Reflections on the Need for Hierarchies in Bioethical Principialism

Reflexiones sobre la necesidad de la jerarquización en el principialismo en bioética

Reflexões sobre a necessidade da hierarquização no principialismo em bioética

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Abstract

Introduction: This paper presents an analysis of biomedical principlism as proposed by Beauchamp and Childress, establishing non-hierarchical posture based on the four principles of (autonomy, beneficence, non-maleficence and justice). Development: It is argued that a hierarchy of principles is needed to establish an ethical foundation, without which medical practice can fall into a relativism that is damaging to the integrity and dignity of patients. Furthermore, it is argued that the strengthening of the autonomy principle would hierarchically privilege opportunities to generate a non-patronizing medical perspective and medical practices commensurate with the defense of primary human rights. *Conclusion*: The strengthening of the principle of autonomy will allow to generate a more horizontal doctor-patient relationship by allowing the recognition of it's faculty in regards to the solution of ethical dilemmas.

Keywords: Autonomy, dignity, beneficence, justice, non-maleficence, Beauchamp, Childress, Kant, categorical imperative.

Resumen

Introducción: en este trabajo se hace un análisis del principialismo biomédico propuesto por Beauchamp y Childress, en el que asumen una postura no jerarquizada de cuatro principios (autonomía, beneficencia, no maleficencia y justicia). *Desarrollo*: la tesis que se desarrolla es que hay una necesidad de jerarquización de los principios en cuanto a su fundamentación ética, ya que, de otro modo, dicha práctica puede caer en un relativismo y, así, en una afectación en la integridad y dignidad de los pacientes. De la misma manera,

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se sostiene la tesis de que el afianzamiento de la autonomía como principio jerárquicamente privilegiado daría las posibilidades para generar una perspectiva medica no paternalista que posibilitaría, a su vez, una práctica profesional acorde con la defensa de los derechos primarios de los humanos. *Conclusión*: el afianzamiento del principio de autonomía permitiría generar una relación más horizontal entre médico y paciente, al reconocer su facultad en la solución de dilemas éticos.

Palabras clave: autonomía, dignidad, beneficencia, justicia, no maleficencia, Beauchamp, Childress, Kant, imperativo categórico.

Resumo

Introdução: neste trabalho se faz uma análise do principialismo biomédico proposto por Beauchamp e Childress, no que assumem uma postura não hierarquizada de quatro princípios (autonomia, beneficência, não maleficência e justiça). *Desenvolvimento*: a tese que se desenvolve é que há uma necessidade de hierarquização dos princípios em quanto a sua fundamentação ética, já que, de outro modo, dita prática pode cair em um relativismo e, assim, em uma afetação na integridade e dignidade dos pacientes. Da mesma forma, sustenta-se a tese de que o afiançamento da autonomia como princípio hierarquicamente privilegiado daria as possibilidades para gerar uma perspetiva médica não paternalista que possibilitaria, à sua vez, uma prática profissional acorde com a defesa dos direitos primários dos humanos. *Conclusão*: o afiançamento do princípio der autonomia permitiria gerar uma relação mais horizontal entre médico e paciente, ao reconhecer a faculdade na solução de dilemas éticos.

Palavras-chave: autonomia, dignidade, beneficência, justiça, não maleficência, Beauchamp, Childress, Kant, imperativo categórico.

Freedom, Sancho, is one of the most precious gifts heaven gave to men; the treasures under the earth and beneath the sea cannot compare to it; for freedom, as well as for honor, one can and should risk one's life, while captivity, on the other hand, is the greatest evil that can befall men.
Miguel de Cervantes, trans. Edith Grossman

Introduction

In their 1979 work, Tom Beauchamp and James Childress established a series of ethical principles for professional medical practice. Their work continues to be one of the theoretical pillars of medical bioethical thinking in the United States and around the world.

Beauchamp and Childress seek to generate a reference framework for medical practice, articulating utilitarian and deontological principles. In their proposal, a series of *prima facie* moral and ethical principles are established. This means that there are general ethical principles that can be applied to all value-based questions in the medical context by establishing obligations, and that none of these principles (autonomy, beneficence, non-maleficence, and justice) constitute absolute obligations. Thus, when there is a conflict between these principles, any of them may override another if it is more binding in the particular situation and therefore produces a greater obligation (1).

One of the great problems with this proposal is the relativist nature of its premises. Since no categorical hierarchy is established for the principles, acts that violate the autonomy of the patient may be justified, depending on the salience of autonomy, considered in terms of overall potential benefit. In this sense, the well-being of patients, their dignity, and respect for their autonomy must not be sacrificed in the interests of finding a pragmatic solution to a moral dilemma. In their proposal, they try to establish an equilibrium between deductivist and inductivist perspectives in which they prefer to adopt weighted rather than absolute norms.

