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Rethinking Principlism: Is Bioethics an American Plot?

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Many people now question whether the universalist aspirations of traditional ethics can stand up to historical, sociological and philosophical scrutiny, and prefer more culturally specific mores. Even if we agree that some global bioethic is possible and desirable, there will be rival claimants as to which it should be and a proper suspicion of 'values colonialism'. By far the most influential bioethic in the world today is *Principlism.* To the extent that this bioethic has any stable content at all, it tends to presume – and subtly impose – a North-Eastern, establishment, American value set.

In this issue, Anthony Fisher argues that 'the Georgetown mantra' of *beneficence, non-maleficence, autonomy* and *justice* actually represents the competing mantras of four poles of a moral compass. Many Asians (and others) incline to the South-East of this compass (getting on with others and doing one's duty is what counts) and many Anglo-Americans (and others) to the North-West (getting your own way and getting results is what counts). He argues that this must make us wary of the globalisation of the Georgetown bioethic.

Anthony Fisher then offers an alternative reading of 'the four principles' which treats them not as principles but as four aspects of morality, no one of which should be absolutized because all of which are needed – and much more – for a richer and more useful bioethic.

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1. The Globalisation of American Bioethics

There is much talk today of 'Asian values' and 'Western values' in bioethics as elsewhere.[i] Many people now question whether the universalist aspirations of traditional ethics can stand up to historical, sociological and philosophical scrutiny, and assert that more culturally specific mores are the only legitimate ones. Following the exposure of a number of horrific biomedical experiments before, during and after World War Two, the World Medical Association published a code of ethics for all medical practitioners and declarations on various matters such as human experimentation.[ii] Some secular academics now doubt the usefulness of such universal codes.[iii] Within my own – Catholic – moral tradition some scholars are now similarly sceptical about the universalist claims of papal encyclicals such as *Veritatis Splendor, Evangelium Vitæ* and *Fides et ratio* or of Church documents such as the *Catechism of the Catholic Church* and the Vatican *Charter for Health Care Professionals*. If this contemporary scepticism is justified it has serious implications not just for healthcare practice and bio-lawmaking, but for the formation in professional ethics offered in our higher education institutions and by professional associations.

Even if we agree that some global bioethic is *possible* and *desirable*, there will be rival claimants as to which it should be and there may be a suspicion that one culture is colonizing the mores of the other ('values colonialism'). By far the most influential bioethic in the world today is *Principlism*. In response to a series of unethical experiments the National Research Act 1974 directed the Secretary of the US Health Department to appoint a commission to identify the basic ethical principles that the federal government should use in funding and regulating medical research and practice. The 1979 *Belmont Report* identified *respect for persons, justice* and *beneficence* as the three basic principles of bioethics – and the only three over which there was a general consensus.[iv] This attempt to reduce ethics to just a few basic principles reflected the simplification and secularisation of the much richer Hippocratic tradition of medical decorum and the more religious 'Medico-Moral' tradition that had reigned in healthcare well into the twentieth century.[v]

Following the Belmont Report a version of 'Principlism' was popularised by Thomas Beauchamp and James Childress of Georgetown University in Washington DC in their classic text.[vi] With the explosion of the bioethics industry this approach spread like a virus through the world, transmitted by the textbook (now in its sixth edition[vii]) and by thousands of students returning from quick courses in Georgetown and elsewhere, ready to put up their shingle as a 'bioethicist'. What many people found attractive about this approach was the way it eschews commitment to any one culture, religion or moral theory or to any particular set of metaphysical or moral foundations. It also avoids prescribing any detailed moral norms, while proposing some (supposedly) common ground on 'middle order principles'. The globalisation of ideas has meant that products like these are readily exported to almost everywhere in the world and very widely consumed, so that we hear Principlism parroted as often in the East as in the West, in the South as in the North.[viii]

2. The Georgetown mantra

Principlism seeks to reduce bioethics to four basic 'principles': *beneficence, non-maleficence, autonomy* and *justice*. This is commonly called 'the Georgetown Mantra' because after learning to rattle off those four words, some people think they've got bioethics. Yet as many critics have noted, the four principles are not really moral principles at all. They are so 'neutral', 'thin' or 'empty' as to invite many interpretations and to allow their users to rationalize almost any practice. To the extent that have any stable content at all, they tend to presume – and subtly impose – a North-Eastern, establishment, American value set. This commonly includes a dogmatic

secularism and a radical individualism that proves empowering for the already powerful but disempowering or even lethal for embryos, the unborn, handicapped neonates, persons living with disabilities, the frail elderly, the unconscious or demented, the poor and the dying. The supposed 'neutrality' of Principlism, then, is naïve at best, disingenuous at worst.[ix] It is this last complaint that is the basis of my provocative question about bioethics, not as it could or should be, but as it is actually practised today: *is it really an American plot?* I am not suggesting, of course, that there is any mastermind behind the export of the Georgetown product, though that university has famously had many links with the CIA over the years! However, this consumer product has proven so successful in penetrating the world 'market of ideas' that it has often been too uncritically adopted in other cultures.

