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Ethics First Aid: Reframing the Role of "Principlism" in Clinical Ethics Education and Practice

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INTRODUCTION

Just over a decade ago the eminent physician-ethicist Edmund Pellegrino published a short article in which he recounted briefly the history of medical ethics.[1] His primary focus was on recent developments, with a particular emphasis on the role of "principlism." Principlism is the term that identifies the "four principles" approach to bioethical decision making (autonomy, beneficence, nonmalificence, and justice) as it has been formulated and popularized in succeeding editions of Beauchamp's and Childress's widely read and highly popular *Principles of Biomedical Ethics*.[2] The four principles approach came to dominate bioethics throughout the 1980s. But by the time Pellegrino penned his article in 1993, principlism was under attack.[3] Hence, Pellegrino dubbed the time in which he was writing the "period of anti-principlism," and suggested that medical ethics was about to enter a "period of crisis." He wondered what direction medical ethics would take in succeeding years, as principlism appeared to be on the wane and absent any alternative unifying philosophy that would serve to underpin this nascent discipline. "It is clear," stated Pellegrino, "that principlism in its present form is unlikely to survive unscathed through the next decade."[4]

It is now more than a decade since Pellegrino anticipated the demise (or at least, the radical transformation) of principlism. In the intervening years, Beauchamp and Childress have published a fourth and then a fifth edition of their text, and have expanded the theoretical discussion in each subsequent edition in response to their critics. In this respect, it is true that principlism did not survive the decade unscathed. But although philosophers continue to debate the merits of principlism as a model for methodological case resolution in bioethics,[5] and while Beauchamp and Childress and their defenders have continued to respond,[6] this debate has been largely unnoticed by those who make ethical decisions at the bedside. For the most part, clinicians continue to rely extensively on the four principles as a ready means by which to assess and address ethical problems, and they appear to be largely ignorant of or unconcerned by theoretical and methodological squabbles. On the front lines of clinical ethical decision making, principlism appears to have changed little in the intervening decade, as it continues to play a dominant role.

The purpose of the present article is not to review yet again the supposed merits and demerits of principlism. Rather, the intent is to assess some of the reasons for its resilience within clinical medicine despite ongoing theoretical and practical challenges. For while the debate regarding principlism has transpired in some of the mainstream journals in biomedical ethics, for the most part this debate has been ignored or has gone otherwise unnoticed by bedside clinical decision makers. This is not to say that the continuing debate about principlism is irrelevant to clinical bioethics. It is just that there are certain features of the form that principlism has taken from its inception that could guarantee its central role in clinical bioethics well into the future, irrespective of ongoing theoretical and methodological challenges. Thus it is important that those who invoke "the four principles," both in the teaching and the practice of clinical bioethics, have some understanding of the appropriate role and function of principlism at the bedside.

The discussion to follow begins with a brief review of some reasons why principlism has assumed a central and dominant role in clinical bioethics. For the most part, the reasons canvassed have more to do with the form that principlism has taken, rather than with the content of the principles themselves. Put otherwise, there are certain structural and contextual features of the teaching and practice of clinical bioethics that make principlism an especially attractive approach to clinical ethical assessment and decision making. Given this reality, it is argued that the proper role of principlism in the teaching and application of clinical ethics should be that of a preliminary assessment tool. That is, the four principles provide a ready means to assess some key ethical features of a given clinical situation. However, applying the four principles should not be confused with providing rigorous ethical analysis of an issue. Rather, invoking the four principles in clinical ethics training and bedside consultation should be understood as akin to providing ethics first aid.

THE RISE AND ENDURANCE OF PRINCIPLISM

The metamorphosis of bioethics to which Pellegrino alludes has been detailed admirably in Albert Jonsen's *The Birth of Bioethics*.[7] Jonsen recounts how rapid advances in medical technology throughout the 1960s and 1970s provided opportunities for philosophers and theologians who had long worked in the field of ethical theory to apply those theories to emerging ethical problems. However, these new opportunities presented additional theoretical and practical challenges. On the theoretical front, it was thought important for the emerging discipline of medical ethics to identify and describe a unifying theory. For practical purposes, it was necessary that philosophers be less arcane in their language and that theologians be less sectarian in their discussions if they hoped to affect physicians and researchers working in the field.

