Principlism's Colonial Ties

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Abstract

Since the establishment of modern bioethics in standardized medicine in the mid-late 20th century, the paradigm of Principlism has dominated its teleological landscape. This dominance is largely attributable to the success of the book, *Principles of Biomedical Ethics*. The multi-faceted nature of the titular principles defined within effectively describe, advise against, and adapt to a wide variety of ethical issues in medicine. However, these principles are not without flaw.

This work will demonstrate that Principlism fails to adequately address its relation to and continuation of colonialism in clinical healthcare. More specifically, I argue that the Principlist paradigm is foundationally entangled with colonial thought – a mindset that permits the health-based oppression of Indigenous persons in countries such as Canada under the appearance of “ethical” conduct. This entanglement will be illustrated by presenting the core arguments of *Principles of Biomedical Ethics* against a backdrop of colonial wrongdoings involving medicine and Indigenous persons. The discord between these wrongdoings and the paradigm’s espoused righteousness reveal that Principlism avoids anti-colonial ideas about persons’ moral considerability – among other things – while also minimizing the importance of persons’ existence as communal and interrelated beings.

The project concludes that these inadequacies can be improved upon by reconstructing the existing edifice of Principlist thought. This reconstruction has two facets: 1) presenting the existing core principles as virtue-based rules to better express an active obligation towards morally sound healthcare, and 2) adding a fifth, hitherto underappreciated, virtue rule about humility to the paradigm. Altogether, these revisions create a more robust paradigm that can approach and encourage anti-colonial healthcare. I do not suggest that the arguments presented here will definitively decolonize healthcare; this is but a step in that direction.

Preface

The *Cultural Safety* subsection in Chapter 3 owes many of its ideas to a previous original work of mine, “Smith, Eric, ‘Safely Embracing Culture: The Adequacy of the Cultural Safety Paradigm in Canadian and American Indigenous Healthcare’, in *Minorities in Canada: Intercultural Investigations*, ed. by Miklós Vassányi, Judit Nagy, Mátyás Bánhegyi, Dóra Bernhardt, and Enikö Seps (L’Harmattan, 2021), pp. 245–65”. The subsection of this thesis has not been published elsewhere as it is presented here, but many of its ideas and phrasing rely on this previous work.

Acknowledgements

Discussing the merits of the theories behind healthcare provision is imperative for improving the health of the global community. However, the value of this discussion is limited by the parties involved. Philosophers locked in a proverbial ivory tower may debate on how to better care for “the people”, but this means little if the ideas of said people are not adequately involved. This issue becomes even more pronounced in the context of this work: a single philosopher, locked to their couch due to a pandemic, putting to paper a discussion of issues caused by a White community to which I belong and faced by an Indigenous community to which I do not. While this fact may reduce the value of my discussion on its face, I hope to have found ways to mitigate the influences of my sociocultural positioning.

With this mitigation comes concerns about my partaking in some form of self-defensive “cancel culture”. That is, in virtue of highlighting some of the issues with “bad” or at least indifferent White people, I implicitly remove myself from being one of the oppressors. However, this removal is neither my personal objective nor the goal of the project. I do not pretend to think that this project is some whistle-blowing exposé on White people or Whiteness in general that should grant me asylum. Rather, it is a critique of existing power and power I also act with.

To these ends, I extend my gratitude towards my supervisors Drs. Jennifer Welchman and Jessica Kolopenuk for helping to check and balance my personal echo chamber as this project has developed. Moreover, I am extremely thankful for the times in my life I have been allowed to be part of the discussion surrounding Indigenous communities. Whether they have been close friendships, professional collaborations, or academic pursuits, they have all been incalculably eye-opening to my still naïve understanding of the world. I undertake this project as another step in the process of developing a more holistic sense of improved healthcare for everyone.

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Introduction

Principlism, one of the most pervasive approaches to bioethical issues, posits that moral obligations in the medical sphere are encompassed by a set of distinct, yet equally important *prima facie* principles. In other words – according to principlist approaches – healthcare practitioners are at their most moral and effective when abiding by several core tenets in a series of ethical considerations[1]. Although there is notable disagreement on what these considerations should be and/or how healthcare practitioners are supposed to abide by each principle simultaneously, most of this disagreement is overshadowed by the dominance of a single variant of the principlist doctrine, the "four principle" paradigm[2]. The monopoly held by this paradigm (and the pervasiveness of principlist frameworks as a whole) primarily stems from Tom Beauchamp and James Childress' book, *Principles of Biomedical Ethics* (hereafter, PBE). In a way, PBE is the handbook of principlism.

While the word "monopoly" often carries a negative connotation of close-minded dominance, Principlism – in its handbook-like status – is not entirely dictatorial. If a paradigm is truly the best at deriving positive outcomes in healthcare, it should be expected that other paradigms are given less credence. PBE has and continues to demonstrate its ability to benefit healthcare (or at least police its degradation), so it makes sense that it holds the power that it does. Indeed, it would be willfully ignorant to assume that PBE has solely maintained its influence by leveraging inertial complacency and/or a collective apathy towards improving the state of bioethical issues. If this assumption were true, new editions of PBE would not reflect the significant changes that they often do (the book is currently on its eighth edition since first being published 40 years ago). However, even with the eagerness for improvement that Beauchamp, Childress, and the greater Principlist medical community possess, some important change has yet to come. Such is the case in PBE's address of colonialism and its institutional oppression of Indigenous[3] persons.

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[1] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 8th edn (New York: Oxford University Press, 2019), 15; see also Robert M. Veatch, 'How Many Principles for Bioethics?', in *Principles of Health Care Ethics*, ed. by R. E. Ashcroft and others, 2nd edn (John Wiley & Sons, 2007), 47.

[2] In this work, the capitalized term "Principlism" is used to refer to the four-principle paradigm from PBE. The lowercase term "principlism" is used to refer to moral theories that employ principles in general (which includes, but is not limited to, Principlism); see Veatch, 43–50; see also K. Danner Clouser and Bernard Gert, 'A Critique of Principlism', *Journal of Medicine and Philosophy*, 15.2 (1990), 219–36.

[3] The term "Indigenous" imperfectly encapsulates all the peoples and the richness/complexity of the peoplehoods it intends to refer to here. However, it is the most common designator for the persons who reside(d) on native land that was overtaken by European colonial forces; see the *Colonialism & Indigeneity in Canada* section in Chapter 1 for

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Indigenous persons in Canada and the United States – the countries in which PBE has the most direct influence – experience inequities across many broad measures of health[4]. Despite these inequities (and the medical field's long-standing knowledge of them), only marginal improvements have been made to lessen these health concerns[5] during PBE's forty-year tenure. Indeed, contrary to popular understandings of the "more ethical" medicine practiced today, the medical sphere has played no small part in worsening Indigenous health over the last half-century[6]. Of course, these shortcomings are not entirely attributable to Principlism; the paradigm is embedded within a network of colonial institutions that have and continue to disadvantage Indigenous persons[7]. Correspondingly, bioethics exists within an expansive medical framework that is being constantly roughed and refined by colonial interests and Indigenous resistance[8]. Any reasonable critiques of Principlism should therefore not condemn PBE as the *sole* contributor to ineffective Indigenous healthcare. However, PBE is still a *key* contributor. Even if a Canadian healthcare provider has never read PBE, it is more than likely that their governing body encourages them to operate under the same principles espoused by Beauchamp and Childress[9]. Although there are several other important colonial forces worthy of extensive critical revision[10], PBE is a far-reaching text from which the interpersonal[11] and structural alterations[12] required to improve Indigenous-directed healthcare can be seeded.

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particulars; see also Ron Mallon, '"Race": Normative, Not Metaphysical or Semantic', *Ethics*, 116.3 (2006); see also Katherine Ritchie, 'Should We Use Racial and Gender Generics?', *Thought*, 8.1 (2019).

[4] Charlotte Reading and Fred Wien, 'Health Inequalities and the Social Determinants of Aboriginal Peoples' Health', *National Collaborating Centre for Aboriginal Health Centre*, 2009; Indian Health Service, 'Disparities', *The Federal Health Program for American Indians and Alaska Natives*, 2018; Statistics Canada, 'Life Expectancy', *Aboriginal Statistics at a Glance*, 2015 <https://www150.statcan.gc.ca/n1/pub/89-645-x/2010001/life-expectancy-esperance-vie-eng.htm>, 1.

[5] Melody E. Morton Ninomiya and Nathaniel J. Pollock, 'Reconciling Community-Based Indigenous Research and Academic Practices: Knowing Principles Is Not Always Enough', *Social Science and Medicine*, 172 (2017), 29–33.

[6] As Chapter 1 will thoroughly demonstrate.

[7] Yin Paradies, 'Racism and Indigenous Health', *Oxford Research Encyclopedia of Global Public Health*, 2018, 4-8.

[8] Jessica Kolopenuk, 'Provoking Bad Biocitizenship', *Special Report: For 'All of Us?' On the Weight of Genomic Knowledge*, Hastings C.3 (2020), S23–29.

[9] For example, all human medical research in Canada is governed by the Tri-council Policy Statement (TCPS2) – an "ethics framework" based on the "core principles" of "Respect for Persons, Concern for Welfare, and Justice" – and the Canadian Medical Association's Code of Ethics and Professionalism (among other clinical practice guideline documents) recommend the same "commitments" (p.2).

