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Beneficence

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Since the point of health care is to benefit the person to whom it is provided, all questions in health care ethics are in one way or another about beneficence: its scope, limits and proper expression. This chapter provides a general introduction to beneficence and its treatment within moral philosophy, and then discusses its application to a number of important issues in the ethics of health care.

'Beneficence' is now an uncommon word in ordinary English discourse. Since it was first coined,* it has been used with different meanings, broader and narrower. At its broadest, it has been used to refer to *doing good* generally – as its etymology would suggest (Frankena, 1987). According to some writers, it now has a much narrower meaning in ordinary English: it 'connotes acts of mercy, kindness, and charity': (Beauchamp & Childress, 2001). In the study of ethics, however, it has come to be used with a meaning intermediate between these two. On this usage, beneficence is appropriately furthering the welfare of others, from that motive.

This is not as broad as the first usage, since it excludes doing good accidentally or in ways other than by promoting others' welfare. On the other hand, it is not as narrow as the second. Saving your life, for example, need not be an act of mercy; but it would also be odd to describe it as kind or charitable. It is simply the minimally decent thing to do. However, as long as it is motivated by the recognition of your interests in receiving help, it counts as beneficent, on the usage now prevailing in ethical theory.

So understood, beneficence has a strong claim to be *the* characteristic attitude of the moral point of view. When we contrast self-interest with morality, the distinction being drawn is between seeking only to further one's own welfare and seeking also to further the welfare of others. This is at the core of all cultures' conception of morality. It is therefore not surprising to find that there have been prominent attempts to construct theories that seek to derive the whole

of morality from a foundation of beneficence. These will be discussed further below.

Some ways of furthering other people's welfare are naive, foolish or even pernicious. If beneficence is something that there is reason to admire, recommend and practise, it must amount to *appropriately* furthering others' welfare (from that motive). Notice that this covers two points. Beneficence furthers those forms of welfare that it is appropriate for us to further, and it does so in the right way.

Obviously, then, a central question in interpreting the moral requirements of beneficence is what distinguishes appropriate from inappropriate ways of furthering welfare. Examining that question is a major focus of this chapter. Other questions I shall discuss along the way include: What is meant by talking about 'requirements' of beneficence and how far do such requirements extend? How are such requirements justified? What is welfare? What are the sub-varieties of beneficence? What is its relationship to other moral requirements, and what determines which of them prevails in particular cases? The latter part of the chapter will demonstrate the relevance of answers to these questions to some prominent issues in health care ethics.

SPECIAL AND GENERAL REQUIREMENTS OF BENEFICENCE AND THEIR LIMITS

An influential idea, endorsed by both Kant (1996) and Mill (1998), is that beneficence is an 'imperfect duty'. I have a duty to treat others beneficently, but have discretion over when and towards whom I perform beneficent actions: I need not be doing so all the time. This attractive idea needs interpretation and defence, however. It is not plausible that the exercise of beneficence is always

**OED* gives 1531 for its first appearance in English, though of course it comes from much older Latin antecedents.

morally discretionary. If I could easily save your life, it is not morally discretionary whether I do so, and if I am a nurse, it is not morally discretionary which of my patients I choose to look after. Beneficent actions like these are ‘morally required’ – not performing them is morally wrong. Kant and Mill ought to be read in a way that allows them to agree with this point.

Some beneficent actions appear to be morally required and others morally discretionary. It makes sense, then, to ask how we are to identify the boundary between the two. It is clear enough how to answer this for those requirements of beneficence that derive from relationships of special responsibility (such as the relationship between nurse and patient): here, we should refer to the responsibility-creating role and the expectations it is reasonable to attach to it. However, identifying the boundary between required and discretionary beneficence is a more difficult problem when it comes to our general relationship towards other needy people. At any one time, the world contains a vast number of people in desperate need of help, and aid organizations stand ready to receive my contributions towards helping them. If it is a requirement of beneficence that I give desperately needed help to another person when the cost to me of helping that person is insignificant, why does this requirement not apply to me in respect of each of those needy people? For a clear statement of this problem, see Fishkin (1982).

