The “Four Principles” at 40: What is Their Role in Introductory Bioethics Classes?

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Abstract. Beauchamp and Childress’s **“Four Principles” (or “Principlism”)** approach to bioethics has become something of a standard not only in bioethics classrooms and journals, but also within medicine itself. In this teaching-focused workshop, I’ll be doing the following: (1) Introducing the basics of the “Four Principles” approach, with a special focus on its relation to the *common morality* and the importance to *weighing* and *balancing* of competing norms. (2) Comparing and contrasting this to other potential approaches, such as those provided by virtue ethics, act utilitarianism, casuistry, and competing versions of principles-based ethics. (3) Considering the ways in which the principles-based approach can best be implemented for lower-level, introductory bioethics classes, where the average student may have little background knowledge in either philosophy or medicine. I’ll be presenting sample activities, case studies, and lesson plans. There will be considerable time reserved for discussion at the end, so that participants can exchange ideas relating to the teaching of both bioethics and other varieties of applied ethics.

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1 PRINCIPLES OF BIOMEDICAL ETHICS[i]

The first edition of ***Principles of Biomedical Ethics (PBE)*** was published in 1979 by philosophers Tom Beauchamp and James Childress (B-C from here on out). It was one of the first textbooks to present a detailed, systematic treatment of ethical decision-making in healthcare and biomedical research, and it laid the groundwork for contemporary research and teaching in this area. The 8th edition was published in October 2019 (T. Beauchamp and Childress 2019).

B-C began the first edition of *PBE* by contrasting the *utilitarian* theory that an action’s moral rightness is determined by its consequences with the *deontological* theory that there are “right-making” features of actions that have nothing to do with consequences. While the authors disagreed as to which theory is correct, they argued that both theories support a set of four “core” principles relevant to ethical decision-making in medicine and biological research. These principles included duties to promote patients’ well-being (**beneficence**), to avoid causing them harm (**non-malfeasance**), to respect their decisions (**autonomy**), and to distribute health

care goods and services in an equitable manner (**justice**). In the remainder of *PBE,* they applied these four principles to a variety of ethical problems that arise in medicine, such as the right of patients to refuse treatment, the problem of determining what counts as informed consent, and the appropriate way of conceptualizing professional-patient relationship.

B-C have issued updated editions *PBE* every few years, and it has been widely adopted in introductory courses on biomedical ethics at both the undergraduate and graduate level. It has also played an important role in raising the academic profile of so-called "applied ethics" in which ethical theories are applied to particular issues that arise in discipline-specific contexts ("business ethics", "research ethics", "environmental ethics", and so on). While much has changed over the years, the "Four Principles" approach to moral decision-making in bioethics has remained constant, as has a focus on virtue/character ethics, which they view as complementary to this principles-based approach.

2 Teaching The Four Principles: Questions for Instructors

The Four Principles approach to bioethics involves a number of key concepts, all of which present both opportunities and challenges to bioethics educators.

What is the Common Morality? What is its relation to the Four Principles? B-C define the common morality as the "set of universal norms shared by all persons committed to morality" (3). That is, every person (regardless of culture, institution, social role, etc.) who cares about morality agrees that these rules should be followed. The common morality includes (but is not limited) to prohibitions against wanton cruelty, dishonesty, etc. It also holds up certain virtues (such as courage or generosity) as being morally commendable. B-C claim that the Four Principles represent an extension (and expansion) of this universal morality to the context of modern medicine and biological research. Some main advantages of this approach are that (1) it allows us to engage in bioethical inquiry without agreeing beforehand on (contentious) questions of ethical theory, while simultaneously (2) offering substantive, universal "middle-level" principles that can serve to explain and justify particular judgments about bioethical cases. Critics have contended, among other things, that we lack evidence for the sort of widespread agreement on moral norms that the common morality posits, or that (even if there is, in fact, such consensus), this doesn't provide normative justification for these norms (Turner 2003; 2004; DeGrazia 2003; T. L. Beauchamp 2003).

Question for Bioethics Teachers. Bioethics classrooms are much more culturally diverse than they once were, as are the eventual work environments in which students will find themselves. In this context, how helpful is the concept of a *common morality* in providing a context/justification for the study of ethics (as opposed to, say, a more traditional discussion of metaethical considerations of particular ethical theories)?

How Can We Apply the Four Principles? On Specifying, Weighing, and Balancing. B-C argue that their four principles—respect for autonomy, nonmaleficence, beneficence, and justice—are general norms, and must almost always be *specified* further to be applied to particular cases (by spelling out to whom they apply, which actions they require, and so on). In many cases, this process of specification is not fully determined by the norm itself (or the underlying common morality), Moreover, even when these norms are fully specified, they hold only *prima facie,* and that norms can conflict with (and be overruled by) other norms in particular cases. There is thus a need to *weigh* and *balance* different norms, and there remains the possibility of encountering genuine *moral dilemmas,* in which morality can demand (or appear to demand) that we do two or more mutually incompatible actions, or in which have moral reasons both to do an action and refrain from doing it. This process of specification, weighing, and balancing allows for a considerable range of moral diversity, and arguably

captures a phenomenon that is central to our experience of moral life (i.e., of feeling conflicted and unsure). However, some critics have argued that the system's failure to provide unambiguous guidance regarding the morality of particular actions amounts to a major flaw (Clouser and Gert 1990; Gert, Culver, and Clouser 2000; Peterson 2017).

Question for Bioethics Teachers. To what extent does learning the language of Four Principles help make our students make *better* moral decisions, and to what extent does it simply make them better at *explaining* decisions they would have already made (or dilemmas they already struggled with) in a new language? If it is primarily the latter, does this undercut the appeal of Principlism?

Where do the Virtues Fit in All of This? Where Does Ethical Theory? While Principlism is (for obvious reasons) associated with the Four Principles, B-C's own presentation gives considerable time/attention to moral virtues, which they argue are "no less important in moral life" than the principles are (32). In particular, they identify *caring* as a "fundamental orienting virtue" for health professionals (37), and devote an entire chapter (2) early in the book to spelling out the application of this approach, in part by offering an account of the "Five Focal Virtues" of *compassion, discernment, trustworthiness, integrity,* and *conscientiousness.* This stands in contrast to their treatment of more traditional ethical theories (such as utilitarianism or deontology) which are dealt with only late in the book (chapter 9), and in a much more condensed form. Beauchamp (2004) has suggested in writing that the theory-practice gap within current ethical theory may limit its ability to contribute to the (interdisciplinary, pragmatic) field of bioethics. Others (Holland 2011; Oakley 2013) have outlined approaches to bioethics that are more purely virtue-based.

Questions for Bioethics Teachers: To what extent are discussions of traditional ethical theory useful for introductory bioethics students, especially when these students are current/aspiring medical professionals who seek practical guidance regarding issues they might face? Can/should these approaches be supplemented (or entirely replaced) by a virtues-based approach?