In many respects, attempts to address these twin challenges have worked at cross-purposes. That is, while theoretical debates have been ongoing throughout the life of the still relatively young discipline of medical ethics, attempts to refine the discussion have tended to drift increasingly toward the esoteric. Nowhere is this more evident than in the ongoing debate about the relative theoretical and practical merits of principlism itself. As a case in point, an article published in 2002 in defense of principlism purports to repudiate a widespread deductivist misinterpretation and to develop the fundamental meta-ethical disagreement by outlining the deductivistic critique of principlism, and then restructuring the dispute between casuistry, deductivism, and principlism. This leads to the conclusion that "principlism is the most attractive position, if the perceptual model of weak intuitionism is made more explicit."[8] The point here is not to trivialize or otherwise dismiss what is undoubtedly an important theoretical and methodological debate, but to illustrate that those who engage in such discussions often speak a language that fails to resonate with those in clinical practice.

The genius of Beauchamp and Childress is that they managed early on to distill the central elements of some long-standing theoretical debates in moral philosophy down to four fundamental ethical principles. This is at least a partial explanation for the continuing popularity of their approach. Not only are the four principles easy to comprehend, but the emphasis on the principle of autonomy in particular resonated well with a general cultural movement toward greater individual freedom and with the concomitant distrust of

authority that was so prominent in the post-Vietnam era. At the same time, beneficence and nonmaleficence comport well with the long-standing Hippocratic tradition in medicine. The principle of justice, in turn, speaks to the need to balance competing interests in the increasingly complex domain in which bioethical decisions must be made.

It is the very complexity of the field of bioethics, however, that has motivated some to resist what was perceived as oversimplification and reductionism on the part of Beauchamp and Childress. The criticisms of their detractors have not fallen on deaf ears. Although they continue to insist that the principles they present are not intended as a general moral theory,[9] in each subsequent edition of *Principles of Biomedical Ethics* Beauchamp and Childress have expanded their discussion to address some of the ongoing theoretical and methodological challenges, and to include other elements of moral discourse as well. The most recent edition, for example, includes a chapter on moral character, as well as extensive discussions of alternative moral theories, method, and moral justification.

The amendments Beauchamp and Childress have made to their model over the years have helped to clarify their position regarding the theoretical status of principlism, and have made their presentation more complete. But while such amendments may address some of the concerns of the more theoretically inclined, much of this discussion is wasted on clinicians who are charged with making ethical decisions at the bedside, and perhaps even, to some degree, for those whose task it is to educate clinicians regarding various approaches to ethical decision making. This is not because these amendments are irrelevant to clinicians and educators. Rather, the context in which clinicians are educated and practice is just not conducive to deep philosophical reflection and protracted discussion about theoretical completeness and methodological rigor. Indeed, the theoretical and methodological issues regarding principlism that have been raised over the years have never been much of a concern to bedside ethical decision makers, simply because those on the front line have neither the time nor the requisite background knowledge and training to engage in those debates.

The vast majority of medical students come to the study of medicine with little or no background or training in philosophical ethics. Their pre-clerkship years are dominated by courses in physiology, biochemistry, anatomy, and the like. Such courses are extremely demanding and consume a considerable amount of a student's time and effort. Students are often introduced to medical ethics at this early stage in their medical training. However, the students' lack of background and experience, coupled with the time constraints imposed by an overcrowded curriculum, result in limited time for instruction in the finer points of moral theory and ethical decision making.

Similar pressures are felt by those who are charged with the teaching of ethics to medical undergraduates. Limited class time makes it all but impossible to develop the theoretical models that are necessary to properly evaluate the relative strengths and weaknesses of various approaches to ethical decision making, let alone the complexities of the clinical cases encountered. Furthermore, the context of most undergraduate medical education is one in which a tremendous amount of information is dispensed in a relatively short period of time. Students are expected to assimilate this information quickly. There are few opportunities to reflect on broader conceptual themes, and relatively little patience for doing so. In an overcrowded curriculum in which mnemonic devices for committing vast quantities of information to memory are the norm, four principles for ethical decision making are especially attractive. However, unlike the majority of other courses to which medical undergraduates are exposed, ethics requires nuanced reflection with an understanding that, in most situations, there are better and worse responses, rather than right and wrong answers that can be tested on multiple-choice exams.

Principlism provides a quick introduction to ethics for the busy medical undergraduate and a ready compromise for the ethics educator. Faced with the continuing challenge to provide some useful tools to prospective practitioners that will assist them in navigating the complex moral terrain they are about to enter, the ethics educator can fall back on principlism. Not only do the four principles speak to a variety of key ethical considerations that surface in many clinical situations, but their origin in two of the long-standing ethical traditions (deontology and consequentialism) provides an opportunity for the instructor to make at

least a passing reference to such theoretical considerations. Although it may be optimistic to believe that the majority of medical practitioners who have been educated in the West over the past two decades could recall the theoretical origins of principlism, it is probably not unreasonable to suggest that most have a degree of familiarity with the four principles themselves.