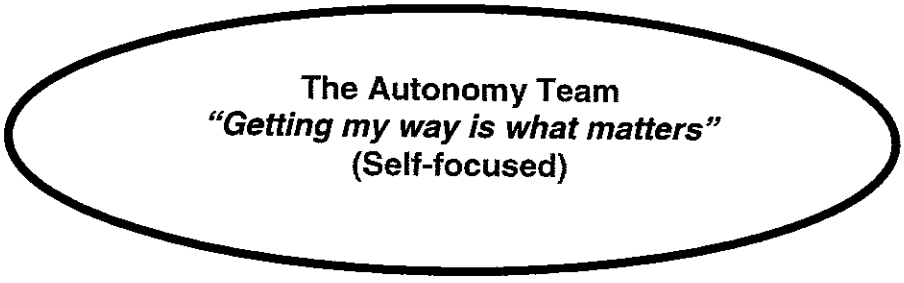
3. Making sense of Principlism: Four competing bioethical teams?

Before we can adopt or critique Principlism we must understand what it is proposing. What sense might we make of these very popular *four principles* and where might this point us from here? Bioethics should be rational reflection upon what people should be and do in the spheres of life, death, health and healthcare. It should start with the human person, the traditions and experience of action in those particular arenas, the general principles of morality and the dilemmas of contemporary practice. Anyone following reason's guidance, undeflected by distracting emotion, prejudice or convention, has the basis for a morality that educates conscience, shapes virtues and makes possible wise decisions in particular cases.

I want now to suggest a way that we might read 'the four principles'. I suggest that they are not four principles at all, but rather the poles of four different cultural-ethical perspectives. We might say that there is *not one Georgetown mantra but four*, the war-cries for four rival bioethical football teams. This may help to explain the intractability of bioethical debates and the unlikelihood of one global bioethic emerging any time soon. Individuals and communities are presently polarised around one or more apparently competing sets of values.

4. The Autonomy Team

The most common feature of American bioethics, that has been increasingly globalised in recent years, has been 'individualism' or what we might call in the present context *the autonomy team.* Its players come from diverse backgrounds such as egoism, subjectivism, libertarianism and situation ethics. They include followers of Adam Smith, John Stuart Mill's *On Liberty*, Jean-Paul Satre, Ayn Rand, Robert Nozick and Alan Gewirth; from contemporary philosophy the 'neocons' and free-market liberals such as the recently deceased Michael Novak; and from bioethics and theology players as Max Charlesworth, Charles Curran, Tristram Engelhardt and Joseph Fletcher.[x] The catchcry of this team is that *getting you own way is what matters.* Thus when Americans such as Beauchamp and Childress do bioethics, 'autonomy' – though supposedly one principle amongst many – usually 'trumps all'. On this account individual rights are much more important than concern for others.



Advocates of such approaches to bioethics emphasize independence and taking responsibility and deplore the paternalism they find in traditional medicine. They insist that decision-making in life, death, health and healthcare should be made by the individuals most immediately concerned, taking into account their own particular values and circumstances. In healthcare this spotlights respect for patients, informed consent, privacy and confidentiality. The chief (and arguably only) constraint on 'getting one's own way' in this model of bioethics is allowing a similar freedom to others.

Take the issue of whether we should tell those with a terminal condition that they are dying. According to this perspective they should certainly be told: only the patient can make appropriate decisions about what healthcare she should have and how healthcare fits into the bigger picture of her goals and values. Only she can properly make the decision about whether to continue treatment, and which treatment, and where, and she can only do this if she is told her diagnosis, prognosis and treatment options. Whether she wishes to share this information and discuss her options with family members or others is up to her. But what is clear here is that the terminally ill should be told. This very Western, one might say very American, perspective on end-of-life care is highly contested in Asian cultures.

Consider another contemporary bioethical controversy: euthanasia. Who should decide? Those who chant the autonomy mantra would say: the patient and anyone she chooses to involve in her care. Religious leaders, lawmakers, the profession and other busy-bodies should 'get out of people's faces' on such matters and leave it to the individual to decide for themselves. If I want euthanasia I should be free to decide when, by what method and on what conditions. If you are against it because of your religious beliefs or your Hippocratic ethics, you are free to choose otherwise. The law and professions should remain neutral or, indeed, promote choice. As long as it is truly voluntary, it should be permitted, even assisted. Once again, more traditional cultures that place a high value upon respect for elders, resignation in suffering, the support of extended family and so on, are a long way away from this very individualistic response to care at the end of life.

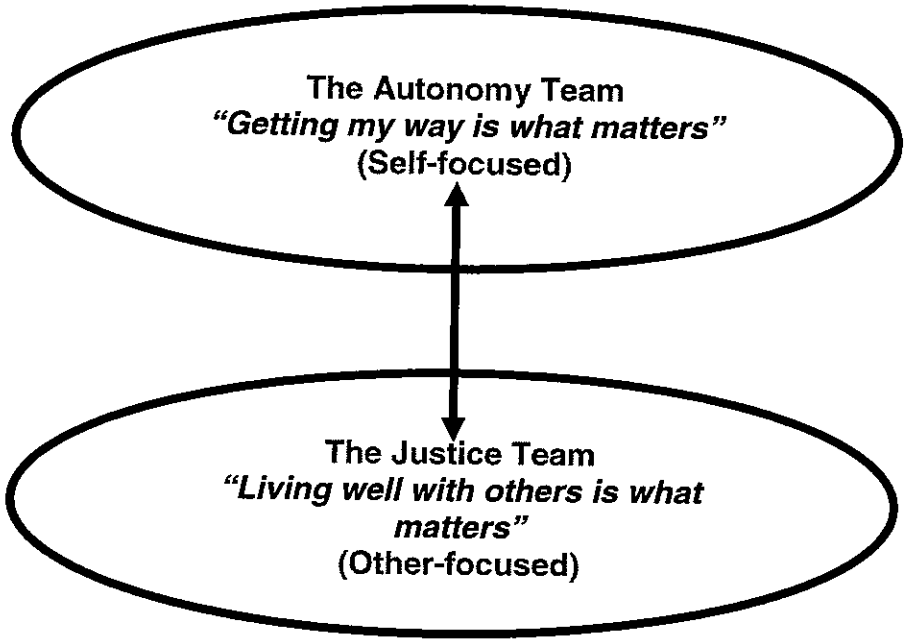
Part of the attraction of autonomy-oriented approaches is that they ostensibly recognize the dignity and rights of each person as a free agent and no-one's slave or pawn. They avoid grand moral theories that may not do justice to the complexity of individual situations and to pluralism of opinion. The downside of such approaches is that they can reduce conscience to a private internal voice or intuition beyond external criticism, with authority to decide what to do without much regard for objective truth or tradition. Autonomy-based approaches to morality also offer little or no basis for scrutinizing personal prejudices and give puzzled individuals no help in making decisions. They allow people to compromise basic values such as reverence for life and compassion for the suffering, and can easily become anti-social or adversarial with respect to others.

