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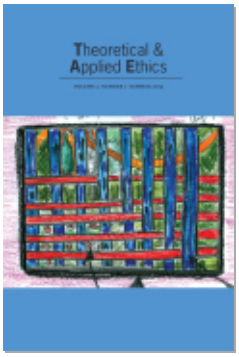

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Is Professional Ethics Grounded in General Ethical Principles?

This article questions the commonly held view that professional ethics is grounded in general ethical principles, in particular, respect for client (or patient) autonomy and beneficence in the treatment of clients (or patients). Although these are admirable as general ethical principles, we argue that there is considerable logical difficulty in applying them to the professional-client relationship. The transition from general principles to professional ethics cannot be made because the intended conclusion applies differently to each of the parties involved, whereas the premise is a general principle that applies equally to both parties. It is widely accepted that professionals are required to recognize that clients or patients possess rights to autonomy that are more than the general rights to personal autonomy accepted in ordinary social life, and that professionals are expected to display beneficence toward their clients that is more than the beneficence expected of anyone in ordinary social life. The comparative component of professional ethics is an intrinsic feature of the professional situation, and thus it cannot be bypassed in working out a proper professional ethics. Thus, we contend, the proper professional treatment of clients or patients has not been explained by appeal to general ethical principles.

From Ethical Principles to Professional Ethics

A basis in general ethical principles is not the only model for the biomedical or health-care ethics of the past fifty years, but it has been and is still the dominant model. It is understood as the application of, commonly but not exclusively, four ethical principles: respect for persons (or autonomy), beneficence, nonmaleficence, and justice. The principles are seen as applicable to a variety of practical biomedical or health-care contexts, such as professional-patient relationships, medical research approvals, health-care

resource allocation, and genetic manipulation. The dominant principlist text has been Beauchamp and Childress's classic work *Principles of Biomedical Ethics* (1979 and subsequent editions). Principlism can be viewed as an example of the application of general ethical principles to particular contexts. And there may be any number of good ethical principles—as few as one or as many as ten, according to various accounts (following Veatch, 2012, pp. 164–182). Whatever the number, we will call each of these approaches a version of principles-based ethics if the favored principles are used as the main basis for resolving problems and guiding behavior in practical ethics.

The principles-based approach to ethics has been the subject of much debate (e.g., Richardson, 1990; DeGrazia, 1992; Lustig, 1992; Pellegrino & Thomasma, 1993; Veatch, 1995; Engelhardt, 1996; Gert, Culver, & Clouser, 2000; Richardson, 2000; Strong, 2000; O'Neill, 2002; Beauchamp, 2003b; Campbell, 2003; Dawson & Garrard, 2003; Gillon, 2003; Macklin, 2003; May, 2003; Tauber, 2005; DeMarco & Ford, 2006; Rhodes, 2007; Walker, 2009). Primarily the debate has concerned the appropriate weighting of one principle over the others. Extensive though this debate has been, it is not clear to us that there has been much discussion of the relation between principlism and professional ethics. The two are usually discussed separately. Our topic is the relation between them. We wish to present a logical criticism. Our contention is that no form of principles-based ethics can justify the conclusions that they have been commonly used to support in professional health-care ethics. The conclusions may be morally admirable and in accordance with accepted professional practice, but the inference from principles to conclusions in professional health-care ethics, we will argue, is invalid.

We will focus our argument on principlism, and specifically on two of the four principles put forward by Beauchamp and Childress. One is the idea of patient (or client) autonomy; the other is the idea of professional altruism or beneficence, sometimes also called an ideal of service. We accept the consensus view that patient or client autonomy is important and should in the normal case take priority over the professional paternalism that may result if beneficence is given priority over autonomy. We also accept that professionals should be motivated by a special kind of altruism or beneficence. This beneficence manifests itself in various ways: in not exploiting the monopoly position conferred on the profession; in under-

taking a certain amount of pro bono work; in being willing to pass on one's knowledge and skills to the next generation of the profession; but most of all it is manifested in a zeal for the well-being of one's clients, at least in the range of matters that falls within one's professional expertise. A professional should put that expertise into the service of the client.

