



ARTICLE

APPLYING THE FOUR-PRINCIPLE APPROACH

JOHN-STEWART GORDON, OLIVER RAUPRICH AND JOCHEN VOLLMANN

Keywords

principlism, four principles, specification, balancing, common morality, applying principlism

ABSTRACT

The four-principle approach to biomedical ethics is used worldwide by practitioners and researchers alike but it is rather unclear what exactly people do when they apply this approach. Ranking, specification, and balancing vary greatly among different people regarding a particular case. Thus, a sound and coherent applicability of principlism seems somewhat mysterious. What are principlists doing? The article examines the methodological strengths and weaknesses of the applicability of this approach. The most important result is that a sound and comprehensible application of the four principles is additionally ensured by making use of the organizing meta-principle of common morality, which is the starting point and constraining framework of moral reasoning.

INTRODUCTION

The *Journal of Medical Ethics* 2003, a festschrift edition in honour of Raanan Gillon, includes articles on the question of how to apply the four principles – autonomy, nonmaleficence, beneficence, and justice – to different cases in biomedical ethics. Although the essays are interesting, they seem too perfunctory with regard to a thorough application of the principles to different cases. It is striking that there is hardly any literature that is thorough on the question of how to apply the four-principles approach to a special case. This might be for two different reasons: first, the authors pay, in general, rather little attention to presenting a detailed case study, or secondly, there is a systematic weakness in this approach.

Beauchamp and Childress hold a common morality approach, which can be roughly described as follows:

The common morality is the set of norms shared by all persons committed to morality. The common morality is not merely *a* morality, in contrast to other moral-

ties. The common morality is applicable to all persons in all places, and we rightly judge all human conduct by its standards.¹

Furthermore, the justification of the four universal *prima facie* principles rests on the shared considered judgements of persons who are serious about morality. Common morality is the starting point and the constraining framework of moral reasoning. Particular moralities contain non-universal moral norms, which are due to cultural, religious, or institutional sources. These norms are concrete and rich in substance, unlike the universal principles, which are abstract and content-thin. The method of specification and the method of balancing are the main tools for enriching the abstract and content-thin universal principles with empirical data that come from the particular moralities. That is, people from different particular moralities may specify and balance the principles differently by virtue of differing empirical data and sources. Some particular moralities, such as the *Pirates'*

¹ T. Beauchamp & J. Childress. 2009. *Principles of Biomedical Ethics*. Oxford: Oxford University Press: 3.

Address for correspondence: John-Stewart Gordon, Queen's University Kingston, Department of Philosophy, Kingston, Ontario K7L 3N6, Canada. jsgordon@queensu.ca

Creed of Ethics, lie outside the boundaries of the common morality and, hence, are deficient. Beauchamp and Childress seem to claim that the other particular moralities strive for perfection and try to come as close as possible to the common morality. The most developed particular morality is closest to the common morality.

In this article we present a case study using the method of principlism in order to analyze methodological strengths and weaknesses with regard to the applicability of this particular approach. The first part of the article contains the case description, which will be the starting point for the present case study. The second part offers a systematic application of the four-principles approach by presenting different specifications in order to grasp the moral conflict. The third part deals with the issue of how a principlist can deal with a given moral problem after discovering that it cannot be solved by a simple application of the four principles. The fourth part examines the methodological question of whether principlists (can) make use of an organizing or guiding principle in order to decide between conflicting principles. The last part contains some closing remarks.

1. THE CASE OF MARIA²

Maria was a woman from Athens who died at the age of 82. She was seriously incapacitated by arthritis for over two years prior to her death and was also virtually blind following unsuccessful cataract and glaucoma treatment. Maria had been cared for at home by her family, who never complained. Maria's condition deteriorated drastically when she suffered a severe stroke and was admitted to hospital where she fell into a 'semi-coma'. There, Maria was provided with artificial nutrition and hydration by means of a nasogastric tube. According to the physician, no other treatment was appropriate as Maria was very unlikely to recover.

Maria's family visited her at the hospital regularly but they found these visits very upsetting. Maria found it extremely difficult to speak and was very distressed. Right from the beginning, Maria found her situation intolerable and during the first six weeks of her hospitalization she repeatedly expressed her wish to be allowed to die. She did this through the use of signs and hard-fought words, even though this was itself extremely difficult and distressing for her. Maria became increasingly frustrated and made several repeated attempts to remove her feeding tube.