In contrast, a European tradition has tried to establish a series of absolute ethical principles that can provide a concrete grounding for morality. As Diego Gracia mentions, one of the most important proposals of this kind has been the Kantian categorical imperative that implies "absolute obligations" that directly relate to the autonomy of the person. These obligations would be derivations of the categorical imperative and can be summarized in the principles of non-malfeasance and of justice, or of moral minimums or perfect moral obligations. The historical experience of Europe, particularly the two world wars, can to a great extent explain the intention of this tradition (1).

In Latin America – also resulting from its historical experience (wars of conquest, colonization, genocide committed against original populations, military dictatorships) – there is also a tendency to lay down categorical and universal ethical principles for medical practice, related to social and political commitment. In addition, there is a tendency strongly influenced by US principlism with all its pragmatic implications (2).

In this work I will offer an interpretive and critical reflection with respect to the principlist approach of Beauchamp and Childress, to support the idea that their formulation responds to the legitimate need to provide medical practice with the fundamental bases for resolving practical problems, but it can lead to a form of relativism that is not up to the task of solving certain kinds of ethical dilemmas. Thus, the need to establish normative principles to guide professional activity. They should be absolute and categorical ethical principles that provide stronger bases for solving ethical dilemmas in the field of medicine.

Development

Medical Bioethics and Principialism

In the context of reflections on bioethics, and after several journalistic exposés regarding the abusive practices of medical doctors in biomedical research (principally the research project on syphilis carried out with human subjects in an Afro-American community in Tuskegee, Alabama, and research on the course of hepatitis infections in children with Down syndrome and other forms of cognitive disability at the Willowbrook School for developmentally disabled children in New York), the US Congress passed the National Research Act, establishing the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (NCPHSBBR). Among other things, this commission produced the 1979

Belmont Report,[2] which established three principles for conducting experiments with human subjects, as follows (3):[3] 1) respect for persons; 2) beneficence; and 3) justice (4-6).

The Belmont Report develops the implications of applying these principles, including "informed consent," "the assessment of risks and benefits" and "guidelines for the selection of human subjects for participation in such research."

In 1979 Tom Beauchamp, a utilitarian philosopher who participated in the NCPHSBBR, and James Childress, a Christian deontologist, both professors at Georgetown University, published the book *Principles of Biomedical Ethics*. This book presents a moral paradigm for medical and health professionals that establishes theoretical elements for the solution of concrete situations in different contexts, based on a proposal for four basic ethical principles (7).[4]

The reference to these two authors in the discussion on establishing ethical principles for medical practice is essential. Their proposals invite a multidisciplinary debate and discussion of these principles' relevance and specificity. Their positions have dominated and taken root, for better or worse, in the professional practice of medical and health sciences. Thus, the need to begin the discussion by taking account of their paradigm.

The Beauchamp and Childress Proposal

Principles of Biomedical Ethics, by Tom Beauchamp and James Childress, is a classic work in the field of bioethics. The authors posit that moral dilemmas take two forms. In the first case, "some of the evidence indicates that act *x* is morally right, and some of the evidence indicates that act *x* is morally wrong, but the evidence on both sides is inconclusive." In the second case, an agent believes, on moral grounds, that he or she ought to perform act *y* and ought not perform act *x*. He or she feels obligated by one or more moral norms to perform act *y*, but due to do circumstances performs neither *x* nor *y* (8, p9).[5]

This is the key point in the development of principlist thinking. To resolve the dilemma, one must establish rational parameters for its examination and analysis. Principles are reference points for rationally considering the options that become available and the context in which they arise.

2 It was called the Belmont Report because the commission met at Belmont House in Washington D.C. At least three documents preceding the Belmont Report intended to establish guidelines for medical practice and biomedical research: the Nuremberg Code (1948), the Declaration of Helsinki (1964), and the Declaration of Lisbon (1981).

3 The principles in this report are defined as "general judgments that serve as basic justification for the many prescriptions and ethical evaluations (4) that are particular to human activity."

4 The principlism that Beauchamp and Childress develop systematically would be echoed in The Foundations of Bioethics, by Engelhardt (United States, 1981), *Fundamentos de bioética* by Gracia (Spain, 1989), and *Princples of Healthcare Ethics*, by Gillon (England, 1993) (9).