There are two phases in the professional-client relationship, phases that may be repeated in series throughout the relationship: the contracting phase, when the treatment or service is decided upon; and the performance phase, when the treatment is carried out. The principle of respect for client autonomy operates at the first stage, and the principle of beneficence comes into play mainly, though not only, in the second stage. We accept the contention that the principle of client autonomy normally takes precedence over professional beneficence when the two are in conflict (Gillon, 2003; but see also Dawson & Garrard, 2003), but we will argue that basing an ethic for professionals on general principles does not explain *why* client autonomy should take precedence.

Nothing in our argument is intended to count against the importance of client autonomy and professional beneficence as guides to ethical conduct in the professions. Our argument is *an argument against an argument* for certain conclusions, not an argument against the conclusions themselves. For example, "Fred is a philosopher, so Fred is a wise man" is an argument that can be countered with "But many philosophers are unwise" (examples can be adduced). This sound counterargument in no way shows that Fred is not a wise man. Our concern is about the inference from general principles to professional health-care ethics.

The Logic of the Problem

It is our view that those who follow principlism must be drawing a certain kind of inference, and that the inference is invalid. However, we face an initial difficulty. To present our argument, the obvious strategy would be to quote those passages where the inference we object to is being drawn. But it is no easy matter to show exactly where the inference is spelt out. If we turn, for example, to any of the seven editions of Beauchamp and Childress's *Principles of Biomedical Ethics*, we can nowhere find a passage where the problematic inference lies plainly on the page. That there is such an inference is nicely shown by Tom L. Beauchamp when he says:

> A principle, in our [Beauchamp and Childress's] account, is a fundamental standard of conduct from which many other moral standards and judgments draw support, standing, and specification. For example, core professional duties can be delineated on the basis of basic moral principles. (2003a, p. 28)

It is the validity of this "delineation" or inference that we are questioning. How exactly do core professional duties "draw support, standing, and specification" from these principles? We will return to *Principles of Biomedical Ethics* further below.

For our purposes, then, it is best to construct an artificial argument to exhibit the general form of the invalidity. Here is a very simple form of principles-based ethics, using the two key principles:

(1) Since respect for autonomy is a sound ethical principle, the autonomy of patients (or clients) ought to be respected by health-care professionals.

(2) Since beneficence is a sound ethical principle, health-care professionals ought to act toward their patients (or clients) in a beneficent manner.

These are both arguments, each with one premise and one conclusion. In both, the premise is a general one, while the conclusion is specific.

Our objection to these arguments is simple. In the professional situation, when professional and client are engaged in making decisions about treatment, there are two parties, each of whom is capable of being the final decision maker and each of whom has a claim to have her autonomy respected and to be the recipient of beneficent actions. However, principles-based professional ethics concludes that it is the client and not the professional whose autonomy is to be respected and whose needs are to be treated beneficently. These conclusions are not sustained by arguments of the form in (1) and (2) above, because in each case the premise applies equally to client and professional and not differentially to privilege the client or patient. It is generally agreed that there is an asymmetry between the ethical expectations that apply to the professional and those that apply to the client. Professional ethics is designed to ensure that the professional uses her knowledge ethically and well, that is, in the interests of the cli-

ent or patient. However, it places no special expectations on the client or patient as to how one should behave toward the professional. The asymmetry arises at least from the imbalance of knowledge between the two parties. As Pellegrino and Thomasma put it, "The professional possesses the knowledge that the patient or client needs. This places the preponderance of power in her hands. She can use it well or poorly, for good or evil, for service or self-interest" (1993, p. 155). Or, in the words of William F. May, "This asymmetricality in knowledge [between professional and layperson] creates in turn an asymmetricality in power, a gap between the powerful and the relatively powerless. This discrepancy in power intensifies the moral duties of professionals, especially in the helping professions" (2001, p. 8). How, though, does this discrepancy intensify the moral duties of the professional? What further premises are being assumed here?