5. The Justice Team

Many commentators have suggested that the biggest difference between American (or Western) ethics and Asian (or Eastern and Southern) ethics is that for the latter the kinship group, village, people, class, gender and/or nation rather than the individual is the locus and end of decision-making. Despite the globalisation of Anglo-American individualism, many people and cultures remain more group-focused or other-focused. The community or Justice Team might include members of 'traditional' cultures, followers of the great Eastern philosophies, as well as Marxists, feminists and other radical social critics, proponents of culture-specific ethics and recent writers

in justice such as the disciples of John Rawls. Players from contemporary philosophy might include Annette Baier, Carol Gilligan, Alasdair MacIntyre and Charles Taylor and from bioethics, (the later) Daniel Callahan, Norman Daniels, Ezekiel Emanuel, Renee Fox and Verena Tschudin.[xi] Their mantra is: *getting on with others is what matters.*

Followers of such approaches to bioethics emphasize interconnectedness, dependence and interdependence, compassion, authority and loyalty, culture, tradition and profession, and deplore the wilfulness and injustices they see inherent in individualist-capitalist medicine. They insist that decision-making in life, death, health and healthcare should be made by the communities most directly concerned, or by individuals with an eye to the interests of that community, taking into account the group's values and needs. In healthcare this spotlights the codes and customs of the profession, the fair allocation of health opportunities and resources, the cares of extended families and other groups.



Take our example of the person diagnosed with a terminal condition. Followers of this more community-focused approach may well hold that the patient's spouse or children should be told, and that *they* should make any decisions in conjunction with the health professionals. Whether the dying person will be told would depend upon local custom and the judgment of those others about the usefulness of telling the patient. It might, after all, only frighten her and cause her to lose hope. She should be freed at this time from the burden of such hope-robbing information and such difficult decision-making. In Asia, unlike America, she may very well *not* be told.[xii]

Or consider our other contemporary bioethical controversy: euthanasia. People at this pole might say the community must decide whether such a practice in general, or in this particular case, is appropriate. Respect for elders and the need to protect the weak, including the frail, handicapped and dying, from their own despair or from the pressures of others who would rather not continue their care, would militate strongly against euthanasia. The law would generally exclude it. The

push for euthanasia is, unsurprisingly, nowhere near as strong in Asia as it is in America, Britain and Europe.

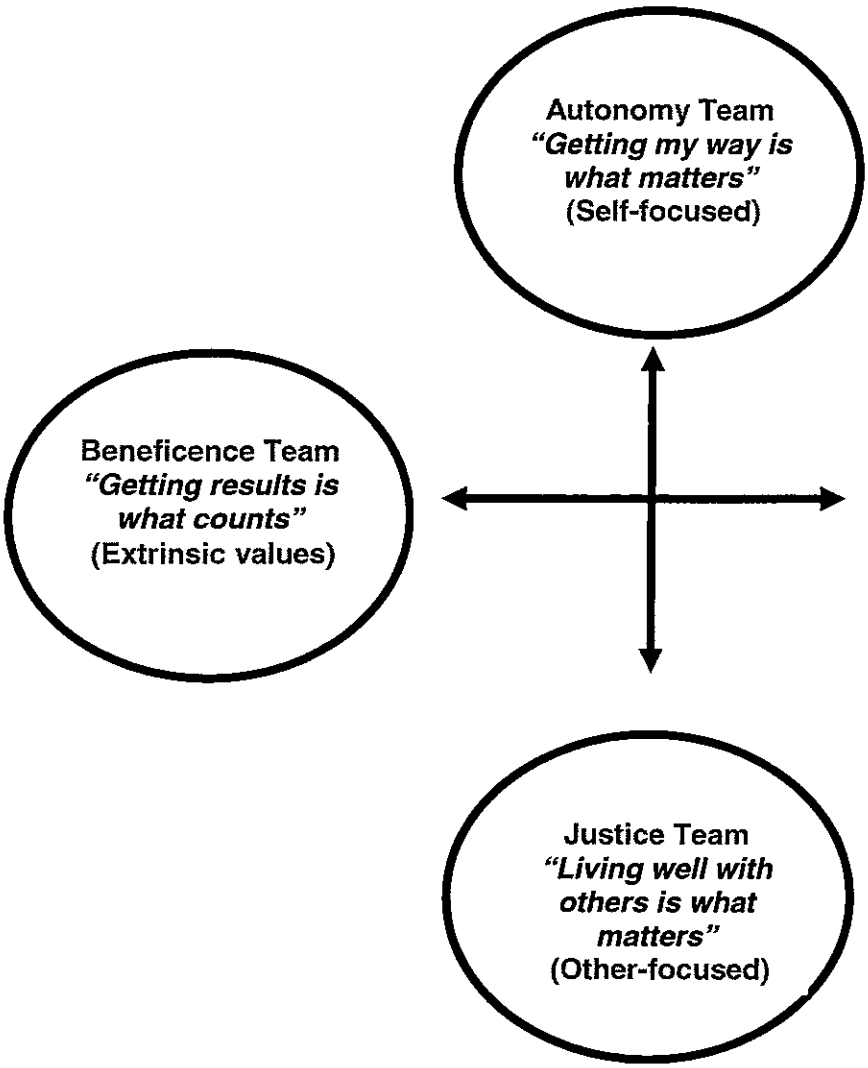
Part of the attraction of such community or justice perspectives is that they recognize the reality that, far from being independent atoms, every human person is part of a web of relationships and forms and expresses their values in company with others. Even recognition of individual rights requires a rich view of the common good and joint effort with others to promote the flourishing of all. At least as important as rights are ties to family, community, tradition. Such approaches avoid the asocial individualism of the capital- and technology-driven West and encourage people to take responsibility not only for their own health but for that of others. The downside of such theories is that they can discourage personal initiative and promote the dream of some corporatist utopia. As the twentieth century demonstrated repeatedly, the vain attempt to achieve such dreams usually comes at a great cost to individual freedom and even life. Community or justice-oriented approaches to ethics commonly fail to allow space for individual differences and can incline their followers to a blind obedience to the group that reduces to a cultural relativism.