Moral philosophers have offered diverging responses to this problem. Arguably closest to moral ‘common sense’ is the view that the general requirements of beneficence are limited by considerations of the overall cost to an agent of helping others. Helping others is morally required when, overall, it does not significantly impinge on my own welfare; once it does that, it becomes discretionary. However, the recommendation of moral ‘common sense’ is not by itself a strong defence of a moral judgement. What is required is a fuller explanation (which moral philosophers have attempted in several different forms) of *why* general requirements of beneficence cannot impinge significantly on my own welfare. My own attempt to explain this is set out in Cullity (2004).

THE JUSTIFICATION OF BENEFICENCE

How do we justify judgements about the requirements of beneficence? We want to be able to do so for two reasons. First, we ought to be able to say something in defence of the idea that beneficence *is* morally important. But secondly, we also want guidance about how to prioritize it in relation to the other things that seem morally important: the protection of rights, justice, fidelity to commitments, open dealing with others, and so on.

One popular answer to this question treats beneficence itself as the foundation for the whole of morality. Theories in the ‘welfarist’ tradition do this: they claim that moral rightness is determined by the production of the greatest overall welfare. Utilitarianism is the most famous theory of this kind: it adds the further claim that welfare consists entirely in happiness. Utilitarianism in effect explains the moral importance of beneficence by saying that morality *is* impartial beneficence (Foot, 1988, p. 236; Warnock, 1971). Anything else that has moral importance derives that importance from its effects on welfare; and that tells us how to prioritize different moral considerations when they conflict. We ought to protect others’ rights, keep our commitments to them and so on, insofar as doing so best promotes welfare, but no further.

In opposition to this are those views which claim that the moral importance of beneficence is to be derived from something else more fundamental. Historically, the three most influential such views have emphasized contractualist, Kantian and Aristotelian ideas, respectively.

Contractualists see the whole of morality as arising from the norms we have reason to agree on to regulate our interaction with each other: plausibly, a graduated set of norms for beneficence will be included. An idea advocated in different forms by different thinkers is a ‘mutual insurance’ argument for a requirement of mutual aid. This appeals to the reasons we have to agree to assist each other by offering mutual assurances of protection against calamities. We have reason to agree to require from each other limited forms of assistance in protection of our most important interests, but not to impose such onerous requirements of beneficence that we impair our ability to live independently fulfilling lives (Scanlon, 1998).

While this contractualist approach appears to have had an important influence on Kant’s thinking about beneficence (Herman, 1984), contemporary Kantians emphasize also a second, potentially independent line of thought. This treats respect for autonomy as the foundation from which beneficence should be derived. On this view, morality is the set of practical requirements that governs our recognition of each other as autonomous equals. Our most fundamental interests – the ones calling for protection by moral requirements – are interests in autonomous agency. These are the interests which ground requirements of beneficence, but which also must be protected by limiting those requirements. For accounts of this Kantian argument, see Herman (2002), Hill (1993) and Buchanan (1982, pp. 41–3). Caution is needed in understanding the role which autonomy plays in Kant’s own thought about the foundation of morality: on this, see O’Neill (2003).

A third approach is inspired by Aristotle’s discussion of friendship in the *Nicomachean Ethics*. This emphasizes the way in which beneficence creates relationships

of friendship and community between those who have a concern for each other's welfare. It thus create goods the possession of which is at the heart of a flourishing human life (Wallace, 1978), (Blum, 1980). This view again suggests a way of thinking about how beneficence is limited by our other moral priorities: the task for moral thought is to combine these priorities in the way that best conduces to a flourishing life.