What are the Alternatives to Principlism in Teaching Bioethics? While Principlism has been highly influential within bioethics education, it is not without its rivals. On the one hand, there are theory-driven approaches such as Gert's "Morality as Public System" approach (Gert, Culver, and Clouser 2006), Singer's Act Utilitarianism (Singer 2011), and various religiously-grounded approaches. Such approaches (at least in theory) offer the promise of more definitive guidance on tough moral questions, without the need for balancing competing norms. On the other, there are case-based, "casuist" approaches that dispense with principles altogether, and proceed directly by the consideration and comparison of case studies (J. D. Arras 1993; Dancy 2017; Jonsen 1995; Cudney 2014). B-C present Principalism as a sort of "middle ground" between these two views.

Questions for Bioethics Teachers: To what extent does the apparent disagreement on "experts" as to what counts as appropriate methodology for bioethical decision-making present a problem for a field that aims (at least in places) to provide "practical" education for practitioners? Over the last few decades, there has been a great deal of interest (and investment) in bioethics education from areas outside of philosophy. To what extent has bioethics education and research "earned its keep" (at least from the point of view of these stakeholders) in helping our students make better ethical decisions?

3 SAMPLE ACTIVE LEARNING IDEAS

Here are a few samples of activities that I've found success with while teaching bioethics from a Four Principles Approach. I have included several others in the (online) appendixes.

1. **(Pair Activity: Common Morality.)** In this activity, I'd like you to reflect on how people can have moral disagreements even when both disputants accept the common morality. To begin with, you should (a) briefly describe a debate that involves a disagreement that involves morality. Now, do the following (b) identify at least two important factual and moral beliefs that are SHARED between the two sides of debate, and (c) identify at least one important factual/moral claim they disagree with. (We work through the example of gun control in class).
2. **(Individual Writing Assignment: A Guide to the Caring).** Pretend that you are writing a short guide to the "Five Focal Virtues" of caring for new employees at a hospital. It is your job to clearly and accurately describe each of the virtues (using your own words), and then to say what this means of their job. This will require that you give detailed, specific examples showing how each of the five focal virtues can be followed or not followed.
3. **(Bad Behavior in the Movies: Autonomy).** Begin the class by showing an episode or film related to medicine in which there are flawed medical professional-patient interactions. It need not be realistic, and in fact, cartoonishly bad behavior can be a valuable teaching tool for students first learning the concepts (in the past, I've had good luck with *House, Scrubs, Wit, The Cider House Rules,* and even *Grey's Anatomy*). Before students view the episode, direct them to take notes on the degree to which the principle of autonomy is respected (and the related notions of informed consent). This can now be built into a class discussion and from there into an independent writing assignment.
4. **(Physician-Aid-in-Dying debate: Non-maleficence).** Have the students count off by 4. Now, give each student 10 minutes to write the best argument (using the 4 principles) for a position I assign to them (1) PAD should be illegal, and these prohibitions should be strictly enforced, (2) PAD should be illegal, but we should recognize/allow individual acts, (3) PAD should be legal, but restricted to terminal illness, (4) PAD should be illegal, and should be allowed for at least some cases besides terminal illness. Now, break the students into groups based on their position, and give them 10-15 minutes to prepare a presentation of their best "collective" case to the class.
5. **(In-class Research in Pairs: Beneficence/Paternalism).** Choose an example of a paternalistic law or policy that interests you, preferably one that involves health in some way [drug policy, surrogacy, prostitution, sugar taxes, organ sales, etc.]. This could be one that is already "on the books," or it could be one that people have discussed. Now, consider what the best arguments FOR and AGAINST this law might be. You should include a discussion of soft/hard paternalism (and of the potential conflicts between autonomy and beneficence), but you can also bring up other ethical considerations from the class material that you think are relevant, as well as from online research.
6. **(Whole class Activity: Case Studies in Bioethics).** Over the course of the semester, I reserve several entire class periods for the discussion of case studies. Excellent, open-access studies related to bioethics can be found We begin by learning a five-step process for responding to case studies (see appendix), and by working through an example case. Students are then broken into groups to work through other case studies. Group members are assigned various roles (of note-taker, speaker, researcher, etc.), and groups present their findings at the end of class. Good open-access sources for case studies include the *American Medical Association Journal of Ethics* (2019)*,* the *Markkula Center for Applied Ethics* (2019)*,* and the Ethics Bowl Case Archive (Center For The Study Of Ethics In The Professions 2019)
7. **(Individual Interview Activity).** Conduct a 25- to 30-minute conversation about bioethics with someone (not in this class) who works in medicine, biological research, or a related area. In this interview, you should choose one or two ideas that you've found especially interesting in class (such as a theory of moral status, or the virtue of caring, or informed consent), and carefully explain what these ideas to the person (it's your job to "teach" these ideas, even if the person is already familiar with them). Now, talk to the person about the applicability of these principles/ideas to their own line of work. Write up a transcript of the conversation, together with some reflections on what you learned while doing it.

4 APPENDIXES

The following section contains a number of items that may be of interest to other bioethics instructors. Please feel free to use/adapt these within your classes.

4.1 MODEL SYLLABUS: INTRODUCTORY BIOETHICS (FOUR PRINCIPLES)

Instructor		Course number	PHIL 1135-01,91
Contact Info		Prerequisites	None (However, this is a college-level class, so you should be comfortable with reading college-level texts and writing responses to these. See below for more details.)
Office		Class location	
Drop-in Office hours		Class time	

Welcome to PHIL 1135: Bioethics! I'm your instructor, Brendan Shea (I prefer "Brendan"; "Dr. Shea" or "Prof. Shea" work if you are feeling formal). This is the syllabus for the course. If you have short questions that are NOT answered here, email is generally the best way to get ahold of me. For more detailed questions about the class, I'd encourage you to talk to me during office hours (either in person or over the phone), or to set up an appointment.

Course Description: This course provides background ethical theories, principles and concepts necessary to grasp the ethical issues in life, death, health care, biotechnology and the life sciences. Specific attention will be given to the social context of ethical decisions and there will be an emphasis on critical reasoning and justification. Special topics that may be discussed include: definitions of life and death, autonomy, paternalism, voluntary informed consent, rights, obligations, clinical trials, confidentiality, abortion and reproductive technologies, cloning, stem cells, end of life issues, transplantation and fair allocation of limited resources. (3 cr, 3 hours lecture per week)

4.1.1 Course Content and Learning Outcomes (Institutional)

As specified by institution.

4.1.2 Required Course Materials

- Beauchamp and Childress, 2012, *Principles of Biomedical Ethics,* 7th edition (New York: Oxford University Press).
- This course will require that you have reliable, regular internet access (to complete online quizzes, etc.).