[10] Such as land ownership disputes and Indigenous political sovereignty mandates; see Eve Tuck and K. Wayne Yang, 'Decolonization Is Not a Metaphor', *Decolonization: Indigeneity, Education and Society*, 1.1 (2012), 1-7, 27.

[11] Silke Schicktanz, Mark Schweda, and Brian Wynne, 'The Ethics of "Public Understanding of Ethics'-Why and How Bioethics Expertise Should Include Public and Patients" Voices', *Medicine, Health Care and Philosophy*, 15.2 (2012), 129–39.

[12] Paradies, 8-10.

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To understand how these alterations may be made, it is worth briefly expounding on the titular principles of Principlism. Although they will be detailed more thoroughly in Chapter 2, the loose summary given here will serve to contextualize how Principlism's contributions currently have few things to say against colonial medicine.

Beauchamp and Childress' approach centres on the four principles of respect for autonomy, nonmaleficence, beneficence, and justice. In PBE, these four principles serve as a sort of charter for medical ethics[13]. For any moral obligation in the medical sphere to be considered legitimate, it must be consistent with at least one of the principles without simultaneously clashing with another in an intense way[14]. For example, a rule requiring that all physicians harvest at least 2 organs from each of their patients cannot be considered a morally legitimate obligation because it is unclear which principle such a rule might align with, and it clearly presents an intense conflict with each member of the core[15]. There are four distinct principles because each of these core members contains unique *prima facie* obligations (the particulars of which have changed over the course of each edition[16]) that, when taken as a whole (and coupled with a variety of virtues), encapsulate the central obligations of healthcare providers. This includes what the authors call "specifications" (i.e., subsidiary principles, which tend to take the form of rules) that provide more contextually-relevant guidance for the complex circumstances wherein persons attempt to adhere to the principles.

While each of the four core principles are equally important (i.e., *prima facie* binding), their circumstantial importance varies and must be balanced according to the context in which they are employed[17]. For example, when considering their obligations in delivering health services, a physician may judge that respecting the autonomy of patient X, given patient X's circumstances, is more important than any other principle; thereby leading their obligations to manifest as a full disclosure of diagnostic information accompanied by a thorough process of patient-centred

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[13] Veatch; Bernard Gert and K. Danner Clouser, 'Morality vs. Principlism', in *Principles of Health Care Ethics*, ed. by Raanan Gillon and Ann Lloyd (Chichester, England, 1994), 251–66.

[14] Conflict between the principles alone is insufficient to render something immoral. There are many cases in which rules and/or obligations are consistent with one principle, but clash with another. The *intense*, morality-determining conflicts are those that require the *complete abandonment* of one or more principles to resolve them.

[15] A staunch Utilitarian could argue that such a rule would provide a net good to society (i.e., principled alignment) through the increase in available organs for people on transplant waiting lists; but said Utilitarian is hardly concerned with the pluralistic sort of morality in Principlism, so such an argument means little here.

[16] John D. Arras, 'Principlism: The Borg of Bioethics', in *Methods in Bioethics - The Way We Reason Now*, ed. by James Childress and Matthew Adams (Oxford University Press, 2017), 1–26.

[17] Beauchamp and Childress, 19-23; 430.

treatment planning. The physician may also judge that for patient Y, given patient Y's circumstances, the principle of justice is the most important consideration and will therefore be much choosier with how much is said to the patient for fear of crossing a line, opting instead to focus more on equitably treating this patient based on their condition. As these examples demonstrate, exactly how one should balance the principles is not always clear. PBE gives some guidance to this end, but admits that "experience and sound judgment are indispensable allies"[18] that cannot be wholly converted into a checklist for moral balancing.

This seems to suggest that Beauchamp and Childress permit moral relativism. So long as a healthcare provider is using "sound judgement", they can justify using completely different courses of principled actions for different patients "according to the context". This also seems to permit two different providers appraising "the context" differently, thereby arriving at different courses of action. However, this is not the argument being forwarded. Beauchamp and Childress believe that there is a right way to go about employing a balanced compliment of the four core principles. This "right" way may be context-dependent, but it does not mean that people can retroactively justify any decision by simply appealing to a principle. Instead, Beauchamp and Childress believe that morally committed healthcare providers will tend to converge on the right way of operationalizing Principlism because they all share a commitment to a set of norms that provide the foundation for the principles.

According to PBE, this overarching set is a universally agreed upon series of moral rules, which the authors call the "common morality"[19]. These rules are common insofar as they are presumed to be ascribed to by all people[20] and part of morality insofar as these people are also moral agents. Moral agents are apt to ascribe to these rules because they help to promote human flourishing in most (if not all) contexts. As such, rules like "do not kill"[21] are part of the common morality because all moral agents concur that abiding by this rule helps to promote human flourishing. These sorts of rules are the metric for formulating each of the core principles (which, in turn, inform specifications of these beliefs for guidance in particular circumstances). If a

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[18] Ibid., 430.

[19] While a summary of the common morality will be given here, a much more in-depth description is given in the section, *Principles from Rules and Principles to Rules* in Chapter 2.

[20] Supposedly including people oppressed by current institutions of power.

[21] Beauchamp and Childress, 3.

principle (or rule/virtue) captures some mandates of the common morality, then it is morally right. If something seems to go against the common morality, then said thing is morally wrong.

While the common morality functions as a bulwark against charges of relativism, one may wonder why – given the intuitable nature of this set of *moral* obligations – equally intuitable *immoral* practices exist and/or persist at all[22]. For example, many of the reprehensible behaviours linked with Canada's colonial history continue to this day[23], yet we still systematically fail to excise these issues, despite our supposed knowledge of the so-called common morality. Not wanting to ignore this glaring problem, Beauchamp and Childress' clarify that the common morality – despite its universality and eye for flourishing – "is not where it should be"[24] – particularly in terms of its ability to clearly identify/oblige equitable moral considerability.

This admission quickly brings into question how universal the tenets of the common morality are (and if this universal set operates impartially). Indeed, it admits that certain people are deemed more morally considerable (or at least more worthy of certain treatment) than others under this "common" morality; a fact that hardly insinuates universal approval.

Without the backdrop of a universal morality, Person A could think that only As are owed moral considerability, while Person B could think that only Bs are owed moral considerability. Irrespective of A or Bs actual entitlement to moral consideration, if the As outnumber the Bs or happen to possess more resources for lobbying their case, Bs at large will not be granted as much moral consideration as As. This exact sort of scenario plays out in the ever-present context of colonial medicine, where Indigenous people are disparaged at the behest of the "civility" or "moral excellence" of European settlers[25]. Simply by virtue of the exertion of majority force, European ideals are made "common" or "normal" and subsequently render proximity to Indigenous ways-of-life "rare" or "odd". With the backdrop of a universal morality, we *should* have the tools to prevent this conflation; at least some members of the universal accord would recognize such problems being made manifest. However, the common morality, as described, does not properly acknowledge such members.

Assuming that Beauchamp and Childress are correct in supposing that there is *some* common morality underlying the primary obligations of biomedicine, the admitted difficulties of

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[22] Beyond the "slip-ups" that are bound to happen from the rare bad-faith actor and/or mistake.

[23] See the end of Chapter 1 for *some* (of the most widely publicized) examples of this.

[24] Beauchamp and Childress, 447.

[25] See the *Colonialism & Indigeneity* section of Chapter 1 for examples of this.

their depiction do not bode well for the core principles. Can the principles effectively promote moral obligations and reject immoral behaviours, despite their source needing improvement? Are the principles able to detect and encourage the excision of colonial legacies as immoral? Progress to date (or lack thereof) is not reassuring.

Although this work is far from the first to note the shortcomings of Principlism, it does hope to be one of the first to argue that Principlism lacks a proper address of the colonial oppression admitted by its core principles and the common morality, particularly in the realm of clinical ethics[26]. Clinical care was chosen as the area of focus because it has yet to receive the same attention as research about Indigenous people[27] and because it is the "omega point upon which the actions of individual doctors as well as the whole health care system converge – that moment when some human being in distress seeks help from a physician within the context of a system of care"[28]. Simply put, clinical care acts as a metric of success in healthcare more generally.

By drawing on Indigenous critiques of clinical healthcare in Canada, this thesis explores the ways by which Principlism permits (and occasionally encourages) healthcare providers to act in ways that preserve colonialism and promote Indigenous ethnocide[29]. After revealing these inequitable permissions, the thesis aims to reconstruct the core components of Principlism into tools for fighting colonial harms in contemporary healthcare. Although these tools take the form of mere words – a paltry contribution compared to the Indigenous-led initiatives required for decolonization proper – language's power as a *bridge* to (but not a replacement for) decolonial progress is still worth assessing[30]. Put eloquently by John Arras, "moral progress often depends as much on finding (or fashioning) the right words as on applying the right principles"[31]. For settlers like me, the progression of our morals is a necessary step in opening our eyes to the social progress we are still far from achieving.