This asymmetry makes the conclusion that a principles-based ethics seeks to validate necessarily a comparative one; that is, the expectation for the client differs from the expectation of the professional in the above examples. General ethical principles are meant to govern the behavior of any and all, not just the behavior of some to some others. That is what is meant by calling them "general." It follows that, all else being equal, the general ethical principles of respect for autonomy and of beneficence apply equally to how clients should treat professionals and to how professionals should treat clients. Thus, clients should respect the autonomy of professionals quite as much as professionals should respect the autonomy of clients. Likewise, if beneficence is required of professionals, it is equally required of clients. This being so, the general ethical principles as employed in (1) and (2) do not vindicate the conclusions they are supposed to vindicate.

For a principles-based ethics to require the professional always to put the patient or client first, that is, for it to apply more strongly to the professional in any professional-client (or patient) relationship, the argument would need to be amended somehow. But can that be done?

We might, for example, amend the argument to a form something like these:

(3) Since respect for autonomy is a sound ethical principle, the autonomy of clients ought to be respected by health-care professionals in a manner that gives priority to the client's treatment preferences over the professional's preferred treatment in cases where the two clash.

(4) Since beneficence is a sound ethical principle, health-care professionals ought to act toward their clients in a manner that demonstrates greater beneficence than the beneficence expected of the client toward the professional.

The conclusion is what we want, but the inferences are plainly invalid. The premises are simply irrelevant to the conclusions. Since the conclusions we are seeking to justify involve a comparison between two items in a certain category, we need reasons that bear on that comparison, not merely reasons that point out general features of the category as a whole. No general principle can generate specific conclusions in this way. The problem in these arguments is not merely that they are not deductively valid; it is that the inferences are not even weakly justified.

If we are right about this, and since the point is not an arcane one when presented as we present it, how is it that it has not been noted and dealt with long ago? The answer seems to be found in the way we have formulated the conclusion of the principlist argument. In our view, the conclusion has to be a comparative one, that is, one that applies differentially to professional and patient or client. As far as we can tell, this point is not commonly observed. The conclusion is commonly seen as simply a matter of how professionals should behave or of what respect patients should be accorded.

The Nature of the Conclusion

We need further discussion about the conclusions that a principles-based ethics aspires to defend. We can simplify matters by focusing on the principle of respect for autonomy. In its general form, it requires respect for persons as autonomous agents. But exactly what conclusion is that principle intended to justify when applied to professional ethics? The conclusion is commonly assumed to be something about patient rights or, more generally, client rights. The rights of the patient in the professional consultation should be respected. Stated in that way, nothing is said about what those rights are. The rights of the patient may consist simply in the right to the best possible treatment, as determined by the clinician or the health-care professional. But this is not what the principle of respect for autonomy is meant to vindicate; in fact, it is the very thing that it is supposed to overturn. The intended conclusion is that, after consultation and the disclosure

of treatment options by the professional, the competent patient has a right to be treated in a way *determined by the patient*. The principle of respect for autonomy, as commonly understood in professional ethics, involves the allocation of a decision-making right to the patient. That is the core of the idea of informed consent. At the end of the consultation process, in most cases (e.g., where the patient is a conscious and competent adult) the patient gets the final say. In practice, this right may amount to nothing more than the right to choose between a very limited set of options. Sometimes there may be only one course of treatment that the professional can propose. But always the patient reserves the right to refuse treatment, and, when more than one option is available, the choice of treatment lies with the patient. The point is that, if we accept the autonomy principle, then we accept that the professional proposes and the patient disposes. Were it the case that the professional both proposes and disposes, then the principle of autonomy would have been overridden.