Maria's family knew that their mother had a lifelong aversion to hospitals and medicine. They also felt a duty

to respect her wish to die. After discussing this among themselves, Maria's children decided to approach her physician about the possibility of withdrawing treatment and allowing her to die. The physician made it very clear that he would not consider acceding to such a request. He emphasized that the request would contravene his responsibilities as a physician. Further, he argued that Maria's request should not be taken at face value since Maria had a recent history of mild depression. Maria's family were unhappy with this decision and with the physician's reasoning; they thought that they had no other choice but to accept it.

One week later, Maria fell into a full and irreversible coma. After further discussion with the family, the physician agreed to withdraw nutrition but refused to withdraw hydration. Maria had no complications during the next two weeks; she then died suddenly when she suffered a second stroke.

After Maria's death, her son complained bitterly to the physician about the way his mother had been dealt with. He argued that his mother would have died sooner and would have suffered a great deal less if the physician had agreed with the family's request to withdraw all kinds of treatment when this was originally requested. He claimed that when it is clear that a patient will die soon, the physician's duty is to alleviate the patient's suffering; this means that it can sometimes be wrong to keep a patient alive for as long as possible and at all costs.

The physician responded that hydration was not simply another 'form of treatment' but, in fact, the most fundamental form of care. It was his duty as a physician to provide this fundamental care to any patient. Although he would not unnecessarily prolong a dying patient's life, he strongly believed that allowing a patient to die from lack of hydration could not be considered a dignified and peaceful death. This would, in fact, contravene his duty of care as a physician. Additionally, he argued that such action would be against any Greek medical or religious tradition and against his personal beliefs.

2. APPLYING THE FOUR-PRINCIPLE APPROACH

The following analysis is an attempt to apply the four-principle approach thoroughly to a particular case and may be helpful for the examination of other cases as well. In the case of Maria, we detected two main differing views: (i) the principle of nonmaleficence (as interpreted from Maria's and her relatives' view) and the principle of beneficence (as interpreted from the physician's view) are conflicting, and (ii) the persons concerned interpret the principle of autonomy differently. Both points are addressed in order.

² M. Parker & D. Dickenson. 2005. *The Cambridge Medical Ethics Workbook: Case Studies, Commentaries and Activities*. Cambridge: Cambridge University Press (abridged version): 4–5.

(i) Nonmaleficence and beneficence

Both Maria and the physician agree that there is no chance Maria will recover and that she will die soon; hence the goal is not to prolong life but to provide appropriate care at the end of her life. However, according to Maria, nutrition/hydration is harmful because it prolongs suffering, and therefore a dignified and peaceful death means – with regard to her present situation – allowing her to die by withdrawing treatment. According to the physician, artificial nutrition and hydration is not just another form of medical treatment but the most fundamental form of care which a terminally ill patient should receive by any means. It is a necessary condition for a dignified and peaceful death. To withdraw hydration and nutrition would undermine the patient's dignity. This conflict can be specified as follows:

Maria

1. Do respect the principle of nonmaleficence.
2. Do respect the principle of nonmaleficence by not harming another person.
3. Do not harm another person by violating another person's dignity.
4. Do not violate another person's dignity by preventing a patient who will die soon from dying in a dignified and peaceful manner.
5. Do not prevent a patient who will die soon from dying in a dignified and peaceful manner by providing life-sustaining treatments which prolong suffering.
6. Do not sustain the life of a suffering patient who will die soon by providing artificial nutrition and hydration.

Physician

1. Do respect the principle of beneficence.
2. Do respect the principle of beneficence by promoting good.
3. Do promote good by promoting/enabling dignity.
4. Do promote/enable dignity by letting a patient die in a dignified and peaceful manner.
5. Do let a patient die in a dignified and peaceful manner by (still) providing fundamental care.
6. Do provide fundamental care for a patient by providing artificial nutrition and hydration.

(ii) The principle of autonomy

As we saw, the principle of nonmaleficence (as specified from Maria's viewpoint) and the principle of beneficence (as specified by the physician's viewpoint) are in conflict with one another. The core of the conflict seems to be that

artificial nutrition and hydration is a precondition for a dignified death, according to the physician, while Maria believes that it is incompatible with a dignified death. How can we decide this issue? Whose view should prevail? Could the principle of autonomy solve the case? The following analysis concerns the principle of autonomy and presents in detail the differing readings of the persons concerned. Maria wants to die through the withdrawal of treatment and she wants her wish to be respected. The physician, however, denies her request, in part because he thinks that Maria's recent diagnosis of mild depression calls her competence into question. Further, and more important, he stresses the traditional duties and commitments of his profession, that is, his professional autonomy.