5 The Spanish version of the fourth edition is used for the purposes of the following discussion. This is relevant because changes and corrections to the work over the course of seven editions have provided elements for the continued study, analysis, and critical approach to the subject. According to Osório and Garrafa, however, it is in the fourth edition that Beauchamp and Childress began to respond to criticisms of their proposal as lacking a moral theory. They then incorporated the theory of *common morality* in their attempt to ameliorate this deficiency. With their conception of *common morality*, they justify their decision to seek coherence between the goals of the act and the moral system (10, 11).

According to Beauchamp and Childress, dilemmas may result from conflicts between moral principles or rules. This would imply that the fulfillment of one obligation or adherence to one rule would mean the violation of another. In such a case, the situation must be evaluated and the acts to be taken by the subject would be determined by a comparative consideration of the rules in conflict (8).

Their proposal is that different moral principles can produce conflicts in moral life. They propose that if conflicts create moral dilemmas, then moral justifications will be required to resolve them, and deliberation to identify the most convincing moral argument will require a consideration of the moral reasoning that produced the dilemma.

This kind of situation leads to the question of "what is justification in ethics, and by what method of reasoning do we achieve it?" They identify three models of justification in ethical theory: 1) deductivism: the covering-precept model; 2) inductivism: the individual-case model and 3) coherentism, which is neither top-down nor bottom-up (8).

Setting aside deductivism and inductivism due to their inherent problems (establishing general and particular conclusions, respectively), they look more favorably on the model of coherentism. Following John Rawls, they indicate that under this model and pursuing the goal of *reflective equilibrium*, they seek to reach a balance between the general and the particular. They emphasize Rawls's concept of *considered judgments* on which ethical theory should be based,[6] judgments in which the moral capacity of those who participate in the deliberation can be developed without distortions. The point of departure, in other words, should be the moral convictions in which they have the highest confidence and those that suppose as little bias as possible (8).

These judgments, to the extent that they are initial reference points for moral acts, are liable to revision because the "goal of reflective equilibrium is to match, refine, and adjust considered judgments so that they coincide and are rendered coherent with the premises of the theory" (8, p18).

This equilibrium is reached by considering the strong and weak points of a moral judgment, incorporating the widest possible variety of legitimate moral beliefs.

In their reading, then, coherentism finds a balance between reductionism and inductivism, ameliorating the deficiencies of each of these two postures for moral and ethical grounding and justification. It provides the elements necessary to develop what they call a "practical ethics," an ethical theory that seeks to incorporate theory with moral experience to optimize the decision-making process in situations of uncertainty. The relation between moral theories and experience is assumed to be dialectical. The coherence that this approach seeks to reach is based on recognizing general principles and evaluating them on the basis of concrete practical cases that will in turn make it possible to establish new general principles.

To a great extent, the validity of this posture will be contingent on the coherence of the justification, i.e. the coherence of the facts and the arguments used in evaluating a case and promoting a solution, taking general principles into account to arrive at a particular judgment.

6 In broad strokes, Rawls supposes that a society's agreed-on problem solving approach, its established behavioral norms and rules, etc. should conform to an assumed rationality of social agents who seek to lessen inequality in access to goods and services and the satisfaction of basic needs (12).

Considering the reflections above, the authors try to identify the basic moral and ethical principles of biomedical practice. Under the framework of coherence, they suppose that abstract principles should be conceptually developed and normatively defined to reflect in some way concrete behavioral norms and practical judgments. To do so several factors would need to be considered, including efficiency, institutional rules, law, and acceptance by practitioners. The intention is to make a practical strategy available for resolving daily problems, to generate a procedural ethics that can guide the solution of concrete cases.

Adopting the coherence model, an expression of principled pragmatism, they explicitly decline to consider cases in relation to absolute norms. They uphold considered norms (rules, rights, and the like rather than absolute norms or hierarchically ordered rules), to be *prima facie* elements. Nevertheless, they indicate that "some specific norms are virtually absolute, so they generally don't need to be balanced against other factors." One of the problems with this assumption is that no arguments or theoretical justification are offered to explain why any such norms are "virtually absolute" (11, p18).

The problem now is to establish how *prima facie* norms should be considered. Drawing on W. D. Ross, the authors distinguish between *prima facie* and *actual* norms. They consider a *prima facie* obligation as one that is binding unless it is "overridden or outweighed by competing moral obligations of equal or greater magnitude."[7]

By this standard, the moral agent in a conflict between *prima facie* norms must locate what Ross calls "the greatest balance of right over wrong." (8)

What then are the "virtually absolute" principles applicable to biomedical ethics which are nevertheless *prima facie* principles? They propose four principles that derive from "considered judgments in the common morality and medical tradition": 1) respect for autonomy, 2) non-maleficence, 3) beneficence, and 4) justice. Along with these principles, the authors propose a series of rules: a) substantive rules (about truth telling, confidentiality, privacy, fidelity, and rules pertaining to the allocation and rationing of healthcare); b) rules on rules (regarding decisional authority); c) procedural rules (regarding what procedures should be followed).