So, we might treat beneficence as morally fundamental and seek to derive the rest of morality from it, or we might treat something else as morally fundamental and derive from it the importance of beneficence. There is a further possibility. This is that there are several fundamental, mutually irreducible sources of moral requirements, and beneficence is one of them. This kind of 'pluralistic' view seems to offer a close fit with ordinary moral thought and has become influential in thinking about health care ethics. The four-principle approach of (Beauchamp and Childress 2001) is a prominent example. For a survey of others, see Veatch (in press). When we ought to promote others' welfare, it does not seem that this is because doing so will help us achieve something else more fundamental. So beneficence does seem to be a basic source of moral requirements. But there are other moral requirements that do not seem readily reducible to a concern for welfare. I ought to respect people's entitlements to decline needed help, to pursue projects that are misguided or involve personal sacrifice, and to refuse to be used in the service of others' welfare; and I also ought to contribute to general schemes of cooperation even when they are large enough to mean that my joining in confers no perceptible benefit on anyone.

BENEFICENCE AND WELFARE

Beneficent action seeks to promote others' welfare – or to put it another way (as I have been doing already) to promote their interests, do what is good for them or benefit them. For guidance on what beneficence requires from us, then, it is natural to look for an account spelling out what human welfare consists in.[†] There are three main possibilities. For further discussion, see Griffin (1986), which remains the best introduction to this topic.

One kind of account – with a long pedigree, dating back to the ancient Epicureans – tries to locate this in the nature of our experience. For example, hedonistic theories hold that welfare consists in pleasure: the best state for a person at any time, and the best life for a person overall,

is the most pleasant. Accounts of this kind confront the serious problem of pleasant experiences based on false beliefs. If I live under the happy illusion that my children are flourishing and my work is seriously regarded, then that does not make me well-off. On the contrary, I am badly off in two different respects: first, my children are languishing and my work is ignored, and, secondly, I am unaware of this.

The second and most popular kind of theory of welfare – a desire- or preference-based theory – can be formulated in a way that avoids this objection. If we say that a person's welfare consists in the satisfaction of those desires that are not based on ignorance, then we avoid the problem just mentioned, while preserving the attractive feature that a person's welfare will depend on what she takes an interest in. However, there remain two significant problems. One is that it seems we can have desires for objects unconnected with our own welfare, the satisfaction of which makes us no better off. The other, deeper problem is that it seems to get the explanatory relationship between welfare and desires the wrong way around. Usually, we desire things because we recognize their goodness: it is not our happening to desire them that makes them good. If I suffered a bizarre psychological change which made me prefer that my children languish and my work is ignored, that would not make these things good for me: it would itself be bad for me.

The alternative to these accounts is a view on which things are beneficial and harmful to us independently of whether we succeed in appreciating this. Philosophers have proposed different candidate lists of goods that are intrinsic contributors to welfare. Four kinds of goods that appear on most such lists are, first, goods of fellowship, a broad category comprising personal relationships of friendship and love as well as participation in communities; secondly, experiences of enjoyment and pleasure; thirdly, achievements in the course of worthwhile projects; and fourthly, knowledge that is worth having about oneself and the world. See for example (Griffin, 1986, p. 67). I shall mention fifth below.

Clearly, there is scope for debate about the exact extension of any such list and about how exactly the content of any such list is derived. However, one thing that seems clear without having to tackle those questions is that certain other goods will be instrumental to the intrinsic goods on any plausible list. Money is one of these; another is health. Having money or good health but not using them to attain anything else that is good would not give you a good life. They are not good in themselves. But lacking these things can significantly

[†]This is not the only possible approach. An alternative is to try to give an independent psychological characterization of the attitude of caring for a person, and then to use this to derive an account of the appropriate objects of this attitude. This seeks to derive the content of welfare from that of beneficence, rather than the other way around. For this approach, see Darwall (2002).

impair your ability to attain the things that *are* good in themselves.

The primary reason of beneficence governing the provision of health care is therefore to supply an important instrumental good – health – to those who need it. However, an important secondary reason should not be overlooked. If goods of fellowship feature amongst the core components of human welfare, then the expression of solidarity and support for the needy is itself an important benefit we can, and should, confer upon them.