Chapter 1 will explore the historical rise of colonial healthcare in Canada to help understand its oppressive power today. Chapter 2 will delve into PBE to address the common morality and

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[26] There have been many excellent Indigenous critiques of bioethics, many of which can and do apply to Principlism's colonial grounding; many of them are mentioned throughout this work.
[27] See the *"Decolonizing" Saviours* section in Chapter 1.
[28] E. D. Pellegrino, 'The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions', *Journal of Medicine and Philosophy*, 26.6 (2001), 560.
[29] Indigenous ethnocide and colonialism are not synonymous, but are similar; see *Colonialism & Indigeneity in Canada* in Chapter 1 and Richard Matthews, 'Health Ethics and Indigenous Ethnocide', *Bioethics*, 33 (2019), 829.
[30] Paul Mikhail Catapang Podosky, 'Privileged Groups and Obligation: Engineering Bad Concepts', *Journal of Applied Philosophy*, November (2019), 4.
[31] Arras, 17; see also Richard Rorty, *Contingency, Irony and Solidarity* (Cambridge University Press, 1989), 9.

the four core principles as they are argued for by Beauchamp and Childress. Chapter 3 contains several sections: the first, *Addressing Principlism*, describes the gaps in PBE's argumentation and how they are tied to colonial healthcare; the second, *Redressing Principlism*, details two of the most successful attempts at amending Principlism's colonial ties (despite their being indirect attempts) and describes the ways in which they leave certain things to be desired. Chapter 4 meets this desire with a proposal for a proper reconstruction of Principlism that paves the way for a healthcare system that leans critically into its settler roots and welcomes calls for Indigenous governance and decolonization.

Chapter 1: Handshakes, Papers, and Saviours

In the same manner as Beauchamp and Childress[32], this work is a combined drawing from history and moral theory. The arguments throughout this critique employ this combination because they operate under the assumptions that: 1) effective ethical reasoning cannot exist in a vacuum, and 2) the line between descriptive and normative ethics is blurred at best[33]. It may be amusing to philosophize on how we can redistribute, rework, or reorient healthcare provision from a blank slate, but these musings will certainly miss key historical/formulative aspects of systems in need of direct address. Instead, if the time is taken to understand moral missteps of the past, we are not only made more capable of avoiding the repetition of history but are also given the tools to perceive and manage novel instances of morally mistaken behaviour. One would not expect a discourse on colonialism to only note how colonial ideas impact the world today for these very reasons. The historical structure of colonialism's ethos needs to be understood to minimize its impacts and guard against its reoccurrence. Similarly, Principlism (and, to a substantial degree, bioethics as a whole) cannot be disentangled from colonialism[34], so including descriptive elements of its history is imperative for a complete assessment of its normative merits. This chapter aims to illuminate these descriptive elements.

At the outset, it is worth noting that any discussion of injustices against Indigenous persons is not benign. Indeed, discussing trauma that I have little experience being on the receiving end of is easier for me than it may be for others. I can walk away from this history in the current

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[32] Beauchamp and Childress, 1.

[33] Erica Haimes, 'What Can the Social Sciences Contribute to the Study of Ethics? Theoretical, Empirical and Substantive Considerations', *Bioethics*, 16.2 (2002), 99-107.

[34] Kolopenuk, S24.

political climate with little in the way of change on my life, Indigenous persons cannot. At the same time, it is for this reason that discussing colonial history is so important. Doing justice to this project requires being as much a part of the history of Principlism as the foremost experts on it: those who make it, and those who experience its impacts.

What follows is a truncated depiction of the history of colonialism in Canadian healthcare or – more properly – Indigenous-settler relations through Canadian healthcare. While colonial history will be discussed in general, particular attention will be paid to the mid-late 20th century. The focus on this timeframe is relevant because of its coincidence with the publishing of the first edition of PBE and the events that shaped its contents. While the "Handshake" era – from the first colonial encounters up until the mid-19th century, the "Paper" era – which lasted throughout the 20th century, and the "Saviour" era of today[35] all contain swaths of valuable historical knowledge, their particularities fall outside the scope of this work[36]. Altogether, this chapter aims to illustrate *how* colonialist healthcare has and continues to oppress Indigenous groups, which will subsequently reveal a more nuanced version of *what* colonial influence is in Principlist bioethics today. Possible avenues for recognizing and mitigating this influence are explored in the Chapters that follow.

Colonialism & Indigeneity in Canada

In Canada, the term "colonialism" refers to the institutions and mindsets that permit (and/or encourages) the relegation of Indigenous people to a sociopolitical and/or spaciotemporal margin of society[37]; a margin opposed to the mainstream in which European settlers (and their

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[35] The names of each era mentioned here have been chosen by me and are not (to my knowledge) commonly accepted identifiers of colonial history, nor should they be considered comprehensively accurate to Canadian colonial history. This being said, the "Handshake" era (lasting from approximately 1500 CE to 1867 CE (Canada's confederation)) refers to the period in which Indigenous-settler relations in "Canada" were primarily marked by agreements/altercations between persons or groups. The "Paper" era (lasting from approximately 1870 CE to 1979 CE (the time of PBE's first publishing)) refers to the period in which Indigenous-settler relations were primarily determined by Canadian governmental mandates and policies. The "Saviour" era (lasting from approximately 1980 CE to today) refers to the period in which Indigenous-settler relations are primarily defined by an internalized understanding that Indigenous people are things to be saved, not people in need of empowerment.

[36] For a detailing of the "Handshake" era, see James Daschuk, *Clearing the Plains* (University of Regina Press, 2013). For a detailing of the early "Paper" era, see Maureen K. Lux, *Medicine That Walks - Disease, Medicine, and Canadian Plains Native People, 1880-1940*, 3rd edn (University of Toronto Press, 2012). For a detailing of the later parts of the "Paper" era, see Maureen K. Lux, *Seperate Beds - A History of Indian Hospitals in Canada, 1920s-1980s* (University of Toronto Press, 2016).

[37] Sherene H. Razack, 'When Place Becomes Race', in *Race, Space, and the Law: Unmapping a White Settler Society* (Toronto: Between the Lines, 2002), 3.

descendants) are encouraged to grow and thrive while Indigenous persons are oppressed in the expectation that their culture and peoples will eventually disappear[38]. More specifically still, colonialism is largely based in the withholding of land as "property"; the creation of "categories of proprietaryness [that] are born of the episteme of Western culture, which has made manifest the existence of order functioning through the logic of possession"[39]. In other words, European settlers frame Indigenous land and bodies as possessions owned by them and use this "ownership" to enforce and perpetuate a societal dominance. This is accomplished through the application of externally and internally[40] focused policies that work to "authorize the metropole and conscribe her periphery"[41]. The more entities the eponymous colonies of colonialism own, the more power colonists have, and the easier it is to relegate Indigenous personhood as something that is undesirably other. This othering can apply from anything ranging from social exclusions to entire structures of moral considerability[42].

The description of colonialism presented helps illustrate two things. Firstly, it draws attention to the fact that colonialism is more than mentalities and actions between persons. While interpersonal actions are *part* of colonialism, the system has many more tendrils – which include geographical and political aspects[43] – that are all worthy of address as an intersecting matrix. Holding this more holistic understanding of what colonialism is gives us the theoretical space to extend PBE beyond its current focus on interpersonal boundaries. Secondly, specifying that

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[38] Although this definition is technically more akin to a specific form of colonialism, "settler colonialism", wherein colonists live in (i.e., "settle" on) native land and supplant its customs (see Tuck and Yang, (p.1–7)), the general term "colonialism" will be used going forward for the sake of simplicity. It is also worth noting here that this "colonialism", despite being about "colonies" in a sense, is about more than a group of people being a sect of some motherland; it has to do with the supplanting of Native persons, not just the place from which the settlers may have come or remain beholden to.

[39] Aileen Moreton-Robinson, *The White Possessive: Property, Power, and Indigenous Sovereignty*, ed. by Robert Warrior (Minneapolis: University Of Minnesota Press, 2015), xxiv.

[40] Externally focused colonialism aims to naturalize resources for exploitation, while internally focused colonialism works to directly entrench ideas about settler superiority.

[41] Tuck and Yang, 5.

[42] Although the colonial mindset in Canada shares some features of other discriminatory "-isms", colonialism is unique insofar as it is larger in scale, directed towards members of native land (and their possession), and profoundly concerned with relegated erasure of fabricated difference, not just haphazard opposition to it. I also recognize that this still does not necessarily distinguish colonialism from concepts like fascism or Naziism. However, the point being made here is that colonialism is wide-ranging and deliberate to such extremes that many colonizers are unaware of the relegation they partake in; it is not a small or easily solved problem.

[43] In colonies like Canada, particularly in modern day, the "metropole" and the "periphery" have a great deal of overlap. Discourse over land, personage, and sovereignty cannot exist in isolation (as much as the Canadian government has historically tried to make possible with programs like Residential schools). In virtue of occupying and making use of the space that is also being marginalized, the "strictly personal" aspects of colonialism also involve non-personal factors.

colonialism is an active institution of oppression helps to avoid conflating the term with bigoted and argumentatively unsatisfactory definitions like "anything that is bad for Indigenous people"[44]. Colonialism is not a buzzword for social justice in the name of Indigenous communities; it is about actions that intentionally make everyone "colonized"[45]. Some people are deemed members of the colony while others are relegated to be outsiders.