Maria

1. Do respect the principle of autonomy.
2. Do respect the principle of autonomy by respecting the concept of informed consent.
3. Do respect the concept of informed consent by respecting individual informed consent.
4. Do respect individual informed consent by giving the patient the right to decide what is in his or her best interest.
5. Do respect the patient's right to decide what is in his or her best interest by respecting his or her refusal of artificial nutrition and hydration.

Physician

1. Do respect the principle of autonomy.
2. Do respect the principle of autonomy by respecting the physician's right to self-determination.
3. Do respect the physician's right to self-determination by respecting his or her personal and professional belief that nutrition and hydration is the most fundamental form of care all terminally ill patients should receive.
4. Do respect the physician's personal and professional belief that nutrition and hydration is the most fundamental form of care all terminally ill patients should receive by respecting his decision to refuse Maria's wish to withdraw artificial nutrition and hydration.

EVALUATION 1: WHERE IS THE MORAL CONFLICT?

The first step of principlism (and any other ethical theory) is to detect and determine the moral conflict of a given case by using the power of judgement. In the case of

Maria, two vital conflicts have been examined: (i) the conflict between the principle of nonmaleficence (Maria) and the principle of beneficence (physician), and (ii) the different specifications of the principle of autonomy, i.e. autonomy as respect for informed refusal (Maria) and as respect for conscious objection (physician). At first sight, the analysis of the moral conflict above seems successful, although we should say something more about this below. One should always keep in mind, however, that there is no absolute certainty that one is able to determine all the issues of a given case by one single method; good work is done when the core problems of a case are identified and a solution presented.

It is obvious that the physician does not need to deny that nutrition or hydration prolong Maria's suffering but he can still argue that dying through the withdrawal of treatment is even worse because it undermines Maria's dignity. Hence, it is better to suffer physically and psychologically at the end of one's life than to die without dignity. Whether it is possible that Maria acknowledges the physician's point of view but nevertheless adheres to her wish to die is questionable for logical reasons if the manner of her death undermines her concept of dignity. The deep conflict between the principle of nonmaleficence (Maria) and the principle of beneficence (physician) in the present case is challenging and should be further examined. There is no (absolute) certainty that all central aspects of a given case are always properly reconstructed. Case analysis rests for large parts on experience and the ethical power of judgement irrespective of the particular method applied, although different methods, of course, generally determine the outcome. We hold the view that the central issues have been discovered, but it seems to us that we need more information in order to make a sound principlist decision. This can be done by adding missing facts and by examining the assumptions of the conflicting views.

Deepening the analysis

First, from what does Maria suffer? Maria suffers from severe pain which is both physical (problems with swallowing) and psychological (total dependency on others);³ she has made it clear, by signs, hard-fought words, and repeated attempts to remove her feeding tube, that she wants to die. She is distressed and frustrated, has great difficulty in speaking, is handicapped and solely dependent on other people, and has had a lifelong aversion to hospitals and medicine. In addition, she will die soon and wants no further nutrition or hydration because she supposes that this will quicken her death, which in turn will end her suffering.

³ Unfortunately, the case description offers no other details about Maria's pain, which could help us to determine issues with important consequences for the evaluation of the case.

Secondly, given that Maria has mild depression, as the physician diagnosed, which affects her capacity for decision-making, what follows from this? The decisive question is whether the depression rests on her increasing frustration because of the physician's refusal to let her die by withdrawing nutrition and hydration, or whether it rests on her initial ill-health so that she was already incompetent when she first expressed her wish to die after being admitted to hospital. According to us, it seems more likely, with regard to the case description, that her mild depression rests on the physician's refusal to let her die; and thus her initial wish to die should be respected. To put it in a nutshell, it may be, of course, that Maria's condition is getting worse during her illness but it seems somewhat inappropriate to question her initial decision to be allowed to die by virtue of her later, deteriorated condition; this would be putting the cart before the horse.