Nothing is gained at this point by conceiving of the professional and client as arriving jointly at a treatment decision, even though both usually do contribute to the decision. The old Polish saying that "When we agree, you decide; when we disagree, I decide" illustrates this point. What matters is who has the say when they disagree. Of course, our argument presupposes that the patient is in a fit and proper state to participate in the decision-making process, but we are taking that for granted here. Where the patient cannot make appropriate decisions, then her "autonomy" passes to her next of kin or to some nominated proxy; and where this is impossible, a professional or some professional group must act as her trustee. But all this only shows that she really does have autonomy that ought to be respected as far as it possibly can be. It does not show that she lacks a set of rights; only that she lacks the capacity to exercise those rights. A proxy or trustee who acted in disregard of those rights would be acting wrongly.

The discussion so far shows that the conclusion that the autonomy principle is intended to support is indeed a comparative one. That is, in a professional-client relationship, the conclusion for one party differs from that for the other party. Thus, the conclusion as described in argument (1), that is, "the autonomy of patients (or clients) ought to be respected by health-care professionals," is not sufficient. The conclusion needed is in fact as described in argument (3), that is, "the autonomy of clients ought

to be respected by health-care professionals in a manner that gives priority to the client's treatment preferences over the professional's preferred treatment in cases where the two clash." As we said above, for the argument to be consistent with accepted practice, the conclusion has to be that *the client and not the professional* is to make the decision.

The conclusions that a principles-based ethics intends to vindicate are comparative in nature. Yet the argument designed to support those conclusions fails because the inference is invalid. The asymmetrical conclusion in principles-based professional ethics that it is the client and not the professional whose autonomy is to be respected and whose needs are to be cared for cannot be sustained by arguments of the form of (1) and (2). The premise applies equally to client and professional, but for a comparative conclusion to be valid the argument has to contain a reason why in a professional-client relationship one and not the other should make the final decision.

Alternative Formulations

Of course, the principles-based argument may be more complex than we have allowed. It may possess more than the one premise we have allowed to it. Objections to an argument may fail because the argument has been misconstrued or oversimplified. That is the essence of the straw man fallacy. So, possibly, we have been attacking a straw man. Here we will try to reconstruct the principlist position more charitably.

If the principles strategy is to work, the additional premises need to lead to conclusions about the professional situation. Thus, some features of that situation must appear in the premises employed by the principles approach. We will put forward some ways that the description of the situation might appear in the premises and show that in each case there is an invalid inference.

The premise we need cannot simply be that principles are being applied to the professional situation. Such an argument might look like this:

(5) Since respect for autonomy is a sound ethical principle, and since professionals ought to respect the autonomy of their clients, the autonomy of patients ought to be respected by health-care professionals in a manner that gives priority to the patient's treatment preferences over the professional's preferred treatment in cases where the two clash.

In this argument neither the second premise nor the first includes the comparative element that appears in the conclusion, and it is the lack of this comparative element that we see as causing the inference to fail in the standard formulations by which a principlist approach is applied to professional situations.

Alternatively, it might look like this:

(6) Since respect for autonomy is a sound ethical principle, it follows that professionals ought to respect the autonomy of their clients; and from that we can conclude that the autonomy of patients ought to be respected by health-care professionals in a manner that gives priority to the patient's treatment preferences over the professional's preferred treatment in cases where the two clash.

This is a two-step argument. The first step is straightforward, the conclusion being merely an instantiation of the generalization that the premise articulates. The problem now lies in the second step, and clearly, the problem (the lack of a comparative element) is unchanged. Neither (5) nor (6) is what we are after. The same points apply, *mutatis mutandis*, to the application of the principle of beneficence to the professional situation.

The problem we are dealing with arises because the conclusion we wish to justify is comparative, and for the argument to be cogent the premises must bear on that comparison. For the inference to be valid, the general ethical principle needs to be supplemented by some other premise that contains a comparative component.

Professional ethics differs from general ethics in large part because (as we saw from Pellegrino and Thomasma and from May) there is asymmetry in knowledge between the parties involved in a professional-patient (or client) relationship. So, why not build this asymmetry into the premises? Taking beneficence as the target, the argument might go like this:

(7) Since beneficence is a sound ethical principle, and since those who possess superior knowledge owe beneficence to those who are less knowledgeable, healthcare professionals ought to act toward their clients in a manner that demonstrates greater beneficence than the beneficence expected of the client toward the professional.