6. The Beneficence Team

We might disagree about what is good or what are the best or permissible ways of achieving it or for whom: but wherever you are from in the world, ethics requires that you try to do the good. However, a feature of Anglo-American and some European ethics, perhaps more commonly than ethics in other parts of the world, has been notion that acts gets their meaning from the results they produce and that the right action is always the one than achieves the most net good. We might call those who take this view the *Beneficence Team*. They include various consequentialists, including the utilitarians who until recently dominated the academies of Anglo-America and its allies and the proportionalists who until recently held many seminaries and theology faculties captive. On this team are followers of classical pragmatism and utilitarianism, as well as contemporary bioethicists such as Peter Singer, Michael Tooley and Julian Savelescu. Players from moral theology include Josef Fuchs, Richard McCormick and Jack Mahoney, to name a few.[xiii] The war-cry of this team is that *results are what count.* Intentions, motives, inherent values and duties are less important: agents must consider all the likely consequences of each option before them and pick the one that maximizes net sum of good consequences over bad.

To return to our example of the person diagnosed with a terminal condition: followers of this results-focused approach will not accept any absolute norm of telling the truth to patients, nor of leaving it to the children and others to decide. They may have some rules of thumb, but in each case they will decide what is likely to produce the best result. Directly lying to the patient or to the relatives, involving or excluding others from the decision-making without the patient's consent may well be in order. What matters it what gets the best result.

Most consequentialists favour euthanasia. One clear way of reducing the amount of suffering in the world is to reduce the people who are suffering. Singers of the beneficence mantra say "they shoot horses, don't they?" and insist that human beings deserve a similar 'mercy'. Consequentialists will agree with individualists on a pro-euthanasia position, but will be less particular about all euthanasia being voluntary. After all, children, the handicapped, the demented and unconscious might all be rated as *better off dead* and their deaths might also benefit those around them.

