether they need to make modifications in their conception of how moral reasoning should proceed when principles come into contingent conflict.

Section 1 in the article treats the main case of a seriously compromised and mildly depressed patient, Maria; and Section 2 concentrates on how to think through this and other cases, that is, how to apply the four-principle approach. The authors omit discussion of moral directives that are less general than principles such as moral rules, guidelines, codes, and regulations (which can themselves be assessed for adequacy on a principlist account). However, this omission does not detract from the methodological thrust of the article, because contingent conflict situations occur at all levels of generality, and principlist *methods* are invariant across the levels of generality in conflict situations.

A related problem is whether the methods of handling contingent conflict and the application of general norms – as presented by Gordon, Rauprich, and Vollmann – affect only principlist theory. Their arguments can without difficulty be interpreted as general lessons in 'applied ethics', despite the fact that the methods under discussion are those that have been proposed in the literature by principlists. As long as the focus is solely on the four principles and their application, then nonprinciplist alternative moral theories or frameworks (e.g. Bernard Gert and Danner Clouser's theory) will not come under discussion. But other accounts could easily be included in the scope of the arguments in this article. Nothing is unique to principlism when it comes to contingent conflict, balancing, and specification of general norms. Put another way, Gordon, Rauprich, and Vollmann could make the claim that the methods they identify are the methods required for any successful applied ethics, or at least required for any account that starts from norms of obligation. This claim is defensible, and I would like to see them head their arguments in this direction.

When discussing decision-making in the case of Maria, the authors invoke the method of specification. They are right to say that the 'method of specification and the method of balancing are the main tools for enriching the abstract and content-thin universal principles' proposed in principlist theory. Since the authors do not explain what specification is, a short explanation of it here may prove helpful. Specification is a methodological tool that adds content to abstract principles, ridding them of their indeterminateness and providing action-guiding content for the purpose of coping with complex cases. Many already specified norms will need further specification to handle new circumstances of indeterminateness and conflict. Incremental specification can progressively reduce circumstances of conflict to more manageable dimensions. This increase of substance is essential for decision-making in clinical and research ethics. Otherwise, abstract principles cannot be carried to the ground and will not be serviceable for the resolution of cases.

Specifying norms is achieved by narrowing their scope, not by interpreting the meaning of terms in the general norms (such as 'autonomy'). The scope is narrowed, as Henry Richardson puts it in his pioneering work on the subject, by 'spelling out where, when, why, how, by what means, to whom, or by whom the action is to be done or avoided.'[1] A definition of 'respect for autonomy' (as, say, 'allowing competent persons to exercise their liberty rights') clarifies the meaning of a moral notion, but it

[1] Henry S. Richardson. 2005. Specifying, Balancing, and Interpreting Bioethical Principles. In *Belmont Revisited: Ethical Principles for Research with Human Subjects*. J.F. Childress, E.M. Meslin & H.T. Shapiro, eds. Washington DC: Georgetown University Press: 205–227.

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does not narrow the scope of the norm or render it more specific and practical. The definition is therefore not a specification.

The authors' treatment of the conflict at work in the case of Maria's desperate circumstance conforms to this conception of specification. The authors say that specification has the potential to enrich moral analysis of, and even 'solve', the problems in the case. I agree with the general direction of their argument, and in particular I support their attempt to reconcile the different points of view that arise in the case. I also agree with their resolution of this case: 'It is hard to see how the physician can argue in another [i.e. any other such] well-justified way with regard to principlism.'

Nonetheless, their analysis needs additional clarity regarding which norms are in contingent conflict and how the several norms are specified. They claim that the principles of nonmaleficence and beneficence are in conflict, and they also suggest that the patient's point of view in invoking these principles and the physician's point of view in invoking these principles are in conflict. They even speak of 'the differing principles of Maria and the physician'. These claims seem to derive from their view that *Maria* accepts the principle 'Do respect the principle of nonmaleficence,' whereas the physician accepts the principle 'Do respect the principle of beneficence.' However, this confluence of claims and arguments is confusing. The principles in the physician's outlook are not different from the principles in the patient's outlook. They both accept the principles of nonmaleficence and beneficence. They simply have different *specifications* of these principles. That is, the patient does not have *principles* that differ from the physician's principles. Differences arise only because the principles are competitively specified (and with some differences in the interpretation of central concepts).

