Appendix I

More About Ethical Theories

In this appendix the introduction to fundamental concepts and principles of ethical theory begun in Chapter 2 is continued. The focus will be on general ethical theories. As you saw in Chapter 2, the resources of ethical theory are necessary to supplement guidelines developed by the professional community. There is a long tradition of theorizing on matters of values and ethics in Western culture, although in most cases this has only recently been applied to health-care issues. The discussion will deal with the theories in the abstract and explore their application to health care and to the issues discussed throughout the text.

One goal of this text is to help you become more aware of your own personal values and fundamental ethical principles, and one of the best ways to accomplish this is for you to pay attention to the way your own thinking "resonates" or "clashes" with various positions described in this appendix. These positions represent a spectrum of different ethical theories. Don't think, however, that you have to adopt one of these classical theories "whole hog." It may be possible to combine elements of different theories into a consistent, working ethical system. However, not all combinations of these theories are consistent, so you will need to proceed carefully with attempts to create a hybrid system of thought.

You will find it useful to review the discussion in Chapter 2, Section 2.1 for some terminology that is important here, i.e., the distinction between evaluative obligation, and character judgments.

1 Utilitarianism and Other Goal-Based Theories

1.1 Teleologyism, the Goal-Based Approach

In this view the basis of duties and rights (i.e., obligation judgments) lies in the consequences of our actions. The main task of the moral life is to produce as much good as we can through our actions while at the same time avoiding and eliminating harm or bad to the extent possible. More formally, the basic guiding principle of teleologism can be stated thus:

Of all the alternatives open to a given agent at a given time, the one she or he ought to perform is the one that produces the greatest balance of good over evil for the
members of the moral reference group. If two or more alternatives are equally optimific (i.e., create an equivalent balance of good over evil or bad but greater than any other alternative), then the agent ought to perform one or the other of these and it would be equally right to perform either of them.

In contrast, deontological approaches maintain that the basis of duties and/or rights is to be found in something other than evaluating the consequences of our actions. Extreme forms of deontologism (e.g., Kant's view) hold that consequences do not have any influence at all in determining duties and/or rights. (Some forms of deontologism will be examined in detail in Section 2. For now, it is sufficient to grasp this fundamental difference between these two approaches in order to have an alternative to teleologism to consider as you read this section.)

There are at least three important questions that this guiding principle of teleologism leaves unanswered: 1) Who is to be included in the moral reference group? 2) What is to count as good and bad? 3) What sort of alternative is to be considered? Is the standard to be applied to specific actions, one at a time, or can it be used to formulate rules or policies for actions of certain kinds?

The answers to these three questions distinguish different forms of teleological or goal-based theories. In the following sections you will look at some different answers that have been given to each of these questions.

1.2 The Moral Reference Group

Who counts, morally? Whose welfare do we, as moral agents, have a responsibility to promote? The answer to these questions determines the "moral reference group."

A full spectrum of answers to these questions has been given in the history of Western philosophy and theology. At one extreme is egoism. In this view the only person toward whom each agent has any moral responsibility is him- or herself. Each person ought to do all he can to promote his own welfare (and to avoid harm to himself), but he has no obligations toward anyone else at all. The proponent of egoism does not necessarily mean any harm to others and may have no objection if others prosper. She merely sees no obligation to assist others. This is an extreme ethic of individualism. Each person is to look out for herself.

At the opposite extreme is the view we might call vitalism, which considers all living creatures to be members of the moral reference group. This would entail that we have a responsibility as moral agents to promote the good and minimize harm for all living things; thus plants and the lower animals are regarded as fully equal in importance to ourselves and our fellow humans. One who held this view would face a moral dilemma at the thought of having to kill a flower in order to make a medicine to save a human life. Or he might find it troubling to think that his lymphocytes are killing bacteria. [This is one way in which "sanctity of life"]
principles might be interpreted, as they figure prominently in the issues of suicide and abortion (see Chapter 4).]

Intermediate positions, between the extremes of egoism and vitalism, will limit membership of one’s moral reference group to some identifiable set of individuals. For example, racism is the view that only persons with a certain racial heritage count as members of the moral reference group. Sexism says the same about members of one gender. Nationalism counts only fellow-citizens of one’s nation as members of the moral reference group.

One way to explain what is wrong with racism and sexism is to consider what would be required to justify these positions. To begin, one would have to give reasons why the particular individuals included in the group do matter enough that responsibilities arise to promote their welfare. (Without this argument, the egoist position wins the debate by default.) But then, one would also have to give reasons why our responsibilities end with the group singled out. What is the difference between these individuals and others, and why should this trait be considered as grounds for ignoring the welfare of those not included in the “in-group”? Clearly, it will not be easy to locate any trait with all three of these requisite features: 1) being common to all members of the moral reference group, 2) not shared with any individual outside the group, and 3) having the proper moral significance to justify the proposed differences in the way we act toward the parties.

There is one particular intermediate position that should be noted at this point, since it plays an influential role in the ethical thinking of many health-care professionals. This is the view that professionals owe a special responsibility toward their patients that they do not owe to other individuals who may be in equal or greater need of their services. The law often recognizes something similar to this difference in responsibility. Thus, for example, (in most states) a physician or nurse who drives by an auto accident is under no legal requirement to stop and render assistance. Similarly, a new patient who shows up at a physician’s office may be turned away without treatment. (Recall the provision from Section VI of the 1980 AMA Principles of Medical Ethics: “A physician, except in emergencies, shall be free to choose whom to serve.”) However, once the physician has accepted someone as a patient, to deny that person treatment when it is needed may invite legal charges of “abandonment.” Professional ethics and personal conscience extend still further this sense of duty within an established professional-patient relationship. A professional is expected to go “all-out” for his or her patients. The justification for singling out this group as special is found in the nature of the professional-patient relationship that has been established. Some implications of this view of a limited moral reference group are examined in connection with the discussion of the physician-patient relationship in Chapter 1, as well as in connection with the “moral center” of medicine in Chapter 3.

The doctrine of the moral reference group most widely held in Western thought falls somewhere between the wide-ranging principle of vitalism and the special-
interest views of sexism, etc. There is some controversy about precisely how to formulate it, so three variants are offered here; think about how the differences between them might affect issues such as abortion and the definition of death:

1. Humanism: The moral reference group includes all human beings, and only human beings.
2. Personalism: This view, which is closely related to humanism, states that the moral reference group includes all persons, and only persons.
3. Universalism: The moral reference group includes all sentient (i.e., conscious) creatures, and only sentient creatures.