4.1.3 Grading and Course Policies

Grading Scale:: >=90.0 (A), 80.0-89.9 (B), 70.0 -79.9 (C), 60.0-69.9 (D), <60 (F).

Your final grade is a weighted average of the following:

- **Bioethics Readiness Quiz (5%).** This quiz will cover the material on the syllabus and chapter 1 of the textbook. It will also ask you to reflect on your own goals for the class, and the ways in which you can best meet them. If you get lower than a B (80%) on this quiz, I'd highly encourage you to contact me to set up an appointment.

- **D2L Quizzes (10%).** For textbook readings, there will be a short D2L reading quiz made up of T/F or multiple-choice questions intended to help you focus on key points in the reading. You will get TWO chances to do each quiz, and your grade will be the BEST of the scores.
- **Activities (25%).** Face-to-face students will do occasional in-class and out-of-class activities, while online students will post to the discussion board. Online students can find the grading criteria for discussion boards below.
- **Three Essay Exams (60% total).** Each exam will consist of three essays, which you can answer in 1,500 to 3,000 words total (6 to 12 pages). I will DROP your lowest exam score. However, everyone is required to take the first and second exams. You don't need to take the third exam if you are happy with your grade on the first two.
- **Extra Credit (up to +2%).** There may be occasional opportunities for extra credit, which I will let you know about. For reasons of fairness, I can't offer extra credit opportunities to individual students, so please don't ask.

Plagiarism and Academic Integrity. Your work should be your own—please don't use your classmates, friends, parents, internet sites, etc. to help you write your papers or answer test questions. And when you do use outside sources, make sure to given appropriate citation and acknowledgment for any words, ideas, or arguments. If the preponderance of the evidence suggests cheating has occurred (that is, if the evidence suggests that this is *more likely than not)*, you will receive a failing grade on the assignment. A second violation will lead to failing grade for the course. Please also see the RCTC statement on academic integrity later in the syllabus.

Attendance. Students in face-to-face classes are expected to attend class regularly, while online students are expected to participate in the class discussions and activities. If you miss more than two weeks consecutively, or 1/3 of the total class sessions, you may receive a failing grade of FW. This may endanger your ability to receive financial aid. With this in mind, it is *your* responsibility to withdraw from the class if you decide not to continue. I am willing to make exceptions if circumstances require, but you need to let me know about these in a timely manner.

4.1.4 Policy on Late Work: Please read before emailing me!

Please read the following *before* e-mailing me to request an extension on an assignment. If you a quiz or activity due to a brief sickness, work conflict, class trip, computer malfunction, wedding, auto problem, court date, funeral, sporting event, etc., you do NOT need to email me (though it's fine if you want to give me a heads up). Here are my policies for making up missed or late work:

Over the course of the semester, you can make up to TWO missed activities, discussion board posts, or quizzes by writing a 500 to 750-word response on the relevant material. This response should (1) clearly explain the main ideas in your own words, and (2) offer a thoughtful, considered response to it (the review questions on the handouts are a good place to start). **They should be submitted within ONE WEEK of the missing assignment**. Full or partial credit will be assigned based on how complete/accurate your response is. A special D2L assignment folder will be set up to submit these. When submitting this, please clearly indicate:

- Which activity or quiz you missed, and what the initial due date was.
- What resources (textbook, lecture notes, etc) you used to prepare this essay.

Take-home essay exams CANNOT be made up for full credit. For exams 1 and 2, your grade will be capped at 90% if it is submitted within 48 hours of the due date, and 80% if it is submitted within one week. Extensions past one week require my prior approval, and may result in additional penalties. Exam 3 cannot be submitted late. I will make exceptions to these policies if you can demonstrate a genuine need. Please come talk to me if anything comes up that is preventing you from succeeding in class. ALL late work should be submitted to the

D2L "Late Work" assignment folder. NO LATE WORK WILL BE ACCEPTED DURING THE LAST WEEK OF CLASS (again, absent exceptional circumstances).

4.1.5 Other classroom Policies (Face-To-Face Students)

This is a college-level class! With that in mind, I don't anticipate having to do much policing of behavior 😊. However, my general expectation is that you will respect your fellow classmate's right to learn, and that you avoid doing anything that will make this more difficult for them (such as repeatedly showing up to class late, off-topic talking during lectures or group work, etc.). Disruptive behavior of this sort may lead to students losing activity/quiz points associated with that class, without the opportunity to make them up. Repeated (or especially serious) violations will be referred to the college, and can lead to more severe consequences.

Technology: "No Cell Phone" and "No Laptop" policy. In this class, my expectation is that all technology (including cell phones, laptops, and tablets) will be turned off and put away (in your bag/pocket, not on the desk), absent a very compelling reason to do otherwise that you let me know about ahead of time (e.g., a documented medical need or learning accommodation). There may be times in class when technology is allowed—I will let you know when this is the case. Research[1] has repeatedly found that cell phone use in classroom is linked to poorer learning outcomes, not only for the student who is using the technology, but for other students in the class. These effects persist even if the cell phone is not actively being used (and is instead simply left face-down on the desk, etc.). With this in mind, I will treat violations of this policy the same as any other disruptive behavior.

4.1.6 Reading and Writing about Philosophy

Reading and writing about philosophy can highly rewarding (and even fun!), but it also can be difficult, even for people with lots of experience (even professional philosophers still find it difficult sometimes!). With this in mind, here are my expectations/suggestions with regard to the level of reading/writing in this class:

1. Philosophy as a discipline doesn't require any "special" academic background, and philosophers have come from almost every imaginable profession: stonemasons, mathematicians, teachers, physicians, etc. However, philosophy does require the ability to ask "uncomfortable" questions about one's own beliefs and actions, and to take seriously arguments and ideas that disagree with our own most deeply held beliefs.
2. Before starting this class, you should be confident in your ability to read and understand a college-level textbook. This does NOT mean I expect you to grasp every concept/idea right away (I know that some of this stuff is pretty tricky, and that's why I am here to help!). However, I do expect that you will read the textbook BEFORE you come to class (or post to the discussion board, etc.), and come away with a basic understanding of main ideas. If you're unsure about your ability to do this, get in touch with me *early* in the class so we can discuss this.
3. On average, students should expect to spend about five minutes per standard textbook page of philosophical reading, which includes the following:
    a) "Pre-reading" the chapter or article to get a sense of the structure, headings, key terms, etc.
    b) Reading the chapter carefully, stopping to take notes at least every page or so. At the minimum, your notes should include major topics addressed, definitions of key terms, important arguments or objections to arguments, and notable examples.
    c) Taking time to review the material AFTER you have finished reading a section. Basically: spend 5-10 minutes trying to review what you have learned WITHOUT looking at the text or your notes. This can help you get a better sense of what you've grasped well, and what you still need to work on. Research has also found that this is a key step in actually being able to remember/use the information in the future.

