Principlism, common morality and the normative independence of biomedical ethics

Principialismo, common morality e l'indipendenza normativa dell'etica biomedica

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ABSTRACT

Since the emergence of contemporary bioethics in the 1970s, no theoretical approach has proved more influential than principlism. Yet no critics have shaped its development more profoundly than Bernard Gert, K. Danner Clouser, and Charles Culver. This article reassesses their critique of Beauchamp and Childress's framework and examines the replies offered in the eighth edition of Principles of Biomedical Ethics. I argue that this debate reveals not merely competing theoretical commitments but two fundamentally incommensurable paradigms: a "philosophy-to-practice" orientation that derives bioethical norms from systematic moral theory, and a "practice-to-philosophy" approach that abstracts principles from existing clinical guidelines. While GCC correctly identify principlism's lack of theoretical foundation as a structural limitation, they fail to recognize that a satisfactory biomedical ethics cannot be derived from an account of common morality alone. I conclude by suggesting a possible synthesis: grounding bioethical deliberation in the systematic framework of common morality while incorporating role-specific professional duties—duties that the principlist framework, given its demonstrated resonance with clinical practice, may help articulate.

SOMMARIO

Sin dalla nascita della bioetica contemporanea negli anni Settanta, nessun approccio teorico si è dimostrato più influente del principialismo. Eppure, nessun critico ne ha plasmato lo sviluppo più profondamente di Bernard Gert, K. Danner Clouser e Charles Culver. Questo articolo riesamina la loro critica al framework di Beauchamp e Childress e analizza le risposte offerte nell'ottava edizione dei Principles of Biomedical Ethics. *La tesi che sostengo è che questo dibattito non rivela semplicemente impegni teorici in competizione, ma due paradigmi fondamentalmente incommensurabili: un orientamento "dalla filosofia alla pratica" che deriva le norme bioetiche dalla teoria morale sistematica, e un approccio "dalla pratica alla filosofia" che astrae i principi dalle linee guida cliniche esistenti. Sebbene GCC identifichino correttamente la mancanza di fondamento teorico del principialismo come un limite strutturale, non riconoscono che un'etica biomedica soddisfacente non può essere derivata unicamente da un resoconto della moralità comune. Concludo suggerendo una possibile sintesi: fondare la deliberazione bioetica nel framework sistematico della moralità comune, incorporando al contempo doveri professionali specifici di ruolo — doveri che il framework principialista, data la sua comprovata risonanza con la pratica clinica, può contribuire ad articolare.*

KEYWORDS

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INTRODUCTION

Since bioethics emerged as a distinct field in the 1970s, the principlist framework developed by Tom L. Beauchamp and James F. Childress has exercised unparalleled influence over both theoretical discourse and clinical practice[1]. Through eight successive editions of *Principles of Biomedical Ethics* (PBE), their approach has demonstrated a remarkable capacity for evolution, absorbing and responding to critical challenges while maintaining its core architectural features[2]. Among the various theoretical engagements their work has provoked, none has proven more impactful and systematic than the critique advanced by Bernard Gert, K. Danner Clouser, and Charles Culver (GCC)[3]. Writing in the final chapter of their eighth edition, Beauchamp and Childress themselves acknowledge that when serious challenges to their framework emerged in the 1980s, those grounded in Gert's moral theory represented their «most unsparing critics»—a characterization that understates the profound influence this dialogue has exercised on principlism's theoretical development[4].

The term 'principlism' itself bears witness to this critical encounter. Clouser and Gert coined it in their 1990 article not as neutral description but as diagnosis—identifying what they saw as the problematic «practice of using 'principles' to replace both moral theory and particular moral rules and ideals in dealing with moral problems that arise in medical practice»[5]. This baptism proved so compelling that even Beauchamp and Childress came to adopt the term, though stripped of its critical valence. Equally telling is the genealogy of 'common morality' within the PBE framework: while both approaches are now routinely classified as common morality theories, the first three editions of *Principles* (1979, 1986, 1989) made no reference to this concept[6]. Only with the fourth edition (1994) did Beauchamp and Childress introduce common morality as their foundational commitment—a theoretical pivot that represents an attempt at incorporating one of the key elements of Gert's moral theory, specifically his belief in a 'common' or «universal morality that is not relative to cultures, individuals, religions or professional associations»[7].

This article reassesses both the GCC critique and Beauchamp and Childress's replies. By foregrounding their exchanges, I argue that the GCC critique correctly identifies principlism's lack of a unified theoretical foundation as a problem. Yet, it also fails to appreciate that a theory of biomedical ethics cannot be derived from an account of common morality alone.

The debate ultimately reveals not merely competing theoretical commitments but two fundamentally opposed orientations regarding the direction of bioethical inquiry. For Gert and coauthors, medical ethics must depart from a systematic account of morality to be then applied to the moral issues of biomedicine. For Beauchamp and Childress, by contrast, bioethics should instead start with the urgent problems arising in biomedical contexts and then proceed to identify a minimal set of conceptual tools that allow to decide amidst persistent moral disagreement. This directional difference—philosophy-to-practice versus practice-to-philosophy—explains why the two sides often appear to talk past one another. Each evaluates the other using standards that belong not only to a different moral theory, but to a different conception of what bioethical theory could and should be.

To demonstrate this, the following two sections focus on the key textual *loci* that capture the essence of GCC's critiques and Beauchamp and Childress's replies. For the former, this is represented by the chapter entitled 'Principlism' in *Bioethics: A Systematic Approach*, the 2006 revision of their previous *Bioethics: A Return to Fundamentals* (1997). This chapter is particularly relevant because here GCC consolidate and refine all their previous critiques of principlism. For the latter, I examine instead the eighth and final edition of the *Principles*, specifically the passages and chapters where Beauchamp and Childress directly address GCC's criticisms.

2. COMMON MORALITY AS AN ALTERNATIVE TO PRINCIPLISM

When GCC published the 2006 edition of their textbook on bioethics—originally released in 1997—they made a significant change to its subtitle. The original *Bioethics: A Return to Fundamentals* became *Bioethics: A Systematic Approach*. As the authors explain in their Preface, this deliberate revision was motivated primarily by the need to distinguish their approach from other theoretical alternatives and especially principlism, then already considered the dominant approach.