1. *The principle of autonomy*. The authors define the concept of autonomy as "self-rule that is free from both controlling interference by others and from personal limitations, inadequate understanding, for example, that prevent meaningful choice." They establish two essential conditions for autonomy: "a) *liberty* (independence from controlling influences), and b) *agency* (capacity for intentional action)" (8, p114).
2. *The principle of non-maleficence*. Non-maleficence is presented as the obligation to do no harm, in other words to abstain from intentionally inflicting harm. Thus, the principle is expressed as a negative imperative: "you shall not." It also takes on concrete form in

7 Ross's moral philosophy is based on the premise that all values are in principle (*prima facie*) binding, but that none of them is categorical and should be considered as an ***a priori*** rule for solving dilemmatic situations. Ross recognizes *prima facie* obligations, which are more or less commitments between people that for their execution require the most serious possible reflection on the concrete case, assuming one's personal responsibility in the actual situation and the *prima facie* obligation in the situation as *sans phrase*, i.e. unqualified (13).

moral rules: "Do not kill," "Do not cause pain or suffering to others," "Do not incapacitate others," and "Do not deprive others of the goods of life."

3. *The principle of beneficence*. The authors define beneficent actions as those that benefit other persons. As a principle it would be the moral obligation to act for the benefit of others. They state that this principle should not be understood in a utilitarian sense. Since the principle of beneficence is *prima facie,* it is not the ethical principle. Thus, it is limited to application after weighing the relevant costs, benefits, and risks.

The principle of beneficence gives rise to the problem of *paternalism* in the practice of medicine. Beauchamp and Childress identify a justifiable form of medical paternalism, which they call *justified strong paternalism*. It is justified when there is no medical means to alleviate the patient's condition, but a medical act avoids suffering.

4. *The principle of justice*. This principle indicates that health insurance and health care should be freely accessible to every person who needs it, and the authors reflect on the concept of justice, which can be understood in a very general and summary form to mean "[…] fair, equitable, and appropriate treatment in light of what is due or owed to persons" (8, p312).[8]

Their proposal assumes rational assessment as an essential evaluative principle in the making of decisions. Consideration, a central concept in Beauchamp and Childress's proposal, assumes that the determination that leads to a medical act will follow the consideration of elements to resolve a dilemma. The possibility of rational determination as an operative principle would not alone be sufficient as a theoretical grounding to determine ethical action, because rationality itself would have to be instrumental in relation to the ethical act, not in relation to its determination.

For a theoretical position like that of Beauchamp and Childress to have ethical content, it would need to refer to the justification for a medical action. Intuiting this theoretical requirement almost unconsciously, they use elements of theories such as that of Rawls, that of John Stuart Mill, of Kant's moral philosophy, and their discussion of W. D. Ross's *prima facie* deontology (12).

One of the principal criticisms of the theoretical inconsistency of Beauchamp and Childress's principlism stems from what is called the theory of *common morality* in the approach to bioethics developed by Gert, Culver, and Clouser.

8 To the authors, the principles that specify the relevant characteristics for equal treatment are material, since the identify the substantive properties for distribution, and this material distribution should be carried out in relationship to the concept of *need*. A series of principles material to the concept of justice constitute the components of pragmatic need:
To each person an equal share.
To each person according to need.
To each person according to effort.
To each person according to contribution.
To each person according to merit.
To each person according to free market exchanges.

The principal criticism stemming from *common morality* is that principialism does not provide for the grounding of a moral decision in such a way, say Gert, Culver, and Clouser, that it can combine elements of Kantian theory, utilitarianism, or any other theory.

According to these authors, their approach draws on Kantian *impartiality*, the idea of morality accepted by all rational subjects, as presumed by contract theories and by "natural law," the requirement that morality be known to and accepted by all adults (14).

They define morality as a public system with two characteristics: 1) all persons to whom it applies understand it; 2) it is rational for those people to accept being guided and judged by it. In this sense, morality is characterized by a public system that applies to all moral agents (14).