In the past these three principles often have been carelessly lumped together as if there were no significant differences between them. Part of the reason for this was the belief that the reference groups all designated the same set of individuals, i.e., human beings = persons = sentient creatures. However, recent discussions have shed doubt on this presumption of equivalence. Animal-rights advocates point out that the lower animals are sentient, even though they are neither human beings nor persons. Science fiction literature introduces the possibility that there might be extraterrestrial creatures we would classify as persons although they are not human beings. Furthermore, it is a serious issue for debate whether permanently comatose patients should be considered to be persons or sentient, although they undoubtedly remain human beings.

For present purposes, look at the elements these three views have in common and see how they would combine with various answers to the other two primary questions about teleologism. Differences between them can then be considered in connection with specific, concrete issues.

1.3 Theories of Value

The second question left open by the guiding principle of teleologism deals with evaluative issues: what counts as good (and thus to be promoted), and what counts as bad (and thus to be avoided or minimized)? Without an answer to this question, the teleological approach cannot give us guidance in particular choices we must make. We would not know what aspect of the consequences counts for and against the alternative.

Suppose, for example, one were invited to take part in a certain activity and were told only that it would have the effect of causing certain body tissues to increase in size and quantity. No reasonable judgment can be made about whether the activity is worth the effort until we know what tissue is being referred to and whether an enlargement would be valuable or not. Is it muscle tissue, so that the result would be a healthier, more robust appearance? If so, then it might be worth
pursuing. Is it brain tissue, so that the result would be increased intellect? Then, again, it might be worthwhile. On the other hand, is it fatty deposits, so that the result would be obesity? Or is it tumor tissue, so that the result would be suffering and death? Obviously, the value of the consequences makes all the difference.

Let us look at some different answers that have been given to this question of what things have value.

1.3.1 Subjective Preference  Many people would contend that it is at once both futile and presumptuous to attempt to develop a general theory of value. Such an attempt is thought to be futile because value judgments are regarded as totally subjective and individualistic. "Everybody is unique, and each of us has our own set of values and preferences." Thus any effort to state a list of "true" values is presumptuous, because whoever developed the list would be imposing his or her own subjective preferences upon others.

The only sound alternative, then, would be to make subjective preference the standard of value and to orient teleological positions toward maximizing the satisfaction of preferences and minimizing their frustration. This is the approach that many contemporary economists, sociologists, and psychologists take in their analyses of values, especially as applied in social planning. However, this is not an inevitable conclusion, nor is it obviously the best approach to take.

The fundamental problem with the subjective-preferences approach is that it overlooks the possibility that some of our preferences may be mistaken. "Mistaken?" you may say. "That sort of statement just proves what was said earlier about an objectivist approach being presumptuous! How could anything be more presumptuous and judgmental than to call someone's preferences 'mistaken'?!" Nevertheless, presumptuous or not, we must acknowledge that subjective preferences can sometimes be mistaken.

Let us explain. In Chapter 2, Section 2.1, two sorts of evaluative judgments are exemplified. They are commonly referred to as instrumental, for those that are good as a means to some chosen end, and intrinsic, for those that are good in and of themselves. It is possible for one to be mistaken about both kinds of values.

Think back to the case cited in the Review Exercise at the end of Chapter 2 (Section 3.2). The end that the child's parents have chosen and are pursuing in this situation is to restore their daughter to health. The means they have chosen to reach this goal include 1) bringing their daughter to a health-care professional for treatment, and 2) demanding "rather abruptly" that the practitioner prescribe antibiotics for their child.

A. Instrumental values. In making this specific demand, the parents have not selected "the best means to their chosen end." An antibiotic will not be effective in restoring their daughter to health. At best, it will make no difference at all in her
recovery ("She will be well in seven days with the drug, without it recovery will take a week"), and it might even impede progress toward the goal through its side effects or if the child has a drug reaction. So, the parents have made a mistaken judgment of instrumental value. Here, as in many such situations, others may be in a better position than the parents to judge instrumental values. Furthermore, it does not seem presumptuous to point out that they may be mistaken in this way. A part of what is involved in making judgments of instrumental value is making factual predictions about what various alternatives are likely to achieve. And it is a fact of life that we are not all completely knowledgeable about all aspects of the world. This is why we rely on experts such as the health-care practitioner—to supplement our own knowledge.

"Okay," you may say, "Perhaps we can say that instrumental values are sometimes mistaken. But the same does not hold true for intrinsic values. Those are entirely a matter of the individual's own subjective preference. Nobody else can presume to tell me what is important to me!"

B. Intrinsic values. If it seems impossible to question the end chosen by the parents in the case study, perhaps this is only because it is, in fact, appropriate. But suppose they had chosen another end instead. Would we always be inclined to accept it as appropriate, no matter what it was? To take an admittedly extreme example, suppose the parents brought the child to the pediatrician with the request that the physician "do something" to arrest the growth process in their daughter, giving the explanation: "We love her so much the way she is right now that we do not want to see her change!" Surely this is an inappropriate and unreasonable goal, not only because it is impossible to achieve (although this may be reason enough to condemn it), but because it is unreasonable even to attempt or to want to achieve it. Or suppose, as an alternative, that they announced, "If you do have to give our daughter any medicine, it must be either pink or green. That is the color scheme in our bathroom, and we insist that the contents of the medicine cabinet match the rest of the decor. If you prescribe anything else, we will not have it in the house." To elevate the goal of a coordinated decor to a status equal with the health needs of their daughter is clearly inappropriate and unreasonable.

We trust that these examples have convinced you in principle that there can be mistaken judgments of intrinsic value. Now we are in a position to consider whether a theory of value might be stated, to guide us in choosing correct values and avoiding mistaken ones.