[1] (Beland and Murphy 2016; Kuznekoff and Titsworth 2013; Ward et al. 2017)

d) As a general rule, techniques like highlighting or rereading are NOT very effective unless they are carefully limited. So, you don't want to be highlighting every other sentence, or trying to re-read a whole chapter. Try to limit your highlighting to just key points, and keep your rereading constrained to parts that genuinely confuse you.

e) I would recommend taking a brief "reading break" every 20 to 30 minutes.

4. As part of the class, you will be expected to write extended, argumentative essays. While you will be learning a bit more about how to write these, you should already be aware of basic principles of composition such as the use of **thesis statements,** how to organize your essays into **paragraphs,** and the importance of **citing** your sources using standard forms such as MLA, APA, Chicago, etc. If it has been a while since you have done this, don't worry! There are a number of excellent resources that you can review online. I particularly recommend the Purdue Online Writing Lab (https://owl.purdue.edu/owl/purdue_owl.html). I'd also encourage you to look at the "Guide to Writing Philosophy Papers", prepared by RCTC Philosophy Faculty (https://philpapers.org/go.pl?id=SHEHTW&u=https%3A%2F%2Fphilpapers.org%2Farchive%2FSHEHTW.pdf)
5. All told, you should be prepared to spend around 100 to 150 hours total on this three-credit class (or 6 to 9 hours per week for a 16-week semester). Very roughly (and this will vary by student), this might break down as something like the following: (a) 40-50 hours on reading, note-taking, and completing quizzes, (b) 25-30 hours working on the exams, and (c) 40-50 hours attending class (or, for online students, reading lecture notes and writing discuss board posts).

4.1.7 Getting in touch with me (and what to include in an Email)

The best way to get ahold of me is by e-mail, which I will aim to respond to within ONE working day (for simple questions) or TWO working days (for more complex ones). I don't generally check email on the weekends or holidays. If you don't hear from me by then, please try emailing me again. In order to help me provide you with quick, effective feedback, here's a general template for what I expect in an email.

Dear Brendan (or Professor Shea):

My name is [full name], and I'm a student in [this section] of [this class]. I had a question regarding [identify quiz, textbook chapter, etc. Be specific, and include a copy of anything I might need to answer your question, including the full problem text, if applicable]. Here's everything I've tried so far to figure out the answer for myself [looked at the syllabus, notes, textbook, etc.], and here's my best guess as to the answer. Could you help me by doing the following? [Be specific in what you are asking me to do.] [Feel free to include anything else you'd like here. I'm always happy when students send along ideas/links/whatever vaguely relating to ethics and philosophy 😊]/

As I rule, I will not respond to requests that you be exempted from class policies without very good reason (e.g., for late-work extensions outside the conditions outlined above), or to emails that lack basic identifying information (your full name, class, etc.). For long or complex questions, I highly encourage you to schedule an appointment so that we can talk (either in person or by phone). Oh, and please don't call me Mr. Shea (That's my dad!).

4.1.8 Resources for Student Success

Include as appropriate.

4.1.9 Course Calendar

Unless otherwise noted, the readings are from *Principles of Biomedical Ethics, 7e*. I will let you know ahead of time if there are any changes. Most of the readings can be found in your textbook; I will make the others available to you online. **QUIZZES** on each chapter will generally be due on the Thursday of that week.

Week	Week Starting	Tuesday	Thursday	Topics Covered
1	8/25	Syllabus	Case Studies	Introduction
2	9/1	Chapter 1: Basic Concepts	Chapter 1 (cont.)	Ethics, Common Morality, Moral Dilemmas
3	9/8	Chapter 2: Moral Character	Chapter 2 (cont.)	Care Ethics, Virtue
4	9/15	Chapter 3: Moral Status	Chapter 3 (cont.)	Animals, Abortion
5	9/22	Chapter 4: Respect for Autonomy	Chapter 4 (cont.)	Autonomy, Informed Consent
6	9/29	Video: TBA	Exam 1/Workshop	Exam 1 (due 10/7)
7	10/6	Chapter 5: Nonmaleficence	Chapter 5 (cont.)	Aid in Dying
8	10/13	IQ2 Debate	NO CLASS	
9	10/20	Chapter 6: Beneficence	Chapter 6 (Cont.)	Cost-Benefit Analysis, Paternalism
10	10/27	Chapter 7: Justice	Chapter 7 (Cont.)	Major Theories of Justice, Right to Health Care
11	11/3	Health Care (Online Readings)	Health Care (Online Readings)	U.S./Global Health Care Systems
12	11/10	Case Studies	Exam 2/Workshop	Exam 2 (due 11/18)
13	11/17	Chapter 8: Professional-Patient Relationships	Chapter 8 (Cont.)	Privacy, Confidentiality, Research Ethics
14	11/24	Chapter 9: Moral Theories	NO CLASS—Happy Thanksgiving!	Major Ethical Theories
15	12/1	Chapter 9 (cont.)	Chapter 10: Method and Moral Justification, Case Studies	Approaches to Bioethics
16	12/8	Case Studies	Exam 3/Workshop	Exam 3 (due 12/16)
17	12/15	To be Announced		Semester Ends 12/20

4.2 A Student's Guide to Responding to Case Studies

Case studies are meant to help you practice how to engage in "real life" ethical deliberation: the problems they present are often tricky, and solving them requires that you consider the needs and interests of multiple stakeholders (including patients, staff, the government, various companies, etc.). With this in mind, remember that the goal is NOT just to say what you "think" or "feel." Instead, you want to find a way to propose a solution that you think you could defend/explain to all those affected by it. (So: put yourself in the shoes of these medical professionals! Do your best to figure out a workable solution). While the details of each case will require a somewhat different response, you generally go through something like the following FIVE steps:

Step 1: Identify the Problem(s) and Describe the Morally Relevant Features of the Case. Before starting to say what should be done, it's important to get clear on what exactly the problem(s) is. With this in mind, take some time to describe the main points of the case study in your own words, and identify what you think are the main ethical issues at stake (i.e., those you'll be addressing later in the case study response). You should make sure to clearly identify any *assumptions* about the case you have made. You'll also want to make clear who the various **stakeholders** in this case are (these are all the people/organizations who have a stake in the outcome). This will often involve reviewing the **sources** that are referenced within the case study.

This step is often overlooked, but it's a hugely important one, as many "disagreements" about ethical issues are often a result of different people having wildly different views of what the "facts" are. Taking the time to make

this clear ahead of time can save a world of trouble. In general, this should be no more than 15 to 20% of your essay (so, a half page of a three-page paper). You should NOT simply the repeat the case study back to me—the goal in this step is to really narrow in on what is important.

