3 Principled effects

Abstract: This chapter explores the significance and the legacy of *Principles of Biomedical Ethics*, a foundational textbook in bioethics which is now in its eighth edition. After briefly explaining the main thrust of the theory of ethics Tom Beauchamp and James Childress developed, known as principlism, it explores the context in which the first edition of this textbook was published and what made it, initially, so foundational. From there, the chapter explores the indirect pervasive effect that *Principles of Biomedical Ethics* has had throughout healthcare law and ethics, focusing on areas in which their influence might not be so well known. It ends with an exploration of some of the ways in which the project Beauchamp and Childress engage in can benefit the understanding of bioethics more generally. This includes an exploration of the effect of their mid-level theory and their 'Borg-like' qualities, as described by John Arras.

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Principled effects

The importance of Beauchamp and Childress's *Principles of Biomedical Ethics*

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The work

This chapter explores the significance and legacy of *Principles of Biomedical Ethics* (*PBE*) written by Tom Beauchamp and James Childress and now in its eighth edition.[1] A foundational text in bioethics and used as a standard textbook across the globe, *PBE* provides rich fodder for exploration. It is a book that has shaped, re-shaped, and influenced both bioethics and healthcare law.[2] It is fundamental not only to an understanding of how doctors and other healthcare professionals should explore the ethical content of their own decisions, but also with how the law should interact with those decisions.

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[1] Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (8th edn, Oxford University Press 2019).

[2] David DeGrazia, 'Common morality, coherence, and the principles of biomedical ethics' (2003) 13 *Kennedy Institute of Ethics Journal* 219.

3 Principled effects

PBE was originally published in its first edition in 1979.[3] Building on the previous work of its authors, the book sets out the basic theory of what has become known as 'principlism' or, alternatively, the 'Four Principles' approach.[4] Beauchamp and Childress refer to their approach as 'mid-level', below grand theories like deontology or utilitarianism but involving more general principles than those that might exist in a particularised ethical system such as casuistry.[5] The four general principles are respect for autonomy, beneficence, non-maleficence, and justice.[6] According to Beauchamp and Childress, those working within the fields of biosciences and medicine can use these principles to examine ethical issues which may arise and reach a normatively justified conclusion which can be applied to real cases.[7]

Since the third edition of *PBE*, published in 1993, Beauchamp and Childress have grounded the four principles in what they term 'the common morality'.[8] For them, this morality is the 'set of universal norms shared by all persons committed to morality'.[9] The common morality is applicable to all individuals everywhere, but that does not mean that the precise scope of the principles that form that common morality are not subject to dispute, discussion, or

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[3] Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (Oxford University Press 1979).

[4] Tom Beauchamp and James Childress, '*Principles of Biomedical Ethics*: Marking its fortieth year' (2019) 19 *American Journal of Bioethics* 9.

[5] Beauchamp and Childress (n 1).

[6] ibid 13.

[7] ibid.

[8] ibid.

[9] ibid 3.

controversy.[10] Nevertheless, Beauchamp and Childress argue that the morality is common to all peoples and is not culturally specific.[11] This allows them to claim that the principles that they use are universal and are not limited to a particular jurisdiction. The four principles they use are part of the common morality, although Beauchamp and Childress are at pains to note that they are not the entirety of it.[12] Indeed, there are principles within the common morality including moral norms like 'do not steal' or 'nurture the young and dependent' and virtues like gratitude and lovingness beyond the four that they focus on.[13]

Beauchamp and Childress specify that not only do all four principles apply in all cases but also no principle has a natural hierarchy over any of the others.[14] This has been a point of some controversy, with many assuming that respect for autonomy is the pre-eminent principle and the others subservient to it.[15] However, Beauchamp and Childress do not state that, and, in fact, insist on a contrary position. They argue that while a principle may be controlling in a particular scenario, other principles may take priority in a different scenario or even the same scenario at a different time or place.[16] Some commentators have expressed concerns about this approach, arguing that it means that principlism does not provide clear answers to ethical

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[10] ibid.

[11] ibid.

[12] ibid.

[13] They provide a fuller list of examples in ibid 3–4.

[14] Beauchamp and Childress (n 4) 11.

[15] Raanan Gillon, 'Ethics needs principles – four can encompass the rest – and respect for autonomy should be "first among equals"' (2003) 29 *JME* 307. doi.org/10.1136/jme.29.5.307; Beauchamp and Childress (n 4) 11.