This need for differentiation finds its fullest expression in the fifth chapter, 'Principlism', which follows right after the exposition of their account. This chapter is entirely devoted to a sustained critique of the PBE four-principles approach. Here GCC's declared intent is to demonstrate that «the lack of any unifying theory in principlism makes it far less useful in dealing with controversial issues» than their systematic account based on common morality[8], for theirs offers «a detailed moral system with justification» while principlism «presents only a schema of an account of morality and no attempt to justify it at all»[9].

These claims encapsulate the essential contrast between the two approaches and reflect their different conceptions of 'common morality' as the normative foundation for their respective view of biomedical ethics. Following the tradition of natural law theory—particularly Hobbes—GCC conceive morality as a public system in which all moral agents always know what it prohibits, allows, encourages, or discourages. For them, the primary task of moral theory is to describe the moral system and justify it to the extent that is possible.

By contrast, following Ross and other moral intuitionists, Beauchamp and Childress understand common morality as the contingent state of socially recognized moral norms shared by human communities. On their view, common morality functions as a pre-theoretical layer that lacks a deep, unified, and systematic structure that can be grasped through philosophical and conceptual analysis, serving instead as a descriptive starting point for bioethical deliberation[10].

This fundamental theoretical divergence provides the basis for all critiques that GCC address to principlism, as well as the replies provided by Beauchamp and Childress, namely: (i) that the principles of principlism lack sufficient action-guiding content; (ii) that specification cannot solve conflicts between principles or supply their content impartially; and (iii) that principlism blurs a fundamental moral distinction between moral rules and moral ideals[11]. In this section I will present GCC's critiques as they articulate them, reserving theoretical evaluation for the subsequent section where I examine them in light of Beauchamp and Childress's responses.

2.1 First critique: principles without an underlying theory offer no action guidance

GCC's most fundamental charge targets the very nature of principlism. True ethical principles, they argue, function as shorthand for comprehensive moral theories. Mill's utility principle encapsulates utilitarianism; Kant's categorical imperative expresses deontological ethics; Rawls's two principles of justice — the liberty principle and the difference principle—capture his theory of justice as fairness. These principles guide action precisely because they express systematic theoretical commitments. When conflicts or ambiguities arise, practitioners can return to the underlying theory for resolution and clarification.

Principlism's four principles, by contrast, float free from any theoretical anchor. Beauchamp and Childress deliberately extract what they consider useful from various major moral theories while discarding what is controversial, believing that each theory illuminates important aspects of moral life, but none provides a complete vision. On this view, each major normative theory is like a blanket that is always too short to cover the whole of our moral life in a satisfactory way. In this they follow Ross, whom they acknowledge as the thinker who has had «more influence on the present authors than any recent writer in ethical theory»[12].

Yet this approach, as Gert and Clouser noted in their 1990 analysis, creates a twofold theoretical problem with very practical applications. First, principlism's principles lack the action-guiding content that genuine ethical principles possess, since they are severed from the theoretical frameworks that give them normative force. The four principles, they argue, are merely chapter headings for key-ethical considerations, coexisting without systematic connection. Each principle appears to focus on the key aspect of some leading theory—justice from Rawls, consequences from Mill, autonomy from Kant, and nonmaleficence from Gert—representing historically important emphases but stripped of their underlying theoretical foundations and, more critically, lacking any unifying theory to coordinate and integrate these disparate features of morality. They function merely as «reminders» of values to consider, so that «they provide a guide only when no guide is needed; when guidance is need-

ed, they are of no use»[13].

Second, by presenting free-standing principles derived from mutually incompatible moral theories—Mill, Kant, Rawls—principlism propagates what GCC diagnose as the 'anthology syndrome' in bioethics[14]. Clinicians are presented with notions drawn from different and irreconcilable normative approaches—Kantianism, deontology, utilitarianism, virtue ethics, and contractarianism—and told, in effect, to choose whichever seems most appealing for the case at hand without any underlying theory guiding how such application ought to proceed. On the practical plane, this propagates the problematic notion that there is not one morality, but many incommensurable and equivalent moralities, from which practitioners may simply select according to personal preference.

These two problems—the absence of action-guiding content and a misconception about the nature of morality—combine to generate the second critique: the principles inevitably conflict with one another in particular cases, yet no impartial procedure exists for resolving such conflicts.

2.2 Second critique: specification and the requirement of impartiality

The PBE principlism cannot by themselves guide action in particular cases due to their degree of abstraction, nor can this level of abstraction be reduced by appeal to an underlying moral theory. For a framework explicitly devised to address actual dilemmatic cases in biomedical contexts, this poses a serious difficulty. By being practically empty, the principles do not speak to particular cases and thus offer no guidance on how we should conduct ourselves in specific situations. Relatedly, in many cases the principles are bound to conflict with one another, making it difficult, in absence of a theory, to decide in each specific case what ought to be done.

Beauchamp and Childress's primary solution to both problems is specification (combined with weightening and balancing), a method they borrow from Henry Richardson. Specification serves to progressively fill the principles with content, moving from the general to the particular by narrowing their scope, refining their meaning, and introducing contextual qualifiers—thereby «reducing the indeterminacy of abstract norms and generating rules with action-guiding content». Applied to the first problem, specification addresses the emptiness of principles by elaborating them into increasingly determinate norms with content. Applied to the second problem, by specifying the various principles in context, it either leads the conflicts to disappear, or at least makes balancing possible, thus allowing one to select one's actual duty between the various competing *prima facie* obligations, all things considered.

GCC accept that some form of refinement is inevitable, but they argue that the principlist version of specification undermines, rather than secures, the action-guiding function of moral norms. Indeed, far from solving the dual problem identified above, specification exacerbates both issues. Their critique centers on two closely related concerns that correspond directly to the two original problems.