THE VIRTUES OF BENEFICENCE

Like many moral qualities, beneficence can be attributed both to particular actions and to people who characteristically perform them. Used in the latter way, it names a virtue – or rather, a family of overlapping virtues.³ A list of these would include at least the following: kindness, generosity, compassion, sympathy, considerateness, sensitivity, loyalty, friendliness and affectionateness, as well as what I called above decency, meaning by that a readiness to render effective help to others in an emergency. These qualities differ from each other in various ways. They differ in their degree of emotional involvement (sympathy involves being upset by others' distress, decency need not), their characteristic expression (considerateness anticipates others' needs, compassion responds to them once they arise) and their scope (loyalty arises within preexisting relationships, kindness can be either selective or general). Given these differences, people can possess some of these virtues without others – or can possess these virtues in their relationships to some people but not to others. What unifies them is that they are ways of treating others' welfare as a reason for helping them.

Listing the virtues associated with beneficence reminds us of the way in which some expectations of beneficence attach to special relationships which one bears towards some but not all other people. There are two broad classes of such relationships to consider. One concerns those personal relationships of friendship, family relationship and communal association that give us reasons for special concern for others' welfare. But the other concerns those professional relationships that are understood to be directed towards aspects of a person's welfare. It is the job of financial advisors to promote the financial interests of their clients, the job of lawyers to promote their clients' legal interests and the job of social workers to help their clients to avoid social deprivation. In presenting yourself to others as a practitioner of one of these professions, you present

yourself as offering to serve these aspects of their welfare, and this gives them an entitlement to expect that you will do so conscientiously.

BENEFICENCE AND HEALTH CARE

The professional field that is most obviously governed in this way by expectations of beneficence is of course health care. The relationship between health care professionals and their patients is governed by a mutual understanding that the role of the former is to use their medical expertise for the benefit of the latter. The expectations and entitlements thus created provide the core of health care ethics. Accordingly, the most prominent issues in health care ethics are all issues about the proper exercise of beneficence. The main ones concern its scope, its proper expression, its relationship with other ethical priorities, and the exercise of authority in making judgements about it. The remainder of the chapter offers a brisk treatment of each of these topics, drawing attention to the ways in which the general points made above can help us to think about them.

SCOPE

Two groups of problems in health care ethics are problems about the scope of beneficence. First, there is the problem of demarcating those to whom it applies. Familiar issues about the beginning and end of life arise here. Thinking of the core responsibilities of health care professionals as responsibilities of beneficence does not make the resolution of these issues automatic, but it does at least tell us how to think about them. The primary questions to ask are which human beings have a welfare, and which kinds of action have an impact on that welfare. It will obviously matter whether we accept or reject an experiential account of welfare. Rejecting it means that we cannot take sentience to be the key moral question about the beginning or end of life. On the other hand, what is relevant to beneficence is the impact a death will have on actual, and not merely potential, welfare. This is the primary question to ask; it is not the only one, however. Beneficence is the *appropriate* furthering of others' welfare. The important secondary question, then, is whether the promotion of welfare for those who have it is being achieved by morally objectionable means (and if so, in what ways are those means objectionable).

The other important question about scope concerns which aspects of patients' welfare are the responsibility of health care workers. If we understand the primary application of beneficence to health care as deriving from the special relationship of trust that is created between professionals and their patients, this suggests a simple answer. The professional

³For an objection to thinking of beneficence itself as a virtue, see Frankena (1982, pp. 66–8).

responsibility of health care workers is to further the medical interests of their patients. A corresponding restriction applies to the other professions that generate special requirements of beneficence. My financial advisor should apply her professional expertise to telling me what is in my financial interests: her job is not to tell me how to live. In the same way, it might be argued that any views that health care professionals may have about the nonmedical aspects of my welfare are irrelevant to doing their job. A minister of religion (or a philosopher?) might claim professional expertise in giving general advice on the best way for a person to live. But this is not the role of a medical professional.