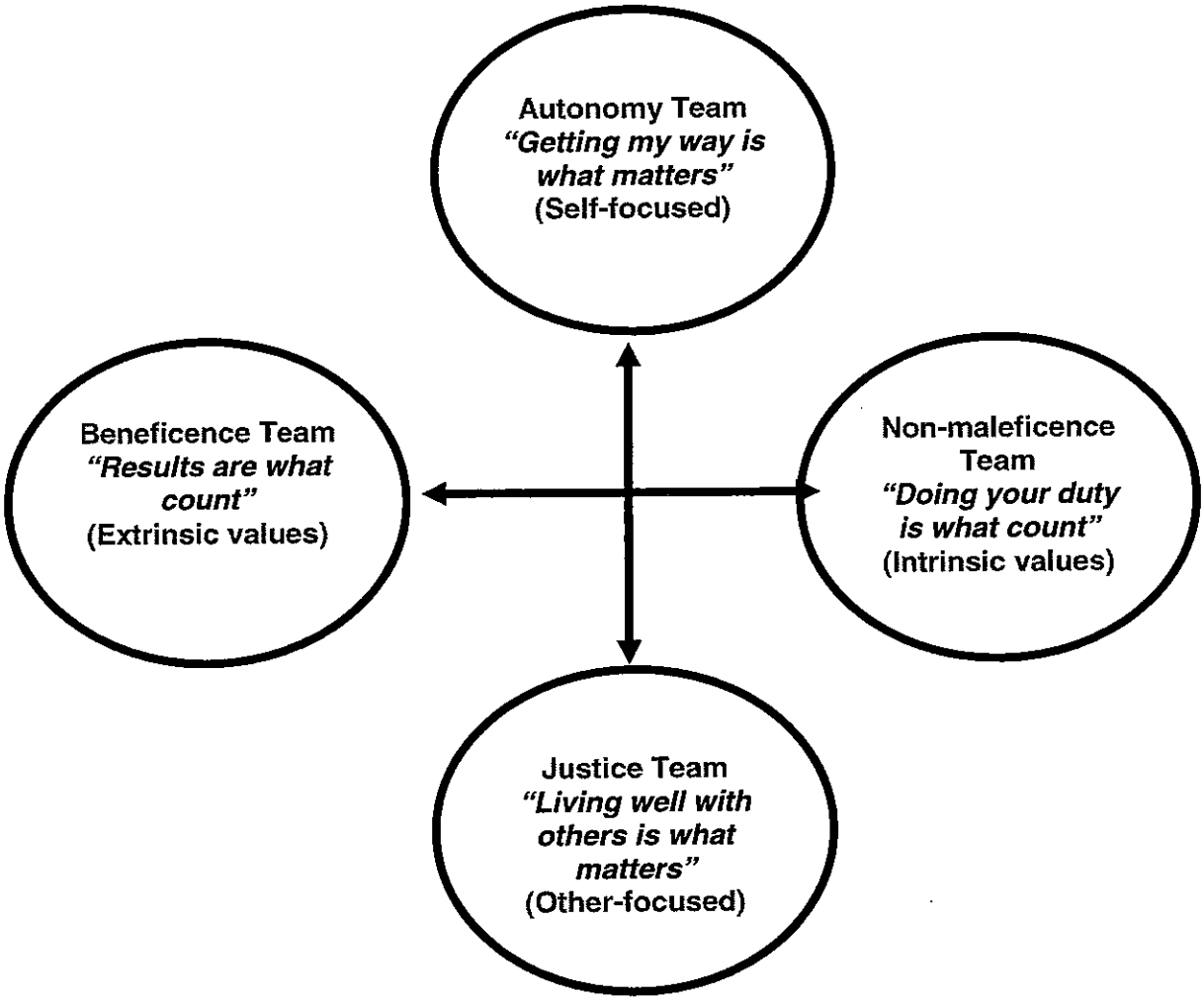


Others have identified and critiqued the strong consequentialist tendencies of much contemporary bioethics.[xiv] The attraction remains, however, because such approaches appeal to the benevolence and 'can do' mentality of many in 'the helping professions'. Many health professionals have little time for rules that constrain advances and prefer a scientific mindset focussed on effectiveness and efficiency. The problem is: what is a good result? What counts as a benefit and a loss, how are we to predict, measure, aggregate and compare all the 'apples and oranges' involved, how are we to make rational comparisons across individuals and communities? Does anything go, as long as the best result is achieved? The beneficence mantra allows, indeed requires, its devotees to compromise justice, the sanctity of life, human rights, truth-telling and promise-keeping when this serves 'the greater good' however defined.

7. The Non-maleficence Team

A last ethical tendency – one that possibly influences some Eastern or Asian ethics more than Anglo-American ethics – emphasizes the intrinsic value of certain acts and thus duties to self and others, honour, keeping face and obedience to authority. The adherents of this approach are the *Non-maleficence Team.* They say there are some things health professionals and others just never do, some harms they should never entertain bringing about. Amongst the ethical approaches that coalesce here are many faith or tradition-based ethics, as well as deontological or Kantian ethics. This team includes many adherents of the great monotheistic religions, philosophers within the Kantian tradition such as Alan Donagan and Martha Nussbaum, and health professionals who

follow the great codes from Hippocrates, Maimonides, Nightingale, the World Medical Association and the International Council of Nurses. Recent 'players' on this team include Paul Ramsay, Leon Kass, Benedict Ashley, Gilbert Meilaender and William E May.[xv] This team sing *doing your duty is what counts*: we must consider our duty or debt to the moral law-giver, whether that is God and his representatives, the extended family and community, the profession with its ethical codes, or to right reason and honour; we must obey rules that oblige because of the authority of that law giver, whatever the results.



Followers of these approaches to bioethics may exercise prudence as to when and how they tell a dying person of their condition, but they will never lie to them, as direct lying is an attack on truth, disrespectful of the victim of the lie and degrading to the liar him/herself. Likewise most deontologists oppose euthanasia, as it is a direct attack upon the good of life, is lethal for the victim and renders the agent a killer. According to most religions, lying and killing are also against God's law.

Amongst the attractions of such non-maleficence approaches to bioethics is that they tend to offer a clear, principled approach to healthcare dilemmas, enable formation of conscience in duty and obedience and provide a basis for criticism of personal and social prejudices. *Primum non nocere* – the first principle of Hippocratic medicine – opposes any exterminative kind of medicine that seeks to 'solve' sickness (or some other problem) by killing the sick, and any exploitative kind

of medicine that uses people (such as very early human lives) destructively. Faith and reason require the pursuit of integral human fulfilment in all its aspects, and refuse to compromise basic human goods and principles of morality even for the best of results. Opponents of this bioethical football team deny the alleged self-evidence of the authority or norms it proposes. They complain that such approaches yield moral absolutes that are arbitrary, legalistic, inflexible and often irreconcilable.

8. Subtotal: Principlism as cultural imperialism

So Principlism directs our attention to four poles of practical or moral reasoning, four competing ethical worldviews, discourses or team catchcries, rivals for players and audience. I have painted this version of Principlism in very broad brush-strokes. Of course, few people sit neatly at one pole of the moral compass or support one ethical team only, all the time; people who are most often concerned for themselves will sometimes be concerned also for others; people who mostly follow a fairly pragmatic policy will say there are *some* lines they will never cross; and so on. Individuals may inhabit a quadrant with two poles, rather than a particular pole. Or they may find themselves more at a particular pole much of the time, but not always: there will be other times when they act more from another place on the compass.