First, specification fails to provide stable normative content, thus worsening rather than resolving the emptiness problem. Because the principles are formulated at a high level of abstraction, they require substantial elaboration before they can support moral judgments in particular cases. Yet this elaboration must occur in each domain of application, yielding not a unified moral framework but a patchwork of locally defined derivations and potentially conflicting specifications. As a result, no one can ever know what the specific content of, for example, the principle of respect for autonomy is, because each process of specification leads the principle to vary in content across domains. On GCC's view, this transforms the moral principles into the recipients of local normative agreements: instead of functionally shared moral standards, specification depends on the discretionary interpretive work of specific practitioners and institutions. Consequently, bioethical morality becomes partly private rather than public, since it is effectively impossible for all moral agents to know what the content of the principles is at any given moment or place. This is the structural limitation of a theoretical framework that envisions nearly empty principles to be subsequently filled only by local specification.

Second, specification lacks a determinate procedure capable of distinguishing legitimate from illegitimate refinements, thus transforming the conflict problem into an impasse of incommensurable interpretations or, worse, into *ad hoc* justifications. Beauchamp and Childress provide

neither a hierarchy among principles nor a morally impartial procedure for resolving conflicts among competing specifications. Different agents may therefore specify principles differently and assign different weights to the reasons at stake (or not weight at all), rendering the process potentially parochial and thus systematically exposed to bias. Two deliberators may arrive at opposed conclusions while each claiming to have properly specified and balanced the relevant principles, with no impartial standard available to adjudicate between them. This makes principlism suitable more for providing retrospective *ad hoc* justifications than for offering prospective guidance.

By contrast, GCC propose a systematic alternative based on the idea that morality is a public system in which all moral agents always know what it prohibits, encourages, rewards, or stigmatizes. Only as such can morality be a valid system for everyone. This underlying moral theory—which comprises also an account of the concepts of morality', 'rationality', 'impartiality' and of their relation—allows the common morality approach to have a minimal core of abstract and very general negative norms (e.g. 'do not kill') and yet to provide guidance in most ordinary cases.

In addition to its normative core of negative moral rules and moral ideals, the common morality system also provides a structured procedure to guide moral deliberation in particular cases. This procedure entails two steps. First, one must describe each case using only its morally relevant features. This involves describing each case in a way that all moral agents could understand, that is, without referring to beliefs that only some may have (i.e., scientific or culture-based concepts). In this way, the moral system can be applied to each particular case without the need to constantly adding and modifying the content of the general principles.

Second, one must ask what foreseeable consequences would follow if it were made publicly known that in that case one could act in one way rather than another. If all moral agents would favor a certain conduct to be publicly allowed, and thus would accept the consequences also of others acting in the same way in the same circumstances, then that conduct is strongly justified. If no moral agents would favor a certain conduct to be publicly allowed, then that conduct is morally unjustified. If some would favor it and other not, then the conduct is morally controversial: one could act in that way but, depending on the context and the circumstances, one could also still be liable to punishment.

On GCC's view, this procedure grounded in common morality proves superior to principlism's reliance on content-thin, free-standing principles supplemented by specification and balancing. First, it preserves morality's public character, ensuring all moral agents operate within a shared framework rather than generating private interpretations through specification, and thus constantly adding content to the principles. Second, it incorporates a substantive criterion of impartiality that constrains moral deliberation, limiting the influence of personal interests and preventing moral reasoning from collapsing into sophisticated self-justification. Where principlism offers flexibility that masks arbitrariness, common morality provides structure that ensures genuine moral deliberation.

2.3 Third critique: the fundamental distinction between moral rules and moral ideals

GCC's third critique targets a blurring of fundamental moral distinctions that they see embedded in principlism's architecture. The four principles, they argue, fail to preserve the essential distinction between actions that morality requires and actions that it only encourages. This conflation undermines what they regard as a cornerstone of moral theory derived from Gert's account of the moral system: the structural difference between moral rules and moral ideals.

In Gert's theory, the system of common morality has three main components. One is the two-step procedure mentioned above. The other two are distinct but complementary components with different normative force. Moral rules are impartial prohibitions against causing direct harm—'Do not kill', 'Do not cause pain', 'Do not disable', 'Do not deprive of freedom or opportunity', and 'Do not deceive'. These rules are universally binding. As GCC explain, they share three defining features: «First, all are prohibitions against causing some harm or evil»[15]. Second, violating a moral rule makes one liable to punishment unless one has an adequate reason for such violation. Third, a moral rule, to be strict, must be capable of being impartially respected all the time by all persons. If this were

not the case, then people would be liable to punishment for failing norms that they cannot respect. Yet no rational agent would favor a moral system of that sort. Such a system would be self-defeating, as it would increase the chances of everyone to be arbitrarily harmed by others.

Moral ideals, by contrast, «encourage the prevention and relief of harm, but, unless one has a duty to do so, morality does not require following those ideals»[16]. Like the moral rules they are universal precepts of morality known to all, but differ in that they cannot be followed impartially and, crucially, no one could be punished for not respecting them. Aiding those in need provides an example: «Morality certainly does not require people to work for Oxfam or for Amnesty International, let alone both. It is not morally required to give or work for any charity, although morality certainly encourages such behavior»[17]. Following moral ideals always requires agents to be partial in allocating time and efforts—for one cannot relieve all suffering everywhere.

This fundamental distinction between moral rules and moral ideals is, on GCC's view, wrongly embedded within principlism's framework, turning even the specified version of the principles into confused guides for action. Among the four principles, only nonmaleficence properly functions as a moral rule, as it embodies the general negative commandment 'do not harm'. In contrast, the principle of justice is mostly empty, as «it does not even pretend to provide a guide to action» and is «the prime example of a principle functioning simply as a checklist of moral concerns»[18]. As presented in the PBE, «it amounts to no more than saying that one should be concerned with matters of distribution; it recommends just of fair distribution without endorsing any particular account of justice»[19].