[16] Beauchamp and Childress (n 4) 11.

questions as a result.[17] Nevertheless, Beauchamp and Childress have persisted in their view that none of the four principles have an automatic priority over any of the others.[18]

The context

When Beauchamp and Childress were writing the first edition of *PBE* towards the end of the 1970s, bioethics as an academic subject was very different from that in which the most recent edition was published in 2019.[19] In the late 1970s, bioethics was in its infancy.[20] Some important principles had been set down by the 1947 Nuremburg Code,[21] and there had been a series of ethical scandals involving scientific research in the United States. This included the Tuskegee Syphilis Study,[22] which led to the National Commission for the Protection of Human

[17] See, for example, Søren Holm, 'Not just autonomy: The principles of American bioethics' (1995) 21 *JME* 332. doi.org/10.1136/jme.21.6.332; Tuija Takala, 'What is wrong with global bioethics? On the limitations of the four principles approach' (2001) 10 *Cambridge Quarterly of Healthcare Ethics* 72. doi.org/10.1017/S0963180101001098; Tom Walker, 'What principlism misses' (2009) 35 *JME* 229. doi.org/10.1136/jme.2008.027227.

[18] Beauchamp and Childress (n 4) 11.

[19] ibid 9.

[20] ibid.

[21] Beauchamp and Childress's definition of autonomy seems to develop from important principles first outlined in the Code. Beauchamp and Childress (n 1) 118, 136.

[22] Susan M Reverby, *Examining Tuskegee: The Infamous Syphilis Study and Its Legacy* (University of North Carolina Press 2009).

Subjects of Biomedical and Behavioral Research, the first public national body focused on bioethics within the US.[23] The National Commission published the Belmont Report in 1979, the year the first edition of *PBE* was published, and in the report the principles that ought to apply to research ethics were explored.[24] Three principles espoused in that report, which Tom Beauchamp co-wrote as a staff philosopher on the commission,[25] were respect for persons (including respecting the autonomy of persons), beneficence, and justice.[26] Thus, when PBE was first published while there was interest in the new and burgeoning area of bioethics, it had nothing like the edifice it has today, and the focus was more on clinical research than clinical practice.

Having said that, important articles on ethical and medical issues were published during the late 1960s and 1970s, including on abortion, end-of-life issues, and scarcity problems in

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[23] See <https://bioethicsarchive.georgetown.edu/pcbe/reports/past_commissions/>.

[24] National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, *The Belmont Report* (Department of Health Education and Welfare 1979) <www.hhs.gov/ohrp/regulations-and-policy/belmont-report/read-the-belmont-report/index.html> accessed 15 February 2022.

[25] Beauchamp and Childress (n 4) 10. Childress also worked for the commission on the report, although his role appears to be less comprehensive than Beauchamp's: Renee C. Fox and Judith P Swazey, 'Interview with James F Childress' (1999) *Acadia Institute Project on Bioethics in American Society* 25 <https://repository.library.georgetown.edu/handle/10822/557025> accessed 24 June 2022.

[26] *The Belmont Report* (n 24).

organ donation.[27] Issues which impacted upon healthcare and ethics were thus being considered, but there was little in the way of an overarching systemic treatment of the subject. This meant that the field of bioethics, especially bioethics which applied clinically, was largely a blank page. This can have benefits for writers who are able to set the stage for a field of study, but it can also be challenging if there is little research within the subject on which to help with that stage-setting. For Beauchamp and Childress, they could, at least, fall back on their teaching responsibilities at the Kennedy Institute of Ethics at Georgetown, which provided an impetus to think through these various issues.[28] Even then, as there were no textbooks in the area, they were able to establish the types of questions and methods which were relevant to the field, rather than develop the work of others. This is crucial to understanding the place that *PBE* plays in the development of bioethics as a field of study; it provided a framework for those new to the area to begin to explore a new field which was both increasingly important and visible but lacked the necessary materials to develop. Additionally, because of their work elsewhere (for example, Beauchamp's work on the Belmont Report[29] and Childress's work on organ donation),[30] their

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[27] For example, Phillipa Foot, 'The problem of abortion and the doctrine of double effect' (1967) 5 *Oxford Review* 5; Judith Jarvis Thomson, 'A defense of abortion' (1971) 1 *Philosophy and Public Affairs* 47; James Rachels, 'Active and passive euthanasia' (1975) 292 *NEJM* 78. doi.org/10.1056/NEJM197501092920206; Judith Jarvis Thomson, 'Killing, letting die, and the trolley problem' (1976) 59 *The Monist* 204; James F Childress, 'Who shall live when not all can live?' (1970) 53 *Soundings: An Interdisciplinary Journal* 339.