The foregoing explains, to some extent, the reasons for principlism's ascendancy in clinical ethics education and practice, and for its continuing dominant role despite ongoing theoretical and methodological challenges. The short of it is that, given the context of medical education and practice, principlism works. It provides a quick and ready reference tool for medical practitioners and enables them to identify a number of key ethical considerations in a variety of clinical contexts.

For the reasons outlined above, we should expect that principlism will remain popular with frontline clinicians into the foreseeable future. In this respect, the period of crisis that Pellegrino anticipated a decade ago has never materialized on the front lines of clinical ethics. Indeed, it seems unlikely to materialize at this level anytime soon. We should anticipate a sixth and perhaps even a seventh edition of Beauchamp's and Childress's highly popular and useful text, and, given previous experience, we should expect that each subsequent edition will be an improvement. However, barring substantial structural changes in the manner in which medical students are recruited and educated, we should not expect that any additional theoretical and methodological fine tuning in which the authors might engage will have much direct impact on the front lines of clinical bioethics.

ETHICS FIRST AID

What principlism does not do, and what Beauchamp and Childress never intended it to do, is to provide a comprehensive understanding of moral complexity. While this latter observation may strike many as so obvious as to be trivial, it is important to emphasize the point. In the past two decades the medical literature has been littered with articles that purport to offer ethical analyses of any number of complex situations. Often such analysis consists simply of reciting the four principles and providing a superficial application (often of the principle of autonomy) before moving on to other things. Based on personal observation and discussion with other clinical ethicists, I can attest that it is not uncommon to find that a similar level of ethical assessment occurs in complex clinical situations. Given principlism's anticipated continuing popularity, coupled with the constraints upon ethics education that can also be anticipated to continue for the foreseeable future, it is important that clinicians have a proper understanding of principlism's role in medical education and practice. To that end, it is suggested that, in the clinical context at least, principlism should be framed as an exercise in "ethics first aid."

I financed my post-secondary education 20 years ago by working as a subcontractor on reforestation projects in British Columbia and Alberta, Canada. Each summer I would take crews of 10 to 20 fellow students into remote northern regions where we would live and work for weeks on end. Generally the only access to a planting site was by off-road vehicle, and on occasion we were transported by helicopter. In most cases, the closest medical attention was several hours away over rugged logging roads. Labor regulations required that there be a qualified first aid attendant on site, so each year either I or one of my coworkers would complete an intense, two-week training course to earn an industrial first aid ticket.

Fortunately, over several years of tree planting, my first aid expertise was required mainly to attend to minor scrapes, bruises, and blisters, and the occasional twisted ankle. There was only one relatively serious incident when a planter fell while climbing over some fallen trees. He hit his head and lost consciousness temporarily and was impaled on a broken branch in the process. My first aid intervention required field dressing his wound and then monitoring the patient while he was in transit to a medical facility. As we made the three-hour drive, I checked his vital signs regularly. However, while I was fully aware that, should I detect a problem in any area, I was pretty well at the outer limit of my ability to intervene. The only remaining option would be to drive faster.

I relate my experience as a first aid attendant because I think it illustrates nicely the manner in which principlism should be framed in the ethics training and practice of frontline clinicians. As a first aid attendant, I had a rudimentary understanding of the importance of blood pressure, temperature, pulse, and respiration, what might be described as "the four principles of clinical assessment." Detecting an abnormality in any one of these areas might indicate a deeper problem. Unlike a trained clinician, I lacked the requisite knowledge and training to examine the underlying causes of many of these symptoms. At best I could treat the symptoms by providing aspirin if a patient's body temperature was high, by providing oxygen if there were breathing difficulties or if I suspected the patient might be in shock, or any number of other superficial interventions, depending on the presenting problem. This is not to say that such interventions are trivial. To the contrary, many first aid interventions are absolutely vital to the ongoing care and potential recovery of the patient. It is just that they are, by definition, *first aid* interventions, which implies that additional aid by appropriate experts will be forthcoming when necessary.