This argument has merit, in that the premises are plausible and clearly relevant to the conclusion. But it also has two difficulties. First, is it really clear that those who possess superior knowledge owe beneficence to those who are less knowledgeable? Is this a duty generally recognized? Or is it something supererogatory; that is, we admire those who do help others by offering their superior knowledge, but we don't require it? If it is the latter, then this falls short of accounting for the professional *duty* of beneficence toward clients. It is hard also to see how it can be the former, that is, a duty generally recognized. In capitalist markets, for example, superior knowledge is desirable, but those who have superior knowledge are not obligated to demonstrate beneficence to those who (merely) do not. One with superior knowledge may have an obligation to show beneficence to certain groups, such as those who are weak or vulnerable, but this is a general obligation and not one that arises because one has greater knowledge. Second, even if this is acceptable, how can we use this argument to arrive at the professional duty of respect for patient autonomy? A suitable argument cannot be as follows:

(8) Since respect for autonomy is a sound ethical principle, and since those who possess superior knowledge owe beneficence to those who are less knowledgeable, the autonomy of patients ought to be respected by health-care professionals in a manner that gives priority to the patient's treatment preferences over the professional's preferred treatment in cases where the two clash.

Nor can the argument we are seeking be this:

(9) Since respect for autonomy is a sound ethical principle, and since those who possess superior knowledge owe respect for the autonomy of those who are less knowledgeable, the autonomy of patients ought to be respected by health-care professionals in a manner that gives priority to the patient's treatment preferences over the professional's preferred treatment in cases where the two clash.

Here the second premise is incoherent. There is no reason to doubt that respect for autonomy is a good general principle, but having superior knowledge does nothing to increase the level of respect required toward those with lesser knowledge. In general, increased knowledge tends to work the

other way. Parents have greater knowledge than their children, and this is one reason why they can be justified in overruling their children's wishes. Between adults with differing degrees of knowledge, all that is morally required is that the more knowledgeable do not override the autonomy of the less knowledgeable, not that they should defer to their wishes more than they would defer to the wishes of other more knowledgeable people.

The Patient's Body and Interests

When we have presented the above arguments, we sometimes meet the following rejoinder. The argument from general principle to professional obligation can be made successfully if we add a premise or two about whose interests and needs are at stake. The argument can be presented as follows (with thanks to Hugh Breakey for this formulation):

(10) Respect for autonomy is a sound ethical principle.

(11) Autonomy is about having control over one's life and what happens to one's body.

(12) In usual cases, medical treatment of X by Y is centrally concerned with X's life and X's body.

(13) To the extent that Y's life-plan and body are implicated, Y will usually have made such choices prior to meeting the patient (and probably prior to her choosing medicine as her job).

Therefore, (14) in most cases of medical treatment, X's autonomy is a priority.

This formulation has the potential to solve the problem of how to get from general principles to an asymmetrical conclusion, since (12) and (13) together supply the asymmetry needed in the premises. The solution is a simple one. The doctor requires permission to perform an operation because it is the patient and not the doctor who is having something done to her. The patient's agreement is necessary because it is her body that is having things done to it by others.

In response to this apparently cogent solution, there is a preliminary point worth mentioning. If the principlism model is applicable to professional ethics in general, then the special rights of the client and the special duties

of the professional cannot rest simply on the claim that the patient's *body* is at risk. Other professions, such as accountancy, architecture, engineering, law, or teaching, don't deal with human bodies in this sort of way. They deal with the client's finances, buildings, rights and knowledge, and so forth. It may be that these are put at risk when professional guidance and action are sought. The risk is a risk to the client's interests, and not just to her body.

How strong is this apparently cogent argument? Consider first the point about risks. We can agree that the patient or client is subject to risk when undertaking treatment from a professional. But there are risks on the other side too. For example, in addition to harm to a patient, an ill-performed operation can hurt the reputation of a surgeon quite considerably. A moment's carelessness can lead to professional disciplinary action against a physician. Are these risks to be weighed up in allocating decision-making rights? If for some reason the risk to the professional was large and that to the patient was small, would that be sufficient to override the normal assumption that the patient should be the final decision maker? We think not. We think that the decision-making rights of the patient are pre-eminent, regardless of the risks that the professional might face, but that standard formulations of professional ethics based in general principles do not adequately explain this.