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1. We choose extreme and hypothetical examples here to make our point as strong as possible. The claim we are arguing against says that no intrinsic value claim can be said to be mistaken. That claim will be refuted if any are shown to be mistaken.
1.3.2 Hedonism  The theory of value most discussed in the history of Western philosophy is hedonism, which holds that the one and only thing intrinsically good is pleasure, and the one and only thing intrinsically bad is pain. Initially this approach may appear just as subjective as leaving judgments to individual preference, but it can be shown as somewhat of an improvement. A hedonist view provides a basis for criticizing some specific goals as mistaken: hedonist goals involve predictions about what would bring the person pleasure (or avoid pain), and any prediction can be criticized as being incorrect. Thus, we could criticize the parents' demand for antibiotics in the original version of our case study on the grounds that, all things considered, they are unlikely to be made happy by this choice. If the child were to suffer side effects from the drug, the parents would clearly be unhappy, and evidence of the drug's ineffectiveness for the child's condition also would do nothing to enhance the parents' happiness, in even the best situation imaginable. Similarly, we could criticize the goal of arresting the growth of their child on the grounds that this would not really make them happy, on balance, even if it could be achieved. They would be quite likely to regret their choice at some point in the future, when they would realize how they were depriving themselves (not to mention their daughter) by foreclosing future stages of maturation and development. In the final example, the effects on the child's health of foregoing needed medication, just because it does not match the decor, would be unlikely to maximize the parents' happiness: could they really enjoy their coordinated color scheme if their child's suffering from this illness lingered on and on?

The hedonist theory has other strengths to recommend it. The disvalue of pain is especially well recognized in the health-care setting, where enormous efforts are directed at palliation. And the value of pleasurable states seems to require no defense: to experience them is ipso facto to recognize their value as goals worth pursuing.

Philosophers who favor hedonism have had great hopes for its usefulness as a practical basis for individual and social planning. For example, Jeremy Bentham (an eighteenth century English philosopher) proposed a schema he was convinced would allow precise, quantified measurements of pleasure and pain. His proposal included the following parameters:

2. Although there are subtle differences between the terms "pleasure" and "happiness," we will ignore them here and use the two words interchangeably.
A. Four Measures of the Intrinsic Value of an Individual Experience

1. Intensity Some measure of the immediately felt degree of pleasure or pain. For example, the excruciating pain from a kidney stone is considerably more intense than the discomfort of a mild rash. Or the pleasure one receives from watching an uproarious slapstick comedy is more intense than the pleasure of hearing a mildly amusing joke.

2. Duration Measuring how long the feelings of pleasure or pain last. For example, in considering the unpleasant side effects of a certain medication, one must compare how long they will last to how long the pain of illness will last if the medication is not taken.

3. Certainty A measure of how likely one is to receive the type of feelings from a certain activity. For example, for a surgical treatment it is fairly certain that one will experience discomfort as the incision heals, whereas the effectiveness of the surgery in relieving one's original source of discomfort may be more or less uncertain.

4. Propinquity A measure of how much effort one must make to achieve the feeling-state. For example, the satisfactions (and related physical-training effects) from swimming are more remote for most people than those of walking or jogging, since they must travel some distance to a pool in order to swim, whereas they could run in their own neighborhood.

B. Two Measures of the Instrumental Value of an Individual Experience

5. Fecundity The probability of the experience being followed by additional sensations of the same kind. For example, if one enjoys learning to play tennis, this will be a fecund or fruitful pleasure because it also equips one to gain the enjoyment of playing the game later. If some self-destructive behavior is painful, this will be a fecund pain, since it will cause additional pain later from its destructive effects.

6. Purity The probability of it not being followed by sensations of the opposite kind. For example, the "morning after" hangover makes last night's state of inebriation an impure pleasure. The discomfort associated with surgery, on the other hand, is impure pain, since it may bring relief from the original complaint as a consequence.

C. One Measure of the Social Dimension of Experience

7. Extent The number of people affected by the pleasure. For example, a public health measure that relieves some painful state for many people will be greater in extent than an individual procedure that affects the state of health and happiness of only one person.

Bentham proposed as an agenda for the social sciences that they develop objective measures for these parameters as a way of calculating the solution to social problems. Some social scientists have undertaken this task, and some progress along these lines has been made (most notably in economics), but we are still far from achieving the comprehensive "hedonic calculus" that Bentham envisioned.
Furthermore, it is not clear that such an achievement will ever be possible. Establishing objective standards for measuring these parameters is notoriously difficult. The measure that is especially difficult is intensity. It is extremely difficult for one to compare two different pains or pleasures of one’s own with respect to intensity, i.e., is the pain of today more or less intense than the one I experienced yesterday? The difficulty is even greater for interpersonal comparisons, i.e., is my pain of today more or less intense than your pain of yesterday? Anyone who has worked with patients in pain knows the difficulty of judging its intensity. The health sciences have developed some descriptive terms that may help in classifying degrees of pain, but these are still far from precise. For example, one classic textbook of diagnosis says the following:

Quality. Three qualities of pain are recognized: (1) bright, pricking, often described as sharp, cutting, knifelike, lightning-like, (2) burning, also reported as hot or stinging, and (3) deep, aching variously called boring, pounding, sore, heavy, constricting, gnawing.

Severity. Precise measurements of the intensity of pain are impractical for a clinical examination, but meaningful approximations can be obtained from the patient’s descriptions and the examiner’s observations. The patient is asked to liken the severity of the pain to some common experience such as a toothache, menstrual cramps, labor pains, or a sore throat. Intense pain is usually accompanied by physiologic signs perceptible to the examiner and often noted by the patient, such as facial expressions, bodily postures (protecting a limb by holding it), flexion of the thighs upon the belly for severe abdominal pain, reduced bodily activity, sweating, pallor, dilatation of the pupils, elevation of the blood pressure and acceleration of the heart rate, retching and vomiting. (DeGowin and DeGowin 1976, 31–32)

This is vague, and nothing this detailed has been done with regard to pleasures.

In addition to these difficulties with measurement, there is another serious difficulty with hedonism as a working theory of value that makes it largely unacceptable for applying ethics to health care. The problem is that there are values that do not appear to be rooted in pleasure and pain; thus, even if a theoretical account of these values could be constructed in hedonist terms, the result would be too abstract and too far removed from the basis of our ordinary valuation of these things to be of any practical usefulness.