Relegation has and continues to be a factor in the disproportionate burdens of illness faced by Indigenous people[46]. This is the case for colonial institutions in general, but especially so in healthcare. The more relegation is encouraged, the less likely Indigenous persons will be to seek out medical treatment (if it is even made accessible). Consequently, existing health concerns become increasingly difficult to ameliorate and a vicious cycle of essentialist and racist healthcare[47] is perpetuated. That is, health inequalities reinforced by an absence of care eventually come to be viewed as defining "characteristics"[48] of Indigenous persons that are incurable, despite being matters of circumstance, not personage. Tuck and Yang use the clever portmanteau "a(s)t(e)risk peoples"[49] to demonstrate the two primary perceptions about these "characteristics" of Indigenous persons: *at risk* – being naturally more prone to illness and/or more vulnerable to environmental alterations, and *asterisk* – being an addendum of society rather than the primary focus of concern.

In the interest of avoiding the continuance of these perceptions, examples of the disparities in health between settlers and Indigenous persons will be kept to a minimum[50]. Endlessly repeating uncontextualized health statistics does not speak to the injustices they may be the result

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[44] This is like definitions of racism such as, "the thing that persons of colour complain about when things don't go their way". The definition shirks responsibility from the oppressor and places the problem in the hands of the oppressed. If colonialism is just "something bad for Indigenous people" it becomes a matter of misfortune rather than something that could and should have been avoided.

[45] Tuck and Yang, 17.

[46] Ian Mosby, 'Administering Colonial Science: Nutrition Research and Human Biomedical Experimentation in Aboriginal Communities and Residential Schools, 1942-1952', *Social History*, 46.1 (2013), 145–72; Maureen K. Lux, 'Perfect Subjects: Race, Tuberculosis, and the Qu'Appelle BCG Vaccine Trial.', *Canadian Bulletin of Medical History*, 15.2 (1998), 277–95.

[47] Morton Ninomiya and Pollock, 28.

[48] Iris Marion Young, 'Equality of Whom? Social Groups and Judgments of Injustice', *Journal of Political Philosophy*, 9.1 (2001), 12-5.

[49] Tuck and Yang, 22.

[50] Although I will not discuss them here, I recommend the following for some particular examples of health disparities (to be used as reference points for the effects of the cycle of relegation, not evidence of Indigenous people being less than): For life expectancy disparities, see the previously referenced numbers from Statistics Canada and the Indian Health Service. For examples of Indigenous persons being used as convenient research proxies instead of being treated as patients, see Mosby; see also Lux, 'Perfect Subjects'. For social determinant based disparities, see Reading and Wien; see also Daschuk, 13.

of[51]. Changing the critical target to the institutions that allow for disparity grants us an understanding of Indigeneity beyond being numerically and constitutionally deficient.

To this end, it is helpful to loosely understand what Indigeneity in Canada is. "Indigenous" is a social group identifier that is rooted in a sense of collective belonging to native land[52] and its many facets (biotic and abiotic)[53]. The identity expression of the term Indigenous, Indigeneity, is therefore granted and upheld by a person's continued relation to the communities of native land[54]. There are many distinct Indigenous communities in Canada[55], all of whom have their own distinct cultures. Although a sense of collective belonging, among other broad-stroke philosophical paradigms are often shared amongst the groups hailing from the native land of North America[56], much of this sharing is the result of a settler lens of pan-Indigeneity. However – despite not being a particularly accurate indicator of the "biobehavioural"[57] essence or experiences of an individual person (much in the same way "White" does not perfectly describe the personal identity of all European settlers[58]) – "Indigenous" does encapsulate some degree of shared beliefs and experiences. Correspondingly, the term is also used as a designator for groups of people who face the structural injustices of colonial policy[59]. Canadian Indigeneity can therefore roughly be defined as a sense of identity based in social connectedness to native land as well as a shared experience of colonial oppression (even if it is indirect (e.g., intergenerational).

This is an oversimplification of Indigeneity and what it means to be Indigenous in Canada. However, this oversimplification helps to set the stage for the more detailed aspects of Indigenous critique that will reveal themselves throughout this work. Chapters 2, 3, and 4 will

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[51] Young, 16.

[52] "Native" here could be understood to roughly refer to one's ancestral place of origin, though this is ambiguous since said origin would be subject to change depending on how far back in the cosmological timeline we travel to locate our ancestry (e.g., the line "our home and native land" in the Canadian national anthem could be technically considered correct for descendants of settlers if we define "native" as "3 generations prior"). As such, it is more appropriate to think of "native land" as a noun itself, referring to a place on Earth inhabited by communities that once formed their basic social structures of life within.

[53] Gregory Cajete, *Native Science: Natural Laws of Interdependence*, 2000, 94.

[54] However, the expression of Indigeneity will vary drastically by the person and the group(s) that they belong to.

[55] The primary groups are the Inuit, First Nations, and Métis, but each of these groups have many distinct communities and identities.

[56] Shay Welch, 'Radical-Cum-Relation: Bridging Feminist Ethics and Native Individual Autonomy', *Philosophical Topics*, 41.2 (2013), 206.

[57] Mallon, 529.

[58] Although it does, however, do a good job of describing the power structure that European settlers exist within.

[59] Ritchie, 37.

help to expound on the nuances of Indigenous refinement against PBE, while the remainder of this chapter will help to detail what the "shared experience of colonial oppression" is.

Handshakes and Papers

The relegation cycle of colonialism in Canada goes back centuries, but it is nearly impossible to pinpoint when it began. One could argue that it began with the first arrival of French/English "explorers" on the Eastern shores of what is now known as Canada. However, this would mean that simply being present on native land constitutes colonialism, which seems untrue given the fact that other people had sailed to "Canada" long before this, but are rightly not classified as colonizers. Instead, one could argue that the cycle of colonialism began when a settler first refused to abide by the customs of the land (i.e., established a colony) and/or made significant transgressions against an Indigenous person[60]. While refusals/transgressions of this kind are more akin with colonialism, this argument also does not do much to illustrate how such obstinance evolved into systemic oppression.

Despite this indeterminacy, what is at least clear is that the Fur Trade Era (which roughly lasted from the early 17th century to the mid-19th century) was instrumental in embedding colonialism in "Canada". This early period involved ebbs and flows of Indigenous populations as they continued to increase their involvement with European settlers[61]. Much has and continues to be written about this period and I cannot do full justice to it here. Distilled to its most important colonialism-embedding points, this era was predominantly made up of Indigenous and settler "handshakes" – the creation of promises, possessions, and structures of power – which paved the way for settlers to renege on their promises and turn indifferently from the consequences of their seizure of power.

Settler patterns of indifference towards Indigenous death have changed little since this early period, though they have become more systematized. The cycle goes as follows: 1) Indigenous populations and power are dwindled through intentional and/or opportunistic means, 2) economic resources are "discovered" in the midst of Indigenous communities and labeled proprietary by the settlers, 3) settlers lord the promise of returned power over Indigenous people

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[60] The term "transgression" here could mean many things: a physical harm, the displacement of land/culture, the transmission of illness (be it physical (i.e., smallpox or mental (i.e., addiction)), etc.

[61] Daschuk, Chapter 2; Lux, *Medicine That Walks*, 12-17.

in exchange for the opportunity to extract said resources, 4) Indigenous groups reluctantly agree to work for the settlers in this resource extraction, thereby making themselves resources as well. Occasionally, the cycle may appear broken when a settler actor, through a recognition of this oppression, attempts to use their (often monetary) power to support the independence of Indigenous peoples[62]. However, simply by presuming that the means of helping is to participate in commodifying colonial structures, such well-intentioned actors will only exacerbate the problem. *Settlers cannot, without complete removal from it, be the end of the cycle*[63].

For centuries, this cycle of indifferent (or poorly reasoned) economic fervour persisted with a strong focus on the resources of fur and land[64]. As the number of key trade and life-sustaining species like beaver and bison dwindled due to the demanding fur trade, land became the primary focus of settler economics. Specifically, settlers were determined to make land claims in Western "Canada", yet untapped. These claims were not only highly profitable, but crucial to legitimizing the newly minted country of Canada (1867)[65]. As they progressed in their legitimacy campaign, the Canadian government also began to push the creation of devoutly Christian[66] hospitals that would act as sanatorium spaces to protect settlers from the "consumption" (tuberculosis) epidemic that was plaguing Indigenous groups who were quickly losing land and food[67]. Despite resistance to these institutions and the occupation of the West in general[68], the Canadian government was successfully using proselytizing and fear-mongering healthcare systems to hone its procedure for indifference against Indigenous ways of life.

As rates of illness, malnutrition, and mortality increased, many Indigenous groups entered into contracts with the Canadian government in hopes of preserving the economic and political sovereignty they still held[69]. The agreements signed during this "treaty period" were, and

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[62] For example, "supporting Indigenous people" by using the relative wealth of White persons to purchase and own Indigenous art or artifacts.

[63] An important note about the capacity of this project that I, a settler, am hoping will make change.

[64] Daschuk, 22, 106-7.

[65] The Canadian Constitution Act (1867) §91(24) granted the Canadian government "exclusive Legislative Authority" over "Indians, and Lands reserved for the Indians" as it did over material things such as banks, hospitals, and prisons.

[66] Lux, *Separate Beds,* 20, 43.

[67] Daschuk, 173.

[68] Most famously, armed resistances led by Louis Riel (1869) and other Métis individuals (1885) at trade hubs that connected Eastern and Western Canada (i.e., Winnipeg and Kenora). However, there was constant resistance from Indigenous groups all along the occupation of Canada.

