HOW MUCH AID IS ENOUGH? THE PRINCIPLE OF BENEFICENCE

Bioethics: Course Notes | Brendan Shea, PhD (Brendan.Shea@rctc.edu)

In this lecture, you'll learn to:

1. Distinguish the principle of beneficence from that of nonmaleficence.
2. Analyze the relationship between beneficence and the moral norm of reciprocity.
3. Explain the debate between libertarians, utilitarians, and principalists regarding the scope of beneficence.
4. Apply the principle of beneficence to issues such as continued and expanded access to experimental treatments.

The common morality requires that we both respect the decisions of competent persons (the principle of **autonomy**) and that we refrain from harming other people and animals (the principle of **nonmaleficence**). It also requires that we take positive steps to *aid* others, and that we consider what the net *outcomes* of our actions will be (for everyone affected by them). These requirements fall under the principle of **beneficence,** or the "moral obligation to act for the benefit of others."[1] This principle mandates that we do the following, at least in cases where it is relatively easy for us to do so:

1. Intervene to prevent others from being harmed, or to protect their rights. Rescue those in danger.
2. Give aid to others that need it, in the form of money, time, emotional support, and so on.
3. Help people who cannot fend for themselves (children, those with disabilities, perhaps some animals).

Ethical theorists have widely diverging views about how much this principle demands of us:

Some **libertarian** or **rights-based** theorists have argued that while we may have duties of **specific benevolence** (toward family members, patients, patients, and so on), we have almost no obligations of **general benevolence** (toward strangers). According to these thinkers, morality requires simply that we "mind our own business" by respecting others' autonomy and not harming them. One problem: This view underestimates how much we ourselves have been benefitted by the actions of other people/animals (and thus, how much we owe them). It implausibly suggests that it is morally OK for us to stand by and allow people to drown, starve, or be killed even when we could prevent this with little effort.

Utilitarianism holds that our *only* moral obligation is that of beneficence, and that an act is moral just in the case it maximizes net well-being (or minimizes net suffering) for absolutely all persons and animals affected by it. Peter Singer (a famous bioethicist) argues that both utilitarianism and many traditional religious ethics entail the following: "if it is in our power to prevent something bad from happening, without thereby sacrificing anything of comparable moral importance, we ought, morally, to do it." One problem: Singer's principle would require that we give nearly ALL of our time and money to causes such as poverty relief. For many people, this is simply far too demanding[2].

Principlism (the view defended by B-C) holds an intermediate view between these two "extreme views". In particular, it claims that I have *prima facie obligations of beneficence* toward person P when:

1. P is "at risk of significant loss of or damage to life, health, of some other basic interest."
2. My action (either by itself or in concert with the actions of others) is necessary to prevent this loss or damage.
3. My action will *probably* work to prevent this loss or damage.
4. My action "would not present significant risks, costs, or burdens" to me.
5. The benefits to P can be expected to outweigh any harms or costs that I expect to incur.

The differences between these three theories show up in different judgments about cases. So, for example: A libertarian holds that you are *never* morally required to help a stranger (no matter how small the cost to you!). A utilitarian, by contrast, would hold that you are *always* required to help strangers, so long as it doesn't harm you more than it helps them (so, you would have to sacrifice your own life to save two strangers' lives). Finally, a principlist would hold that you sometimes have to aid strangers (so long there is no *significant* risk, cost, or burden to you).

EXPANDED ACCESS AND CONTINUED ACCESS

On some occasions, researchers have offered patients **expanded access** to treatments or drugs that are still undergoing testing. In other cases, they have offered **continued access** to these (not-yet approved) drugs/treatments to patients who have *participated* in preliminary

[1] For an overview of the importance of the beneficence in work on applied ethics, see: Tom Beauchamp, "The Principle of Beneficence in Applied Ethics," in *The Stanford Encyclopedia of Philosophy*, ed. Edward N. Zalta, Spring 2019 (Metaphysics Research Lab, Stanford University, 2019), https://plato.stanford.edu/archives/spr2019/entries/principle-beneficence/.

[2] For an introduction to this debate see Peter Singer, "Famine, Affluence, and Morality," *Philosophy & Public Affairs*, 1972, 229–243; https://www.utilitarian.net/singer/by/1972----.htm, Richard W. Miller, "Beneficence, Duty and Distance," *Philosophy & Public Affairs* 32, no. 4 (2004): 357–383.

tests of these things, and who have shown positive results. A question: Does beneficence morally *obligate* researchers to offer patients expanded or continued access?