For example, we value knowledge at least to some extent; research scientists have dedicated their lives to pursuing this value. It is true that knowledge can often be useful in promoting pleasure and preventing pain. To this extent, its value might be accounted for in hedonist terms. But is this the whole story? What about “basic” research of a sort not likely to lead directly to the cure of disease or to other socially beneficial applications? Here knowledge seems to be sought “for its own sake,” “as an end in itself,” and not as a means to pleasure or prevention of
pain. The standard hedonist reply is to point to forms of pleasure and pain that may be involved even in this sort of knowledge: 1) there is always the possibility that some beneficial application will stem from the knowledge in question; and, anyway, 2) the researcher gets satisfaction from the accomplishment of bringing this knowledge to light and/or from contemplating this new insight. But this type of account is the sort of abstract and remote result mentioned earlier. If the link between pleasure/pain and values is as esoteric as this, it is not clear how the criterion of hedonism can be of any use in making health-care decisions.

This hypothesis about the uselessness of a hedonist theory of value can be tested further by attempting to apply it to some of the specific issues discussed throughout this text. Meanwhile, let us continue our search for a satisfactory theory of value for use in health-care decisions.

1.3.3 Quality of Life  A more promising theory of value for health-care ethics stems from the notion of "quality of life" (QOL). This is often little more than a slogan, but it contains elements that can be developed—with thoughtful analysis—into a value basis for decision making.

In our ordinary thinking, we tend to approach the concept of QOL from the negative side. In the health-care context we speak of "diminished QOL" that results from disabling injuries or through the pain and suffering of lingering illness. In other contexts we speak of the "lowered QOL" in terms of air pollution in our cities and crime in the streets.

However, judgments about positive values can readily be derived from this catalogue of disvalues. If the loss of a certain ability diminishes one's QOL, then it must be because the possession of that ability previously made a positive contribution to one's QOL. For example, if paralysis diminishes one's QOL, then mobility must be regarded as a positive contribution to the QOL of those of us fortunate enough to have escaped a paralyzing injury.

By continuing in this way—that is, by listing the disvalues that diminish QOL and then stating their positive correlates—a catalogue of values that make positive contributions to QOL can be generated. The list might be continued by thinking about the constituents of our own life and listing those elements that make it "worth living." We could add to the list still further by listing our aspirations—things we would like to add to our life that we think would make it even more worthwhile. If the resulting list were too full of specifics, we might try to generalize it by looking for abstract common features within the specific things we value as contributions to QOL.

If each of us undertook such a project independently, the resulting lists would contain largely (but not entirely) the same items. For example, look at the following list generated by a pair of social scientists who conducted a several-stage process, much along the lines described above, to develop a list of features with direct bearing (some positively, others negatively) upon QOL. They had respon-
Students list relevant items and (after the lists had been consolidated) rank them in terms of relative importance. Their conclusions are summarized below [adapted with permission from Dalkey (1972, 71)]:

<table>
<thead>
<tr>
<th>Importance</th>
<th>Relative Importance</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>15.0</td>
</tr>
<tr>
<td>Love, caring, affection, communication, interpersonal understanding; friendship, companionship; honesty, sincerity, truthfulness; tolerance, acceptance of others; faith, religious awareness.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11.5</td>
</tr>
<tr>
<td>Self-respect, self-acceptance, self-satisfaction; self-confidence, egoism; security; stability, familiarity, sense of permanence; self-knowledge, self-awareness, growth.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10.0</td>
</tr>
<tr>
<td>Peace of mind, emotional stability, lack of conflict; fear, anxiety; suffering, pain; humiliation, belittlement; escape, fantasy.</td>
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</tr>
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<td></td>
<td>9.5</td>
</tr>
<tr>
<td>Sex, sexual satisfaction, sexual pleasure.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8.0</td>
</tr>
<tr>
<td>Challenge, stimulation; competition, competitiveness; ambition; opportunity, social mobility, luck; education, intellectual stimulation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8.0</td>
</tr>
<tr>
<td>Social acceptance, popularity; needed, feeling of being wanted; loneliness, impersonality; flattering, positive feedback, reinforcement.</td>
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</tr>
<tr>
<td></td>
<td>7.0</td>
</tr>
<tr>
<td>Achievement, accomplishment, job satisfaction; success; failure, defeat, losing; money, acquisitiveness, material greed; status, reputation, recognition, prestige.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.0</td>
</tr>
<tr>
<td>Individuality; conformity; spontaneity, impulsive, uninhibited; freedom.</td>
<td></td>
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<tr>
<td></td>
<td>6.0</td>
</tr>
<tr>
<td>Involvement, participation; concern, altruism, consideration.</td>
<td></td>
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<tr>
<td></td>
<td>6.0</td>
</tr>
<tr>
<td>Comfort, economic well-being, relaxation, leisure; good health.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.0</td>
</tr>
<tr>
<td>Novelty, change, newness, variety, surprise; boredom; humorous, amusing, witty.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.5</td>
</tr>
<tr>
<td>Dominance, superiority; dependence, impotence, helplessness; aggression, violence, hostility; power, control, independence.</td>
<td></td>
</tr>
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<td></td>
<td>2.0</td>
</tr>
<tr>
<td>Privacy.</td>
<td></td>
</tr>
</tbody>
</table>

Surely all of us can "resonate" with this listing. Even though we might dispute some of the groupings and rankings, we can appreciate the significance of the values being expressed.

Consider some other listings. The well-known "self-actualization" theory of Abraham Maslow (1968) can be viewed as an attempt to characterize the QOL concept. Maslow postulates five levels of needs and claims that one takes an interest in satisfying those at the next higher level when—and only when—those on a lower level are set. The five levels are

1. survival
2. security
3. belongingness
4. esteem
5. self-actualization.
The social philosopher John Rawls constructs much of his theory of justice on the basis of a list of "primary goods," which he describes and lists in the following passage:

Suppose that the basic structure of society distributes certain primary goods, that is, things that every rational man is presumed to want. These goods normally have a use whatever a person's rational plan of life. For simplicity, assume that the chief primary goods at the disposition of society are rights and liberties, powers and opportunities, income and wealth. (Later on, in Part Three the primary good of self-respect has a central place.) These are the social primary goods. Other primary goods such as health and vigor, intelligence and imagination, are natural goods; although their possession is influenced by the basic structure [of society], they are not so directly under its control. (Rawls 1971, 62)³

It would take us too far afield to attempt to critique these lists, reconcile the differences between them, and consolidate them into a single coherent theory of QOL. Thus, we must be satisfied with drawing upon one or more of these lists in analyzing the QOL elements in concrete cases.