Step 2: Identify MULTIPLE Possible Solutions or Approaches. After you are done with step 1, you should have identified one or more specific questions that need to be answered. For example, our question might be "What is the morally right thing for X to do?" or "What should the law/policy about Y be?" Now, we need to identify *more than one* possible answers to this question. In some cases, we'll already know what X did (and we're trying to figure out whether it was the right thing to do); in other cases, we'll be starting from scratch. You should make sure to include both (1) obvious solutions (the ones you know people will bring up) and (2) "creative" solutions (ones that occur to you as you work through the problem). Make sure you describe each of these solutions/approaches in enough detail so that a reader can understand what each would entail.

Step 3: Determine Which Ethical Principles or Ideas Might Be Relevant, and Explain Why. As you start trying to solve the problem, you'll want to think about what ideas might be most relevant. These might be general ideas (e.g., the idea of autonomy, or beneficence), specific policies (e.g., regarding things like abortion, euthanasia, etc.), or even a different case study with which you see similarities. Now, clearly and succinctly explain *why* these ideas are relevant. Don't assume your audience will automatically know what you are talking about—take your time to explain, even if it seems obvious to you. This is a great place to bring in class material (from the notes, textbook, etc.), or from outside resources (though be sure to cite this).

Step 4: Argue for Your Chosen Solution. Now, go to work! Use the ethical ideas/concepts you've identified in step 3 to argue for ONE of the solutions in step 2. This is the "heart" of your response (and it may take up 50% or more of your essay), but you shouldn't start on this step until you've worked through steps 1 through 3. While this doesn't occur until relatively late in the process, you'll want to make sure your **thesis statement** (that is, a statement about what your conclusion is re: this case) comes early in the essay.

Step 5: Consider Objections to Your Solution. To close, try to think about possible objections to your solution. These might include (1) potential misunderstandings (which you can answer by clarifying) or (2) genuinely bad things about your solution (here, you'll have to argue that your solution is still better than the alternatives, despite these problems). When doing this, you'll be trying to take the point of the view of someone who favors one of the *other* solutions to the case study. When it comes to the exams, a failure to adequately deal with objections is often the difference between an A-level response and a B- or C-level response.

4.3 Sample Lesson: The Focal Virtues

In this lesson, you'll be learning to:

1. Define moral virtues, and explain how they relate to professional roles in medicine.
2. Explain the tension between an "ethics of care" and an "impartial ethics."
3. Describe the "Five Focal Virtues" of caring.

According to B-C, a **moral virtue** can be defined as a "dispositional trait of character that is morally valuable and is reliably present in a person." In simpler language, we might say that a moral virtue consists of a *habit* of doing the right thing, for the right reasons, and with the right attitude. The common morality recognizes a number of virtues, including generosity, courage, and kindness. Being virtuous is not the same as simply "following the rules," since a person may be virtuous without knowing each and every rule (but simply may "feel" the right thing to do) and a person who follows the rules may not be virtuous (for example, if the person follows the rules only to get a reward or avoid punishment).

In order to understand the importance of virtues in health care, a few definitions may help: Every **professional role** ("physician", "nurse", "surgeon", "radiographer") is associated with certain standards tied to **professional practice.** These standards are closely associated with both moral and non-moral virtues. For example, being a "good physician" requires that one be knowledgeable about medicine, have good leadership skills, and be capable of weighing the evidence relevant to diagnosis. Being a "good nurse" requires that one be able to advocate for patients and interact well with other members of a medical team. Both physicians and nurses must be capable of doing things like relating well to patients and acting with integrity.

Some of these standards are **standards of technical performance,** which are tied to *non-moral virtues***.** These include things like *technical skill* (for example, how well can you carry out various medical techniques?) and *judgment* (for example, how good are you at figuring out which technique to use in a particular case?). Other standards are **standards of moral character,** which are tied to *moral virtues*. These include *normative* skills (for example, how compassionate and conscientious are you?). In most professions (and in health care, in particular), people are much more forgiving of errors related to technical performance or judgment and much *less* forgiving of errors related to moral character.

4.3.1 What is Caring? How does it Relate to Impartiality?

In health care professions, as in many other areas of life, a highly important moral virtue is that of **caring,** which involves the "care for, emotional commitment to, and willingness to act on behalf of persons with whom one has a significant relationship." In particular, a "good" (or *virtuous*) health care professional should care about one's patients, and his or her behavior should reflect this. B-C defend a version of the **ethics of care,** which claims that caring is the *most important* moral virtue[2]. All of the other virtues we will discuss are supposed to represent different *aspects* of caring.

The "Ethics of Care". The ethics of care was originally formulated and defended by feminist philosophers, who had noticed that discussions of moral "obligations", "duties", and "rights" often tend to ignore the role that *caring relationships* play. One reason this is important is that different people (e.g., women and men) have tended to have different sorts of relationships, and thus different obligations. For example, it is because of women's relationship with their children (historically, they were almost always the primary care-takers) that they have felt "morally obligated" to do more for children than did the fathers (and these obligations have prevented many women from doing other things). The basic idea of the ethics of care is that, since morality is based on relationships, it is important to make sure that everyone has an equal opportunity to form valuable, caring relationships that allow them to develop as human beings.

Limitations on the Ethics of Care. While the ethics of care has been influential, a number of scholars have pointed it can't be "the whole story" about ethics. In particular, critics of this approach have asked two important questions:

- **Is caring in conflict with impartiality?** While caring is very important, it can sometimes be in tension with the moral ideal of **impartiality** that is emphasized by many other important moral traditions (including many versions of utilitarianism, deontology, and Judeo-Christian-Islamic ethics). According to the ideal of impartiality, a morally virtuous person should show *no favoritism whatsoever* to friends or family (hence, the ideal of a saint-like person who leaves his or family to go and help the truly needy). An ethics of care, by contrast, emphasizes that one *should* treat some people (such as friends, family, coworkers, and patients) differently than others.
- **Does the ethics of care overemphasize the role of emotion in making ethical decisions?** Impartial ethical theories often emphasize the idea that one should do the right thing "merely because

[2] For an accessible introduction to the ethics of care, see (Sander-Staudt 2019)

it is the right thing to do" and not, for example, for "merely emotional reasons." The ethics of caring, by contrast emphasizes that emotional connections (especially with patients, in the context of medicine) can play an important role in motivating us to do the right thing.

While there is no perfect formula for balancing caring vs. impartiality, or emotion vs. pure intellect, part of developing a moral character involves taking all of these competing (and morally relevant) issues seriously, and learning to balance them.

4.3.2 What are the Focal Virtues? How do They Relate to caring?

Becoming a caring person requires *practice.* In particular, it requires that one work to develop a number of more specific skills. In the medical professions, the following **focal virtues** are especially important.