Thirdly, is artificial hydration just another 'form of treatment' or is it the 'most fundamental form of care that [. . .] a physician feels is his duty to provide to any patient'? This point seems somewhat controversial: On the one hand, it is certainly true that artificial hydration is, of course, a form of medical treatment. On the other hand, we acknowledge the fact that the physician wants to make a distinction between other forms of treatment and providing a patient with hydration, which he claims to be 'the most fundamental form of care'. Losing a patient because he or she dies of thirst seems to be like having to bite the bullet against the background of probably the most important medical credo, *primum nil nocere*. According to other people, however, providing hydration is seen in some cases as a futile treatment, which only prolongs the patient's suffering, and hence patients should be allowed to die through the withdrawal of treatment. We think that there is no ultimate solution to this issue; one has to examine each case in order to find its suitable solution.

Fourthly, should the medical tradition of a given country always prevail over the patient's personal beliefs? To justify his decision to refuse Maria's demand to die, the physician claims that acceding to this request would contravene the medical tradition of his country. Maria is also Greek but she may not be absolutely devoted to the rules of the predominant medical tradition of her country. The decisive question is whether this should play any vital role in the process of ethical decision-making. Who decides which tradition is the predominant one and how many people should support it? Should it be 51%, 75%, or over 90% of the people in the country, or just the highest number of supporters in comparison to other groups (30%, 28%, 22%, 10% etc.)? Should the predominant tradition be allowed to influence the lives of other people who live according to different standards? There seems to be no one tradition or culture; there are always different ways of being devoted to a country's tradition and culture.

Fifthly, should the religious beliefs of the physician play any decisive role? According to principlism, the country's religious traditions are part of the particular morality. The particular morality provides the empirical data for the specification and balancing of the four principles of the common morality. Regarding the religious tradition and the physician's religious beliefs, one may question whether either should play any vital part in the decision-making process. It is difficult to assess whether the specific religious beliefs of a given country or idiosyncratic convictions (ever) lead to valid specifications of universal principles. Religious beliefs may well explain why one holds a special view but they seem less good at justifying particular specifications or forming a reasonable and reliable guide for solving conflicts by meeting universal demands.

The main result is that the abovementioned facts⁴ are additional determinants in the process of decision-making. They provide us with additional information on issues related to the main conflicts of the case in question and are meant to broaden our minds to be more case-sensitive.

3. HOW CAN A PRINCIPLIST DEAL WITH THE PRESENT MORAL PROBLEM?

There are two different ways, at least, to enrich the moral analysis of a particular case with regard to the principlist strategy: (i) to make additional specifications, and (ii) to make use of the method of balancing.

(i) Additional specifications

By making additional specifications, the principlist tries to solve the conflicts between (a) differing principles (e.g. nonmaleficence and beneficence) or (b) different interpretations of one principle (e.g. autonomy). Conflicting principles and interpretations should be reconciled against the background of new facts and assumptions in order to solve the moral conflict.

(a) *Beneficence*

The following specification of the principle of beneficence (physician) can solve the conflict between the differing principles of Maria and the physician. The line of argu-

⁴ (i) The kind of harm Maria suffers, (ii) the assessment of Maria's competence with respect to her capacity to make informed decisions, (iii) whether artificial nutrition is a form of treatment or the most fundamental form of care, (iv) the issue of whether the medical tradition of the country should play a vital role in the process of decision making, and (v) whether the personal and religious beliefs of the physician should be acknowledged.

mentation is as follows: Dying through the withdrawal of treatment (nutrition/hydration) is an undignified death if and only if it expresses disrespect for the person in question (Maria). However, withdrawing treatment and, at the same time, providing high-quality palliative care and personal attention to Maria would certainly not express disrespect, and hence it should not be seen as an undignified death.

(b) *Autonomy*

The principle of autonomy was initially directed against the more paternalistic reasoning of physicians who cared little about patients' wishes. In the present case, however, 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. At the time of her decision, she must be competent and her decision voluntary; her initial decision must not be conditioned by a state of depression (or maybe mild depression), in order to be sure that she is able to make sound decisions. It seems plausible to us, then, that Maria's initial wish can be seen as an oral advance directive, assuming that she was competent, which functions as her present living will in cases of incompetence. Thus, the physician should acknowledge and accept this as legally binding. This means that he is committed to her initial wish that artificial nutrition and hydration should be withdrawn.

The additional specifications support the general line of argumentation that Maria should be allowed to have her treatment withdrawn. High-quality palliative care and her initial will, which can be seen as an oral advance directive, seem to be appropriate reasons for her justified decision. It is hard to see how the physician can argue in another well-justified way with regard to principlism, given the prior examination of the principles concerning the case in question. Therefore, it seems that no sound alternative specifications are available for the physician that could justify his view. The analysis is determined in form and content by the method of principlism.