[69] Importantly, not all Indigenous groups signed such treaties or ever ceded land to the Canadian government, despite occupation by colonial forces. There are still several unceded Indigenous territories within the Canadian border and the sovereignty of these territories has been hotly contested.

continue to be, some of the most influential pieces of documentation on Indigenous-Canadian life. Many treaties were phrased as being binding "for as long as the rivers flow, the grass grows, and the sun shines". In other words, they were intended to apply indefinitely. The first set of documents signed during this period, the Numbered Treaties (1871-1877), were phrased in terms of offering the "Queen's kindness" to Indigenous parties in mid-Western Canada. Signing Chiefs often specified the nature of this "kindness" as some amount of food, tools, money, or clothing for their people[70]. Treaty 6, headed by Chiefs Sweetgrass and Poundmaker, is particularly notable for being the only Numbered Treaty to specify the provision of government-supplied medical care[71]. Despite these formal agreements, the government persistently argued that "neither law nor treaty"[72] compelled federal or provincial offices to provide medical assistance to First Nations[73]. Even in the rare cases where medical assistance was provided, it was more concerned with proselytizing than it was providing necessities like food or holistic medicine[74].

It was through these treaties and the Indian Act (1876) that the Canadian government "inaugurated an aggressive assimilationist agenda that would attempt to transition what it defined as Indians into civic life"[75]. This agenda would also apply to Indigenous groups that were not in the mid-West and, as such, had not necessarily signed treaties with the government. Through a series of amendments and addendums to the Indian Act[76], Indigenous people were forced to live in close-quarters squalor (i.e., on reserves), work farm jobs that they did not have the tools to

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[70] Lux, *Medicine That Walks*, 24, 26.

[71] Specifically, the treaty involves two clauses: 1) a pestilence clause – "That in the events hereafter of the Indians comprised within this Treaty being overtaken by any pestilence or by a general famine, the Queen, on being satisfied and certified thereof, by her Indian Agent or Agents, will grant to the Indians , assistance of such character as to extent as here Chief Superintendent of Indian affairs shall deem necessary and sufficient to relieve the Indians of the calamity that shall have befallen them", and 2) a medicine chest clause – "a Medicine Chest shall be kept at the house of the Indian Agent for the use and benefit of the Indians at the discretion of the Agent." <http://treaty2.com/index.php/medicine-chest-treaty-6/> Accessed 11 August, 2020.

[72] A phrase uttered by the Minister of National Health and Welfare, Brooke Claxton in 1946. In the longer passage from which this quote is extracted, he goes on to say that the eradication of illness in Indigenous populations is for the "necessary protection to the rest of the population of Canada" and based in "humanitarian reasons".

[73] Lux, *Separate Beds,* 148; Mary Jane Logan McCallum and Adele Perry, *Structures of Indifference - An Indigenous Life and Death in a Canadian City* (Winnipeg, MB: University of Manitoba Press, 2018), 89.

[74] Daschuk, 197; Lux, *Medicine That Walks*, 4.

[75] Kolopenuk, S23.

[76] Some notable original points and amendments: relocation to reserves was made mandatory, food and supplies would be supplied to reserves based on agrarian-based output, and right to government aid were based on patriarchal bloodlines, and; in 1895, §114 was added to limit or ban traditional healing dance practices and attendance at residential schools was made mandatory; in 1914, amendments are made to encourage Indigenous persons to avoid alternative and/or "dispensary" forms of medicine, but attend hospitals instead, hospital attendance was later made compulsory in 1951; in 1953, amendments criminalized any Indigenous person's disobedience of medical orders.

succeed in[77], and have their children taken to "study" at assimilatory and proselytizing Residential Schools. All of this greatly exacerbated existing issues such as malnutrition and the tuberculosis epidemic. This also fuelled the fires of settler fears about Indigenous "savagery"[78] creeping into "civic life". If evidence of Canadian healthcare's ineffectiveness was not already apparent, the number of living Indigenous persons from the treaty period until 1890 was at its lowest point in recorded history[79].

As Canada moved into becoming an even more "civilized" country in the early 20th century, the federal government began to target Indigenous groups' (already tenuous) participation in formalized healthcare settings. The fact that Indigenous people *could* hitherto access hospital care had proved enough to fully instill fears of the continued spread of "savagery" to areas of Canada outside of reserves[80]. Consequently, when the first federal Department of Health was established in 1920 (in wake of the influenza pandemic) Indigenous people were intentionally excluded from partaking in its creation[81]. This exclusion served to further the idea that Indigenous health (or lack thereof) was the product of lesser race or biology[82]. Since race is not actually determinant of health in this way[83], federal officials were able to quickly point out that curing Indigenous people, as Indigenous people, was a losing battle. Indigenous persons came to be viewed as pathological beings rather than products of ameliorable determinants of health influenced by social policy and environmental change.

While the remainder of the first half of the 20th century saw little in the way of service to ameliorate Indigenous health issues, the 1930s saw the continuation of a profound interest in the

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[77] Lux, *Medicine That Walks*, 150, 164; Daschuk, 185, 204, 224.

[78] "Savage" being a common slur for Indigenous persons around the world. A quote from a newspaper of the time: "The natives of this land are fully up to the buzzards of the south. Few deceased animals escape their rapacious maws. A horse died a few nights ago on the street opposite to our office, and at early dawn we beheld a posse of native beauties cutting up the dead animal a la buffalo mode of past days, and conveying it to camp, where a grand gorge was being prepared." Saskatchewan Herald, 4 July 1881, 1; see also Sir William Francis Butler, *The Great Lone Land*, 1872, 250.

[79] Daschuk, 229.

[80] Although the Bryce Report (1907) and the Lafferty Report (1908) had already been published, both identifying governmental policy as the primary catalyst of illness in Indigenous populations, these reports were either not made public or ignored by government officials who instead opted for a fear-mongering approach; see Lux, *Medicine That Walks*, 124, 127-8.

[81] As such, they were also largely excluded from benefitting from the services that it provided to the rest of the citizenry; see Daschuk, 235.

[82] Lux, *Seperate Beds*; Daschuk, 234-43.

[83] Being part of a certain "racial group" is a social determinant of health insofar as it influences the ways people of other groups treat a person and/or grant said person opportunities. However, this does not mean that being of a particular "race" biologically predisposes someone to a certain quality of life.

study of "Indigenous pathology". From 1936 to 1945, in the wake of the Depression and Second World War, Indigenous persons were officially placed under the auspices of the Department of Mines and Resources[84], who instructed hospitals to remove "all Native people with chronic conditions"[85] from their care. For the Indigenous persons who were still able to find hospital care, they quickly found themselves left to choose between a sanatorium[86] or no care at all. This opened the floodgates for interested parties to begin conducting long-term studies on illness in debilitated (and/or "less evolved"[87]) populations that they could not procure elsewhere[88]. R.G. Ferguson took this opportunity to test out the efficacy of the new bacillus Calmette-Guerin (BCG) tuberculosis vaccine on Indigenous children at the Fort Qu'Appelle Sanatorium (which only allowed Indigenous patients on the grounds that they would not be taking a bed from a White patient[89]). Despite BCG's efficacy already being experimentally proven several times over elsewhere[90], Ferguson and his funding body found it prudent to ensure that nothing was left to chance. By inoculating 306 of the 609 Indigenous infants that participated in the study[91], the hope was to provide a control that would demonstrate the vaccine's efficacy. While this demonstration was certainly accomplished, this essentially condemned 303 infants to death in the deplorable conditions in which the government forced them to live. Several years later, Lionel Bradley Pett organized a series of similar nutritional experiments on Indigenous children in residential schools[92] with the goal of determining the effects of type and amount of food on overall well-being. Despite possessing the obvious knowledge that these children were lacking anything resembling a basic healthy diet, the study proceeded and observed many preventable deaths. Neither Ferguson nor the operators of these nutritional experiments were unusually malicious; they were conducting what was considered important confirmatory science.

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[84] Daschuk, 235; Lux, 'Perfect Subjects', 290.

[85] Lux, *Medicine That Walks*, 219.

[86] Although sanatoriums were considered best practice for some illnesses – often irrespective of class or race – the "treatments" provided there did not nearly approach what was given in hospitals. Sanatoriums were relatively secluded, often unregulated facilities that could allow for many people to receive "treatments" like long periods of basking in the sunlight and being exposed to fresh air (a common procedure for tuberculosis patients at the time). For Indigenous persons suffering from serious, treatable maladies, sanatoriums would rarely suffice.

[87] Lux, 'Perfect Subjects', 277.

[88] Mosby, 152, 167.

[89] Lux, 'Perfect Subjects', 280.

[90] Ibid., 281-2.

[91] Ibid., 289.

[92] Mosby, 158-64.

The parallels of these studies to the notorious Tuskegee syphilis study that ran from 1932-72[93] are striking. These studies were government funded, were based on presumptions that individuals' health status was largely determined by race and was therefore immutable, procedurally required ignoring available treatment options that could save lives, and involved conduct that would be deemed morally reprehensible if performed on "more civilized" settler populations. While the Tuskegee syphilis study was not the product of colonialism *per se*, the fact that such a notoriously abhorrent study shares most of its features with colonial medical research should be cause for reflection.