The authors indicate that not all decisions are rational. There is an element of irrationality in human decision making and human action, they say, and the rationality of an act depends on an evaluation of the extent to which the realized act maximizes the satisfaction of a desire or a need. The irrational act is defined as that act which is inconsistent with the principle of maximization. Nonetheless, this also supposes the existence of a moral system in which individuals should act rationally. Thus, the rules of a moral system must be rational. This principle requires "impartiality" with respect to moral agents (14).

Impartiality is understood in the sense that the moral norm should be supported by rational judgment and should not formally establish advantages (of a kind that detract from equity) that translate into substantial moral elements for one party with respect to the other.

To the extent that a subject considers that his or her rationally considered act is framed in the context of an underlying moral system (based, in turn, on a rational system) this subject will find justification for his or her act. This leads him to suppose that his moral relationship with other subjects is based on the same premise that he assumes for himself: the act framed in a rationality. This is to say that the subject belongs to a moral society and operates within a rationality that would not allow him to apply arbitrary criteria by which to evaluate his or her decisions and acts. These suppositions describe a *common morality*, the basis for a supposition of rationality in the system within which moral agents act (14).

The justification of a moral act is the rule "Do your duty." Nevertheless, obligations can be developed with respect to different roles and relations. The importance of an obligation would be to show how a general moral rule can be significant for a culture. Thus, say Gert, Culver, and Clouser, we cannot speak of universal duties. There are valid expectations for a putative and desirable universality, but it cannot be applied in concrete cases. They further indicate that the "duty" grows and is more informally codified in different cultures. Gert, Culver, and Clouser say that although the medical literature frequently discusses the "duties" and obligations of health professionals, most of the time these "calls to duty" are simply *ad hoc* declarations (15).

Bioethical principles should be seen as a classification of professional duties in healthcare with a certain level of generality. The theory of "common morality" would be more satisfying because principlism only explains and justifies agreements regarding moral decisions, not the disagreements between principles and justifications in dilemmatic medical cases. In the same way, the theory of "common morality" clearly and coherently explains how it applies to the medical question.

To summarize, principlism is criticized for claiming to be a conglomeration of moral principles not deducted from an ethical theory, which is its argumental deficiency. Since it does not have that ethical rounding, it cannot provide satisfactory resolutions in the case of practical conflicts. Rational "consideration" is developed procedurally, but a mere operational procedure cannot replace ethical grounding.

It seems to me that the theory of *common morality*, *despite* an attempt to provide it with an ethical grounding, reflects a kind of pragmatism that makes an explicit ethical basis unlikely. If the ethical basis for decisions and responsibilities reflect a putative consensus based on the presumed rationale of moral consensus, in a medical context this opens the doors to acts that violate the dignity and integrity of the person. As rational as a consensus may seem, it does not assure the defense of the dignity of patients. Nazi doctors, for example, operated based on rationales that underlay their decisions, but their consensus-based rationality allowed for the murder of millions, including through brutal pseudo-medical experiments using prisoners as subjects. What in fact is sought through ethical and moral grounding is the establishment of general and universal principles.

The theoretical deficiencies of both principlism and common morality are salient in the medical context. The relationship between the doctor or health professional and the patient is inevitably unequal. The medical provider is an active agent carrying out activities that affect a subject other than him or herself. Thus, the legitimacy of that action must be recognized by the affected person. But due to the vulnerability of the person affected, recognition cannot be based on a rational consensus. The material assumptions upon which rational consensus is based are not present, because the parties are by definition unequal. Their inequality stems from social, cultural, and economic conditions, and from the intrinsic susceptibility and vulnerability of the patient. Consensus between them would entail an ethical foundation underlying the professional decision, and the action that is taken would reflect that ethical foundation. Based on the Beauchamp and Childress's principlism it can be argued that the four established bioethical principles (autonomy, beneficence, non-maleficence, and justice) come together in the defense and advocacy for the other, the patient. Those criteria are insufficient, however and do not assure respect for dignity and self-determination, because dignity and self-determination are themselves inherent qualities of the person. So, when weighing these principles, what happens is that their recognition is relativized (e.g. in the case of medically assisted suicide there may be a conflict between the principles of autonomy and non-maleficence). It could be argued that the principles are in fact proposed primarily to protect the "integrity" of the patient in the Hippocratic spirit.

I would specifically like to discuss the principle of beneficence. According to this principle, professional acts should always be oriented toward producing a "benefit" for the patient. Nevertheless, it must be asked what is meant by a "benefit." Medical acts are carried out in the context of an unequal relationship in terms of the directionality of the action, in terms of the active position of the medical professional directed toward a passive party, i.e. the patient. Given this logic defining the relationship between medical provider and patient, the "benefit" that is the ultimate objective of the professional act is at the discretion of the medical provider as active agent. The notion of benefit, however, can only be ethically grounded

by the self-determination of the patient, which justifies the possible benefit of the medical act. This premise should be assumed in relation to any ethical judgment in the context of an intrinsically unequal relationship. If the ontic nature of the determination is not taken as primary, then benefit, maleficence, and even justice become significantly ambiguous and imprecise principles that can be used to justify an act that is detrimental to the integrity of the patient.