It has seemed equally obvious to some writers how this answer should be applied to some practical controversies. For example, an orthodox view about euthanasia is this. It may be best, overall, for a person's life to end. However, it is not the business of medical staff to make an overall judgement about what is best, overall, for a patient (any more than a lawyer or financial advisor should be guided by such judgements in their dealings with clients). The job of medical staff is to tend to the medical interests of their patients, and these can never be served by killing them. Actively killing a patient can never have a *medical* justification (Callahan, 1992).

However, on reflection, this approach proves to be too simple. To see this, consider the widely held view that it can at least sometimes be right not to seek to prolong a life through medical intervention. This seems to be part of a sensible and humane attitude towards palliative care for the dying (Weir, 1989). It raises the following important point. If we conceive of 'medical interests' in a way which means that it can be bad for me overall – detrimental to my overall welfare – to have my medical interests furthered, then there will sometimes be no good reason to further my medical interests. More broadly, there will only be good reason for medical staff to serve a patient's medical interests to the extent that this furthers his overall welfare. And this in turn means that we collectively have a good reason not to confer on medical staff the responsibility of furthering the medical interests of their patients when this is detrimental to their overall welfare.

It is sometimes argued on these grounds that doctors' responsibilities extend to promoting the overall welfare of their patients (Pellegrino & Thomasma, 1988). However, this overlooks a more plausible intermediate position. The proper aim of medical staff treating me is to further my medical interests, *insofar as this is in my overall interests*. This is consistent with the source of special requirements of beneficence in relation to medicine, which is that medical staff offer to use their expertise for their patients' benefit. We can say this without ceding authority to medical staff to act on judgements about their patients' overall interests. It is a patient's prerogative to do that. But medical professionals

may have special expertise about the extent to which different forms of medical treatment will contribute towards or detract from their patients' overall well-being. And this expertise is something that it is their role to exercise for the benefit of their patients.

PROPER EXPRESSION

A question often discussed in textbooks of professional ethics is how to find a 'balance' between professionalism and personal concern. This is a question about the proper expression of beneficence in professional contexts. The discussion so far suggests that, in the health care context, we should think about it as follows.

As my doctor, your professional responsibility is not to be my friend, but to provide me with competent medical treatment.[§] However, for any given course of medical treatment, there will be more and less considerate ways of delivering it. And reasons of considerateness should govern your choice between them: there is the same case for thinking this as for accepting that such reasons should govern your dealings with other people generally. Being treated considerately is itself an important benefit.

Notice, moreover, that it is not just that nonprofessional reasons of considerateness provide a way of breaking a tie between ways of delivering medical treatment that are of equal professional merit. That this is wrong is suggested by our discussion of the scope of beneficence in health care. It is the responsibility of health care professionals to provide me with the health care that it is in my interests to receive. Given two forms of treatment that are equally effective in medical terms, it is better for me to receive the one that treats me with more consideration. Therefore, it is the responsibility of health care professionals to provide it to me.

RELATIONSHIP TO OTHER ETHICAL PRIORITIES

Broadly speaking, there are two ways in which ethical theories can tell us to think about our competing ethical priorities. As we saw earlier, some theories offer us one fundamental ethical value or principle by reference to which all of our ethical priorities are to be ordered; others give us a plurality of fundamental ethical principles, the importance of which is not to be derived from a single master-principle. Views of the latter kind are attractive in making room for different ethical principles that do not seem readily reducible to each other, but face the objection that they are of little help in dealing with cases in which those principles conflict. Proponents of such views often resort to the metaphor of 'balancing' competing principles against each other. This has the merit of encouraging us

[§]For arguments to the contrary, see Pellegrino and Thomasma (1981) and Englehardt (1996).

to respect experienced and reflective opinion about cases of moral conflict, rather than to search for a simple algorithm for moral decision-making. However, talk of ‘balancing’ is rarely a helpful way of thinking about the relationship between beneficence and other important ethical considerations. I shall briefly illustrate this with reference to Beauchamp and Childress’s influential version of pluralism, which sees beneficence as one of four fundamental principles of health care ethics, alongside the respect for autonomy, justice and nonmaleficence.