[28] Beauchamp and Childress (n 3) 9.

[29] See (n 25).

[30] Childress (n 27).

views dovetailed with much of the contemporaneous work on the regulation of research and clinical ethics. Beauchamp and Childress were, therefore, good candidates to pull together a number of these issues into a systemic treatment that helped the field of bioethics to coalesce.

The significance

As a foundational text in bioethics, the significance of *PBE* cannot be overstated. It is often one of the first texts that those new to the area will be exposed to. It has had a substantial impact upon how we think of the four principles, and there is a cottage industry in healthcare law and ethics designed around examining, critiquing, and discussing *PBE*.[31] However, the greatest significance of *PBE* might be how pervasive its *indirect* effect has been. *PBE* has changed the landscape in such fundamental ways that even those who might not have had any direct exposure to it can be influenced by the ideas and concepts that have been developed within its pages.

An example is illustrative. In the 1992 English case of *Re T (adult: refusal of treatment)*,[32] the Court of Appeal expressed concern about whether the patient, T, had really made an autonomous decision to refuse a blood transfusion. The Court had three main concerns. First, that because T had been in a car accident and was on medication, the stress and her physical condition meant that she did not have the capacity to make an autonomous decision.[33] The second concern was that T had not received the proper information to be able to make a

[31] Beauchamp and Childress (n 4) 9–12, in which Beauchamp and Childress discuss some of their main critics. In addition, see, for example, Daniel Sokol, 'Sweetening the scent: Commentary of "What principlism misses"' (2009) 35 *JME* 232. doi.org/10.1136/jme.2008.028514. Also see other articles referenced in this chapter.

[32] [1993] Fam. 95.

[33] ibid 13.

decision, since some of the information told to her by healthcare professionals turned out not to be accurate.[34] Finally, the Court was concerned that T had been subject to undue influence from her mother and that the refusal of a blood transfusion was, therefore, not her own decision but one pushed on her by her mother.[35] While the Court ultimately relied on the lack of proper information to ground its decision that T's refusal did not have to be respected,[36] it expressed its reservations about all three grounds, and the Court determined that three things are necessary for an autonomous decision: capacity, sufficient information, and to be free from outside control.

Where did these three requirements for an autonomous decision come from? They do not appear as a three-requirement framework in previous case law in England and Wales, and the Court did not rely on precedent when making its decision. Nor were the three requirements included in statute, although they appeared in subsequent cases,[37] and statutes.[38] Furthermore, the Court in *Re T* did not specify why those three requirements were so important. One answer might be to look at the use of the requirements in case law, where they had appeared independently. Capacity as important to decisions about medical treatment had been noted in *Re F (mental patient: sterilisation)* in 1989.[39] The importance of providing information had been discussed by the Court in the 1981 case *Chatterton v Gerson*,[40] and, as noted in *Re T*, undue influence had been considered in a range of cases in probate.[41] All three requirements thus had

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[34] ibid 113–14.

[35] ibid 115.

[36] ibid.

[37] See, for example, *Re C (adult: refusal of medical treatment)* [1994] 1 All ER 819.

[38] Mental Capacity Act 2005.

[39] [1990] 2 AC 1, sub nom *F v West Berkshire Health Authority* [1989] 2 All ER 545.

[40] [1981] QB 432.

[41] *Re T* (n 32) 118–19 (Butler-Sloss LJ).

some legal pedigree prior to the Court of Appeal's decision in *Re T*, although none had been used in a case on similar facts. Indeed, *Re F* involved a patient who was in a long-term care facility; *Chatterton* was a negligence case where the patient argued that she had not been correctly informed and should be allowed to recover damages as a result; and the judges in *Re T* did not believe that probate cases were similar enough to medical cases to be applicable.[42] None of these seem sufficiently similar to the facts of T, as T appeared to usually have capacity but might be lacking it temporarily in relation to a decision which was made prior to the treatment in question. Additionally, the three requirements in question had not been applied consistently with the previous decisions. For example, in *Chatterton* it held that it was sufficient for the patient to be 'informed in broad terms of the nature of the procedure that is intended',[43] but the Court of Appeal seemed to want a more significant understanding from T for her refusal of a blood transfusion to be respected.