When you stop to consider its implications, the concept of "quality of life" has some very interesting features. First, although it clearly relates to the notions of happiness or pleasure and subjective preference, it is not coincidental with any of these notions. We would expect that improving one's QOL would increase one's happiness and the degree to which one's subjective preferences are met, but this is by no means automatic. To achieve these goals, the agent must make use of the opportunities and abilities that constitute his or her QOL. For example, one may have the native ability to learn a foreign language, and training programs provided by the community may be accessible and affordable; but unless one takes advantage of these opportunities, one will never receive the pleasure of learning a language, or satisfy the desire to learn it. In other words, QOL appears to indicate certain fundamental conditions necessary as prerequisites for happiness or preference-satisfaction, rather than these states themselves.

Second, QOL standards offer a perspective for evaluating individual subjective preferences or choices in pursuit of happiness or pleasure. Many of an individual's choices and preferences have as their object constituents of the individual's QOL. (For example, almost everybody desires to be healthy and thus makes choices that would enhance health.) Other choices and preferences are individual idiosyncrasies or tastes that are neutral with respect to the individual's QOL. (For example, whether a person prefers a decor that is pink and green or one that is blue and beige does not make any difference to his QOL.) Still other choices, however, (such as the parents' desire to arrest the growth and development of their child, or their preference for decor above the health needs of their child) will be evaluated as misguided or mistaken precisely because they are antithetical to the individual's QOL.

³ Later in his book, Rawls develops what he calls a "full theory of the good," which amounts to a theory of subjective preferences corrected by rational deliberation.
Third, QOL considerations are not "subjective," although they are "subject-oriented." As Nicholas Rescher points out:

Information of the sort available not necessarily to the person himself but to an expert outsider provides the crucial basis for judgment. However, this information is in large measure not something general and universalizable; it will hinge critically upon the specific data regarding the characteristic makeup of the particular individual at issue. (Rescher 1972, 20–21)

1.4 Act vs. Rule Approach

The third general question to be answered by a teleological or goal-based theory is whether the standard is applied to individual concrete actions or more generally for formulating policies for action in all situations of a certain type.

Think back to the case from Chapter 2, Section 3. Having assessed all the particulars of this specific case and diagnosed a viral infection, the physician weighed the pros and cons of prescribing an antibiotic and decided against it. Must she then perform this same detailed evaluation each time a similar case arises? Or would it be better to have a general policy: "Do not prescribe antibiotics when clinical signs indicate a viral condition" or "Prescribe antibiotics whenever . . ." (and attempt to spell out the conditions under which an antibiotic would be appropriate)?

Some traditional ethical theorists argue for each of these approaches. The arguments on both sides are largely put in terms of goal-based considerations themselves. The primary arguments in favor of a rule or policy approach are those that appeal to efficiency and consistency.

1. To calculate all possible effects on all members of the moral reference group for each such decision would take enormous amounts of time. It would be a great time-saver to work through this sort of calculation once for each class of situation and henceforth act on the policy arrived at as a result of this calculation.

2. Even more serious than the time consumed by a thoroughgoing act approach is the danger that some relevant factor will be overlooked on some occasions, which might make a significant difference to the decision.

3. Consistency is not only a canon of reason, but also a moral virtue. If the doctor were to refuse the parents' request for antibiotics today, and yet give another set of parents a prescription tomorrow in virtually identical circumstances, she could properly be charged with inconsistency or "unfairness." (Think of a child's reaction to such a perceived inconsistency in the actions of a parent, and you will see the moral relevance of this notion: "But you said yes to Johnny when he asked the very same thing yesterday! You like

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4. Implications of this point in connection with QQL judgments are discussed in Chapter 4.
5. The popular aphorism notwithstanding, it is not always a "hobgoblin of little minds."
him best!" In general, children are very sensitive to moral principles—
especially those that serve their own interests.)

On the other side, the primary argument in favor of an act approach is that it is
more sensitive to the specific factors in the situation and thus more likely to be
morally correct than an approach in terms of general policies. Consider the process
of clinical diagnosis in the case. The analog to a rule or policy approach in moral
decision making might be for the physician to have a clinical policy: "All sore
throats are assumed to be viral infections." But this would never be acceptable as
an approach to clinical decision making. The physician is expected to examine all
the particular elements of this specific case and take them into account in arriving
at a specific diagnosis of this child's sore throat. Why should the process of moral
decision making be any less thorough than this? It is certainly no less important to
arrive at the correct moral decision than it is to arrive at the correct clinical
decision.

1.5 Applying Goal-Based Theories

To summarize this discussion of goal-based theories, let us consider how one
would go about making a decision in their terms. The steps leading to a decision
will be presented in schematic form, then you will be asked to apply them in some
detail in the Review Exercise that follows. The decision steps are somewhat
different for an act approach and for a rule approach, so they are sketched
separately.

1.5.1 Act Approach

1. Step 1: Consider the concrete situation in which you are about to act. Since
this is an act approach, you cannot make any sort of general determination
about what kind of action is always (or generally) appropriate. You can only
determine what you ought to do in the specific situation. In other (different)
situations, it might turn out that you should do something quite different.

2. Step 2: Enumerate all the alternatives for action open to you in the situation
at hand. Here the great danger is that you will prejudge the whole investiga-
tion by omitting possibilities you find unappealing. For example, in argu-
ments about sexual questions, people may refuse to consider the possibility
of abstinence from sexual intercourse. "That would be impossible," they
say. What they mean is that it would be unpleasant. But we need to
determine just how unpleasant it would be. It might turn out that all other
alternatives are even less desirable in the long run. And if this is the result,
then it follows that sexual abstinence is what ought to be practiced.
3. **Step 3: Predict all the consequences each of these alternatives are likely to have as they affect any member of the moral reference group.** The danger here is that crucial factors will be left out. You must consider all the effects of the alternatives, even those in the distant future and those that are very much indirect. You should also estimate the probability of occurrence for each consequence. The more remote the probability, the less weight the consequence should carry in your decision.

This is obviously an enormous undertaking—far more than could be accomplished in deciding what to do in a specific situation. However, it is the ideal of rational decision making under this model, so we must attempt to come as close to it as possible.

4. **Step 4: Evaluate these consequences.** Apply the theory of nonmoral value you find most plausible. Determine how much intrinsic value and how much intrinsic disvalue each of the actions themselves contain. Then determine the value and disvalue of each of the consequences. (This will be the instrumental value of the action.) Finally, sum these evaluations to determine the final or total value of the action.