The principles of respect for autonomy and beneficence, however, present a more complex and problematic case, as they systematically conflate moral rules with moral ideals. Consider first the principle of respect for autonomy. In some contexts, it functions as a moral rule—specifically, the prohibition against deception and coercion in medical practice. When a physician deceives a patient about diagnosis or treatment options, or when a patient is coerced into accepting an intervention against their will, clear violations of moral rules occur. These are instances where the principle tracks genuine prohibitions: 'Do not deceive' and 'Do not deprive of freedom'. However, Beauchamp and Childress extend the principle of respect for autonomy far beyond these rule-based prohibitions. They interpret it as requiring also positive actions to promote and enhance patient autonomy—providing extensive information, facilitating deliberation, supporting decision-making capacities, and creating conditions for autonomous choice. These positive requirements function as moral ideals rather than rules. This is a mistake: there is no general obligation to always promote everyone's autonomy as doing so would be impossible to follow impartially. No physician can devote unlimited time and resources to enhancing each patient's autonomous capacities. Yet by presenting these distinct normative demands under a single principle, principlism obscures whether respecting autonomy means refraining from interference (a rule) or actively promoting autonomous decision-making (an ideal).

The principle of beneficence exhibits a parallel conflation. At its core, beneficence as presented by Beauchamp and Childress combines two fundamentally different moral requirements. On one side, it includes the prohibition against causing harm—which properly belongs to the moral rule of nonmaleficence and should not be duplicated under beneficence. On the other side, it includes positive obligations to prevent harm, remove harm, and promote good. These positive obligations function as moral ideals. As GCC observe, preventing all harm and promoting all good for all patients would be impossible to follow impartially; healthcare resources and professional time are finite. A physician must make partial decisions about which harms to prevent and which goods to promote for which patients. Yet principlism presents beneficence as a single principle without distinguishing these categorically different moral demands. The result is systematic confusion about whether a particular obligation is a rule that must be followed impartially or an ideal that permits partiality in application.

This blurring has also significant practical consequences. When moral rules and moral ideals are conflated within single principles, practitioners lose the ability to distinguish between absolute prohibitions that admit of no exceptions (absent adequate justification) and aspirational norms that guide but do not strictly obligate.

The systematic framework needed to adjudicate between competing moral considerations dissolves. More fundamentally, by failing to ground bioethical principles in the systematic structure of common morality, principlism severs bioethics from its proper moral foundations. According to GCC, this results in the dangerous misconception that bioethical reasoning can proceed without systematic moral grounding, as if the medical context somehow exempted bioethical deliberation from the normative requirements at the basis of morality.

In sum, these three critiques all stem from principlism's deliberate renunciation of a systematic moral theory. The absence of theoretical grounding generates empty principles, discretionary specification without impartial procedures, and systematic conflation of rules with ideals. For GCC, these are necessary implications of attempting to practice bioethics without a prior systematic account of common morality. Beauchamp and Childress's responses, as we shall see, defend this theoretical abstinence as itself a reasoned position about how moral philosophy relates to biomedical practice.

3. PRINCIPLISM AND THE NORMATIVE INDEPENDENCE OF BIOMEDICAL ETHICS

Beauchamp and Childress have engaged in sustained dialogue with GCC's critiques across multiple editions of the *Principles*, culminating in their most comprehensive response in chapters two and ten of the eighth and final edition of their work. Their final replies reveal fundamentally different conceptions of what bioethical theory should aim to accomplish, operating within distinct methodological paradigms that often prevent genuine engagement with the substance of GCC's objections.

3.1 The reply to the first critique: embracing moral pluralism

To the charge that principles without an underlying theoretical foundation provide only a partial and incomplete guide for action, Beauchamp and Childress offer what appears to be a complete concession:

«We do not claim to have constructed either a general ethical theory or a comprehensive theory of the common morality, and we do not claim that our principles and methods are analogous to or substitutes for the principles and methods of justification in leading ethical theories, such as utilitarianism, with its principle of utility, and Kantianism, with its categorical imperative»[20].

They further acknowledge that their principles merely «order, classify, and group moral norms that require additional content and specification» and that until principles are «analyzed and interpreted [...] and then specified and connected to other norms [...], it is unreasonable to expect more than a classification scheme that organizes normative content and provides a basis for specific moral guidance» [21].

For Beauchamp and Childress, this admission reflects a deliberate methodological choice. To be justified, however, it needs to be considered within the expanded account of how the principles acquire content. In their view, practitioners never start from zero or encounter bare, unspecified principles as abstract starting points. Rather, moral deliberation always begins with at least four interconnected elements already in place: individual moral intuitions that agents bring to ethical reflection; the pre-theoretical layer of common morality consisting of socially recognized norms shared across communities; the framework of legal regulations and particular moralities that govern specific domains of practice; and finally, the ongoing process of wide reflective equilibrium that works to bring these diverse elements toward coherence over time. One could thus argue that GCC's critique, while theoretically accurate, misunderstands the practical orientation of principlism by assuming one begins moral deliberation from a theoretical vacuum.

This more nuanced response reveals that for Beauchamp and Childress the principles function not as free-floating abstractions awaiting content but as organizing frameworks for moral elements that already possess some determinate, if evolving, meaning. Through iterative processes of specification and wide reflective equilibrium, the four principles gradually acquire increasingly refined content while maintaining sufficient flexibility for contextual application. The principles thus operate within a rich normative landscape rather than a theoretical desert, drawing their initial content from multiple sources and achieving greater determinacy through repeated application to particular cases.

This response, however, is successful only in addressing the objection at how the principles acquire content, but it fails to answer GCC's fundamental challenge about normative authority and arbitrariness. The question is not whether principles can acquire content through these multiple sources—clearly they can and do—but whether this content possesses any legitimate normative force in the absence of theoretical justification. When Beauchamp and Childress extract autonomy from Kant while discarding his systematic account of rational agency, or adopt beneficence from Mill while rejecting utilitarian calculation, they sever these concepts from precisely the theoretical machinery that explains why they should guide action. What remains are conceptual frameworks that practitioners fill with content drawn from intuitions, social norms, and professional standards, but this process of filling lacks principled constraints that would distinguish legitimate from illegitimate specifications.

The anthology syndrome that Gert and Clouser identified emerges precisely from this theoretical vacuum. By presenting principles derived from mutually incompatible moral theories—Kantian deontology, Millian consequentialism, Rawlsian contractualism—as equally valid starting points, principlism implicitly endorses a form of moral eclecticism whereby practitioners can select whichever theoretical perspective suits their purposes in any given case. Beauchamp and Childress treat this eclecticism as a virtue, arguing that it allows principlism to capture insights from multiple moral traditions without being constrained by any single theory's limitations and without the need to preemptively solve any deep, underlying moral disagreement. Yet without criteria for determining when to apply which theoretical perspective, this flexibility becomes indistinguishable from arbitrariness, bringing to the fore the decisive objection of favoring only a parochial morality.