(ii) Balancing: personal autonomy trumps professional autonomy

The principle of autonomy can be specified in different ways; in Maria's case two rival but valid specifications (personal autonomy and professional autonomy) conflict with each other. One systematic way for the four-principle approach to deal with such conflicts is to balance the conflicting specifications⁵ We hold the view

⁵ Balancing is, according to Beauchamp and Childress, 'especially important for reaching judgments in individual cases' (T. Beauchamp & J. Childress. 2001. *Principles of Biomedical Ethics*. Oxford: Oxford

that personal autonomy trumps professional autonomy in the present case because the six conditions given by Beauchamp and Childress seem to justify the former in a more appropriate way. Professional duties and traditions, that is, professional autonomy, should play an important role in daily medical practice but they are improper when they undermine the personal autonomy of a patient who prefers treatment to be withdrawn because he or she will not recover, is suffering greatly, and will die soon.

In order to show why we think that personal autonomy trumps professional autonomy with regard to this particular case we would like to focus on the third condition, 'the infringement is morally preferable', in more detail. We have seen that the physician's position of preferring to provide fundamental care causes severe physical and mental harm to Maria. Given that she is an old woman who has lived her life and will die soon it seems somewhat inappropriate to refuse her initial wish (i.e. her oral advance directive) for treatment to be withdrawn against the background that high-quality palliative care could be provided. Professional autonomy is certainly very important in health care, but there are cases where the personal autonomy of the patient should prevail. It seems morally preferable to us that personal autonomy prevails in the present case and, therefore, to treat Maria according to her initial will, which will give her dignity, at least in her view.

EVALUATION 2: SOLVING THE MORAL PROBLEM

The opponents of principlism such as Gert and Clouser claim that principlists do not use a guiding principle and hence are unable to make a justified decision with regard to opposing specifications in a particular case. The reason is that Beauchamp and Childress' conception of principlism, in their view, does not contain an organizing meta-principle such as Kant's Categorical Imperative or the Utilitarian principle that decides which of the four principles or particular specifications should prevail when people are faced with a deep moral

University Press: 18), i.e. balancing is 'the process of finding reasons to support beliefs about which moral norms should prevail' (Beauchamp & Childress, *op. cit.* note 1, p. 20). This means that balancing has something to do with providing good reasons for justified acts. The following six conditions meet the important objection that balancing seems too intuitive and open-ended: (1) the overriding norm is more reasonable, (2) the infringement's justifying objective must be achievable, (3) the infringement is morally preferable, (4) the infringement must be in accord with the primary goal of action, (5) the infringement's possible negative effects must be minimized, and (6) there must be impartiality in action (Ibid: 23). That is why Beauchamp and Childress make the conciliatory claim that 'in some circumstances we will not be able to determine which moral norm to follow' (Ibid: 24).

conflict, such as in the case of Maria. This also holds against the background of the method of balancing, which is helpful, as we saw above, but still not sufficient.⁶ At first sight, this (standard) objection seems to have some plausibility if people only consider the differing specifications without making any attempt to reconcile them in a second step. At second glance, however, one acknowledges that the common morality itself is a principle that organises the specifications, at least, to some extent. The next section examines this promising way of principled reasoning.

4. COMMON MORALITY AS AN ORGANIZING PRINCIPLE

First, we would like to begin with a clarification with regard to ethical theories that apply a single organizing or guiding principle, such as is provided by classical Kantianism (the Categorical Imperative) or Utilitarianism (the greatest good for the greatest number). Proponents of these classical theories usually argue that their theories are superior to other theories that have no single organizing principle but several independent principles. This is so, according to their view, because the other theories are simply unable to solve moral problems in a clear and comprehensible way (e.g. principlism). This can be called the standard objection. It remains unclear, however, whether this is really the case; Kantianism and Utilitarianism usually have greater problems when they are applied to complex cases in applied ethics because of their lack of case sensitivity. These ethical theories adhere to the deductive model of justification (theory–principle–rules–judgement), which seems to be less sufficient in the area of applied ethics, in particular, bioethics.