Bringing these disparate threads together is not impossible, but what is needed is more than random principles. A *theory* is required as to what consent to medical treatment means and how that applies to a patient like T. A sufficiently robust theory can provide reasons for why the capacity requirement from *Re F* (despite being about whether to sterilise an institutionalised woman), the information requirement from *Chatterton* (despite being about failure to inform of risks for a woman whose capacity is never questioned), and the undue influence provisions from probate cases that the Court believed were not applicable to the case in issue, can come together to form the three-part test so important in determining whether doctors should have to abide by T's statements to refuse a blood transfusion. While we can generate a rough sketch of what the Court's theory must include, based upon their decision in *Re T* (capacity, sufficient information, and freedom from controlling influence), the next question is where that theory comes from.

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[42] ibid 119 (Butler-Sloss LJ); 121 (Staughton LJ).

[43] *Chatterton* (n 40) 443.

3 Principled effects

Given that the Court in *Re T* does not articulate its theory or its reasons for believing in it, I can do no more here than sketch a possible answer. Those requirements might have been conceived by the judges in *Re T* based upon what they understood 'autonomy' and 'consent' to mean. It is, perhaps, likely that those ideas developed from things they had read or discussed elsewhere. One possibility is that the justices had some knowledge of Ian Kennedy's work at the time.[44] In a chapter in *Treat Me Right*, Kennedy discussed what is necessary for valid consent and set out the same three requirements that the Court later espoused in *Re T*.[45] While that does not provide us with a confirmed link, as the Court did not reference Kennedy, this is a plausible suggestion because of Kennedy's general impact on healthcare law and ethics from the 1980s onwards. Tracing these requirements to *Treat Me Right* is, though, only part of the way there, as Kennedy did not claim to have been the originator of these requirements. Instead, although he argued that they were common knowledge,[46] he did not reference anyone for that common knowledge at that point. What he did do, however, was reference the second edition of *PBE* (which was the current edition at the time he was writing) within the same chapter.[47] Beauchamp and Childress, in the second edition of *PBE*, described, and discussed to a considerable degree, the things that were necessary for autonomy – competence to consent,

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[44] For further discussion see the chapter by José Miola in this collection.

[45] Ian Kennedy, *Treat Me Right: Essays in Medical Law and Ethics* (Clarendon Press 1988) ch 10.

[46] ibid.

[47] ibid 217. Kennedy specifically references the second edition of *PBE* about the Declaration of Helsinki.

voluntary consent, and disclosure of information.[48] There are other sources which will have likely also influenced Kennedy's views, such as the Nuremberg Code[49] and the Belmont Report,[50] but we have here a direct link between Kennedy and the work of Beauchamp and Childress. We can thus be reasonably sure that *PBE* had some effect upon Kennedy's thinking, even if it just solidified and supported his previously existing views. If the link between Kennedy and the Court of Appeal in *Re T* is reasonable, then the work of Beauchamp and Childress makes its way into the Court's thinking via Kennedy.

Going further, it is important to consider how much this three-requirement definition is associated with *PBE* and Beauchamp and Childress' work. There are a number of ways to conceptualise autonomy and the focus on capacity, information, and freedom from controlling interests is only one. Alternative theories do not have those requirements. For example, another prominent theory of autonomy in the Millian process-oriented vein[51] is provided by Gerald Dworkin. Dworkin states that a decision is autonomous if an individual's first- and second-order

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[48] Beauchamp and Childress (n 1) 70. Beauchamp and Childress add a fourth: comprehension of information. While that forms an important part of the doctrine of informed consent in the United States, it never found favour in courts in England and Wales.

[49] The Nuremberg Code (1947) published in (1996) 313 *BMJ* 1448.

[50] *The Belmont Report* (n 24).