3.2 The reply to the second critique: specification without impartiality

The second critique comprises two interrelated charges: that specification renders principles private and local rather than public and universal, and that it lacks any procedure for impartial resolution of conflicts. Beauchamp and Childress's response to these challenges reveals what I believe are fundamental tensions in their theoretical architecture.

To the first charge—that specification privatizes moral principles—they offer no direct reply. The reason is that, for Beauchamp and Childress, biomedical ethics need not constitute a public system like common morality does in GCC's strict sense. Within biomedical ethics, they maintain that the four principles possess sufficient shared meaning among medical professionals to guide practice. While acknowledging that particular cases require varied specifications, the process of wide reflective equilibrium will gradually produce convergence over time, transforming initially divergent interpretations into stable consensus through repeated encounters with similar cases and sustained intersubjective confrontation. Yet this response does not explain why the consensus emerging from unconstrained specification represents genuine moral progress rather than mere parochial convergence. The deeper problem—which Beauchamp and Childress never adequately address—concerns the systematic absence of a substantive account or criterion of moral impartiality in all critical junctures of their model: specification, balancing and reflective equilibrium. This absence manifests at two distinct levels, each fundamentally compromising the system's normative legitimacy.

At the micro level of clinical decisions, the problem emerges with particular clarity. When a physician deliberates about withholding information from a patient, she simultaneously functions as advocate, arbiter, and judge in her own case. She alone evaluates the reasons, examines the case, assigns weights to competing values, and determines the actual duty. This structural arrangement creates what Sissela Bok aptly identifies as a «discrepancy of perspectives»—an inevitable tilt toward the decision-maker's own interests and viewpoints [22]. The physician who specifies 'respect for autonomy' to justify selective disclosure may sincerely believe her reasoning impartial, yet without external constraints, she remains captured by the gravitational field of her own perspective. At the macro level of principle specification, the problem compounds systematically. Medical professionals collectively shape what the principles mean in practice, often without sufficient input from those most affected by these determinations. When healthcare institutions specify 'justice' to prioritize institutional efficiency, or when profes-

sional associations interpret 'beneficence' to preserve clinical discretion, the resulting norms reflect existing power dynamics rather than impartial moral requirements. The process of wide reflective equilibrium, rather than correcting these biases, may instead aggregate the perspectives of those already within the system, potentially entrenching rather than eliminating partiality.

This malleability is not merely a theoretical weakness but carries significant practical risks, as the framework may inadvertently legitimate existing power imbalances. A prominent example of this risk can be found in the recent revision of the WMA International Code of Medical Ethics. While presented as a universal standard, the Code was primarily drafted and approved by the medical profession itself—the very group it is intended to regulate. As I have argued elsewhere, such a process raises critical questions regarding its political legitimacy [23]. In the absence of a broader and more inclusive consensus-building process, the resulting principles may reflect the specific interests and perspectives of a single professional group rather than a genuine common morality, thereby serving as a neutral-sounding 'moral veneer' that reinforces the *status quo*.

This structural deficiency presents principlism with an inescapable dilemma that admits only two solutions, each requiring fundamental theoretical revision. The first solution would incorporate a substantive criterion of impartiality to constrain specification, balancing and the overall process of reflective equilibrium. This is what GCC would advocate. Their sophisticated account of impartiality—imported from Gert "elliptical" view, which requires specifying both in which regard and with respect to what group one is "impartial"—provides operational constraints on moral deliberation[24].

The two-step procedure ensures that moral judgments counterbalance private interests or parochial values. First, one must describe the case using only morally relevant features that do not depend on anyone's specific knowledge or privileged position. Second, one must evaluate the foreseeable consequences of everyone knowing that a given conduct would be publicly allowed. This test of publicity transforms impartiality from an abstract ideal into a concrete procedural requirement.

Yet Beauchamp and Childress cannot embrace this solution without abandoning their commitment to theoretical minimalism. Any substantive account of impartiality—whether grounded in Kantian universalizability, the Rawls's original position, or Gertian view of morality as a public system—necessarily presupposes at least a minimal moral theory. But this is precisely what principlism refuses to accept. None of its constituent elements can supply the missing criterion: moral intuitions remain pre-theoretical and often conflict about what impartiality requires; common morality, as they conceive it, offers merely descriptive content about shared beliefs; wide reflective equilibrium provides a process, not a standard, and cannot generate its own criterion of assessment. Their sole acknowledgment of this requirement—the assertion that specifications must proceed from an 'impartial' standpoint—remains theoretically empty. Without defining what impartiality means, without specifying whether they intend Kantian, Rawlsian, Gertian, or some other conception, this requirement functions as a promissory note that principlism's theoretical commitments prevent it from ever redeeming.

The alternative solution would be to abandon any external criterion of impartiality altogether, and ground biomedical ethics purely in a deliberative process. Engelhardt's approach exemplifies this strategy, reducing bioethics to a series of contingent agreements reached within communities of moral strangers[25]. But following this path would transform principlism into something else entirely—a purely procedural theory where even the four principles become contingent outcomes of deliberation rather than necessary starting points. Nothing would prevent a community from adopting entirely different principles or abandoning their framework altogether.

The question of impartiality thus poses for principlism both a theoretical problem and a political challenge. Theoretically, it reveals a fundamental contradiction: principlism cannot simultaneously reject all moral theory while claiming to provide impartial moral guidance. Politically, it exposes how principlism may inadvertently legitimate existing power imbalances by providing no resources to critique specifications that favor dominant interests. The concept of impartiality requires theoretical specifications that Beauchamp and Childress do

not provide. This is not a peripheral difficulty but a structural impossibility—the price of theoretical abstinence is normative indeterminacy and partiality.