Even one of the most vehement opponents of principlism, Bernard Gert, acknowledges in his work, *Common Morality. Deciding What to Do*:

But the claim that morality is based solely on human nature does not mean that common morality provides a unique correct answer to every moral question. It is impossible to provide a description of morality that will both resolve every moral disagreement and also be endorsed by all rational persons. Common morality is a framework or system that can help individuals decide

⁶ One may gain the impression that there is still no really sufficient solution to the case in question; but this is somewhat misleading. One has to distinguish two levels in this issue: the practical level and the theoretical level. Practically speaking, the results at stake seem sufficient for solving the problem but still lack the theoretical constraining framework. That is, the theoretical level should be examined in more detail in order to help us see how it can enrich the practical level by providing more methodological certainty.

what to do when faced with a moral problem, but within limits, it allows for divergent answers to most controversial questions.⁷

His considerations are certainly true, but what is most interesting concerning his criticism of principlism is that he seems to accept plausible divergent answers to controversial issues for his own theory, but denies the same right to Beauchamp and Childress. In the following, however, we would like to show how one could conceive of common morality as an organizing or guiding principle.

Common morality not only concerns certain particular moralities by being their starting point and constraining framework, but also applies to concrete situations, in which, for example, one knows not to lie, not to steal property, to keep promises, to respect the rights of others, not to kill or cause harm to innocent persons, and the like.⁸ This is important because common morality can, then, function as a guiding principle in situations where diverse principles and rules may conflict. Of course, we do not hold the view that common morality is able to provide a unique correct answer,⁹ but it can be seen as a constraining framework that, first, separates ethical from unethical answers, and secondly, indicates which ethical answer seems more appropriate with regard to the ideal of common morality without saying that this is the only correct available answer. However, if the regulative idea of common morality can be seen as the proposed meta-principle of principlism, then we should be able to apply this meta-principle to the present case in order to provide a well-justified solution for the moral conflict.

What then are the particular weighting considerations that can be derived from the common morality in order to solve the particular conflict? An appropriate response to this important question concerns the notion of common morality itself and how the common morality is justified. In recent years, Beauchamp and Childress have offered three main ways to determine the common morality: (i) by appealing to morally serious persons,¹⁰ (ii) by appealing to persons committed to the objectives of morality,¹¹ or (iii) by appealing to persons committed to morality.¹²

⁷ B. Gert. 2007. *Common Morality. Deciding What to Do*. Oxford: Oxford University Press: 4.

⁸ Beauchamp & Childress. *op. cit.* note 1.

⁹ The view that there is only 'one' best solution to a moral problem has been held by various well-known philosophers such as Aristotle (virtue ethics), Kant (deontology), and Bentham (Utilitarianism). Other philosophers, however, e.g. Beauchamp and Childress (principlism) or Gert (common morality approach), believe instead that there can be different and equally good solutions to moral problems. To 'solve a moral problem', then, means to provide a well-justified solution for a particular moral conflict without necessarily claiming that this is the only acceptable answer.

¹⁰ Beauchamp & Childress, *op. cit.* note 5.

¹¹ T. Beauchamp. Defense of Common Morality. *Kennedy Inst Ethics J* 2003: 13(3): 259–274.

¹² Beauchamp & Childress, *op. cit.* note 1.

In the first approach, common morality is defined as a set of norms shared by all morally serious persons. In the second approach, common morality is defined as a set of norms shared by all persons committed to the objectives of morality, which are those 'of promoting human flourishing by counteracting conditions that cause the quality of people's lives to worsen'.¹³ In the third approach the notion of common morality is based neither on morally serious persons nor on the objectives of morality but on the idea that common morality – as a set of norms shared by all persons committed to morality – is applicable to all persons in all places and judges all human conduct.

We believe that the first approach (morally serious persons) is the best one to use in applying common morality to particular cases. Although considered judgements are moral convictions of the highest grade of confidence and the lowest level of bias, Rawls¹⁴ claims that considered judgements should be accepted 'provisionally as fixed points' but that they are 'liable to revision'. For Beauchamp and Childress the aim of reflective equilibrium is to match, prune, and adjust considered judgements in order to make them coherent with the premises of the most general moral commitments concerning human conduct. Furthermore, the powerful methods of specification and balancing provide further 'weighting considerations' in order to solve the moral conflict, as we have thoroughly demonstrated by our detailed analysis of how to apply principlism in the present case of Maria.