Consider the point about needs. We can take it as given that the patient has special needs that lead her to seek professional help. We can agree that "In usual cases, medical treatment of X by Y is centrally concerned with X's needs." But, again, there may be needs of various sorts on the other side. The physician may be stressed, overworked, underpaid, unwell, and so on. If so, beneficence toward her would be a good thing. Indeed, as Draper and Sorell (2002) argue, a patient or client would have obligations toward the professional in such a situation, obligations that "flow from general ethics" and which would apply to all people. But facts of this sort about the professional's situation don't alter the decision-making rights of the patient with regard to her own treatment. The needs of the professional are matters to be dealt with in other ways.

The general problem here is to explain why, in the professional situation, the principles of autonomy and beneficence are regarded (in our view, rightly) as indefeasible in all normal cases. Of course, client or patient autonomy is not unlimited: professionals cannot be morally required

by their client or patient to do things that are illegal or futile or a waste of public resources or financially unremunerative when the client can afford to pay. Special cases such as where the patient seeks an abortion or euthanasia and the doctor's conscience will not allow her to perform it are not at issue here. For one thing, in such a case the doctor would have not proposed abortion or euthanasia as a possible treatment. Our concern is only for the situation that arises after treatment options have been proposed by the professional to the patient. In that situation it is not too much to regard the patient's right to decide as indefeasible, assuming only that the patient is competent to make such a decision.

The Problem in *Principles of Biomedical Ethics*

So far in this article we have been outlining what we called an "artificial argument" and following its logic to demonstrate a serious difficulty in applying general ethical principles to the professional situation. We have not to this point tried to show that any writers do in fact fall victim to the problem we are trying to articulate. However, we do have an obligation to discuss at least one instance where in our view the problem does arise. The key text in the principlist literature is Beauchamp and Childress's *Principles of Biomedical Ethics*, now in its seventh edition (2013). As we remarked earlier, it is not easy to find a passage anywhere in *Principles* where the problematic inference is plainly visible. One possible place is their chapter on "Professional-Patient Relationships," in which the authors deal with "rules" governing veracity, privacy, confidentiality, and fidelity (2009, pp. 288–331). In this chapter, veracity, privacy, and confidentiality are topics that do not generate the problem we are diagnosing. No question arises of comparing the professional's and the layperson's obligations with regard to these topics, since it is only sensitive information relating to the patient's condition that is under consideration.

In the case of the rule of fidelity, however, our concerns do arise. They characterize professional fidelity as

> giving the patient's interests priority in two respects: (1) the professional effaces self-interest in any situation that may conflict with the patient's interests, and (2) the professional favours the patient's interests over others' interests. (2009, p. 311)

Clearly, this is what we have discussed as professional beneficence. The general question is how to account for the higher standard of beneficence expected of professionals toward their patients as compared with the beneficence expected between ordinary members of the community. In their third edition they remark:

> Most obligations of positive beneficence in health care rest on fidelity-generating contracts and role relations. In establishing a relationship with a patient the physician makes an implicit or explicit promise to seek the patient's welfare. The promise appears in the physician's pledge or oath upon entry into the profession or in the profession's code of ethics. (1989, pp. 341–342)

They then discuss "covenant" and "contract" approaches to the nature of fidelity. However, the discussion ends inconclusively:

> It is misleading to try to capture the relationship between health-care professionals and patients in any single metaphor or model such as contractors, partners, parents, friends, or technicians. No single metaphor or model adequately expresses the complexity of health care or the moral principles and rules that should govern such relationships. (1989, pp. 343–344)

The point here that is relevant to our concerns is the argument that bases professional beneficence on promise keeping. This argument does deal with the comparative problem, since the professional has made a promise that the patient has not. But the introduction of a specific promise means that it no longer argues from the general principle of beneficence to beneficence in the professional situation. In a footnote the authors observe that Charles Fried "has grounded the obligation of promise keeping in respect for autonomy" and that John Rawls "has plausibly contended that the principle of fidelity is only a special case of fairness applied to social practices of promising" (1989, p. 362). Thus, the general ethical principle at work here is not beneficence but either respect for autonomy or fairness. At best, there is a two-step justification of professional beneficence.