5. **Step 5: Compare the alternatives.** The alternative with the greatest final value, i.e., producing the greatest balance of good over bad, is the one you should undertake.

### 1.5.2 Rule Approach

1. **Step 1: Enumerate all the possible policies or rules for action in the situation at hand.** Here you must think beyond the specific situation and begin to determine how you would act in all situations similar to this one in relevant respects.

2. **Step 2: Predict all the consequences each of these policies are likely to have (if implemented) on any member of the moral reference group.** Here again, the task is enormous. One advantage of a rule approach, however, is that one can come closer to carrying out this step. On issues of social policy, mechanisms such as "environmental impact statements," "risk assessments," or "technology assessments" are attempts to do what is required here.

3. **Step 3: Evaluate these consequences.**

4. **Step 4: Compare the alternatives and choose the rule or policy that maximizes the balance of good over bad.**
1.6 Review Exercise: Goal-Based Theories

Now you are asked to approach a decision in terms of a goal-based theory. In particular, the exercise will follow an act approach. For purposes of this exercise, the process will be simplified considerably, since a full-scale analysis would take much too long. However, be sure to include enough detail in your work to test whether you understand the complexities of this approach to ethical decisions. Consider the following case.

1.6.1 Case: “Don’t Tell the Doctor!”

A young unmarried woman (age 17) was admitted to the hospital with excessive uterine bleeding, which she explained was connected with her monthly period. She stated that this had occurred several times over the course of the past year and was of great concern to her.

A student nurse, of the approximate age of the patient, was caring for her the day after admission. After the student had established rapport with her, the patient confided to the student that she had been certain she was pregnant and had taken some medication that she had been told would bring about an abortion. She insisted that she did not want anyone—not even the doctor—to know about this.

She asked the student to promise not to tell anyone, particularly not the doctor.

(Adapted from Tate 1977, case 15)

What should the nursing student do?

1.6.2 Questions  As you answer the following questions, keep in mind all you have read in this appendix, especially the steps of an act-approach analysis as sketched in Section 1.5.1.

1. What can the student nurse do? What alternatives are open to her? List as many alternatives for action in this situation as you can. (Remember: Do not limit yourself to the obvious, or to those actions you already feel would be morally acceptable. The point here is to acquire material for ethical analysis in the stages to follow.)

2. For purposes of this exercise, choose a moral reference group and defend your choice.

3. For purposes of this exercise, choose one of the theories of nonmoral value discussed in this appendix and defend your choice. Choose any two of the alternatives for action you enumerated in question 1 (including the one you are initially inclined to favor) and list as many of their morally relevant consequences as you can.
4. Label each of the consequences you listed in terms of your estimate of their probability:
   + + = highly likely to occur
   +  = likely to occur
   +/− = as likely not to occur as to occur
   −  = unlikely
   − − = highly unlikely

5. Evaluate the consequences in terms of your theory of nonmoral value. Use the following labels:
   Pro + = extremely good
   Pro  = moderately good
   Neut = neutral
   Con  = moderately bad
   Con + = extremely bad

Be sure to indicate the basis of these evaluations in your discussion.

6. Compare the alternatives. Explain which you think should be chosen by comparing the weights of the evaluations you listed above.

7. Reflect on this process. Do you find yourself comfortable with this way of arriving at a decision? Why or why not? What morally relevant elements (if any) seem to be left out in this process?

2 Deontological Theories

2.1 Duty-Based Theories

This approach proposes a very different way of making moral decisions than the process you have just worked through. Instead of weighing and balancing the values in the situation, a duty-based theory examines the situation for moral factors of a different order. This can be shown most clearly through an example.

2.1.1 Side Constraints Suppose a person had borrowed $50 from a friend to tide her over an urgent financial crisis, on the firm promise that she would pay him back that afternoon. He explained that it was important that she pay him back today because he planned to go to the ballet that night, and he would need the money to pay for the tickets. Now she has scraped together the $50 and is on her way to pay her debt when she runs into an old friend with a hard-luck story. He has lost his job here in town several weeks ago, and all his savings have been exhausted in providing for himself and his family while he looked (unsuccessfully) for another
job. As a result, he and his family (which includes a couple of appealing small children) have not eaten in more than 24 hours. He has a promise of a job in another city, but he has no money for bus fare to get there or for living expenses for himself and his family until his first paycheck.

And here she stands with $50 in her pocket that she knows her creditor friend plans to spend on ballet tickets. How can this use of the money begin to compare, on any goal-based analysis, with the good it could do in the hands of her other friend who is down on his luck? Surely the best use she could make of the money is to give it to this friend and leave her creditor without the resources to go to the ballet.

Of course, a goal-based theory must take into account all the consequences of the action, and so she must consider the anger her creditor is likely to feel when he discovers she has caused him to miss the ballet, the loss of any opportunity on her part to borrow money from him again in the future, and other such factors. But these must be balanced against the disappointment felt by the other friend’s children when he tells them he was unsuccessful in finding any money to buy supper, and the sensations of hunger they experience at going without supper, etc. Thus it still appears that the balance of good over evil would be maximized by giving the money to the friend with a problem instead of to the creditor.

A duty-based theorist would claim that balancing the amount of good and evil that would follow from each use of the money is the wrong way to approach this decision. It is not open to the agent to determine what is the best use she could make of this money, the deontologist would insist. The fact is she made a promise to repay the debt, which means she ought to give the money to the creditor, even if a better use for it comes along. This, after all, is the point of his having extracted the promise from her: to ensure she would not merely consider his plan to use the money as one candidate among others for the best way for her to spend this money. He loaned her the money only on the basis of the assurance that she would repay him that afternoon even if a better use for the $50 occurred to her.

In other words, moral factors such as the duty created by the promise to repay the loan serve as “side constraints” on our goal-based calculations. They restrict our freedom to choose, not only to serve our own interests, but also to attempt to maximize the balance of good over evil for others as well.