To put it in a nutshell, the appeal to common morality suggests the following main line of argumentation: Morally serious persons agree that the wishes of competent adult persons with regard to medical treatments should be respected unless they are not in their best interest. Maria experiences suffering from a serious health condition and will die soon, hence she should be allowed to die by the withdrawal of nutrition and hydration. To prolong the process of dying by acting against her expressed wish seems not to be in her best interest. Given the many details of this case, her request to be allowed to die seems reasonable and in accord with common morality. To act otherwise, that is, to continue the medical treatment, would be unjustified and would undermine her initial autonomous decision.

EVALUATION 3: DOES THE ORGANIZING PRINCIPLE DO ANY GOOD?

By applying the meta-principle of common morality in the above-mentioned way as a constraining framework, it seems that Maria's wish should be respected and that high-quality palliative care and personal attention must

¹³ Beauchamp, *op. cit.* note 11, p. 260.

¹⁴ J. Rawls. 1971. *A Theory of Justice*. Cambridge MA: Harvard University Press.

be provided to her. To act otherwise would harm Maria and deprive her of her initial autonomous decision to arrange the way in which her life should end. Maria's deliberations should be respected even if it means that the physician in charge has serious doubts; and if he is not willing to comply with her wishes, he should refer the case to another colleague. The latter point is of great importance because not to offer Maria the opportunity to see another physician would severely undermine her autonomy and right to self-determination. This would harm Maria in addition to her current situation.

Elderly people who suffer from a severe illness and will die soon are not living puppets in the medical theatre of end-of-life decisions; their wishes should be respected as a form of showing final respect toward them. Human well-being can fall victim to wrong paternalistic and idiosyncratic reasoning when we do not act in the patient's best interest. End-of-life decisions should be made by mutual consent; that is, both parties – the patient and the physician – should act in concert. In complex cases, however, this does not always happen and the important question is, what should then be done. Although the physician, by virtue of his understanding of his medical profession, is no simple handmaid who fulfils all patients' wishes without question, he nevertheless has a duty not to give the patient feelings of helplessness and loneliness by simply acting against the patient's wishes. It seems that, depending on the particular situation, but particularly in hopeless end-of-life cases, physicians should simply accept that their patients might be permitted to do what they want to do.

5. CONCLUSIONS

We have seen that applying the method of principlism is not an easy task. Our analysis showed that principlism is not a mere 'checklist' method when it is done properly.

The application of principlism is a challenging way to solve moral conflicts in biomedical ethics; it follows certain procedures to achieve the best solution it can. The analysis has shown, however, that the most important feature, in addition to the methods of specification and balancing, is the guiding meta-principle of common morality, which functions as a regulative idea to solve deep conflicts between rival principles. The four-principles approach, properly used, is a powerful tool for bioethical decision-making.

Acknowledgements

We are very thankful to the two anonymous reviewers for their helpful comments. This work is funded by the German Research Foundation (DFG, RA 1372/1).

John-Stewart Gordon is Visiting Professor in philosophy at Queen's University in Kingston, Canada. He is a member of the board of *Bioethics* and area-editor of The Internet Encyclopedia of Philosophy (IEP). He is the author of *Aristoteles über Gerechtigkeit. Das V. Buch der Nikomachischen Ethik* (Alber Press, 2007) and *Bemerkungen zum Begründungstrilemma* (Lit Press, 2007), editor of *Morality and Justice* (Rowman & Littlefield, 2009) and co-editor of *Bioethics and Culture* (Cambridge University Press, 2010).

Oliver Rauprich is Senior Research Scholar in medical ethics and Head of Junior Research Group 'Justice in Modern Medicine' at the Institute for Medical Ethics and History of Medicine at Ruhr-University, in Bochum, Germany. His research focuses on four areas: Allocation and Justice in Health Care, Theoretical Foundations of Biomedical Ethics, Public Health Ethics and Evolutionary Ethics.

Jochen Vollmann is Professor and Director of the Institute for Medical Ethics and History of Medicine and Chair of the Centre for Medical Ethics, Ruhr-University Bochum, Germany. He received a prize for Brain Research in Geriatrics from the University of Witten/Herdecke in 1999 and the Stehr-Boldt Prize for Medical Ethics from the University of Zürich in 2001. His research interests include informed consent and capacity assessment, ethics and psychiatry, end-of-life decision-making, advance directives, medical professionalism, clinical ethics committees and clinical ethics consultation.

Copyright of Bioethics is the property of Wiley-Blackwell and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.