Is Expanded Access Required? Why? B-C argue that researchers are NOT (usually) morally obligated to offer expanded access to drugs because (1) there is no evidence these drugs will actually *help* patients and (2) in certain cases, doing so may cause problems for clinical trials (e.g., if the "wrong" type of patient is included in the data, this may lead to the failure of the clinical trial). In some special cases (e.g., when existing treatments have failed, there is good reason to think the experimental treatment might work, and it will not disrupt clinical testing), researchers should consider offering expanded access.

Is Continued Access Required? Why? By contrast, B-C argue that researchers ARE (usually) morally obligated to provide continued access, since (1) they "owe" the patients for their participation in the study, (2) there is good reason to think the patients will be helped, and (3) there is no possibility of this ruining the clinical trial (which has already been completed). In the case of continued access, the researcher's obligation of beneficence is grounded on **reciprocity**, or "the act of practice of making an appropriate and often proportional return—for example, returning benefit with proportional benefit, countering harm-causing activities with proportional criminal sentencing, and reciprocating friendly and generous actions with gratitude." B-C argue that many of our obligations of general and specific beneficence are actually grounded in this way:

RECIPROCITY AND BENIFICENCE

As suggested by the case studies above, medical professionals owe a LOT to other members of society. This includes both formal training in tax-payer subsidized schools, clinics, and hospitals and informal learning based on experiences with previous patients. Medical professionals also rely heavily on publicly-funded facilities and medical research to do their jobs. It is incorrect to think of medical professionals as "independent" or "self-sufficient" individuals who don't "owe" anything to their patients beyond the absolute minimum.

Similarly, patients owe a lot to medical professionals and to other patients, in that their treatments would not have been possible without lots of previous research and experience. This suggests that patients have some obligation to be beneficent—for example, by agreeing to participate in research studies when they can do so with little risk to themselves. We can even have obligations of beneficence to animals used in experiments, in that they have helped us gain knowledge. This means, among other things, that research animals ought to be as well-treated as possible (even if the research will foreseeably lead to their deaths).

REVIEW QUESTIONS

1. In your own words describe the difference between nonmaleficence and beneficence. Can you give an example of a case where these principles might *conflict* (for example, a case where you could help many people, but only by harming someone else)?
2. Suppose that a deadly influenza (or COVID) epidemic breaks out. You are a skilled medical professional and estimate that, if you *volunteer* to work at a local clinic, you could save TWO people's lives. However, you would stand a 10% chance of dying (for at-risk workers, this was probably realistic in cases such as the 1918 influenza pandemic).
    a. Is this a duty of specific or general beneficence? Why?
    b. What would a libertarian say about this situation? A utilitarian? A principlist? What do *you* think?
    c. Would your (moral) duties change if there were very little risk to you (beyond having to work for a few days without pay)?
    d. Would your (moral) duties change if the people you could save were your patients, and treating them was "part of your job" (for which you were paid, had already signed a contract, etc.)? If so, how?
    e. Would your (moral) duties change if the people you could save were "important" people, such as other medical professionals, or important political/religious/scientific leaders? If so, how?
    f. Would your (moral) duties change if the people affected were your family members or friends? How?
3. **Right to Try Laws**[3]**.** In 2014, Colorado passed the nation's first "Right-to-Try" law, and a number of other states have since followed. The laws gives terminally ill patients the legal right to try drugs that have NOT fully passed FDA testing yet, so long as they can get a physicians' prescription AND a drug company to agree to provide access. The laws are sometimes called "Dallas Buyer's Club" laws, after the movie (based on a true story) in which a man with HIV (illegally) imported and sold experimental and unapproved treatments to other patients. Some libertarian political groups (who were the original proponents of these bills) have argued that competent patients (or the surrogates for incompetent patients) are autonomous, and should be able to make their own choices about treatment. Conversely, the overwhelming majority of medical ethicists have expressed concerns about these laws, often on the grounds that patients *radically* overestimate the chance that experimental treatments will work, and underestimate the chance that these treatments will have severe side effects that can make patients' life worse, and hasten their death. (In the "Dallas Buyer's Club" scenario, the widespread availability of "alternative" HIV treatments plausibly ended up harming more patients than were helped.). What do you think?

[3] Rita Rubin, "Experts Critical of America's Right-to-Try Drug Laws," *The Lancet* 386, no. 10001 (2015): 1325–1326. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)00393-1/fulltext