- **Compassion** consists of an "attitude of regard for another's welfare with an imaginative awareness and emotional response of sympathy, tenderness, and discomfort at another's misfortune or suffering." It requires that one have *empathy* for the feelings of others AND that one act on this in an informed, productive manner. One must be careful so that one's compassion for others does not cause one to act in a manner not consistent with the *other* virtues, however[3].
- **Discernment** involves the "ability to make fitting judgments and reach decisions without being unduly influenced by extraneous considerations, fears, personal attachments, and the like." Discernment requires more than merely "knowing a lot of facts"—it requires that you can use this knowledge in a *practical* way to help patients.
- **Trustworthiness** requires that one act in a way that "merits confidence in one's character and conduct." If your colleagues and patients trust you, they have confidence that you have good motives (e.g., you care about their well-being), appropriate feelings (e.g., you feel happy for their successes and sadness for their pains), and that you will act in accordance with the relevant moral norms.
- **Integrity** includes "objectivity, impartiality, and fidelity in adherence to moral norms." It involves both (1) having a well thought-out, internally consistent set of moral beliefs, and (2) being willing to stand up for these beliefs when they are challenged. A person with integrity is one who takes the demands of morality *seriously.* Patients and colleagues often appreciate and benefit from this, even if they may disagree with some of the specific moral beliefs in question. In some cases, there can be conflicts between *professional integrity* ("what you feel morally obligated to do *as a professional*") and *personal integrity* ("what you feel morally obligated to do *as a person*).
- **Conscientiousness** consists of being consistently "motivated to do what is right because it is right, [trying] with due diligence to do what is right, intend[ing] to do what is right, and exert[ing] appropriate effort to do so." A conscientiousness person spends time thinking through tough moral decisions, and is genuinely concerned to do the right thing. A conscientiousness person will intuitively "feel" the need to obey moral norms, and will feel shame, remorse, and guilt if they recognize that their own conduct has violated these norms[ii].

Historically, most medical codes of ethics have emphasized the importance of developing virtues (though the most recent AMA code does not). However, different virtues have been emphasized by different codes. For example, early nursing codes emphasized obedience to *physicians* (even if they disagreed with the physician), where contemporary codes place much more emphasis on the obligation of caring for the *patient* (even if this leads to conflict with physicians).

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[3] For an interesting discussion of empathy, and the potential problems with the ways many people (including parents, educators, and medical professionals) often think of it, see (Bloom 2014)

4.3.3 Questions for Review

Please answer the following questions.

1. Come up with an example of a (real or fictional) someone you feel demonstrates the virtue of caring. Then, assess the extent to which they instantiate the five focal virtues described above (and make sure to give examples).
2. Do you agree that **moral errors** are often "worse" than **technical errors** or **judgment errors?** Why or why not?
3. To what extent do you think morality requires that we behave *impartially* (i.e., that we treat everyone equally, regardless of your personal relationship with them)? Explain and defend your answer.
4. Which aspect(s) of caring do you think it would benefit you personally to work most on improving (especially as this relates to your work life)? Why? Explain and defend your answer.

4.3.4 Caring in Action: Florence Nightengale[4]

Florence Nightingale (1820-1910) was born an era when middle-class women were expected to simply make a good marriage and raise a family, Florence sensed a 'calling' from God at an early age and believed she was destined to do something greater with her life. As a child, she was very academic and particularly interested in mathematics. Her religion gave her a strong sense of moral duty to help the poor and, over time, she held a growing belief that nursing was her God-given vocation. She was also perhaps set to follow the family tradition of reform mindedness, such as the example set by her maternal grandfather who was an anti-slavery campaigner. [More of the case study follows…]

Based on this description, evaluate Florence Nightingale with respect to the five "focal virtues" discussed earlier. In what respects do you think she is a good role model for *modern* medical professionals?

4.4 SAMPLE LESSON: MORAL STATUS

In this lesson, you'll learn to do the following:

1. Explain the problem of moral status, and give examples of specific issues where it becomes relevant.
2. Identify major theories of moral status, apply them to particular cases, and recognize their respective strengths/weaknesses.
3. Reflect on your own beliefs/attitudes related to moral status.

So far, we have discussed a number of basic moral concepts, including rights, obligations, virtues, relationships, and ideals. We'll now begin talking about *what sort of beings* these moral concepts apply to. This is the problem of **moral status,** and many of the trickiest (and most controversial) moral questions are directly related to it. For example, many of the most important questions of biomedical ethics concern "marginal" beings such as (1) human embryos and fetuses, (2) patients with severe dementia or cognitive disabilities, (3) research animals, and (4) "amoral" people such as convicted murderers or rapists. Historically, the debate over moral status has been a hugely important one. Until relatively recently, for example, many societies held that certain groups of people (Africans, Jews, people with cognitive impairments, etc.) had *no* moral status, while other groups (e.g., women, poor people) had *lesser* moral status. This was used to justify practices, such as slavery and institutional sexism, that we now recognize as immoral.

[4] This biography is adapted from ("Biography of Florence Nightingale" n.d.)

4.4.1 What are some Theories of Moral Status? What can We Learn from Them?

A being has moral status if and only if "and only if it or its interests morally matter to some degree for the entity's own sake"[5] Ethicists have proposed different **theories** of moral status. B-C argue that NONE of these theories captures the common morality's position on moral status, though many pick up on important aspects of it.

All and only biological HUMAN BEINGS have full moral status. This theory says that all humans have equal status regardless of their age (e.g., embryos and fetuses) or cognitive capacities (e.g., dementia patients and anencephalic infants). The theory claims that being *biologically human* makes you part of a **natural kind;** this is the *only* thing relevant to having moral status.

[O]ur concept of a person is an outgrowth or aspect of our concept of a human being; and that concept is not merely biological but rather a crystallisation of everything we have made of our distinctive species nature. To see another as a human being is to see her as a fellow-creature—another being whose embodiment embeds her in a distinctive form of common life with language and culture, and whose existence constitutes a particular kind of claim on us. (Stephen Mulhall 2002, qtd by Wasserman in SEP[6])

1. **Problem:** This theory claims (without argument) that animals like chimps, dolphins, and pigs have less moral status than humans, *even if they are smarter and have a greater capacity for emotion and suffering than do some humans (such as embryos or the severely handicapped).* While this may (or may not) be true, there has to be some deeper reason beyond mere species membership. Within the next 100 years, this problem will get worse, as we might well be confronted with non-human (but intelligent) beings like genetically engineered human-chimpanzee **chimeras**, reincarnated Neanderthals, truly intelligent computers/robots, or whatever. Because of this, it simply isn't plausible to claim that being human is a **necessary condition** for having full moral status[7].
2. **Conclusion:** This theory, if limited to normal adult humans, provides a good **sufficient condition** for having full moral status: "If a being is a normal adult human (or is relevantly similar to a normal adult human), then it has full moral status." By itself, however, this theory can't solve tough questions like the morality of abortion or the moral status of animals, though.