A clear view of the relationship between beneficence and respect for autonomy requires an awareness of two different points. First, autonomy is a constituent of welfare. Earlier, I mentioned four intrinsic contributors to welfare: autonomy is a fifth (see Griffith, 1986, p. 67). A life containing friendships, achievements, enjoyments and knowledge which you have chosen for yourself is better for you, in virtue of this self-authorship, than one in which the same goods have been dictated for you. When we think, as adults, that it is bad for us to be treated like children, we are endorsing this idea. Secondly, however, autonomy seems important independently of its contribution to welfare. It seems sometimes to be the case that I ought to respect your autonomous decisions even though it would be better for you to be forced to act differently, all things (including the impact on your autonomy) considered.

These two ideas are consistent with each other. It makes sense to think that autonomy is important as a contributor to well-being, and also important independently of its contribution to well-being. Having noticed this, we find that both ideas have straightforward applications to health care ethics.

First, most cases in which good medical practice requires respect for autonomy are cases in which it is *bad* for us not to have our autonomy respected. It is bad for us to be lied to, to have our privacy invaded, to be subjected to medical procedures without our consent. It is therefore seriously misleading to think of these as cases in which respect for autonomy outweighs beneficence. They are cases in which beneficence – a proper concern for welfare – dictates respect for autonomy.

However, there are also cases in which a proper respect for autonomy extends beyond a beneficent concern for welfare. This follows from our treatment of the scope of beneficence in health care. There is an important distinction to be observed between the decisions about my medical welfare that fall within the professional expertise of medical

staff and those broader decisions about my overall welfare that do not. This means two things: my doctor should leave nonmedical decision-making to me, but should not use this as an excuse for abdicating responsibility for medical decisions. Where my personal, nonmedical priorities are affected by a choice between two medically equivalent procedures, giving the decision to me could be an appropriate way of respecting my autonomy. But it is a mistake to think that my autonomy is being respected by failing to take responsibility for decisions that fall within the field of medical expertise forming the basis of the professional relationship.

Saying this does not involve ‘balancing’ beneficence against respect for autonomy: rather, it involves being clear about the scope of beneficence in health care and the way in which it restricts the appropriate field for medical judgements about patients’ welfare. Moreover, it also seems wrong to think that respect for autonomy is acting as a ‘side-constraint’ on beneficence – a prohibition on taking certain illicit means to pursue beneficent ends.** Here, respect for autonomy does not provide an independent constraint on the practice of medical beneficence; rather, the proper scope of medical beneficence dictates certain forms of respect for autonomy.††

Turn next to the issues often described as conflicts between beneficence and justice. These prominently include the allocation of health care resources. Should public funds be used to pay for procedures that will improve the health of many people by a modest amount, or for more expensive procedures that may yield bigger improvements for a few badly-off people? Principled ways can be found for making quantitative comparisons of this kind – for example, in terms of ‘quality-adjusted life years’ (Nord, 1999). And they can seem to give rise to conflicts between beneficence and justice. Overall welfare might be maximized by benefiting the many, but justice may seem to dictate helping the badly off rather than those who are already significantly better - off (Lockwood, 1988).‡‡

However, it is again unhelpful to think of this as a conflict between beneficence and something else. Rather, it is better characterized as a problem concerning the application of beneficence. Should medical beneficence treat welfare aggregatively? A case against doing so might be developed along the following lines. The primary relationship governing the ethics of health care is that between an individual patient and individual health professional. As my doctor, your treatment of me should be based exclusively on a concern for *my* welfare. What you do to

**Here I am disagreeing with (Englehardt 1996, p. 70).

††I am not arguing that respect for autonomy *never* provides a ‘side-constraint’ on beneficence; only that it is not doing so here.