Thus, the principle of autonomy should be considered hierarchically superior to the other bioethical principles, because it is the only one of them that can provide professional medical practice with an ethical, and perhaps even ontological, basis. This is because autonomy is based on a principle assumed to be a constituent quality of the person, while the others are based on the recognition of things extrinsic to the person in and of himself. Autonomy, that is to say, does not depend on its recognition as such; it is an inherent characteristic and a foundational quality of the human person, or at least that's the way it should be supposed, making the defense of human integrity possible. Making the principle of beneficence real, on the other hand, requires the recognition and action of an "other," as do the principles of "non-maleficence" and "justice."

One may ask what happens in the case of people who cannot exercise autonomy. From the Kantian perspective developed below, the autonomy of a subject is only assumed to the extent that there is recognition of the autonomy of others, and the autonomy of the subject supposes the autonomy of the other. Medical acts, therefore, must be performed based upon the assumed autonomy of the patient, whether exercised or not. While this implies that the other subject with diminished autonomy is unable to exercise it, it also provides a basis for medical acts that require —as a supposition— the recognition of the patient's autonomy.

As a foundational principle, the question of autonomy leads to the discussion of dignity.

The Dignity of the Human Person

Two of the general, basic, and historical concepts in the field of ethical foundations are that of the person and that of human dignity (15).

In his synthesis of various anthropological-philosophical theories, José Luis Jiménez Garrote comments that to various authors, among them Kant and Ortega y Gasset, in order to refer to the human being in an integral sense, and to incorporate an ontological foundation for dignity, it is necessary to accept the person as an ontological basis, i.e. that dignity is essential and inherent to the human being. Thus, the basis for dignity must go beyond the manifestations of the person (such as rationality) and reach within to the integral core of the human person. This perspective would be posed in contradiction to postures that establish an essential dualism in the human being that would make "dignity" subject to rationality and autonomy subject to freedom (15).

An extensive discussion has been established between proponents of these two positions, expressing numerous analytical perspectives in the fields of ethics and law. It has also generated a series of ethical problems and dilemmas whose possible solutions are far from being categorically established. They include questions about abortion, euthanasia, and eugenics, among other things, as well as problems involving perspectives on medical

activity (a paternalistic medical practice or one that establishes horizontality between patient and provider).

One of the answers provided by modernity (from the Renaissance to existentialist thinking and other 20th century ethical theories) is that what gives humanity its specificity is its individual and social capacity for self-government and self-understanding. Nonetheless, the question is still open. Despite efforts to universalize the definition of the human, it is a concept that remains historical and contextual. This is a problem because the elusiveness of a definition precludes clarity on the concept, leading to a problematic relativism (16).

At this time, the question of human rights is an unavoidable component of the discussion. The concept of human rights has been one of the great achievements of modernity, assuming the recognition, attainment, and defense of a series of characteristics that are inherent to the human person and that configure his or her (original) identity, integrity, and defense in multiple ways (biological and psychological, at least). Among these human rights, freedom is fundamental and key to all the others: "Article 1. All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood." (17).

The Universal Declaration of Human Rights speaks of freedom and dignity, to terms that are based upon autonomy, and we understand autonomy as follows:

> [...] knowing how to think and act for oneself, correctly and with sufficient critical capacity to not be swayed by the external environment or by one's own passions or prejudices... In this case autonomy is freedom itself, since a free act is autonomous when it comes from within the person, with an awareness of its motivation (18, p240).

Thus, freedom is conditional on autonomy, providing the ability for the human person to be conscious and responsible for his or her own acts. It is the capacity to reflect and choose, based on criteria that may be said to be one's own, and based on an evaluation of the consequences of one's own acts. Thus, the free and autonomous act originates in the person (18).

In this sense, we refer to autonomy as the determination of an action based on the will of the person, preferably rational, which is to say reflexive based on calculation, evaluation, and accepting the inherent consequences of one's own acts. Through autonomy, people take on the characteristics, status, and dignity of human beings.[9] Thus, the principle of autonomy is indispensable and underlies the ontological constitution of the human being. Without autonomy there can be neither justice nor anything else. The possibility of establishing universal principles such as those of human rights depends on this natural right (freedom).