2.1.2 Absolute Duties According to some deontological theories, these side constraints (or, at least, certain ones) cannot be overridden by any sort of consideration whatever. This claim has a certain initial plausibility, for example, in connection with very serious moral principles such as:

1. It is wrong to kill an innocent person.
2. It is wrong to tell a lie.
3. It is wrong to do physical harm to an innocent person.
Charles Fried expresses his view of the absolute or categorical character of these norms in the following:

It is part of the idea that lying or murder are wrong, not just bad, that these are things you must not do—no matter what. They are not mere negatives that enter into a calculus to be outweighed by the good you might do or the greater harm you might avoid. Thus the norms which express deontological judgments—for example, Do not commit murder—may be said to be absolute. They do not say: “Avoid lying, other things being equal” but “Do not lie, period.” This absolute-ness is an expression of how deontological norms or judgments differ from those of consequentialism. (Fried 1978, 9–10)

2.1.3 Responsibility for Consequences This duty-based approach may sound extremely harsh. Is a person to let himself be murdered, for example, when he could save his life by a “little, white lie”? From what has been said so far, it might seem that one must, according to this theory. However, there are several ways in which the harsh aspects of this view can be toned down a bit. One of them is especially important in some discussions of medical ethics, so it is worth describing at this point.

The basic idea behind the principle of double effect is that one’s actions may have multiple effects (often more than the two suggested by the name of the principle) and one’s moral relationship to the consequences may not be the same in all cases. This point may be put in terms of obligation judgments or character judgments. In its obligation-judgment form, the claim would be that not all ways of bringing about the same consequence are equally morally right or wrong. In character terms, the point is that one is not equally responsible morally for all the consequences of what one does or fails to do.

Consider the following situation: Tom chooses a piece of pie from the cafeteria line and eats it. This action may have a number of effects: 1) it increases the profits of the cafeteria owner; 2) it increases the calorie content of Tom’s diet; 3) it pleases the cook, who looks out of the kitchen and sees the relish with which Tom eats the pie; 4) since this is the last piece of this kind of pie available in the cafeteria and since you are behind Tom in the line, it deprives you of your favorite dessert.

Is this action of Tom’s right or wrong? Is he morally blameworthy for it, or what?

The teleologist would sum the value of these consequences and rule that it is morally right and praiseworthy if this action brought about a greater balance of good over evil than anything Tom could have done in the situation. Otherwise, it is morally wrong and blameworthy.

But the deontologist proponents of the principle of the double effect would maintain that it makes a difference what one’s relationship is to each of the effects. It matters, in particular, which effect(s) of Tom’s action entered into his delib-
eration when he decided to act. If he made the decision to choose the pie in order to increase the profits of the cafeteria owner (because he had heard that the establishment was in financial trouble) or in order to please the cook (because he knew she frequently looks out of the kitchen and is always especially happy to see someone enjoying her pies), then our assessment of both the action and the agent would be favorable. We would judge that he did a good thing and that he is a good person for having done that thing.

On the other side of the ledger, he can hardly be held morally responsible for depriving you of your favorite dessert since (let us suppose) he did not know either that this was your favorite or that this was the last piece available. Moral responsibility also may be negligible for some consequences he does know about in advance, i.e., increasing the calorie content of his diet. After all, the benefit to the cafeteria owner's financial solvency or the cook's self-respect seems to be worth the harm that might come to Tom from a few added calories.

However, suppose we discovered that Tom did know he would be depriving you of your favorite dessert by choosing the piece of pie; and indeed, suppose he confessed that this is precisely what motivated him to choose the pie and eat it with such relish. Then our moral evaluation of the action and the agent would be quite different. To act in order to deprive you of the pie is morally wrong (since it is a spiteful act), and Tom would be blameworthy for acting in this way.

We see, then, that two acts with identical consequences can differ in moral quality. The difference depends on the relationship of each of these consequences to the intentions of the agent in acting.

This distinction might be employed to temper the harshness of an absolutist theory of obligation. It is absolutely and always wrong to kill, but what this means is that one may never directly or intentionally bring about the death of another. However, there might be occasions where one might do something that results in the death of another as an unintended side effect of an acceptable action. And this might be morally justified. For example, a direct abortion is ruled impermissible in this tradition. However, excision of the cancerous uterus of a pregnant woman is permissible, even though the death of the fetus is foreseen as a side effect. This has obvious relevance for issues of life and death discussed in Chapter 4. In particular, it sheds light on the distinction drawn by the AMA Judicial Council between letting a terminally ill patient die and intentionally causing death. (For the full context, see the opinion entitled "Terminal Illness" quoted in Chapter 4, Section 2.1.)

The doctrine of double effect can be stated formally as follows:

1. The act to be done must be good in itself or at least indifferent, i.e., it must not be intrinsically wrong.
2. The good intended must not be obtained by means of the evil effect.
3. The evil effect must not be intended for itself, but only permitted.
4. There must be a proportionately grave reason for permitting the evil effect.
5. There must be no alternative course of action available to the agent that would produce the same, or an equivalent, good effect while avoiding the evil.⁶

2.1.4 Prima Facie Duties  One serious problem with an absolutist view is that moral rules may conflict with one another. If one holds that it is absolutely and always wrong to tell a lie and also to do physical harm to an innocent person, what is one to do if a situation arises in which the only way to prevent physical injury to an innocent person is through telling a lie?⁷

One way of dealing with this sort of problem is to deny that moral rules are absolute. Instead, they may be taken to hold prima facie or "other things being equal." This means that nothing other than another moral rule could override them. It would not be justified to ignore a moral duty because you found it inconvenient, or because you did not want to do what it dictates. However, when two moral rules conflict (as in the preceding example, where the only way to avoid bringing physical injury to an innocent person is to tell a lie), then the weight or stringency of the conflicting rules must be determined, and the weightier or more stringent rule takes precedence.

Many of the issues in biomedical ethics involve conflicts of duties, so you will have plenty of occasion to work with this way of viewing moral rules in discussions of concrete issues. This is roughly the approach illustrated in the discussions of concrete cases throughout this book. Note especially its use in Chapter 4, Section 2.4.

2.2 Kant’s Deontological Theory

Immanuel Kant is often taken to be the paradigm deontologist. He maintains that it is absolutely and always wrong to treat persons "merely as a means and not at the same time as an end in themselves" (Kant 1959). This phrase is far from clear on the surface, however. What all is ruled out? Let us explore its meaning.

To treat someone as an end is to respect the ends or goals that she has set for herself. Thus, Kant maintains that we should never impose anything on a person against her will. We may even have a positive obligation to do what we can to help her further her goals. To do otherwise implies she is not important; in the extreme case, it may amount to treating her in the way we would treat an inanimate object—as nothing more than a means to our goals.