Nor does everyone in a particular culture follow the same moral lights. Nonetheless, if I may be permitted two very broad generalisations, I would suggest, first, that most Asians (and perhaps Africans, South Americans, Indigenous Australians...) tend to place themselves in the South-East of my moral compass and that most Anglo-Americans (and perhaps most Europeans today) incline to the North-West. This seems to be especially true of those in the academy. To the extent that this represents cultural conditioning, it must make us wary of the globalisation of the Georgetown bioethic. Secondly, while the great religious traditions are generally too 'catholic' to support any one 'team' and far too respectful to chant only one 'mantra', I do think that they are more often to be found teaching in the South-East of this moral compass than the North-West. Thus Pope John Paul's great encyclicals *Veritatis Splendor, Evangelium Vitæ* and *Fides et ratio* said far more about moral absolutes and the common good than they did about preferences and results. Instead of absolutizing one part of the moral picture as many contemporary bioethics do, a more ancient wisdom might draw us back to the beginnings of the ethical project itself and give us a new way of reading 'the four principles'.

9. An alternative reading of Principlism: foundations for a more global bioethic?

Is there a real alternative to Principlism which nonetheless reflects its central insights? I think so, and it begins by asking: what is it reasonable to do – in life, death, health and healthcare, as elsewhere? What choices 'make sense', are 'good' or 'right'? Moral philosophy begins its answer with three basic features of human persons: (1) that we are *responsible*, (2) that we each want to be *happy* and (3) that we want to be happy *together*. To say that we are 'responsible' is to say that we are free to make choices and can deliberate rationally about our options. *Human beings are choosing beings.* What's more, our choices are self-making and self-telling, they shape our character and express our identity. *Autonomy* or self-rule is not so much a bioethical principle, then, as a fact of human nature and action.

Why we choose what we do is a complex matter, but at its most basic it is that we each want to be happy rather than unhappy. Most people, if they've had the chance to reflect upon these things, recognize that happiness in life is about more than maximising pleasurable experiences

and avoiding unpleasant ones. It is about harmony, wholeness, flourishing. *Human beings are fulfilment-seeking beings.* Some things contribute to that fulfilment: we call them good or 'beneficent'. Other things do not: we call them bad or 'maleficent'. At the heart of the moral life, then, is striving to do what is good and avoid what is evil. *Beneficence* and *non-maleficence* are not particular moral principles so much as the fundamental grounding of all we do (and what such doing does to us). Beneficence-non-maleficence is, as it were, the principle before all principles, the why we have principles at all.

Of course none of us is the only or the most important being in the world, however much some people behave as if they thought they were. We are social beings and much of our good is a shared with others, a good-in-common. Happiness for us includes achieving the good for others and those others being happy by achieving the good. The state of not just me getting my due, but all of us getting our due, we call *justice*. Once again, justice is not so much a principle as an ideal state of affairs and a human disposition to bring that about (a 'virtue'). There are, of course, many principles of justice, such as reverence for the dignity of the human person, solidarity with others (especially the needy), subsidiarity in decision-making, respect for a range of human rights, and so on.

My attempt so far to make some sense of *the four principles* – by showing that they are not really moral principles at all but something more foundational – suggests that authentic morality is not mere personal preference or social convention, but rather the very logic of choices made in the pursuit of happiness for ourselves and others. Read together and in this favourable light, they are the four elements of the most general and foundational principle of all morality, not just bioethics: that *one should will those possibilities whose willing is compatible with happiness for one and all and only those possibilities*. Some have called this ideal 'integral human fulfilment'.[xvi] Put in the language of Principlism we might say: *one should exercise one's autonomy beneficently, never maleficently, and not just for oneself but out of justice for all.*

Of course there is more to morality that that: such fundamentals of morality are only starting points. They tell us what it means to be moral at all. But we still need to articulate a serious morality, including a bioethic, one that more fully explores the nature of the human person and choice, basic human goods such as life, health and community that explain why we do healthcare, and what are the reasonable ways of achieving such goods. The principlists would prefer to avoid being too prescriptive in these matters. However, if this leaves them unable to say that choices shaped by egoism or partiality are wrong, that directly attacking human life or health or using evil means to achieve good goals is unethical, then they are not doing bio-*ethics* at all.

So my 'fifth position' is this: the four principles, as I argued above, are not as principles at all, but aspects of morality that if pushed to extremes, without an eye to morality's other dimensions, reduce to catchcries of warring factions but allow no reconciliation. Rather than any one of these principles being absolutized as the whole of ethics, we might see them as the ethical equivalents of the four elements of fire, water, earth and air in traditional physics. They are the stuff of which every ethic is made, in any and every culture. They are the stuff, too, of a truly global bioethic, if one is possible, as opposed to a merely globalized American bioethic. But what they will not, by themselves, yield is answers to questions such as whether and how we should tell the terminally ill that they are dying or whether and how we should help that dying along. When the principlists claim to pull answers out of hats on those questions, there is a distinct sense of sleight of hand, and that is because they are relying upon various other hidden biases, norms and pre-conclusions. Better to be more up-front about our real principles, to expose them to critique and to apply

them with transparency. A post-principlist bioethic, 'global' in the sense of responding to and seeking to serve people of every culture, such as that articulated by Ashley and O'Rourke, Grisez, Kass, May and Meilaender, is much more likely to help people make sound choices in the real world of hospitals and homes.