All and only beings with complex COGNITIVE CAPACITIES have full moral status. This theory says that moral status is tied to a being having *beliefs, desires, intentions,* a sense of *self-consciousness,* and an ability to *reason* and *communicate* using language. This theory entails that fetuses, embryos, and animals used in research do NOT have full moral status. However, some non-humans (Chewbacca, Dr. Spock, Nemo, Wall-E) might have it.

...every rational being, exists as an end in himself and not merely as a means to be arbitrarily used by this or that will...Beings whose existence depends not on our will but on nature have, nevertheless, if they are not rational beings, only a relative value as means and are therefore called things. On the other hand, rational beings are called persons inasmuch as their nature already marks them out as ends in themselves. (Kant, 1785, 428, qtd by Gruen in SEP[8])

1. **Problem (Argument from Marginal Cases):** Depending on how high we set the bar (e.g., how much cognitive capacity we require), it looks like LOTS of humans won't have full moral status (including young children or elderly people with dementia). Moreover, if degree of moral status depends strictly on how

[5] (Jaworska and Tannenbaum 2018)
[6] (Wasserman et al. 2017)
[7] The definition of "species" (as in "a member of the species homo sapien) itself raises some philosophical problems (Crane 2004; Ereshefsky 1998; Mallet 2001). For a discussion of how these might cause problems for defining "human" in a scenario where there was widespread genetic engineering, see Shea (2016).
[8] (Gruen 2017)

"smart" you are, it looks many animals (such as pigs) will have more moral status than many of these humans. Most people (even animal-rights activists) are probably uncomfortable with this conclusion.

2. **Conclusion:** Again, this theory provides a good sufficient condition for full moral status: "If a being has complex cognitive capacities, it has full moral status." Just as with the earlier theory, though, B and C don't think this provides necessary conditions, since it seems like you can have moral status WITHOUT meeting this criterion.

All and only MORAL AGENTS have full moral status. This theory claims that moral status requires (a) that you be capable of making judgments about whether actions are morally right or wrong; and (b) that you have *motives* that can be judged morally. Like the above theory, this entails the fetuses, embryos, and most animals don't have moral status, and that adult humans (and Chewbacca) do.

1. **Problem (Argument from Marginal Cases, part 2).** This has all the same problems the previous theory did. There are LOTS of humans (including children, sociopaths, and anyone with reduced cognitive abilities) that aren't "moral agents."

2. **Conclusion:** Like the first two theories, this provides a good sufficient (but not a necessary) condition: "If a being can be held morally responsible for his or her actions, then that being has moral status."

All and only beings with SENTIENCE have (some) moral status. This theory claims that moral status is tied to your ability to feel pain and pleasure. It entails that many research animals (including mammals, but excluding insects), most patients with cognitive disabilities, and some fetuses (once they have developed a functional nervous system, at around 20 to 26 weeks) have *some* moral status.

[Animals] want and prefer things, believe and feel things, recall and expect things. And all these dimensions of our life, including our pleasure and pain, our enjoyment and suffering, our satisfaction and frustration, our continued existence or our untimely death—all make a difference to the quality of our life as lived, as experienced, by us as individuals. As the same is true of … animals … they too must be viewed as the experiencing subjects of a life, with inherent value of their own. (Tom Regan, 1985, qtd by Gruen in SEP)

1. **Problem.** While it is plausible that all of the beings just mentioned have a *level* of moral status, the strongest version of it may be impractical, since it entails that many pigs/cows/rats/fetuses will have the exact *same* moral status as adult humans. On the other hand, some people have thought that there are some beings (such as fetuses before 20 weeks) who *are not* sentient, but nevertheless have moral status.

2. **Conclusion.** This theory provides a plausible sufficient condition for having *some* moral status. It may (or may not) provide a necessary condition for having moral status. It isn't satisfactory as a theory of *full* moral status, though.

All only beings with significant RELATIONSHIPS have full moral status. This theory claims that the only way you can get moral status is being in the right *relationship* with the beings you want to respect that moral status. So, for example, it is your role as a family member that "makes" your family members have certain obligations to you, and your role as a "citizen" that makes the other citizens of your nation respect your "rights."

1. **Problem:** This theory entails that people with the fewest relationships (for example, young orphans fleeing war-torn countries, or elderly people dying alone) have the *least* moral status. This seems pretty implausible. It also might entail that inanimate objects (like your smartphone) might have moral status, at least if you cared about them enough.

2. **Conclusion.** While relationships can ground many important moral rights and obligations (doctor-patient, parent-child, friendship, marriage, pet ownership, coworkers, etc.) this doesn't seem like a good

theory of *moral status,* since having relationships is neither necessary *nor* sufficient to guarantee moral status.

There are at least three debates underlying these five theories. First, what does it mean to live a *human life?* Do we mean *biologically human* (if so, then we should count brain-dead patients). Or does it mean a *life that is distinctively human ?* Second, what is the role of *potentiality?* For example, do human fetuses and embryos have *full* moral status, *no* moral status, or some *intermediate* degree of moral status? Finally, is moral status all-or-nothing, or does it come in **degrees**?

4.4.2 Questions for Review

1. On a scale of 1 to 5 (1 = no moral status; 3 = intermediate moral status; 5 = full moral status), how would you classify the following beings? What does this mean for how you ought to treat them? Be prepared to explain and defend your answer.

Type of Being	How much moral status?
Ordinary adult humans	5 (This is the baseline case)
Convicted murderers	
Human infants	
Early term human embryos/fetuses (no ability to feel pain/pleasure)	
Late term human fetuses (ability to feel pain/pleasure)	
Humans with severe cognitive disabilities	
Plants	
Invertebrate animals, such as worms or insects	
Vertebrate non-mammals, such as crocodiles or birds	
Non-primate mammals, such as rats	
Non-human great apes, such as chimps or gorillas	
Intelligent, non-human aliens such as Dr. Spock, Hagrid, or Chewbacca	
Intelligent robots, such as Wall-E (Pretend these really exist)	

2. Based on the above, write down a short (5 to 10 sentence) summary of your OWN "theory" of moral status. You might have discovered that you are an advocate of one of theories discussed above, or a combination of them, or you might have ideas that aren't perfectly captured in any of these. It's OK to feel uncertain about this (and in fact, feeling *too* certain about questions of moral status is plausibly one of the issues that led to the abuses noted above).

4.5 Case Study Analysis Using the Four Principles: Roe v Wade[9]

Abortion has been among the most contentious issues in bioethics, and people (both within medicine and outside of it) have radically different ideas on how it ought to be regulated. While there are a variety of theoretical arguments about the morality of abortion, none has achieved widespread acceptance. This has presented a significant challenge for policy makers who try to set down guidelines, since these guidelines need to (1) be workable in the context of actual medical practice, (2) be acceptable to the public at large. In the U.S., *Roe v. Wade* represents the foundation of contemporary legal thought about abortion.