Basing professional beneficence on promise keeping, whether implicit or explicit, is vulnerable to the objection that the expectation of beneficence would apply even if no promise were explicitly made, as is the case

in most professions, and even if there were no professional code that includes a quasi-promise, as is the case in many professions. In fact in the fifth edition, Beauchamp and Childress say the following (a variation of which is in the fourth edition):

> The patient-physician relationship is founded on trust and confidence; and the physician is therefore necessarily a trustee for the patient's medical welfare. This model of fidelity relies more on values of loyalty and trust than merely on being true to one's word. Whether or not the physician makes a pledge or takes an oath upon entry into the profession, obligations of fidelity arise in this model whenever the physician establishes a relationship with the patient. (2001, pp. 312–313)

This leaves it unclear how trust and loyalty are generated and how they relate to general ethical principles. The argument does not fit with the overall program of *Principles*, and it was dropped in the sixth edition.

In any case, whatever the merits of basing professional beneficence on promise keeping, it would at most provide a grounding for professional beneficence. It would not ground respect for client autonomy, for reasons we have already given.

Beauchamp against Deductivism

It is possible that we are still barking up the wrong tree. We may be trying, misguidedly, to force principlism into a deductivist mold, when no such mold is needed or implied by the proponents of principlism. Such a view is suggested by Beauchamp in a 2007 paper. Replying to the work of Robert Baker and Laurence McCullough, he remarks:

> By "applied ethics," I think they [Baker and McCullough] must mean what, in this literature, has commonly been dubbed *deductivism*—one model of applied ethics and moral judgment in which justified conclusions are deduced from a preexisting theoretical structure of normative precepts that cover the judgment. This model is inspired by justification in disciplines such as mathematics, in which a claim is shown to follow logically (deductively) from credible premises. In ethics, the parallel idea is that justifica-

> tion occurs if and only if general principles or rules, together with the relevant facts of a situation (in the fields to which the theory is being applied) support an inference to the correct or justified judgment(s). In short, the method of reasoning at work is the application of a valid general norm to a clear case falling under the norm, thereby reaching the correct conclusion. (Beauchamp, 2007, p. 56)

Beauchamp's objection to Baker and McCullough is that they construe "applied ethics" on a deductivist model. Beauchamp allows that "deductivism" is "one model of applied ethics and moral judgement," but in his view, "No one uses or defends the model of 'applied ethics' that they [Baker and McCullough] present. They construct a straw man and then propose to replace it. The Baker-McCullough construal of applied ethics not only has had no influence in medical ethics; it has had no influence in philosophical ethics. What they called 'applied ethics' was entertained briefly in the 1970s, but the model was wholly abandoned in less than a decade" (2007, p. 56).

Our argument may be vulnerable to a similar objection. It might be said that we are constructing and then attacking a deductivist straw man. But we think not, for two reasons. First, there is an inference being made by principlism. As Beauchamp put it, "core professional duties can be delineated on the basis of basic moral principles" (2003a, p. 28). We take this delineation to involve a process of inference. We are simply analyzing how this inference might work, or fail to work. Second, we are arguing that no such inference can work, for the very general reason that the inference is from a symmetrical premise to an asymmetrical conclusion. If it is to work, the "delineation" must involve some asymmetry in the premises. But we think that how to build this asymmetry into the premises has not yet been explained. We are not assuming that it cannot be done. We are not assuming that the result must be a logically valid deductive argument. All we are assuming is that it must be a cogent argument.