The conflict in the case of Maria is between the physician's perspective (which by itself coherently appeals, free of contingent conflict, to both nonmaleficence and beneficence and their specification) and the patient's perspective (which also by itself coherently appeals, without contingent conflict, to the principles of nonmaleficence and beneficence and their specification). The conflicting directives reached by the physician and the patient do call for what the authors call a 'deeper analysis' that impartially assesses how to handle the deeper type of conflict at work in the case, and they are right to say that resolution can only be achieved by further specification and/or balancing in light of careful attention to the details of the case.

The authors could have claimed that there is a conflict between respect for autonomy and either beneficence or nonmaleficence (thus highlighting the conflict between patient decision-making and professional beneficence), and I suspect this perspective would have improved the analysis. However, this seems not to be the claim made. They say only that a vital conflict occurs between two competitive specifications of the principle of respect for autonomy. In focusing on Maria's mild depression and her specification of the principle of respect for autonomy, the authors say that 'the line of argumentation concerning Maria's mild depression can be specified as follows: Maria has the right to decide what is in her best interest if and only if her decision is based on her informed consent.' This specification is clearly central to the case, but the claim made is questionable in this form. The more appropriate formulation of the idea is that Maria has the right to decide what is in her best interest if and only if she is acting voluntarily and is competent to make such a decision. This norm descends, by specification, from the more general norm 'respect the autonomy of voluntary and competent patients by following their voluntary and informed decisions about their care.'

The condition of competence is not identical to the condition of informed consent. If Maria is competent, she has the right to decide whether to consent, to refuse, to waive her right by designating a surrogate, and the like. Consent need not be involved in an exercise of the right. This framework allows the principlist to move to the conclusion that Gordon, Rauprich, and Vollmann in fact ultimately reach in the case: 'Maria should be allowed to have her treatment withdrawn.' If Maria is not a competent decision-maker, then another body of principles or specifications would be needed.

The authors next argue that, in Maria's case, 'personal autonomy trumps professional autonomy.' This claim is correct, but at times their formulations suggest that they might be using a general trumping strategy to the effect that whenever genuine exercises of patient autonomy conflict with professional autonomy in decision-making, patient autonomy trumps. However, these authors do *not* make the implausible claim that autonomy is a privileged principle having priority over other principles. They mean to assert only that, all things considered, personal autonomy overrides professional autonomy *in the particular case* of Maria. They do not give any higher place to the principle of respect for autonomy.

This conclusion is exactly in line with the principlist claim that respect for autonomy is not an a priori trump over other moral principles and is simply one principle in a framework of prima facie principles. A theory cannot be principlist while claiming that autonomy always has a privileged priority in circumstances of contingent conflict with professional beneficence. The principle of respect for autonomy has never been treated in principlism as a privileged, overriding principle. Although autonomy is not privileged in this way, it does not follow that a *valid refusal* of treatment by a patient is not a trumping consideration in cases of contingent conflict. Whether valid refusals always trump professional beneficence and

authority is a difficult problem of medical ethics that cannot be considered here. I note only that on the final page of their article (in the conclusion to 'Evaluation 2'), the authors suggest that they might in fact support this particular strong trumping thesis regarding valid refusals, but they do not pause to argue either for or against it.

I am unsure how to categorize and understand the authors' various appeals, throughout their article, to 'dignity' and what is 'undignified'– categories often associated with autonomy, especially in Kant's philosophy. The first three appearances of this notion in their article have to do with a 'dignified death.' Shortly thereafter, the authors shift to the dignity of patients and persons – and from there they shift to a focus on Maria's dignity. Dignity is one of the most frequently mentioned moral notions in the article, yet 'dignity' is not defined or analysed, and it is a moral notion that has never played a role in principlist theory. I suspect that the authors have not made up their mind about either the meaning of the notion or how it might function in their analysis of applied principlism. Most important would be to decide whether dignity is coming through the back door in this article as a fifth principle (in which case we would no longer have a four-principle framework) or whether dignity is to somehow be situated under one or more of the four principles. I think the notion is expendable without loss.

I particularly appreciate the concluding section of this article on 'Common Morality as an Organizing Principle.' I am reluctant to speak of the common morality as a *principle* (rather, it is a collection of principles and rules). However, the authors propose the interesting and promising thesis that common morality can be interpreted as a *meta-principle* rather than a moral principle in the moral framework of principles. This novel idea leads the authors to a provocative contribution of the still thin literature on the common morality and its role in practical ethics. I highly commend the points made about the need for a constraining meta-principle of this sort.

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