10. Conclusion

Some people today dream of a 'value-free' bioethic, liberated from the 'moralizing', 'judgmental' interference of churches and professions and serving instead the self-validating agenda of scientific 'progress' or personal fulfilment. In fact healthcare and medical research are as value-laden as any other human activity and our contemporary scientific and market mindsets have their own moral limitations. A richer ethic than Principlism is required if people are to have a rational basis for judging some science as uplifting for the human person and genuine progress for the human community, and other technologies as degrading the person and regressive for the community.

In this paper I have tried to make some sense of and then critique the Principlist bioethic that has been globalised by the American bioethics industry. One way of reading *the four principles* as competing discourses, catchcries or mantras of four teams, rivals for players and audience. Such catchcries tend to absolutize some aspect of ethics at the expense of others. This helps to explain why thirty years after Belmont we are no closer on an agreed basis for bioethical reflection, let alone a consensus on particular bioethical questions such as reproductive technologies, abortion and euthanasia. Moral principles tend to lose their meaning and rational warrant if just announced (as principlists do) as if plucked out of the air or just the rules of a sports club to be applied, compromised or 'balanced'. A bioethic with such oracular 'foundations' overlooks the true basis for a rational and Christian ethic. I have suggested that a better way forward is to rediscover that these 'principles' are not principles at all but, at most, the building blocks for a richer and more global bioethic.[xvii]

End Notes

i See for example AA Alvarez, "How rational should bioethics be? The value of empirical approaches," *Bioethics* 15 (2001), 501-19; Robert Baker, "Balkanizing bioethics," *American J Bioethics* 3 (2003), 13-14; Gerhold Becker, "Asian and Western ethics: some remarks on a productive tension," *Eubios Journal of Asian and International Bioethics* 5 (1995), 31-33; Michael Cheng-tek Tai and Chung Seng Lin, "Developing a culturally relevant bioethics for Asian people," *Journal of Medical Ethics* 27 (2001), 51-54; Leonardo De Castro, "Is there an Asian bioethics," *Bioethics* 13 (1999), 227-35; Lisa Eckenwiler and Felicia Cohn (eds), *The Ethics of Bioethics: Mapping the Moral Landscape* (Baltimore: Johns Hopkins, 2007); H Tristram Engelhardt (ed), *Global Bioethics: The Collapse of Consensus* (Salem: Scrivener, 2006); Nie Jing-Bao, "Cultural values embodying universal norms: A critique of a popular assumption about cultures and human rights," *Developing World Bioethics* 5 (2005), 252-57; Ruth Macklin, "A defense of fundamental principles and human rights: a reply to Robert Baker," *Kennedy Institute of Ethics J* 8 (1998), 403-22; Catherine Myser, "Differences from somewhere: The normativity of Whiteness in bioethics in the United States," *American J Bioethics* 3 (2003), 1-11; Hyakudai Sakamoto, "Towards a new 'Global Bioethics'," *Bioethics* 13 (1999), 191-97; Hans-Martin Sass, "Asian and Western bioethics: converging, conflicting, competing?" *Eubios Journal of Asian and International Bioethics* 14 (2004), 12-22; Heather Widdows, "Is global ethics moral neo-colonialism? An investigation of the issue in the context of bioethics," *Bioethics* 21 (2007), 305-15; Regina Wolfe and Christine Gudorf (eds), *Ethics and World Religions: Cross Cultural Studies* (Orbis, 1999).

ii E.g. World Medical Association: *International Code of Medical Ethics* (adopted by the 3rd WMA General Assembly, London, 1949; amended by the 22nd WMA General Assembly, Sydney, 1968, the 35th WMA Assembly, Venice, 1983 and the 57th WMA General Assembly, Pilanesberg, 2006); *Oath at the Time of Being Admitted as a Member of the Medical Profession* ('Declaration of Geneva') (Adopted by the 2nd WMA General Assembly, Geneva, 1948; amended by the 22nd WMA General Assembly, Sydney, 1968, the 35th WMA General Assembly, Venice, 1983, the 46th WMA General Assembly, Stockholm, 1994; editorially revised at the 170th Council Session, Divonne-les-Bains, 2005 and the 173rd Council Session, Divonne-les-Bains, 2006); *Ethical Principles for Medical Research Involving Human Subjects* ('Declaration of Helsinki') (Adopted by the 18th WMA General Assembly, Helsinki, 1964; amended by the 29th WMA General Assembly, Tokyo, 1975, the 35th WMA General Assembly, Venice, 1983, the 41st WMA General Assembly, Hong Kong, 1989, the 48th WMA General Assembly, Somerset

West, 1996, the 52nd WMA General Assembly, Edinburgh, 2000, and the 59th WMA General Assembly, Seoul, 2008; notes of clarification added at the 53rd WMA General Assembly, Washington, 2002 and the 55th WMA General Assembly, Tokyo, 2004).

iii E.g. some writers in U Schmidt and A Frewer (eds), *History and Theory of Human Experimentation: The Declaration of Helsinki and Modern Medical Ethics* (Stuttgart: Franz Steiner, 2007).

iv National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, *Ethical Principles and Guidelines for the Protection of Human Subjects of Research* ('The Belmont Report') (Washington DC: Department of Health, Education and Welfare, 1979).

v On the history of bioethics see Dianne Irving, "The bioethics mess," *Crisis* 19(5) (May 2001), 16-21 and many other articles by her; Nancy Ann Jecker, Albert Jonsen and Robert Pearlman, *Bioethics: An Introduction to the History, Methods and Practice* (2nd ed, Sudbury: Jones & Bartlett, 2007); Albert Jonsen, *The Birth of Bioethics* (New York: OUP, 1998) and *A Short History of Medical Ethics* (OUP, 2008); WT Reich, "The word 'bioethics': its birth and the legacies of those who shaped it," *Kennedy Inst Ethics J* 4 (1994), 319-35; David Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making* (New York: Basic Books, 1991).