There is a clear relationship between freedom, autonomy, and human dignity. If it is assumed that dignity is an inherent quality of the human being that is not dependent on any event or contingency, that endows it with an inherent value, this requires autonomy for its consolidation, autonomy understood in the sense of freedom and self-determination (18).

9 The word *dignity* derives from the Latin *dignitas*, derived in turn from dignus. The Latin word implies prestige, decorum, worthy, or deserving, and corresponds to the Greek *axios*: suitable, precious, deserving, or worthy (16).

The discussion regarding the concept of the person and its relationship to dignity is one of the current and central problems of bioethics. Gabriel Amegual has characterized two major positions in this discussion. On the one hand, some take the position of defining the descriptive or metaphysical person based on a series of characteristics including rationality, intentionality, attitude, reciprocity, verbal communication, and even self-consciousness, which must be fulfilled in order to speak of identity; the moral conception of the person, on the other hand, sees the human being as one who is able to understand and act based on principles, using the criteria of good and evil. In this understanding, moral capacity consists of being a free subject exercising will who takes responsibility for his or her acts (19).

I argue that to take on normative characteristics, any foundational ethical principle should have an ontological basis. This puts the problem back in the category of anthropological reflection. In formulating the concept of the person in a descriptive sense, it is assumed that the elements that characterize a person can be deduced from an anthropological principle, but the ontological foundation of the person is not made explicit. The indication is that this concept must necessarily be related to that of *dignity* as its obligatory ontological substrate (19).

The concept of dignity becomes the key element in the definition of the human being through natural law and positive law. It implies going beyond the Cartesian separation of corporality and rationality. The human person's rational capacity does not define his or her dignity, thus the integration of corporality into the concept of "dignity" becomes a basic premise.

The Kantian rationale: the ethical act and the recognition of autonomy

The Kantian theory of autonomy as a foundational principle for the ethical act presumes a strongly possible ability to establish the principle of autonomy as a central element of a principlist theory. This would be accomplished by transferring the ethical nature of the action to the subjective self-determination that allows for the recognition of this element in the possibility of the "other" subject as autonomous.

I have indicated that the practice of medicine necessarily entails an unequal intersubjective relationship in which the practitioner occupies a position unequal to that of the patient, due to the implications and possibilities of the medical act in relation to the latter. In my view, this "de-ethicalization" of the act allows on the one hand, for the affirmation of autonomy in the rational determination of the act, and on the other hand for the recognition of intersubjective autonomy in the formulation of the categorical imperative, overriding the unidirectionality of the action. This is Kant's lesson.

In *Foundations of the Metaphysics of Morals*, Kant rejects both an empirically grounded morality and end-based ethics as proposed by utilitarianism. On the one hand, he does not accept a moral evaluation as determined by the effects of the act, and on the other he criticizes focusing on a superior end such as happiness or pleasure to determine the morality of the act. In both cases, support for the morality of an act is based on its ends rather than on the intent of the subject.

Kantian ethical theory supposes a teleology of the moral act. Within this teleology, the moral act is taken in pursuit of a value: the highest value, that of humanity. Actions should be taken with this criterion so that acting *to fulfill a duty* means carrying out acts that express the value of humanity. This is the sense in which Kantian theory is teleological rather than deontological (20).

In this line of thinking, reason takes on the primordial role of guiding the will to generate a will that is good in itself, not just as a means to another end.

To Kant, the *autonomy* of the will is the only principle that can establish moral laws, unlike the *heteronomy* that is contrary to the morality of will. The only principle of morality would be the independence of objective determination, and moral law expresses nothing but the autonomy of practical reason: freedom (21).

The categorical imperative that can create an ethical act must be rationally grounded. The only thing that can prove the principle is freedom, says Kant, "In other words, it is not a question of knowing the qualities of objects, a kind of knowledge that can be attributed to logic, but rather a kind of knowledge that may establish the foundation of those objects' existence" (21).

To Kant, freedom is an initial action from the causal point of view (cause and effect). To him, freedom never arises from objects in space and time; rather it is related to the concept of causality to the extent that this concept supposes a cause free of all previous causes. In the intelligible character, however, freedom and causality do not relate to each other with reference to a temporal succession of a cause that produces an effect which at the same time becomes a cause (as in science). Rather, causality rests on human action. Freedom develops a causality expressed as duty, but being the intellectual cause of freedom, it must be represented intellectually and must be freely accepted as a rule for behavior. In other words, duty is the basis for will (22).

In moral law, the will responds to reason. This is an imperative of reason to which reason itself must submit.