[51] There are two broad schools of autonomy conceptions. The first derives from Immanuel Kant's work and has substantive criteria such as a decision is only autonomous if it fits within the categorical imperative. The other derives from the work of John Stuart Mill and focuses not on the substantive decision made by the individual but the process by which that decision is made. See, for example, Onora O'Neill, *Autonomy and Trust in Bioethics* (Cambridge University Press 2002). doi.org/10.1017/CBO9780511606250.

preferences align, with first-order preferences being our initial wants and desires, and second-order ones being our feelings and beliefs about our first-order preferences.[52] A court decision based upon Dworkin's theory, then, would not likely include the requirements that one based upon Beauchamp and Childress' theory would. Instead, it might focus on determining what a person's first-order preferences are and whether their second-order preferences are consistent with that. In T's case, it might have focused on whether T had the wish or desire to refuse blood transfusions, and, if so, whether she wanted to be the kind of person who wanted to have the desire to refuse a blood transfusion. One possibility is that the potential undue influence from her mother might have made T want to have a blood transfusion, but T might have also wanted to be the kind of person who was not subjected to undue influence from a parent, which would make her decision non-autonomous under Dworkin's theory. While this might have ultimately led to the same conclusion as the Court actually reached, its method for determining that would be substantially different from the one given in the case.

Even if there are other explanations for the Court's statement in *Re T*, *PBE* may have had a substantial influence on how the *Re T* decision was understood by healthcare professionals. *PBE* was introduced to UK healthcare professionals through several articles in the *British Medical Journal* (*BMJ*) by Ranaan Gillon.[53] In those articles, he explained the principles as

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[52] Gerald Dworkin, *The Theory and Practice of Autonomy* (Cambridge University Press 1998). doi.org/10.1017/CBO9780511625206.

[53] The 26-part series in the *BMJ* is collected in Raanan Gillon, *Philosophical Medical Ethics* (John Wiley & Sons 1986). The original articles were published from (1985) 290 *BMJ* 1117–19 to (1986) 292 *BMJ* 543–5. Gillon is considered 'instrumental in establishing medical ethics as a discipline, particularly within medical schools, in the United Kingdom': Julian Savulescu, 'Editorial: Festschrift edition of the *Journal of Medical Ethics* in honour of Raanan Gillon' (2003) 29 *JME* 265. doi.org/10.1136/jme.29.5.265.

outlined by Beauchamp and Childress and tried to show how they applied to real decisions and how useful the four principles approach could be in clinical decision-making. Gillon published an article around the time that *Re T* was decided, and he continued to extol the virtues of the four principles approach.[54] *PBE* would, therefore, have been familiar to readers of the *BMJ*, as well as within the healthcare community generally. Consequently, when the decision in *Re T* was handed down, it corresponded with at least one known approach to patient autonomy in healthcare decision-making. The consistency between Beauchamp and Childress' approach to autonomy and the Court's decision in *Re T* would thus have aided healthcare professionals' understanding of the decision. It would also have provided a firm ethical grounding for how they might approach implementing the decision in future cases, since literature exploring the *PBE* approach to autonomy would have been directly applicable to their legal duties. *PBE* thus forms an important part of the story of *Re T* because it might have been instrumental in terms of providing a theoretical framework for the Court's decision, and because it provides strong justifications to healthcare professionals as to why that decision is 'correct'.

Moving beyond this example, even areas which are supposed to be reactions to Beauchamp and Childress's work can find echoes in *PBE*. For instance, many argue against Beauchamp and Childress's version of autonomy because it is said to be too individualistic.[55] Beauchamp and Childress have always contested this, arguing that even in early editions of *PBE* they did not consider autonomy to be divorced from social situations and relationships. This is, indeed, the case, and in the second edition of *PBE*, Beauchamp and Childress said that morality is neither 'individual-centered' nor produced by 'atomized "moral" agents disengaged from a

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[54] Raanan Gillon, 'Medical ethics: Four principles plus attention to scope' (1994) 309 *BMJ* 184. doi.org/10.1136/bmj.309.6948.184.

[55] Beauchamp and Childress (n 4) 11. Relational autonomy is also discussed in the chapters by Jo Bridgeman and Emily Jackson in this collection.

cultural setting'.[56] While this does not set out a full argument for relational autonomy, it is instructive to note that even at that point Beauchamp and Childress were thinking more broadly about autonomy than they are sometimes taken to do.