Blood pressure, pulse, temperature, and respiration are preliminary assessment tools utilized by both the first aid attendant and the highly trained clinician. In many cases, the cause of the symptom is obvious, and the required intervention is relatively straightforward and can be managed adequately by a skilled first aid attendant. In other situations, however, the underlying problems are not at all obvious. While the first aid attendant can often manage symptoms temporarily, only a trained clinician has the requisite knowledge and expertise to examine and treat the underlying problem. In a similar vein, in the context of frontline clinical ethics, autonomy, nonmaleficence, beneficence, and justice should be framed as preliminary assessment tools. These tools are utilized by both the ethics first aid attendant and by the expert bioethicist in doing preliminary assessments of the ethical aspects of various cases. In most day-to-day clinical situations, the ethical issues are relatively simple and straightforward. In keeping with the first aid analogy, these might be described as ethical scrapes, bumps, and bruises that the ethics first aid attendant can identify and manage simply by attending to the ethical symptoms highlighted when reviewing the four principles. In some cases, however, a deeper examination is required, and those with the requisite training and skill must be called upon to do their work. Just as the skilled first aid attendant in the clinical situation demonstrates that skill by recognizing situations beyond his or her level of expertise, the skilled ethics first aid attendant will do the same. In any complex situation, be it clinical, ethical, or otherwise, accessing appropriate expertise at the appropriate time can do much to ensure that a relatively minor problem does not escalate into a full-scale emergency.

CONCLUSION

Some 25 years ago, physician/ethicist Mark Siegler proposed a model for clinical ethics education that included close collaboration between ethicist-philosophers and skilled clinicians in providing medical trainees with adequate preparation for bedside ethical decision making.[10] He recommended that, in the preclinical years, ethicist-philosophers should take the lead assisted by clinicians, while, in the clinical years, the emphasis should change, with physicians assuming the primary responsibility, assisted by clinically informed ethicist-philosophers. Siegler's model is still appropriate today. However, given the ever-increasing demands of an already crowded preclinical curriculum, and the equally vexing pressures of clinical practice, the role of the ethicist-philosopher is ever in danger of being usurped.

Beauchamp and Childress are highly respected philosopher-ethicists who have done much to advance the field of clinical bioethics. However, one unintended consequence of their ever-popular *Principles of Biomedical Ethics* is that they may have inadvertently contributed to a reduced role for the philosopher-ethicist in clinical bioethics. That is, in providing a tool by which to reduce the complexity of philosophical ethics to four easy to comprehend principles, they have made it possible to educate an entire generation of ethics first aid attendants. However, the ease by which the four principles can be taught and assimilated by busy educators and students respectively, may lead some to conclude falsely that they have mastered the

essence of biomedical ethics and that the role of the philosopher-ethicist is thus redundant. This is on par with concluding that the lay person who can assess the relevance of pulse, respiration, blood pressure, and temperature has captured the essence of medicine.

Principlism is a valuable pedagogical and clinical tool that will continue to play an important role in medical education and clinical practice well into the foreseeable future. However, within such contexts, principlism is best understood and utilized as an assessment tool in ethics first aid. Availed of this tool, the skilled clinician is ready both to assess and manage the relatively minor ethical problems that arise in day-to-day practice, and to refer more complex issues to the appropriate level of expertise.

NOTES

1. E.D. Pellegrino, "The Metamorphosis of Medical Ethics," *Journal of the American Medical Association* 269, no. 9 (March 1993): 1158-62.

2. T.L. Beauchamp and J.F. Childress, *Principles of Biomedical Ethics,* 5th ed. (New York: Oxford University Press, 2001).

3. K.D. Clouser and B. Gert, "A Critique of Principlism," *Journal of Medicine and Philosophy* 15 (April 1990): 219-36; E.R. DuBose, R.P. Hamel, and L.J. O'Connell, *A Matter of Principles: Ferment in US Bioethics* (Valley Forge, Pa.: Trinity Press International, 1994).

4. See note 1 above, p. 1161.

5. H.S. Richardson, "Specifying, Balancing, and Interpreting Bioethical Principles," *Journal of Medicine and Philosophy* 25, no. 3 (2000): 285-307; B. Gert, C.M. Culver, and K.D. Clouser, "Common Morality Versus Specified Principlism: Reply to Richardson," *Journal of Medicine and Philosophy* 25, no. 3 (2000): 308-22; J. Harris, "In Praise of Unprincipled Ethics," *Journal of Medical Ethics* 29 (2003): 303-6.

6. R. Gillon, "Ethics Needs Principles — Four Can Encompass the Rest — And Respect for Autonomy Should Be 'First among Equals'," *Journal of Medical Ethics* 29 (2003): 307-12; T.L. Beauchamp, "Methods and Principles in Biomedical Ethics," *Journal of Medical Ethics* 29 (2003): 269-74.

7. A.R. Jonsen, *The Birth of Bioethics* (New York: Oxford University Press, 1988).

8. M. Quante and A. Vieth, "Defending Principlism Well Understood," *Journal of Medicine and Philosophy* 27, no. 6 (2002): 621-49.

9. Beauchamp, see note 6 above.

10. M. Siegler, "A Legacy of Osler: Teaching Clinical Ethics at the Bedside," *Journal of the American Medical Association* 239, no. 10 (March 1978): 951-6.