Autonomy fulfills an essential function. The autonomy of the will is the only principle of all moral law and duties. Moral law expresses the autonomy of *pure practical reason,* in other words, of freedom. Duty is the engine of moral acts. When subjects act to fulfill an obligation for moral reasons, when they act due to an obligation, they nonetheless act autonomously to the degree that *they oblige themselves* to act due to the existence of that external obligation. In this sense the individual becomes his own legislator and the moral mandate is fulfilled only in the case that subjects decide to fulfill it, something they are able to do based on their own autonomy (21).

Thus, subjects submit to moral laws that take on the character of duty and products of their own freedom (dictated by their own reason). This conception of moral law paints it as universally applicable to all free and autonomous subjects, which would indicate that every rational creature is *an end in itself* (21).

When the other is treated as a rational creature and an end in him or herself, he or she is treated as an autonomous being. It turns out that this premise is the foundation of the ethical intersubjective relationship in Kantian theory. In other words, it is the foundational

principle of one's obligations towards oneself and others. Likewise, it is the possibility of the universalization of moral law. These principles take shape in the categorical imperative expressed as the fundamental law of pure practical reason: "Act according to the maxim that you would wish all other rational people to follow, one that could serve as a universal law." (21, p35).

Considering the specific problem of autonomy as a possible ethical grounding for an act in the Kantian sense, one interesting question is that if the ethical act is an individual act believed to be supported by a universal principle, why is it that the very principle that rationally justifies the act for the individual does not end up destroying the possibility of an intersubjective ethical relationship? This question is particularly pertinent if we think of this problem in terms of the ethical responsibility that the medical practitioner has toward the patient, which, as I have said, responds to the intrinsically unequal context in which the former must assume the principle of his own autonomy, but in this case with respect to the other, the patient. One may think that this problem, which takes on the characteristics of a paradox, brings us to the impossibility of establishing the autonomy principle as determinant over a hierarchical and nested principlism.

Moral action in Kantian theory is individual in relation to the act and personal responsibility, but it is also an intersubjective action since it is open to the universality of rationality as the engine of the ethical act. The three formulations of the categorical imperative that appear in *Foundations of the Metaphysics of Morals* have the following implications: 1) the universality of moral law relates to one's own acts and to all acts by free beings; 2) respect for the other as a free being and the obligation to not treat the other as a mere means to an end. One's own freedom is only realized when it is understood in the context of intersubjectivity and respect for the freedom of the other; 3) the autonomy of moral law is the economy of all rational beings called to be co-legislators of the community (23, 24).

Conclusions

Kantian philosophy posits the premise that for an act to be ethical it must reflect the action of an autonomous and rational subject who is able to accept responsibility for the consequences of his or her acts; this subject should also be able to recognize and accept the autonomy of acts by other subjects.

The historical development of medicine has been characterized by a paternalist approach, because one of its principal premises is the protection of patients. Therefore, it has prioritized the criterion of beneficence. Diego Gracia defines this approach in the following way:

> Paternalism is to be understood as "strong" beneficence, characterized by the performance of a beneficent act even against [another subject's] will and in any case without requiring it. Paternalism means treating the patient as a parent treats his young offspring (23, p22).

Paternalism impedes the recognition of patients as autonomous subjects within this medical paradigm, depriving them of the ability to make their own decisions based on their personal

judgment about what is best for themselves. As I have suggested throughout this text, a medical act that is outside this paradigm cannot be an ethical act. And medical providers who do not recognize patient autonomy are implicitly not exercising their own autonomy either.

This idea is essential to the conformation of an ethical perspective on medical practice. Within this process of developing recognition for patient autonomy, the medical practitioner's assumption of ethical responsibility in recognizing and protecting the patient as a human being with the attendant dignity due to all human beings becomes the ethical grounding for the practice of medicine.

An act that is carried out principally under the argument of seeking the well-being of the patient or of doing no harm is not in itself an ethical act. Ricardo Páez Moreno has argued, following Diego Gracia, that the principle of non-maleficence, which affirms the obligation to do no intentional harm, is the basic principle of all moral systems. "No other principle," he says, "does more to help us understand in its deepest sense the ethical tradition that Western doctors have never renounced." Beneficent or non-maleficent acts are not ethical acts, however, to the extent that they do not, in and of themselves, recognize the autonomy of the other, the patient (25, p172).

A heightened focus on the principle of autonomy would provide the patient his or her appropriate role in relation to the medical practitioner, recognizing his autonomy in finding solutions for ethical dilemmas in the medical context which would then allow for the establishment of a more horizontal relationship that dignifies freedom and life itself.

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