My arguments here cannot, unfortunately, be backed up by definitive proof. It is not possible to know for certain that Beauchamp and Childress, whether through Kennedy or some other source, had an impact upon the Court's thinking in *Re T* or on how healthcare professionals reacted to the decision. Nor is it possible to discern what role, if any, ideas mentioned in previous editions of *PBE* had on broad theories such as relational autonomy. Indirect influence is, naturally, hard if not impossible to substantiate. Nevertheless, the ideas articulated in *PBE* provide a bioethical language to understand decisions like *Re T* in ways which may not have otherwise existed. As Margaret Brazier and Emma Cave have noted, '[t]he influence of the four principles, and their delicate relationship with legal principles, make it important that in any study of law relating to healthcare a brief account is given of the four principles'.[57]

There is an additional problem to tracing the significance of *PBE*. In a famous article John Arras compared Beauchamp and Childress to the Borg from Star Trek.[58] He argued that

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[56] Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (2nd edn, Oxford University Press 1983) 65.

[57] Margaret Brazier and Emma Cave, *Medicine, Patients and the Law* (6th edn, Manchester University Press 2016) 66.

[58] John D Arras 'The hedgehog and the Borg: Common morality in bioethics' (2009) 30 *Theoretical Medicine and Bioethics* 11. doi.org/10.1007/s11017-009-9093-5. The Borg are an antagonistic race in the Star Trek universe. The Borg are cyborg beings which attempt to take over other species and 'assimilate' them by forcibly injecting them with nanoprobes and enhancing them with cybernetic augmentations. The Borg exist in a hive

when faced with criticism of their work, Beauchamp and Childress often looked to incorporate those criticisms in such a way as to strengthen their argument.[59] This incorporation exercise had significant benefits but also makes it difficult to trace the indirect impact of *PBE*, since at least some of their ideas originated in other sources and, particularly, sources which are potentially antagonistic to principlism as a theory. It may then be difficult to determine what role, if any, Beauchamp and Childress had in the subsequent application of a particular idea. Considering the ubiquity of *PBE* as a core textbook in the area,[60] inclusion of an idea in it is likely to reach a broader audience. This may mean, though, that Beauchamp and Childress receive credit for a theory that was originally conceived elsewhere, or the role of the theory's originators becomes less pronounced. Some of the significance of *PBE* is thus as an *aggregator* of current thought within the field, as seen through the lens of principlism. Although this may seem to be less significant than original theories, *PBE* has played a crucial role in developing the field like bioethics. Furthermore, because bioethics often has no ready 'academic home' and is composed of scholars from philosophy, theology, medicine, healthcare, law, and other fields, all of whom have different expertise, concerns, and knowledge bases, and it can be difficult for new entrants to the subject to be able to find a reasonable overview of current theories. *PBE* provides that as it is a primary textbook within the area, and Beauchamp and Childress's ability to incorporate material is a significant strength and not a weakness.

Determining the significance of *PBE* is a complex task and involves its direct effect on thoughts on principlism specifically and bioethics more generally, and also in the pervasive

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mind called 'The Collective', and the Borg do not exist as individuals but as 'drones' that fulfil the wishes of that Collective. The purpose of the Borg is to achieve their version of 'perfection'. See <https://intl.startrek.com/database_article/borg> accessed 23 June 2022.

[59] Arras (n 58) 12.

[60] Fox and Swazey (n 25).

indirect impact that results from the work. Because it is one of the primary texts in the field,[61] the ideas, concepts, and theories presented in *PBE* permeate the bioethical landscape and have had far-reaching effects within the context of bioethical thought and in subjects such as law, where important concepts have become embedded in legal thought. *PBE* has helped to expand ideas about consent and autonomy, as well as mid-level approaches to bioethical problem-solving which has influenced how people address issues in bioethics generally.

The legacy

PBE is undoubtedly a leading work in health law and ethics, and I emphasise two aspects of its legacy here. The first is Beauchamp and Childress's focus on a 'mid-level' approach to biomedical ethics, a method which originated in *PBE*. A mid-level approach, which Beauchamp and Childress refer to as a version of coherentism, is a middle ground approach between broad grand theories like deontology and utilitarianism and casuistry which is based upon specific cases.[62] Their aim is for an approach based upon general principles without having to trace them back to overarching concepts like the categorical imperative or utility, and which can address specific issues without the particularism that casuistry sometimes requires. Utilising this approach, Beauchamp and Childress attempt to create a system which has the benefits of theory and clinical practice while minimising some of the adverse effects of both. Theory can often be divorced from real-life issues, which the focus on principles helps to avoid. Clinical practice, on the other hand, can often lose any overarching justification for behaviours, which a more generalisable theory such as the four principles approach can provide.