vi Thomas L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (1st ed, OUP, 1979).

vii Thomas L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (6th ed, OUP, 2008).

viii Examples of simple re-presentations of the theory include: Thomas McCormick, "Principles of Bioethics," *Ethics in Medicine (University of Washington School of Medicine)* http://depts.washington.edu/bioethx/tools/princpl.html and Raanan Gillon, *Philosophical Medical Ethics* (Chichester: Wiley, 1986).

ix K Danner Clouser and Bernard Gert, "Morality *vs.* Principlism," in Raanan Gillon (ed), *Principles of Health Care Ethics* (New York: Wiley, 1994), 251-66; Edwin DuBose, Ronald Hamel and Laurence O'Connell (eds), *A Matter of Principles? Ferment in U.S. Bioethics* (Valley Forge PA: Trinity, 1994); John Finnis and Anthony Fisher OP, "Theology and the four principles of bioethics: a Roman Catholic view," in Gillon, *Principles of Health Care Ethics*, 31-44, and several other articles in this collection; Gilbert Meilaender, *Body Soul, and Bioethics* (Notre Dame, IN: University of Notre Dame Press, 1995); and works of Irving and Jonsen.

x Max Charlesworth, *Bioethics in a Liberal Society* (CUP, 1993); Charles Curran, *Issues in Sexual and Medical Ethics* (Notre Dame: UP, 1978) and *The Catholic Moral Tradition Today: A Synthesis* (Washington DC: Georgetown UP, 1999); H Tristram Engelhardt, *Bioethics and Secular Humanism: The Search for a Common Morality* (London: SCM, 1991) and *Foundations of Bioethics* (2nd ed, OUP, 1996); Joseph Fletcher, *Situation Ethics: The New Morality* (Philadelphia: Westminster Press, 1966) and *The Ethics of Genetic Control: Ending Reproductive Roulette* (Buffalo NY: Prometheus, 1988).

xi Daniel Callahan, "Bioethics: Private choice and common good," *Hastings Center Report* 24(3) (May-June 1994), 28-31 and *Taming the Beloved Beast: How Medical Technology Costs are Destroying our Health Care System* (Princeton: UP, 2009); Norman Daniels, *Just Health Care* (CUP, 1985) and Seeking *Fair Treatment: From the Aids Epidemic to National Health Care Reform* (OUP, 1995); Ezekiel Emanuel, *The Ends of Human Life: Medical Ethics in a Liberal Polity* (HUP, 1991); Renee Fox, "The evolution of American bioethics: A sociological perspective," in George Weisz (ed), *Social Sciences Perspective on Medical Ethics* (Philadelphia: UP, 1990), 201-220; Renee Fox and Judith Swazey, "Medical morality is not bioethics: Medical Ethics in China and the United States," *Perspectives in Biology and Medicine* 27 (1984), 336-60; Steven Pearson, James Sabin, Ezekiel Emanuel, *No margin, no mission: Health-care Organizations and the Quest for Ethical Excellence* (OUP, 2003); Verena Tschudin, *Ethics in Nursing: The Caring Relationship* (3rd ed, Edinburgh: Butterworth-Heinemann, 2002).

xii Ruiping Fan, "Self-determination vs. Family-determination: Two incommensurable principles of autonomy," *Bioethics* 11 (1997), 309-22.

xiii Peter Singer, *Practical Ethics* (CUP, 1979) and many other books; Michael Tooley, *Abortion and Infanticide* (OUP, 1983); Richard McCormick, *How brave a new world? Dilemmas in Bioethics* (Garden City: Doubleday, 1981) and many other books.

xiv See e.g. David Oderberg and Jacqueline Laing (eds), *Human Lives: Critical Essays on Consequentialist Bioethics* (London: Macmillan, 1997).

xv Benedict Ashley, Jean deBlois, Kevin O'Rourke, Health Care Ethics: A Catholic Theological Analysis (5th ed, Washington DC: Georgetown UP, 2006); Leon Kass, *Toward a More Natural Science: Biology and Human Affairs* (New York: Free Press, 1985) and *Life, Liberty and the Defense of Dignity: The Challenge for Bioethics* (San Francisco: Encounter Books, 2002); Gilbert Meilaender, *Bioethics: A Primer for Christians* (Grand Rapids: Eerdmans, 1996) and *Neither beast nor God: The Dignity of the Human Person* (New York: Encounter Books, 2009); William E May, *Catholic Bioethics and the Gift of Human Life* (2nd ed, Huntington IN: Our Sunday Visitor, 2008); Paul Ramsay, *The Patient as Person: Explorations in Medical Ethics* (YUP, 1970) and *Ethics at the Edges of Life* (YUP, 1978).

xvi This is argued more fully in Germain Grisez, Joseph Boyle, William May and John Finnis, "Practical principles, moral truth and ultimate ends," *Amer J Juris* 32 (1987): 99-151 and in Germain Grisez's 3-volume magnum opus, *The Way of Our Lord Jesus* (Quincy IL: Franciscan Press, 1983-1997).

xvii This article reworks a paper given to *Building a Culture of Life: Catholic Higher Education and the Challenges of Bioethics,* 17th Annual Conference for the Association of South East Asian Catholic Colleges and Universities (ASEACCU), University of Notre Dame Australia, Sydney, 29 August 2009