Neat fact: This majority opinion was written by Justice Harry Blackmum, who was chief counsel at Mayo Clinic in Rochester, MN from 1950 to 1959. Before writing the opinion, he went back to Mayo to do research on the history of abortion laws. He said his time in Rochester was the "happiest time" of his life.

Summary: "Jane Roe, a single woman who was residing in Dallas County, Texas, instituted this federal action in March 1970 against the District Attorney of the county. She sought a declaratory judgment that the Texas criminal abortion statutes were unconstitutional on their face, and an injunction restraining the defendant from enforcing the statutes.

Roe alleged that she was unmarried and pregnant; that she wished to terminate her pregnancy by an abortion "performed by a competent, licensed physician, under safe, clinical conditions"; that she was unable to get a "legal" abortion in Texas because her life did not appear to be threatened by the continuation of her pregnancy; and that she could not afford to travel to another jurisdiction in order to secure a legal abortion under safe conditions. …

James Hubert Hallford, a licensed physician, sought and was granted leave to intervene in Roe's action. In his complaint he alleged that he had been arrested previously for violations of the Texas abortion statutes and that two such prosecutions were pending against him. He described conditions of patients who came to him seeking abortions, and he claimed that for many cases he, as a physician, was unable to determine whether they fell within or outside the exception recognized by Article 1196. He alleged that, as a consequence, the statutes were vague and uncertain, in violation of the Fourteenth Amendment, and that they violated his own and his patients' rights to privacy in the doctor-patient relationship and his own right to practice medicine, rights he claimed were guaranteed by the First [speech, religion, assembly], Fourth [no search and seizure without warrants], Fifth [right to due process of law], Ninth [individual rights not specifically mentioned are still protected], and Fourteenth Amendments [due process applies to state laws, too.]."

4.5.1 Blackmun's Decision: Three Trimesters

The U.S. Supreme ruled in favor of Roe, and held that Texas's abortion laws (along with those of many other states) were unconstitutional. They laid out a three-tiered framework for determining laws about abortion. These three tiers corresponded to the three trimesters of pregnancy (in 1992, the trimester framework was thrown out, but the basic structure is still the same).

First Trimester of Pregnancy—During the first 3 months of pregnancy, a woman's right to **privacy** was held to trump all other considerations. So, no laws restricting abortion could be passed. The right to privacy is very similar to what we've called **autonomy**, and it concerns people's rights over their own bodies. The court held that this right was implicit in the US Bill of Rights, which protects the rights to freedom of speech, assembly, religion, and the right to not house soldiers. This right was first recognized in **Griswold v Connecticut (1965),** when the court held that couples had a right to use contraception.

Second Trimester of Pregnancy—During the second 3 months of pregnancy, the right to autonomy must be weighed against the state's legitimate interest in protecting maternal health. This similar to what we have called

[9] (Roe v. Wade 1971; Doe v. Bolton 1971)

beneficence—the duty to help other people where we can. The state often does this. For example, it makes it illegal to buy or sell many addictive substances (such as heroin or cocaine), tightly regulates others (such as prescription medication), and taxes some (cigarettes, alcohol). The government also forbids people to practice medicine without proper training. While this involves restricting people's autonomy rights, it is done "for their own good." However, restriction here must be based on medical evidence—e.g., there must actually be evidence that abortion procedure in question is unsafe.

Third Trimester of Pregnancy (Viability)—The court held that a fetus was **viable** (able to survive outside the womb) after 6 months. Because of this, they said states could regulate third-trimester abortion for the purposes of protecting potential life. This is a version of the principle of **nonmaleficence,** which holds that it is generally wrong to harm others. The court did NOT hold that a third-trimester fetus had the same rights as a full adult, but they held that states could take account of the fetus's interests. In ***Casey v. Planned Parenthood***[10]**,** the court revised this requirement to reflect changes in medical technology, which allowed fetuses to become viable before the third trimester.

***Doe v Bolton (1973)*—**In a secondary decision associated with Roe, the court held that states *must* allow abortions necessary to preserve the mother's life or health (even in the 3rd trimester). Their primary grounds for doing so was one of "due process" (which is closely related to "fairness" or **justice).** The basic idea: it would be unfair to make women "jump through hoops" to get a life-saving abortion, since states don't require this for any *other* sort of life-saving medical procedure.

Casey and the "Undue Burden Standard." In 1992, the Supreme Court revised and clarified Roe. Along with getting rid of the strict trimester framework, they proposed a new test. After viability, the state could regulate abortion in order to protect the woman's health and/or the interests of the fetus, but only if this wasn't an **undue burden** to her autonomy or health. This involves what B-C early called **"weighing"** and **"balancing"** of norms, as well as **"specifying"** the scope under which various norms apply.

Common Misunderstandings About Roe v. Wade. Probably because the case concerns a highly controversial subject, there are a number of common misunderstandings of Roe v. Wade.

1. **The decision does NOT legalize "abortion on demand."** It does require that states legalize first-trimester abortion, and they have good reasons for restricting it in the second and third trimester.
2. **The decision does NOT say a fetus has a "right to life."** The decision says that states are allowed to consider a fetus's interests after the point of viability, and that they can prohibit abortion on this basis. However, it does not *require* they do so (so, some states allow late-term abortions, and others do not).
3. **Viability is not the same as "sentience," and both play a distinct role in the abortion debate.** Viability refers to the ability of fetuses to survive outside of the womb. Sentience, by contrast, refers to ability of fetuses to have experiences of pain/pleasure. However, these two things often happen somewhere around the same time (~20 to 28 weeks).

4.5.2 Review Questions

1. Write a 50-word (or close to 50 as you can get) summary of Roe v. Wade. Don't look at the handout when doing so.
2. Some critics of Blackmum have argued that he should have been more "principled"—e.g., he should have come down firmly on the side of the woman's right to choose, or the baby's right to life, rather than attempt to "split the difference". What do you think of this criticism?

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[10] (Planned Parenthood of Southeastern Pa. v. Casey 1992)

3. Many contemporary debates on abortion focus on what counts as an "undue burden": Can states require 24-hour-waiting periods? Viewing of pictures of fetuses? Spousal consent for married women? Parental consent for minors? Hospital admitting privileges for abortion clinics (even if doctors carrying out medical procedures of similar risk aren't required to do so?)? What do you think?
4. The abortion debate has lasted for (at least) 150 years in the U.S., and related debates about infanticide stretch back thousands of years (and across numerous cultures). In 150 years, do you think it will be resolved? Defend your answer.

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[i] This summary is adapted from Shea (2013). For short introductions to Principlism, also see Gillon (1994; 2003; 2015), Quante and Vieth (2002) Gordon et al (2011), Shea (2015) , and Arras (2016).
[iiii] For an argument AGAINST allowing conscientious refusal by medical professionals (and, in effect, denying the distinction between professional and personal integrity as it is understood here), see Clipsham (2012)