While the mid-level approach to ethics championed in *PBE* is often emphasised, its reasons for doing so are less widely discussed. Yet, those reasons are equally important. The first

[61] ibid.

[62] Beauchamp and Childress (n 1) 439–44.

is simply that *PBE* has two authors who do not agree on everything but needed to find a way to create a system which they could both accept. So, they have noted that Beauchamp prefers rule-utilitarianism, and Childress has a preference for rule deontology.[63] These beliefs are held after long consideration of the moral issues involved, but their preferences are only 'slight', and none of the available theories completely satisfy what they believe are the appropriate tests for determining a theory's validity.[64] The upshot of this difference is that it allowed Beauchamp and Childress to recognise where they agreed and where they disagreed, and to focus on their agreements. The mid-level approach that they use, then, is based upon compromise.

More importantly, though, their attempt to find a compromise that they could both accept allowed Beauchamp and Childress to realise that agreement between competing theories is possible. Deontology and utilitarianism are often considered to be polar opposites, with one focusing on inherent traits about the behaviour in question and the other focusing on the results of that behaviour. Beauchamp and Childress realised that even though those theories began and focused on different aspects of the decision in question, they often reached the same *result*.[65] Consequently, agreement *was* possible if individuals focused on the things that they had in common and not on where they differed. This allowed Beauchamp and Childress to avoid the prickly theoretical disputes which often lead nowhere, and which can turn people off from considering bioethics, both in terms of its use as an academic subject and also as a method to

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[63] Beauchamp and Childress (n 4) 9; Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (3rd edn, Oxford University Press 1989) 44.

[64] Beauchamp and Childress (n 4) 9. For Beauchamp and Childress, the appropriate tests appear to be both theoretical (is the theory coherent as a whole and justifiable according to its principles) and practical (can it be applied to real-life situations to determine which behaviours we ought to engage in).

[65] ibid 9.

decide actual moral disputes in medicine and biosciences.[66] It allowed them to realise that principles could be used to organise moral decision-making models, without having to appeal to higher principles and get caught up in discussions which obfuscated and avoided the concerns which needed to be addressed, but without abandoning the general benefits of a theoretical approach.[67]

Crucially, this has pushed bioethics towards being a discipline where the clinical *and* the theoretical are both seen as important goals. It is not just that we need a theory which is coherent and consistent, we also need one which can be applied to real-world clinical problems. *PBE* places bioethics as a field of study which is neither entirely theoretical nor entirely practical, but one which uses both to reach more informed and better decisions no matter how 'better' is defined. This broadening of the remit of bioethics, to include everything from pure theory to pure practice to areas in between, allows for varied voices to be part of discussions. A range of experiences and expertise deepen the conversations in this broader expansive view of the subject, new ways of exploring issues.

There is a second aspect of the legacy of *PBE* that is worth highlighting, and this derives from Arras's discussion of Beauchamp and Childress as the Borg.[68] As I noted earlier, Arras's point is that Beauchamp and Childress assimilate criticisms and critiques of their position into their argument. This means that their theory changes with each edition of *PBE*, sometimes in minor ways and sometimes in major ways (the common morality idea, for example, does not

[66] For discussions of other methodologies in health law and ethics, see the chapters by Louise Austin and Sara Fovargue in this collection.

[67] Beauchamp and Childress (n 1) 439–44.

[68] Arras (n 58).

appear until later editions),[69] but the core aspects of the theory remain. The four principles approach outlined in *PBE* is thus modified, while its essential elements remain pointed in the same direction. It evolves towards a more 'perfect' version of itself, while remaining true to what it is. Like Star Trek's Borg, each iteration is different yet always essentially recognisable.