‡‡For further discussion of the issues surrounding the justification for giving priority to the worst off, and how the worst off are to be defined, see Brock (2002). The question I raise in the text is only one of many that bear on the ethics of health care resource allocation: others include the desert of the recipients, and how to prioritize treating current needs in competition with preventing future ones.

me should not be guided by what is best for others. However, the same applies to your relationship to each of your other patients. This means that you can face the problem of how to allocate scarce resources in doing what is best for each of them. In resolving this problem, it is clear that you can justify not giving them to me if there is someone else who needs them more. (For any complaint I can make about not getting those resources, the other patient would have a stronger ground for complaint if you gave them to me instead of her.)^{***} It is harder to see how you can justify leaving my needs unmet in order to help several less needy patients. When you examine the responsibilities created by your relationships to each of your patients, it can make sense to make a series of pairwise comparisons of benefits and costs to the different individuals involved, but what is harder to see is how it can be relevant to cite the aggregate benefit to a group in justification of your treatment of any individual. And arguably, if the ethics of health care is grounded in the individual relationships of professionals to patients, this tells against the systematic allocation of health care resources to maximize aggregate benefits, rather than to help the neediest. When medical administrators allocate medical resources, they are resourcing individual relationships of professional beneficence between doctors and patients. The strongest reasons of beneficence are generated by the greatest needs. Therefore, these generate the strongest claims on resources.

This is a sketch of an argument needing fuller development. However, it does already suggest that the issue here is not a matter of ‘balancing’ beneficence against justice. Rather, the issue is whether beneficence, as the *appropriate* furthering of others’ welfare, tells us to approach the needs of different individuals by giving priority to those with the greatest needs or by the aggregation of overall welfare.^{†††}

More briefly, let me note the application of the same point to the issues often presented as conflicts between beneficence and nonmaleficence. When we are dealing with a single individual, there is no need to invoke a principle of nonmaleficence to guide our treatment of her in addition to a principle of beneficence. Promoting her welfare implies not inflicting a net harm on her. However, it can seem that we do need to invoke two separate principles in order to explain some judgements about choices between different people – for example, the judgement that it is wrong to harm some subjects in the course of a medical

research project in order to benefit others later. This can seem to require us to say that nonmaleficence has priority over beneficence. But once more, this is questionable. If the ethical norms governing the practice of medicine derive from the individual relationships between doctor and patient, that is enough to explain why imposing a net harm on one of them cannot be justified by greater benefits to others. Imposing a net harm on a person is always incompatible with the requirement of beneficence that properly governs the relationship of a medical professional to a patient.

AUTHORITY IN MAKING JUDGEMENTS

The foregoing discussion has some clear implications for the question where authority should lie in exercising judgements about a person’s welfare. We have seen the need to distinguish between those parts of a person’s welfare which call for judgements of medical expertise and those which do not. In the treatment of competent adult patients, the latter judgements should not be arrogated by medical staff, nor the former avoided. This leaves open the question of where decision-making authority should lie in the treatment of children and incompetent adults. Decisions about the medical aspects of their welfare are rightly taken by medical professionals. How about decisions concerning those nonmedical aspects of a person’s welfare – including what priority to give to good health in relation to other goods – that can have a bearing on choices between different forms of medical treatment? Our discussion suggests three things. First, when an adult has clearly expressed views about his overall welfare, the fact that he is now incompetent does not justify disregarding them. Secondly, the ideal way in treating incompetent patients who have expressed no such views is an open discussion between medical staff and near relatives, generating a consensual decision about what is best overall for the patient. When the patient’s views about his welfare cannot be established, others with relevant knowledge and a concern for his welfare will have to think about that directly.^{†††} And thirdly, when such a consensus cannot be reached, what beneficence will recommend is that there should be an institutional and legal structure in place which is likeliest to result in patients’ interests receiving the best protection. Identifying the best such structure remains beyond the scope of this chapter.

^{***} Compare (Scanlon, 1998), Chapter 5, Section 9.

^{†††} For the view that benevolence is unable to give us guidance in choosing between the good of different individuals, and needs to be supplemented by justice, see Rawls (1971, Section 30).

^{††††} Thinking about what a patient’s own preferences would have been can be relevant to answering that question; but the question to answer in this case is the direct one what *is* best for the patient; not how the patient would have answered that question. On this issue, see Dresser and Robertson (1989).

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