As experiments of these sorts became increasingly common in the post-war era, so too did the recognition that Indigenous health is the result of poor living conditions. Papers documenting this evidence begin to pile up, and the government was forced to produce policy that addressed these concerns. One of these policies was to sanction and build "Indian Hospitals", but these were almost always critically underfunded or run for assimilatory purposes[94]. Gone were the days of explicit proselytization, but they had been replaced by a staggering absence of any adequate services whatsoever. Incidentally, Indigenous tuberculosis rates did decrease after this, but this was almost entirely attributable to the advent of antibiotic drugs, not deft political maneuvers[95].

The post-war period also saw the advent of Medicare in Canada in 1968 and an ever-increasing movement of Indigenous persons from reserves into urban centres that continues today[96]. The new universalized organization of hospitals, coupled with the radical improvements in medical technologies around this time promised great things for all members of the country. However, to be considered eligible to benefit from this new medical regime, people had to prove that they were not in the periphery of "universal" care's reach, which meant being free of

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[93] This study involved studying the effects of latent Syphilis on 600 low income African-American men in Tuskegee, Alabama. Participants were never told the actual nature of the study, instead being told they were being subjected to treatments for the general ailment of "bad blood." Treatments ranged from toxic untested products to placebos, none of which did much of anything to cure the participant's illness. Even after the creation of readily available penicillin (the best proven treatment for Syphilis) in 1947, participants were still left untreated; see Vanessa Northington Gamble, 'Under the Shadow of Tuskegee: African Americans and Health Care', *American Journal of Public Health*, 87 (1997), 1173–78.

[94] Lux, *Seperate Beds*, Chapters 1-4.

[95] Daschuk, 235.

[96] Stewart Clatworthy and Mary Jane Norris, 'Aboriginal Mobility and Migration: Trends, Recent Patterns, and Implications: 1971–2001', in *Volume 4: Moving Forward, Making a Difference*, ed. by Jerry P. White and others (Thompson Educational Publishing, Inc, 2013), IV, 207–34.

entanglements with reserve and/or Treaty policy. Clearly, membership to Canadian civility was still locked behind an assimilatory door.

Just one year after the adoption of these (clearly incomplete) universal healthcare ideals, the infamous White Paper of 1969 was nearly passed. This policy aimed to eradicate treaty rights altogether for the sake of starting anew, integrating Indigenous persons into Canada without historical baggage[97]. Moreover, this proposal aimed to definitively assert that healthcare provisions to Indigenous groups up until that point had been generous, not obligatory, in the hopes of disentangling the government from historical blame. This proposal did not go through and was swiftly responded to by the writing of the Red Paper[98] by the Indian Association of Alberta in 1970. Even if Canada's colonial history could be forgotten, it is impossible to ignore, including the most seemingly beneficent corners of society. As McCallum and Perry note, "[h]ospitals are not jails, foster homes, or residential schools. Yet hospitals have a particular place within the network of institutions and institutional practices that continue to regulate, and not infrequently imperil, Indigenous lives in settler colonial Canada"[99]; the often-obfuscated assimilatory role that structures like hospitals play cannot be forgotten. This role is part of their design. The large hole in healthcare service for Indigenous persons exists for a reason and this reason needs to be faced head on if there is to be any hope of fixing it.

"Decolonizing" Saviours

Regardless of the period in Canadian history, the pattern of indifference towards Indigenous persons[100], conjoined with a passion for commodification, persists. This pattern is so pronounced that the discussion hitherto almost seems irrelevant to the focus of this work, Principlism in clinical care settings.

It seems reasonable to assume that most healthcare providers acknowledge that systemic racism is an issue in Canada. Knowing the history explained thus far would likely help healthcare workers understand how systemic racism has persisted, but it does not change the fact that people already know systemic racism to be a problem. However, it is important to

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[97] Ibid., 97; Lux, *Seperate Beds*, 153.

[98] While the facets of this response are incredibly revealing pieces of the shortcomings of the Canadian government, the title of the document alone is rather indicative of the statement of the presence and importance of "Red" people (an archaic term for Indigenous persons) despite attempts of White suppression.

[99] McCallum and Perry, 69-70.

[100] And subsequent disenfranchisement from healthcare.

understand the particulars of how this problem has manifested. The history described thus far details that relegation of Indigenous persons was a constant, but the resources "discovered" amid Indigenous communities that led to this relegation have changed over time. It began with an exploitation of land, labour, and furs, which transitioned to primarily land; once the land was claimed by Canada, Indigenous bodies became the primary resource for exploitation: first for assimilated labour, then for research. This most recent exploitation of Indigenous persons for research coincided with the uptake of the budding field of medical ethics, which sought to prevent further harms to vulnerable populations. As such, the groundwork for Principlism and clinical Indigenous medicine is tightly bound to this research interest.

Indigenous persons' treatment as objects of scientific inquiry over the last century also happened to coincide with Nazi human experimentation during the Second World War. The affront to humanity imposed by the Nazi regime made all too clear that a field of ethics was needed that could extend the existing frames of best medical practice to hitherto unacknowledged intersections with greater society[101]. At the time, the first intersection to address was human subject research. The more quickly and effectively Nazi-esque research could be stymied, the better suited the biomedical sphere would be to extending its moral boundaries. As such, the infancy of bioethics was predominantly defined by the regulation of research. This regulation centered around promoting respect for the autonomy of research subjects, which was intended to directly combat the perverse experimentation of the recent past. If the subject's autonomy is respected first, morally reprehensible research cannot easily rely on external sources to justify its existence[102]. Consequently, the latter half of the 20th century saw a myriad of movements that reduced the prevalence of autonomy infringing human research. For example, the Declaration of Helsinki (1964)[103] was crucial in Canada's later development of the Social Sciences and Humanities Research Council (SSHRC) Guidelines and the Medical Research Council Guidelines on Research Involving Human Subjects[104]. During this time, numerous

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[101] These intersections had clearly been demonstrated by settler treatment of Indigenous patients for years, but these demonstrations were largely ignored until Nazi Germany made the parallels plainly obvious.

[102] Stephen Joseph Tham, *The Secularization of Bioethics - A Critical History* (Ateneo Pontificio Regina Apostolorum, 2007), 275-81; Joel Feinberg, 'Personal Sovereignty and Its Boundaries', in *Harm to Self (The Moral Limits of the Criminal Law)* (New York: Oxford University Press, 1986), 52–3.

[103] Built off the Nuremburg Code, which was written as a response to the trials of Nazi officials/doctors who planned and operated human experiments during the Second World War.

[104] Mosby, 167.

Indigenous sovereignty movements were also beginning to gain traction[105], and the academic discipline of Native studies was formed. All of these shared a common goal of allying with Indigenous reclamations of autonomy against oppressive research. Done correctly, this process hoped to embolden Indigenous sovereignty, enshrine legal recognitions, seek reconciliation with settlers, and allow for decolonization[106].

Decolonization, linguistically referring to the process of undoing the effects of colonization and colonialist ideologies, is a far departure from the indifferent and proprietary attitudes of the past. Rather than being a future-oriented pursuit of settler progress, decolonization requires a historically-oriented pursuit of rectifying oppression. More specifically, it requires the manifestation of reparations for/of Indigenous life, land, and power. It is impossible to decolonize by continuing to "progress" the way we have, because we will only continue to walk in the wrong direction. The power structures and corresponding rules of ownership through which the world is understood need to be reformed in such a way that we come to see the world more accurately and fairly. As eloquently put by Tuck and Yang, "[d]ecolonize (a verb) and decolonization (a noun) cannot easily be grafted onto pre-existing discourses/frameworks, even if they are critical, even if they are anti-racist, even if they are justice frameworks" [107]. More than simply being an Indigenous brand of social justice, which can operate in tandem with existing structures, decolonization demands a reconstruction of systems and paradigms.

At the end of my Introduction I note that the moral progression of the settler mindset is a required step in the decolonial process. I immediately follow this by suggesting that we can make such progress by reconstructing PBE. However, as the last paragraph correctly identifies, this suggestion is doomed to fail – it is impossible to decolonize by continuing to "progress" the way we have. Even if I am suggesting large changes in a foundational text like PBE, I am still ultimately positing that pre-existing frameworks should be made better, not replaced entirely.

I am ashamed to say that I had not come to this realization until this project was well underway. Indeed, I was once of the mind that I – at least being somewhat conscious of the unjust advantages I am given in Canada as a White settler – could use my education, position,

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[105] Such as the publishing of *Wahbung: Our Tomorrows* by The Indian Tribes of Manitoba in 1971 and movements led by Vine Deloria Jr., Olive Dickason, Jeannette Henry, and D. Scott Momaday, to name a few.

[106] Among other related avenues having to do with reforming existing systems of oppression.

[107] Tuck and Yang, 3.

and time to meaningfully fix what is clearly broken[108]. As the writing of this document progressed, I found it increasingly difficult to put words to paper; I knew (but stubbornly ignored) that the words I wrote were not doing what I said they were. My project could not accomplish a fraction of the decolonization that I had hoped it might because it was structurally incapable of decolonizing at all.

Consequently, the goal of this project shifted to something it could accomplish – *anti-colonialism*, which aims to *reduce* colonial harms. Although this is not an eradication or reversing of colonialism, it can still improve society by stymieing it. That is, Canadian society can morally progress by decreasing the number and/or severity of wrongful harms committed against Indigenous people. As small as the steps may be, the tools provided in this work can at least serve as part of a bridge towards a decolonized future.