However, there is a significant difference between Star Trek's Borg and Beauchamp and Childress's approach. The tagline of Star Trek's Borg – 'Resistance is Futile' – is a threat. Those who engage with them are forced into assimilation, whether they wish to or not, and the results are usually bad for whichever species or group encounters them. The ideas, responsibilities, duties, and wishes of those being assimilated do not matter, and even family groupings are demolished in pursuit of the collective hive mind perfection of the Borg. The Borg cares only about the goals of the Borg. The promise of the Borg, then, is violence and assimilation on their terms and in a way which will not benefit the group or species which is being taken over. Beauchamp and Childress's assimilation in terms of principlism is more benign. It is true that the discussions which began in Georgetown have now reached a global audience, but the prime method has been through discourse and discussion. Beauchamp and Childress appear to care about getting the 'best' answers available, rather than sticking slavishly to their initial theory. They thus react positively to ideas which they think can help them to do that.[70] Bioethics, as performed by Beauchamp and Childress, is an area that is not dependent on the binary debates

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[69] Beauchamp and Childress state the use of the common morality arises in the third edition: Beauchamp and Childress (n 1). This is consistent with Arras ([n 58] 13), although other scholars, such as Oliver Rauprich, place it in the fourth edition: Oliver Rauprich, 'Common morality: Comment on Beauchamp and Childress' (2008) 29 *Theoretical Medicine and Bioethics* 43. doi.org/10.1007/s11017-008-9061-5. Note that the current form of the common morality is different from the one which appears in earlier editions.

[70] Beauchamp and Childress (n 4) 10.

which have happened elsewhere in philosophy, where one must maintain their position despite any opposition and in spite of any revisions which might be beneficial to the overarching theory.

Doing bioethics in this way is a liberating approach to the subject. It allows those within the field to be more reflective and flexible in their beliefs and arguments. If two of the most celebrated bioethicists in the world are willing to listen to reasoned argument and change their views accordingly, there is little reason not to do so for those who are less established in the field. Doing so is not a sign of weakness, nor does it show that the initial argument is worthless. Rather, it shows how additional information, ideas, and experiences can broaden and strengthen the arguments that exist. It can also allow for more honesty among its adherents, who can acknowledge which arguments they have made in the past which can now be strengthened and improved. This would make bioethics as a subject kinder, gentler, and more effective at seeking 'the truth'. Bioethics would then become a subject in which individual ego becomes less crucial than understanding which can be gathered through experience, intuition, and reasoned argument.

This openness, taken to its logical conclusion, is also beneficial because it celebrates the diversity of experiences.[71] Beauchamp and Childress being willing to explore the arguments of others to see how accurate they might be and how they might be incorporated into their own theory, provides an example for the possibility and benefits of accepting viewpoints different from our own. Doing so will help to provide philosophical diversity – the equivalent of the genetic diversity that the Borg are always seeking – and will have an even greater benefit too, because it makes further space for views based on diversities of experience. As Childress has said, it is important to understand our own 'limitations of what we bring to the discussion, which will be true for the philosopher or theologian as well as for anyone else'.[72] If theories can be changed in the light of 'better' and more extensive evidence, there is no reason not to listen to

[71] On the importance of this, see also the chapters by Sara Fovargue and Emily Jackson in this collection.

[72] Fox and Swazey (n 25) 41.

those whose experiences, backgrounds, cultures, faiths, and viewpoints are different from our own. Opening spaces in this way will lead to fruitful and beneficial discussions.

This is not (nor will it be) an automatic part of the legacy of *PBE*, however. And it will not happen unless those within bioethics follow Beauchamp and Childress's lead and approach the discipline, and moral philosophy more generally, in this way. The legacy of Beauchamp and Childress that has developed from *PBE* is at least as dependent on those who have followed afterwards, as it is to Beauchamp and Childress themselves. If the bioethics community abandons those aspects of Beauchamp and Childress' legacy, then that legacy will not be fulfilled. It is thus important to highlight these aspects of Beauchamp and Childress's approach so that they are not forgotten.

Returning to Arras's comments on the Borg, if we treat the legacy of *PBE* as, at least partially, being about inclusiveness and diversity, it may share some elements with the Borg. There is still the search for inclusive diversity, assimilation, and a search for perfection. However, while Star Trek's Borg are ruthless, violent, and seek to eliminate differences on the basis of their view of what is important, *PBE*'s 'Bioethics Borg' seeks to be inclusive, is willing to listen to others, and is keen to seek a shared version of 'better' that derives from a more diverse set of views rather than just one perspective generated from one theoretical approach. This is likely to lead to a more effective search for perfection and one which is less terrifying than the one presented by the Borg in Star Trek.