3.3 The reply to the third critique: positive duties and biomedicine

The third critique concerns what GCC regard as a fundamental conceptual confusion: the failure to distinguish between moral rules (what morality strictly requires) and moral ideals (what morality merely encourages). This charge reveals most clearly the strategic divergence between the two approaches, particularly regarding the respective assessments of the principles of beneficence and autonomy. Beauchamp and Childress reject GCC's accusation directly and comprehensively:

«in response to the Gert-Clouser criticism that the principle of beneficence expresses a moral ideal, not a moral obligation, our claim is that this thesis distorts the common morality. We acknowledge no requirement to benefit others everywhere that confers a benefit or prevents a harm—only to avoid causing harms or harmful events and conditions. Their thesis makes beneficence merely a moral ideal, and thereby misconstrues the commitments of the common morality, which requires some beneficent actions while recommending others as moral ideals»[26].

Their strategy is to demonstrate that even Gert's own theory must acknowledge some positive duties—particularly in easy rescue situations. They quote Gert himself admitting that when «a child collapses in your arms» there exists a genuine obligation to help, thereby undermining the strict dichotomy between rules and ideals that supposedly grounds the critique. By showing that even Gert recognizes this positive duty in his own theory, they argue that the rigid distinction between rules requiring only negative duties and ideals involving positive ones cannot be maintained. Regarding autonomy, they argue that GCC's rejection of positive duties to promote patient self-determination creates practical contradictions. Without obligations to provide information or enhance deliberative capacity, clinicians cannot ensure patients remain free from manipulation—a goal that even GCC's purely negative conception of autonomy requires.

Beauchamp and Childress see two problematic assumptions underlying GCC's critique: first, that biomedical ethics can be derived, entirely or to a large extent, from common morality without much supplementation; second, that principlism attempts to compete as a general moral theory alongside utilitarianism, Kantian ethics, or Gert's own systematic framework. But once put under scrutiny, both ideas become clearly indefensible. Let us start with the latter.

Beauchamp and Childress have consistently maintained that principlism has never aspired to become a comprehensive moral theory. From its inception, they have presented it as a framework tailored specifically for biomedical contexts. Understood in terms of a professional ethics, rather than of a moral philosophy, the supposed conflation between rules and ideals dissolves. Healthcare professionals operating within institutional roles clearly bear both negative and positive duties—obligations that arise not from universal moral requirements but from socially defined professional responsibilities, often incorporating idiosyncratic elements due to their sociocultural context.

GCC themselves appear to recognize this distinction, conceding that

«unless Beauchamp and Childress are describing the professional duties of health care workers, no principle requires us to assist persons in achieving their ends. Beauchamp and Childress do sometimes present their four principles as a way of grouping the special duties of health care workers, but they do this most often when talking about the principles of autonomy and beneficence [...]. It may be that Beauchamp and Childress› uncertainty about whether to regard the principles of autonomy and beneficence as general moral principles or as ways of grouping the duties of health care workers is what leads them to overlook this important distinction between moral rules and moral ideals»[27].

Yet this concession, casually interposed within a broader discussion, fundamentally undermines GCC's third critique. If biomedical ethics necessarily includes role-specific duties that cannot be derived from common morality alone, then it is natural to expect that the specific obligations of healthcare workers include both negative and positive duties. Teachers owe special duties to their students, parents to their children, physicians to their patients—duties

that are both positive and contextually defined. While these must not conflict with common morality's prohibitions, unless such conflict can be impartially and publicly justified, they cannot simply be deduced from them. Significantly, this uncontroversial recognition affects also GCC project of grounding medical ethics entirely in the shadow of the common morality system.

However, a crucial point must be noted: Beauchamp and Childress's countercharge that GCC misunderstand 'the common morality' by insisting on the rule/ideal distinction is itself mistaken. Their claim rests on a selective reading that misrepresents both Gert's theoretical position and the structure of his account of common morality itself. The example of the duty of easy rescue is particularly revealing. It is true that Gert revised his position on this matter along the years, acknowledging the existence of this duty only in his third edition. But as he makes explicitly clear, this represents the single exception within his entire system—a unique case justified only because the combination of minimal cost to the agent and enormous benefit to the recipient (preventing death or severe harm with virtually no sacrifice) makes it impartially acceptable. To generalize from this singular, carefully circumscribed exception to argue that common morality contains extensive positive obligations fundamentally mischaracterizes both Gert's meticulously constructed theory and the phenomenology of ordinary moral experience.

Nevertheless, the exchange illuminates a crucial insight about biomedical ethics' distinctive character. If healthcare professionals necessarily bear special duties that transcend universal moral requirements, then biomedical ethics cannot be purely derivative of common morality. It must incorporate professional norms, institutional expectations, and contextual specifications that vary across healthcare systems and cultural contexts. The question is not whether such duties exist—clearly they do—but how to theorize their relationship to general moral requirements without either reducing them to universal rules or abandoning theoretical coherence.

This returns us once again to the fundamental divergence identified throughout this analysis. GCC seek to ground biomedical ethics from systematic moral theory, moving from universal principles to particular applications. Beauchamp and Childress work in the opposite direction, beginning with professional practices and seeking organizing principles that capture their moral significance.

4. PRINCIPLISM, COMMON MORALITY, AND MORAL DISAGREEMENT IN CONTEXT

In their chapter on principlism, GCC included a section reconstructing the historical genealogy of the four-principle approach in its original context, noting that «the principles emerged from the work of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, which was created by Congress in 1974»[28]. At that time, they recall, clinical research was governed by a body of different codes, guidelines, laws and rules, that «seemed at times inadequate, conflicting, and difficult to apply»[29]. One of the main tasks of the Commission was therefore that of formulating «broader ethical principles [to] provide a basis on which specific rules may be formulated, criticized and interpreted»[30].

As it is well known, the Commission later released the *Belmont Report*, which had at its core the three principles (respect for persons, beneficence and justice) which then became the basis of the four-principles in the first edition of the PBE, published in 1979[31]. According to GCC, the principles for the *Belmont Report* were not derived from any systematic moral theory but were rather abstractions meant to summarize the main concerns in existing guidelines about human research. What is relevant for the present purpose is that, on GCC's view, «these formulations additionally accomplished a crucial maneuver for the Commission. They made possible a consensus in a setting where a more detailed account of morality never would have been agreed upon»[32].