The institutional standards of "decolonization" today – which have (wrongly) informed my own opinion on the reparative powers I hold – are also limited to anti-colonial progress. Existing institutions have everything to lose by enacting truly decolonizing policy. As such, nearly every instance of "decolonizing" behaviours in Canadian healthcare today are misnomers; if they are truly decolonial, we would not recognize them as they are. This is also why the "Decolonizing" in the title of this subsection is in scare quotes; the efforts currently made to make up for the colonial mistakes of the past are not decolonizing, they are merely anti-colonial (if even this applies). Nonetheless, there are some genuine efforts in healthcare to meet the bare minimum of recognizing the oppressive nature of colonialism.

Today, research with Indigenous persons in Canada must prove itself in accordance with several codes of ethics before it can proceed. The main code this research must align with is the *Tri-Council Policy Statement* (TCPS 2). More specifically, the ninth chapter of the TCPS 2[109], which details the guiding principles of effective and anti-colonial research involving Indigenous persons. These principles are quite similar to those of Principlism: respect for persons[110], concern for welfare (which encapsulates both nonmaleficence and beneficence), and justice[111]. This

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[108] I think it could easily be argued that I am still of this mind. I am publishing this thesis after all.

[109] Government of Canada, 'Chapter 9: Research Involving the First Nations, Inuit and Métis Peoples of Canada', *TCPS 2 (2018)*, 2018.

[110] Despite the word "persons" being substituted here in place of the term "autonomy" used in PBE, the emphasis on what is to be respected about a person, according to the TCPS 2, is their autonomy.

[111] Government of Canada, *TCPS 2*.

similarity is no coincidence[112]. However, beyond their similarities, research about Indigenous peoples is further bolstered by other frameworks like OCAP[113] (Ownership, Control, Access, Possession), which explicitly promotes the sovereignty and worth of First Nations groups involved in research[114]. Whether or not this bolstering amounts to research being less colonial is questionable, but what is at least clear is that there is an effort (largely inspired by Indigenous resistance to oppressive research) to explicitly supplement a scheme of principles with anti-colonial practice.

As medical research has continued to internalize pushback from its subjects, it has become abundantly clear that the clinical sphere needs to do the same. Indeed, it was this recognition that inspired the publication of the first edition of PBE in 1979[115]. Inspired by the burgeoning field of medical research ethics, clinical ethics hoped to capitalize on what appeared successful and make use of it. Largely, this meant establishing a significant focus on autonomy. However, this focus on autonomy (among other research-oriented ideas) does not perfectly translate into the clinical space.

Unlike researchers, who are (supposedly) held to an accountability framework of checks and balances, clinicians still hold a great deal of independence that is granted to them through professional autonomy[116]. In clinical care, professional autonomy refers to the allowance for clinicians to make decisions that are free of "unduly restrictive external or system constraints"[117] (i.e., high degrees of bureaucratic involvement). Clinicians are the "omega point"[118] of the health system wherein standards, evidence, and reasoning converge into decisions that directly and immediately impact lives. As such, professional autonomy allows for expedient and effective

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[112] As will be described in Chapter 2.

[113] Morton Ninomiya and Pollock, 32.

[114] Specifically, the framework ensures that: Indigenous groups decide what research involving their people will be of benefit to them, that the knowledge is available to the groups from which it is created, and that the research is owned and possessed by those who embody the data comprising said knowledge. Many of these things are ensured by using methods like community-based participatory research, wherein researcher and "subject" are equally embedded and valuable in the project.

[115] PBE was not directly inspired by decolonizing or anti-colonizing efforts, its publishing was certainly inspired by a lack of ethical regulation in clinical medicine that paralleled efforts of the time to regulate research more strictly.

[116] Professional autonomy was the primary point of contention that slowed the introduction of single-payer health insurance programs in Canada. Although this contention has waned in recent decades with much more support for integrated and shared decision-making, it is still an integral part of clinical healthcare; see Edward A. Pont, 'The Culture of Physician Autonomy; 1900 to the Present', *Cambridge Quarterly of Healthcare Ethics*, 9.1 (2000), 101-5, 107-9.

[117] Doctors of British Columbia, *Professional Autonomy*, *Policy Statement: Doctors of BC* (Vancouver, 2016), 3.

[118] Pellegrino, 560.

decision-making that benefits patients and makes use of the expertise of a healthcare professional. Clinicians are therefore largely self-regulating and are held only to clinical practice *guidelines* rather than clinical practice *mandates*. Guidelines are recommendations for clinical practice that are ideally adhered to but are not obligatory[119]. So long as any decisions made outside of the purview of such guidelines can be deemed "reasonable" given the deciding professional's experience, they are acceptable.

Even if professional clinical groups wanted to institute legally binding anti-colonial practice requirements, such binds have yet to be proven effective. Much like members of other self-regulating professions, clinicians are tasked with shouldering duties towards their clientele (i.e., patients), the integrity of their work, and to the society in which they operate. All three of these duties must be taken into considerations when clinicians[120] create policies of conduct. If any policy neglects (or excessively minimizes) a clinician's duty to the patient, profession, or populace, then the policy fails to adhere to the duties of clinical medicine. As such, policies like "patient-centred care" are not wholly about the patient, but rather, are about placing the focus of care on the patient whilst also upholding the integrity of medicine and quality of its interaction with society. This tri-directional pulling of obligations becomes problematic when we consider that the integrity of medicine and its interactions with the world are steeped in a history of indifference to Indigenous life. As much as a clinician may want to better serve Indigenous patients, they are urged to do so in a way that is compatible with the colonial legacy that defines what medical practice is. Responsibility to Indigenous persons is shirked in the process.

This is not to say that there have not been attempts at clinical policy that might lead towards decolonization. However, the attempts that have been made have yet to make much in the way of substantive change (as already mentioned and as will be explored in Chapter 3). The few *anti-colonial* accomplishments of these attempts, while helping in some ways, still fly under the banner of "decolonization". As such, the healthcare community largely considers their successes as equivalent victories against the colonial enterprise. This comes with the benefit of giving clinicians and policymakers a sense of moral righteousness, or at least a supposed removal from

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[119] It is an interesting point to note that many present-day research regulations also operate in terms of "guidelines". Indeed, the TCPS 2 does just this, suggesting that researchers can also deviate from the ideal so long as they can prove their deviation to be a reasonable one. However, the point being made here is that proving this reasonability is much more arduous, if not always a requirement, in a research setting, while this proof is only sometimes required in clinical care.

[120] And the colleges, governing bodies, and other regulatory groups in which they operate.

the "unbearable searchlight of complicity of having harmed others just by being oneself"[121] without having to do the upheaval required by decolonization proper[122]. However, the cycle of relegation and commodification persists unless actual action is taken *against* it[123].

This sort of "decolonizing" strategy is not always easy to identify. The Canadian Medical Association (CMA) espouses many clinician responsibilities about refusing care to someone on unreasonable discriminatory grounds and includes a dedicated responsibility to allying with (some) reparations for Indigenous peoples[124]. In their code of ethics, this responsibility (number 43) urges clinicians to "[c]ommit to collaborative and respectful relationships with Indigenous patients and communities through efforts to understand and implement the recommendations relevant to health care made in the report of the Truth and Reconciliation Commission of Canada"[125]. This sounds like an excellent responsibility to have. The recommendations being referred to in responsibility 43 are Calls 18-24 of the Truth and Reconciliation Commission of Canada (TRC) Calls to Action[126], a document containing a total of 94 points of change that influential powers in Canada can and need to act upon to work to ameliorate the colonial legacy of the country. Calls 18-24 specifically refer to health-related aspects of Indigenous life currently impacted by the colonial legacy of Canada. As such, it should be expected that if the recommendations within these calls are committed to, we should see decolonial progress in healthcare. However, this depends on who/what is undertaking this commitment.

The phrasing of responsibility 43 does not require clinicians to be the ones to enact the efforts recommended by the TRC. Indeed, the word "through" used in the phrase "commit to collaborative and respectful relationships…through efforts to understand…" implies that clinicians will be respectful allies in the decolonizing project but are not responsible for starting

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[121] Ibid., 9.

[122] A feeling I have come to know well.

[123] Adam Gaudry and Danielle Lorenz, 'Indigenization as Inclusion, Reconciliation, and Decolonization: Navigating the Different Visions for Indigenizing the Canadian Academy', *AlterNative*, 14.3 (2018), 226-7.

[124] This responsibility is still far from decolonization. Also of note, it could be argued that the CMA has two dedicated responsibilities of this nature. Responsibility 38 encourages clinicians to "[r]ecognize that social determinants of health, the environment, and other fundamental considerations that extend beyond medical practice and health systems are important factors that affect the health of the patient and of populations" (p.7). If systemic racism and colonialism are considered social determinants of health (as they should be), then this responsibility also directs clinicians towards colonial reparations. However, I think it is readily apparent that responsibility 38, as worded, is concerned with the general recognition that health is more than what an individual is/does, not uprooting colonial structures.

[125] Canadian Medical Association, *Code of Ethics and Professionalism*, 7.