One way forward here might be that of "specifying" the general ethical principles. Henry S. Richardson (2000) recommended this method, describing it in part as a way of applying general principles without simply engaging in "deductive subsumption." To specify a principle is to do two things at once: to narrow its extension and to gloss its interpretation. The principle is specified more narrowly as applying to a subset of possible

cases, and it is glossed more fully, to show how it applies to that subset. As an example, he proposes that the general principle "be generous and tolerant," when faced with actions that are "beyond the pale," can be specified and applied as the narrower principle "be generous and tolerant towards all persons even when they have transgressed, but towards their behavior only when that behavior is within the pale" (2000, p. 300).

Could something like this solve the problem of this article? Can we specify Beauchamp and Childress's four principles (or any other set of general principles) so that they apply to the professional situation in such a way as to account for the ethical asymmetry between professional and client? In this scenario, the ethical force of the general principles would be seen to apply with extra force to the professional. Beauchamp himself is an advocate of the specification approach. In his interpretation, "Specification is a process of reducing the indeterminateness of general norms to give them increased action guiding capacity, while retaining the moral commitments in the original norm. Filling out the commitments of the norms with which one starts is accomplished by narrowing the scope of the norms" (2003b, p. 269). He adds that "These specified moralities include the many moral norms, aspirations, ideals, attitudes, and sensitivities that spring from cultural traditions, religious traditions, professional practice, institutional codes of ethics, and the like" (2003b, p. 270). A specification that spells out the role of professional practice in the application of general norms does seem very desirable, if it can be articulated. But, at this stage, we think it remains to be achieved: as far as we know, no one has attempted to apply specification to the transition from general ethical principles to professional ethics.

Conclusion

As we see it, then, there is a considerable logical difficulty in applying general ethical principles to the professional situation. Since the introduction of principlism in the 1970s, modern professional ethics has assumed that general ethical principles can provide clients with the rights and protections needed to prevent or remedy the misuse of professional powers. The aim is admirable, but the execution is open to question. The rights of the client or patient against the professional cannot be treated as similar to the rights of person against person. They are not comparable

to the principle of equal liberty advocated by John Rawls (1971) or the negative liberties championed by Isaiah Berlin (1969). They are a special right, not a general right (Hart, 1955). Likewise, the beneficence expected of professionals toward their clients is not comparable to the general beneficence championed by utilitarians and other benevolence theorists. It is a special beneficence.

Our overall conclusion is this. We do not see how principles-based ethics can make the transition from general ethics to professional ethics, and if we are right in thinking that the transition cannot be made, then the most commonly accepted model in modern biomedical or healthcare ethics is irreparably broken. The reason why the transition cannot be made is that the intended conclusion is comparative, that is, it applies differently to each of the parties involved, whereas the premise is a general principle. It is widely accepted that professionals are required to recognize that clients or patients possess rights to autonomy that are more than the general rights to personal autonomy accepted in ordinary social life, and that professionals are expected to display beneficence toward their clients that is more than the beneficence expected of anyone in ordinary social life. The comparative component of professional ethics is an intrinsic feature of the professional situation, and thus it cannot be bypassed in working out a proper professional ethics. Our objection holds against Beauchamp and Childress's principlism and any other form of principles-based ethics, since they all argue from general ethical principles to a position on professional ethics, without taking account of the comparative aspect, the asymmetry, of the professional situation. However, we allow that we have not *proven* that some form of principles-based ethics *cannot* be rescued from our criticism.

Admittedly, we have not tried to show here that the various principlist authors have in fact failed to address the problem we are describing. That would be a very large task. All we have done here is describe the problem in general and document it in the writings of Beauchamp and Childress. We also have to allow that we have not proven that some form of principles-based ethics cannot be rescued from our criticism. Possibly, suitable supplementary premises can be found to make the inference from general ethics to professional ethics valid. However, we do not see what they might be, and we think the onus lies on others to say what they are.

We suggest, in addition, that the issues we are raising apply to all forms of principles-based professional ethics, not just to mainstream biomedical ethics, so the problem we are diagnosing, if real, may be a large one.

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