If this genealogical reconstruction is correct, it aids to elucidate that principlism, inasmuch as it was initially influenced by the experience of the Presidential Commission and the method that resulted in the consensus expressed in the *Belmont Report*, has always been a situated response to two very practical concerns. One is the need to address and possibly solve urgent problems in biomedicine—in the case of the *Belmont Report*, identifying general

principles to guide research with humans. The other concern, instead, is that of confronting such urgent issues in the face of what seems to be an insurmountable state of interpersonal moral disagreement. It is because of this moral disagreement that principlism starts by rejecting any foundational moral theory. For, if moral pluralism does exist, then subordinating the shared resolution of common practical issues in biomedicine to a foundational moral theory would become a hopeless task, as no agreement will ever be possible on which moral foundation one ought to adopt.

GCC advocate a different view, one that acknowledges the presence of frequent and often irresolvable disagreement about many aspects of the moral life, including the controversial issues that arise in biomedicine, from abortion to euthanasia. In difference to Beauchamp and Childress, however, for GCC this recognition does not compel also a commitment to moral pluralism. Rather, it is taken as an index of the fact that the system of common morality is an informal system that does not and cannot provide a unique solution to all controversial moral issues. Depending on one's individual ranking of values, subjective factual assessment, estimates of probability and interpretation of the norms and extension of morality, it is possible for two moral agents who are equally informed, impartial and rational to still disagree on what ought to be done in specific cases. For GCC, moral theories «that provide no explanation or justification for unresolvable moral disagreement are incomplete; those that claim there are no unresolvable moral disagreement are false»[33].

This, however, does not subtract from the fact that, despite these wide areas of irresolvable moral disagreement, the system of morality is one and the same for anyone. Like a loosely structured game, there might be divergent views on what ought to be done in specific circumstances, but there is no genuine disagreement on the most basic rules of the game, which are shared by everyone.

By foregrounding these exchanges, the present article has argued that both approaches suffer from complementary limitations. GCC are right to identify the absence of a unified theoretical foundation as a genuine weakness of principlism—one that leaves the four principles vulnerable to the charge of enabling rationalization rather than guiding deliberation. Yet their alternative presupposes that biomedical ethics can be derived from a systematic account of common morality, underestimating the extent to which practical bioethical problems might require conceptual tools that no abstract moral theory can provide.

What emerges from the debate, then, is not simply a disagreement about which moral theory is correct, but a more fundamental divergence about the proper starting point of bioethical inquiry itself. GCC work from morality toward medicine; Beauchamp and Childress work from medicine toward morality. This directional opposition—which might be characterized as philosophy-to-practice versus practice-to-philosophy—illuminates why the exchange so often resembles two ships passing in the night. The standards by which each side evaluates the other are internal to their respective conceptions of what bioethical theorizing should accomplish.

This philosophical divide generates distinctive vulnerabilities in each approach. Principlism, beginning from pluralism and eschewing theoretical foundations, provides flexible vocabulary for bioethical deliberation but lacks resources to distinguish legitimate specification from sophisticated rationalization. Without a unified moral framework constraining interpretation, the principles risk becoming malleable tools that practitioners can shape to justify predetermined conclusions. GCC's common morality theory, conversely, offers systematic coherence and clear justificatory structure but confronts persistent challenges regarding its practical applicability. The theory's sophistication creates barriers to widespread adoption, and bioethicists and clinicians seeking guidance for urgent practical decisions may find the theoretical apparatus unwieldy compared to principlism's accessible framework.

Whether these complementary limitations might open possibilities for integration rather than mutual exclusion remains an open question. Such an endeavor would require both approaches to evolve: principlism would need more robust accounts of legitimate specification, perhaps drawing on common morality theory's analysis of impartial rationality; common morality theory would need to address more directly how its framework can guide practical deliberation in concrete biomedical

contexts. Exploring whether and how such integration might be achieved is a task for future inquiry.

NOTE

1. For a reconstruction of the origins of principlism, see Albert R. Jonsen, *The Birth of Bioethics* (New York: Oxford University Press, 1998); David J. Rothman, *Strangers at the Bedside: A History of how Law and Bioethics Transformed Medical Decision Making* (New York: Aldine de Gruyter, 1991); and Enrico Furlan, *Il principialismo di Beauchamp e Childress. Una ricostruzione storico-filosofica* (Milano: Franco Angeli, 2020). For a contextualization of principlism in bioethics in Italian, see Massimo Reichlin, *Fondamenti di bioetica* (Bologna: Il Mulino, 2023).

2. T. L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics*, (New York: Oxford University Press), first ed. 1979; second ed., 1983; third ed., 1989; fourth ed., 1994; fifth ed., 2001; sixth ed., 2009; seventh ed., 2013; eight ed. 2019. I will henceforth use "PBE" to refer to the *Principles*, followed by the number of the edition and the pages.

3. To my knowledge, a systematic and critical genealogy of principlism from the point of view of its relationship with Gert's common morality is yet to be completed. From a chronological point of view, the main texts would be the following: PBE, first ed., 1979; second ed., 1983; third ed., 1989; D. K. Clouser and B. Gert, "A Critique of Principlism," *Journal of Medicine and Philosophy* 15 (1990): 219–36; R. M. Green, B. Gert, and K. D. Clouser, "The Method of Public Morality versus the Method of Principlism," *Journal of Medicine and Philosophy* 18, no. 5 (1993): 477–89; B. Gert and K. D. Clouser, "Morality vs. Principlism," in R. Gillon (ed.), Principles of Health Care Ethics, Chichester: John Wiley and Sons, 1994, pp. 251–66; T. L. Beauchamp and J. F. Childress, PBE, 4th edition, 1994; C. M. Culver, "Common Morality as an Alternative to Principlism," *Kennedy Institute of Ethics Journal* 5, no. 3 (1995): 219–36; B. Gert, C. M. Culver, and K. D. Clouser, *Bioethics: A Return to Fundamentals*, New York: Oxford University Press, 1997; Bernard Gert, Charles M. Culver, and K. Danner Clouser, «Common Morality versus Specified Principlism: Reply to Richardson», *Journal of Medicine and Philosophy* 25, no. 3 (2000): 308–322; PBE, fifth edition, 2001; B. Gert, C. M. Culver, and K. D. Clouser, *Bioethics: A Systematic Approach*, second edition, New York: Oxford University Press, 2006. Subsequent editions of the

PBE were published in 2009 (sixth edition), 2013 (seventh edition), and 2019 (eighth edition).