⁶ For further discussion and critique of this doctrine, see Glenn C. Graber (1979, 65–84).
⁷ Actually, absolutists would either 1) deny that such a situation could arise and/or 2) try to avoid personal responsibility for the physical injury that resulted from truth-telling through an analysis using the doctrine of double effect.
The most dramatic cases of using someone as a means would be those in which the person is treated exactly as one would treat an inanimate object. Small children, for example, may not hesitate to step on their father in order to reach objects that would otherwise be too high for them. (He forgives them, because they are very young and do not know better, but he probably fervently hopes they will learn better before they reach a size that would make this practice harmful to him.) In slapstick comedies, one person will sometimes duck behind another to avoid the cream pie that is hurtling toward him. These are paradigm cases of "treating someone as a means only."

Only slightly removed is the act of getting someone to do what you want through deceit or coercion (something we probably all have done at some time or other). Here you know that the other person has no desire to do the things in question. (If the person did want to do it, neither deceit nor coercion would be needed, simply a polite request.) But you do not let the person's unwillingness stop you from getting what you want. You "use" the person by appealing to goals that she does have: the desire not to be harmed, in cases of coercion; a variety of goals, in cases of deceit.

It should be pointed out that you still would be using the other person as a means if you got her to do the thing through a polite request. However, in this case, you would not be using her merely as a means. By offering her the chance to decline the request, you acknowledge respect for her wishes and thus treat her as an end as well as a means. Kant sees nothing wrong in this sort of action.

The question to ask, then, in applying Kant's criterion to specific decisions is: In what you are considering doing here, are you acknowledging the goals and desires of the other person(s) or are you treating them merely as a means to your own goals? Answering this question may still require considerable interpretation, but it is a starting point for moral analysis of concrete situations.

As some authors point out (Benjamin and Curtis 1981, 34), Kant's theory of obligation cuts across the subcategories of deontological theories. The criterion we have just considered is probably best interpreted as a rights-based theory. However, Kant insisted that this formulation was exactly equivalent to the "universal law" formulation of the Categorical Imperative, which is clearly a duty-based criterion.

2.3 Ross' List of Prima Facie Duties

Another important theory of moral obligation that you may find useful in considering ethical dimensions of medical practice is the theory of Sir David Ross (1930). He sets out a list of prima facie duties in the following passage (emphasis in italic is added):

(1) Some duties rest on previous acts of my own. These duties seem to include two kinds, (a) those resting on a promise or what may fairly be called an implicit promise, such as the implicit undertaking not to tell lies which seems to be implied
in the act of entering into conversation (at any rate by civilized men), or of writing books that purport to be history and not fiction. These may be called the duties of fidelity. (b) Those resting on a previous wrongful act. These may be called the duties of reparation. (2) Some rest on previous acts of other men, i.e., services done by them to me. These may be loosely described as the duties of gratitude. (3) Some rest on the fact or possibility of a distribution of pleasure or happiness (or of the means thereto) which is not in accordance with the merit of the persons concerned; in such cases there arises a duty to upset or prevent such a distribution. These are the duties of justice. (4) Some rest on the mere fact that there are other beings in the world whose condition we can make better in respect of virtue, or of intelligence, or of pleasure. These are the duties of beneficence. (5) Some rest on the fact that we can improve our own condition in respect of virtue or of intelligence. These are the duties of self-improvement. (6) I think that we should distinguish from (4) the duties that may be summed up under the title of "not injuring others." No doubt to injure others is incidentally to fail to do them good; but it seems to me clear that non-maleficence is apprehended as a duty distinct from that of beneficence, and a duty of a more stringent character. (Ross 1930, 21)

2.4 Review Exercise: Deontological Theories

1. Analyze the case from Section 1.6.1 from the point of view of either Kant’s theory or Ross’s list of prima facie duties. a) For Kant’s theory, the question to ask is which alternative would involve everyone being treated as ends in themselves and not merely as means. b) For Ross’s theory, 1) choose one of the alternatives for action, 2) explain which of Ross’s prima facie duties relate to it, and 3) explain which set of duties has the greater stringency.

2. Which appears initially more plausible to you: a) the view of moral rules as absolute and exceptionless, or b) the prima facie view of moral rules? Defend your answer, including examples of how the views would differ in practice.

3. Is Ross’s list of prima facie duties complete? Try to think of rules that should be added to the list to make it adequate to deal with moral issues in health care.

2.5 Conclusion

In this appendix you have surveyed a number of ethical theories. These provide the resources for grappling with concrete issues. The ideal may be a theory everyone could agree upon and that would yield a clear answer to every dilemma we encounter. However, as you have seen, this is not possible. Instead, you have examined a variety of theories, each having strengths and weaknesses, and each having some ambiguities that will cause difficulties in applying it to concrete health-care issues. Keep these difficulties in mind as you use these theories in future discussions.
References


Further Reading

Two authors who hold different fundamental theories of ethics approach issues on the basis of principles they can agree upon.
A teleological approach to a variety of ethical issues in medicine. Fletcher is the author who coined the term “situation ethics” in an earlier book with that title.
An excellent summary and analysis of the range of ethical theories.
Bioethics (Clouser KD)
Double Effect (May WE)
Ethics
I. The Task of Ethics (Ladd J)
II. Rules and Principles (Solomon WD)
III. Deontological Theories (Baier K)
IV. Teleological Theories (Baier K)
V. Situation Ethics (Fletcher J)
VI. Utilitarianism (Hare RM)
VII. Theological Ethics (Carney FS)
VIII. Objectivism in Ethics (Gert B)
IX. Naturalism (Wellman C)
X. Non-Descriptivism (Hare RM)
XI. Moral Reasoning (Foot P)
XII. Relativism (Wellman C)
Law and Morality (Brody BA)
Life—II. Quality of Life (Reich WT)
Natural Law (D’Arcy E)
Obligation and Supererogation (Bole TJ III, Schumaker M)
Religious Directives in Medical Ethics
I. Jewish Codes and Guidelines
   (Trainin IN, Rosner F)
II. Roman Catholic Directives
   (Haring B)
III. Protestant Statements (Derr TS)
Rights
I. Systematic Analysis (Feinberg J)
II. Rights in Bioethics (Macklin R)
A comprehensive approach to medical ethics from a deontological perspective.