4. Beauchamp and Childress, *Principles* 8th ed., 428.

5. K. Danner Clouser and Bernard Gert, «A Critique of Principlism», *Journal of Medicine and Philosophy* 15 (1990): 219. The introduction of the article sounds even more direct: « Throughout the land, arising from the throngs of converts to bioethics awareness, there can be heard a mantra '…beneficence… autonomy…justice…' It is this ritual incantation in the face of biomedical dilemmas that beckons our inquiry» (Clouser and Gert, 1990: 219).

6. Rosamond Rhodes, "Why Not Common Morality?" *Journal of Medical Ethics* 45, no. 12 (2019): 770–77, https://doi.org/10.1136/medethics-2019-105621.

7. Beauchamp and Childress, *Principles*, 8th ed., 428. As Beauchamp and Childress write in *Preface* to the 4th edition, «Biomedical ethics was a young field when the first edition of this book went to press in late 1977. Immense change occurred in the field literature between the first edition and the present, fourth edition. Although major changes have appeared in all editions after the first, this edition includes more significant changes than any other […] Several articles critical of aspects of our book have appeared in the literature of biomedical ethics in recent years. Although we do not always concur with our critics, we are especially grateful to our friends John Arras, Dan Clouser, Bernie Gert and Ron Green for some very probing and often penetrating suggestions» (PBE, 4th: viii). The irony of having identified the basis of principlism in common morality went not unnoticed. In the revised chapter devoted to their critique of principlism, in the first footnote, GCC write that «Perhaps in response to our previous criticisms, Beauchamp and Childress now claim that common morality is the basis of principlism […] it is somewhat ironic that they claim that common morality is the basis of principlism, for we have continually used common morality as the basis or our criticism of principlism» (GCC, 2006: 126-127).

8.Gert, Culver, and Clouser, *Bioethics*, 72.

9. Gert, Culver, and Clouser, *Bioethics*, 99.

10. In a 1995 article, Clouser clearly described what he defined as the Gert/Clouser account of morality with the following words «The role of moral theory, as we understand it, is to give a systematic account of the ordinary morality that is practiced day in and day out. More particularly, moral theory is an ongoing attempt to explain and justify common moral intuitions. Ordinary moral experience is our starting point. After all, morality cannot be *invented* […] We must begin with the moral system that is actually used by thoughtful people in making decisions and judgments about what to do in particular cases» (Clouser, 1995: 228).

11. This article examines only these three general criticisms, though reconstructing them requires interpretive work beyond what either side makes fully explicit. Both GCC and Beauchamp-Childress prove remarkably inconsistent in how they articulate their respective positions—presenting critiques and responses in varying formulations that obscure their comprehensive theoretical commitments. This expository opacity, particularly surprising given GCC's emphasis on systematic clarity, likely reflects two factors: first, these arguments have evolved across three decades of exchange, accumulating local refinements and tactical adjustments; second, each side's representation of the other's position often diverges from how that position understands itself.

12. Beauchamp and Childress, *Principles*, 4th ed., 103.

13. Gert, Culver, and Clouser, *Bioethics*, 109.

14. In this article I focus, like Gert, Clouser and Culver, only on the role of principles in principlism. However, it has to be noted that throughout the various editions Beauchamp and Childress progressively assigned a bigger role to other moral elements, like the virtues. I shall not discuss these aspects in the present essay. For a discussion, see Furlan 2020.

15. Gert, Culver, and Clouser, *Bioethics*, 115.

16. Ibid.

17. Gert, Culver, and Clouser, *Bioethics*, 115.

18. Gert, Culver, and Clouser, *Bioethics*, 111.

19. Ibid.

20. Beauchamp and Childress, *Principles*, 8th ed., 431.

21. Beauchamp and Childress, *Principles*, 8th ed., 430.

22. See Sissela Bok, *Lying: Moral Choice in Public and Private Life* (New York: Pantheon Books, 1978); and Marco Annoni, *Verità e cura. Dalla diagnosi al placebo, l'etica dell'inganno in medicina*, (Pisa: Edizioni ETS), 2019.

23. See Marco Annoni, "Toward a Global Bioethics: Principlism and the Problem of Political Legitimacy," Bioethics 40, n. 1 (Giugno 2025): 5–11, https://doi.org/10.1111/bioe.13434, and Marco Annoni, "Vaghezza, dilemmi morali e legittimità politica: un'analisi teorica dei limiti del nuovo Codice Internazionale di Etica Medica," Notizie di POLITEIA XL, n. 154 (2024): 87–107.

24. On Gert's "elliptical" concept of impartiality see Bernard Gert, Morality: Its Nature and Justification, rev. ed. (New York: Oxford University Press, 2005), especially ch. 6; for a discussion see *Rationality, Rules and Ideals. Critical Essays on Bernard Gert's Moral Theory*, edited by Walter Sinnott-Armstrong and Robert Audi, (Lanham: Rowman & Littlefield Publishers), 2002.

25. H. Tristram Engelhardt, *The Foundations of Bioethics* (Oxford: Oxford University Press, 1996).

26. Beauchamp and Childress, *Principles*, 8th ed., 217.

27. Gert, Culver, and Clouser, *Bioethics*, 113.

28. Gert, Culver, and Clouser, *Bioethics*, 107.

29. Gert, Culver, and Clouser, *Bioethics*, 108.

30. Ibid.

31. However, this does not imply that the PBE and the *Belmont Report* are the same, or that the PBE is a simple expansion of the conclusions reached by the Presidential Commission; for a fuller account see Furlan, *Il principialismo di Beauchamp e Childress*, and Jonsen, *The Birth of Bioethics*. However, the claim here at stake is that the experience that resulted in the consensus reached in the Belmont Report was a crucial turning point in the elaboration of the PBE methodological framework.

32. Gert, Culver, and Clouser, *Bioethics*, 108.

33. Gert, Culver, and Clouser, *Bioethics*, 107.

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