[126] Truth and Reconcilliation Commision, 'Truth and Reconciliation Commission: Calls to Action', 2015.

it themselves. While this implication may seem needlessly pedantic, it makes perfect sense that the responsibility is implying a passive allyship. Acting as allies to decolonization allows for the continued authority of professional autonomy because it does not force clinicians to act in a particular manner. Moreover, it allows clinicians to still respect the autonomy of their patients, because it frames decolonization as a project that patients can autonomously choose to involve themselves in, and clinicians must respect that. The TRC was also careful to word their recommendations in this manner. The Calls to Action only directly call on medical institutions to make training on Indigenous health a requirement of medical education (Call 24)[127], all other calls to action in the "Health" section are directed at the (mostly federal) government[128]. This wording is directly referenced by the Canadian Nurses Association (CNA)'s code of ethics, which is "calling on all levels of government"[129] to enact decolonizing change rather than nurses themselves[130]. While medical institutions could very well undertake tasks addressed to government bodies, they are not required to by the TRC (even if the TRC was a legally binding document, which it is not).

To their credit, clinicians have taken some initiative to enact some tasks set by the TRC. For example, the CMA's more recent addendum to their code of ethics, "Equity and Diversity in Medicine" attempts to act upon Call 23 of the TRC Calls to Action. This distinct document aims to generate "fundamental shifts in power structures and power dynamics that perpetuate systemic and structural inequities, systemic discrimination, and systemic racism"[131]. In other words, it hopes to involve Indigenous communities and people more directly in the provision of medicine. Should this goal be accomplished, decolonization *could* be possible. Time will tell if the powers that be end up allowing this to be the case.

Despite initiatives like this, many stories, particularly during the period of anti-colonization (i.e., the last couple of decades) reveal how much the colonial pattern of indifference persists today in the clinical sphere. A comprehensive list of the mistreatment of Indigenous persons in

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[127] Ibid., 2-3.

[128] Calls 18-21 are all explicitly directed at "the federal government" (p.2-3). Call 22 is directed at "those who can effect change within the Canadian health-care system" (p.3), which would include medical institutions; however, this Call only has to do with further incorporating Indigenous healing practices into care. Call 23 is directed at "all levels of government" (p.3).

[129] Canadian Nurses Association, *Code of Ethics for Registered Nurses*, 2017, 19.

[130] Despite the CNA and CMA having distinct codes of ethics, the two codes are intended to align and inspire each other. The CNA code is more in-depth on ethical issues than the CMA code, but they are otherwise the same in terms of their approach to decolonization (i.e., they both draw heavily on Principlism).

[131] Canadian Medical Association, *Equity and Diversity in Medicine*, 2020, 1.

clinical healthcare settings would be impossible to do justice to here, but I will provide a few infamous examples to illustrate the current gaps:

Jordan River Anderson, who was born and lived in hospital for 5 years, passed in 2005 while the Manitoban and Canadian governments could not come to an agreement on who was obliged to pay for their necessary care. This case has since resulted in "Jordan's Principle", which aims to ensure such payment disputes never occur again, but the policy does not apply to all Indigenous children (or at all to Indigenous adults).

Despite the eugenics movement having become a historical relic[132] (though perhaps not as fully as one might think[133]), there are still Indigenous women who are sterilized against their will on the recommendation of clinicians who deem them "unfit" to have reproductive capabilities or care for children[134]. Similar forced sterilizations are almost unheard of in other groups in Canada.

Brian Sinclair succumbed to a bladder infection caused by the blocked catheter he was seeking care for after waiting in a hospital lobby for 34 hours. Hospital staff presumed him to be inebriated and not in need of urgent assistance. The exact reason for this presumption has not yet been proven in a court of law, but it is widely suggested that it is due to his Indigenous appearance. Few people believe that Sinclair would have died if he were White.

Joyce Echaquan passed away in hospital due to excess fluid in her lungs[135] after livestreaming her last moments alive, wherein her care team is seen mocking her screams of pain. Again, few people believe that Echaquan would have met a similar fate if she were not Indigenous.

While few cases of this sort have been ignored by the Canadian government and clinical care providers, responses to these cases have fallen short not only of decolonization, but also anti-colonialism. As remarkable as cases like this seem, they are not the result of bad luck, wherein Indigenous patients happened to meet indifferent and/or callous care providers. Rather, they are

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[132] Although the existence of the eugenics movement at all is abhorrent in itself; see Erica Dyck and Maureen K. Lux, 'Population Control in the "Global North"?: Canada's Response to Indigenous Reproductive Rights and Neo-Eugenics', *Canadian Historical Review*, 97.4 (2016), 481–512.

[133] As I recently discovered, the founder of the Philosophy Department at my university (which resides in the only Canadian province to have had a eugenic sterilization law) was John M. MacEachran, the chairman of the Alberta Eugenics Board from 1929-65. Despite his role at the University beginning nearly 100 years ago, his namesake was used for prizes and lecture series for decades after his death in 1971; see Douglas Wahlsten, 'Leilani Muir versus the Philosopher King: Eugenics on Trial in Alberta', *Genetica*, 99 (1997), 187-9.

[134] Standing Senate Committe on Human Rights, *Forced and Coerced Sterilization of Persons in Canada*, 2021 <https://www.sencanada.ca/content/sen/committee/432/RIDR/Reports/2021-06-03_ForcedSterilization_E.pdf>.

[135] At the time of writing, the incident is still under investigation.

glimpses into a system that says many words about decolonization but does not require truly decolonizing practice.

Chapter 2: Principles of Biomedical Ethics

As was alluded to in Chapter 1, healthcare's transitions from mere professional ethical discourse, to broader biomedical ethics, to the eventual publishing of *Principles of Biomedical Ethics* parallels the timeline of Indigenous-settler healthcare development in Canada[136]. Alongside the push for "civilization" in the 20th century, medicine was becoming more technically competent[137]. Treatments that used to be amalgams of guesswork were now becoming consistent and cost-effective; a transition that was expedited during the First and Second World Wars. With such a wealth of innovation came a wealth of power poised for abuse, which came to a head in the mid 20th century when the horrors of Nazi human experimentation were brought to the world stage. Despite similar atrocities having occurred on North American soil for years, it was at this point that the world came to agree that medicine needed to be reined in. Thus began the era of biomedical ethics[138], a time in which nation-spanning groups worked quickly to ensure that the leniencies previously allowed to powerful medicine would not be granted in the same way again[139]. Several of the most important governing documents to come out of this early period in bioethics have already been mentioned in Chapter 1, but these were by no means the only important documents published at the time.

In 1966, Henry Beecher published *Ethics and Clinical Research*[140], which would bring many of the historical atrocities of human medical research to the attention of the academic sphere. By

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[136] The direct causal history of PBE has more to do with the history of the United States than it does Canada since both of its authors are American. However, the interactions between colonial powers of the United States and Canada during this formative period were extensive (and continue to be extensive), so layering these histories to some extent should not pose comparative issues; see Lux, *Separate Beds,* 5; see also Beauchamp and Childress' note on Canada and America both being "well-informed medical societies", 245.

[137] Lux, *Medicine That Walks,* 224.

[138] Obviously, this era was not the first time that ethics in medicine were considered important. Countless thinkers throughout history have recognized the importance of morally righteous medicine. However, this era was the beginning of "bioethics" as a discipline of study.

[139] In some ways, "powerful medicine" is redundant in this context. The relationship between medical practitioners and their patients/subjects has a built-in power imbalance that is more direct and stark than most other relationships in society (Beauchamp and Childress, p. 103). This is why an ethics for medicine is so important; a moral framework that specifically calls out the righteousness of healthcare workers goes beyond "standard" interactions between people in the general populace, it requires that health professionals acknowledge the power they hold and act in non-abusive ways, despite it.

[140] Henry K. Beecher, 'Ethics and Clinical Research', *New England Journal of Medicine*, 274 (1966), 1354–60.

way of this article, people began to realize just how pervasive the abuse of medical power was. Several years later, Joseph Fletcher and Paul Ramsey, "two diametrically opposed moral theologians"[141] began to lay the groundwork for an arena that could house divergent responses to these realizations – the field of academic bioethics. Although this was a huge step towards giving power to moral arguments for medical regulation, both Fletcher and Ramsey drew heavily from Christian moral frameworks. Such frameworks would not be out of place in the devoutly Christian medical systems of North America of the time, but this was not necessarily a benefit. As Chapter 1 demonstrated, Christian institutions were culpable in allowing immoral medical action in the first place. Bioethics needed to fine-tune itself with a greater emphasis on secular argumentation[142] to avoid perpetuating the same mistakes of the past. As such, a United States committee of medical staff and academic ethicists was created in 1974, which led to the publishing of the Belmont Report in 1978[143] – a foundational document in what bioethics has come to be today. Coincidence with and inspiration for government policy helped propel this document to its influential status. In 1981, the US Department of Health and Human Services codified regulations for human subject research that required such research be approved by Institutional Review Boards (IRBs)[144]. This extra level of regulation led members of IRBs to further seek out authoritative declarations on biomedical ethics that they could cite in their rulings. Hence, a thirst for documents like the Belmont Report and PBE grew immensely.

The report espoused three guiding principles for medical research on humans: respect for persons, beneficence, and justice[145]. These three principles bear a striking resemblance to the four presented in PBE, even in their strong emphasis for respect for autonomy (i.e., "persons"). This resemblance is no coincidence. Tom Beauchamp, although not part of the committee that deliberated the contents of the report, was charged with putting this content to paper[146]. As such, the Belmont Report was highly influential not only as a standalone document, but also as a

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[141] Arras, 3.

[142] Or at least argumentation that was not blatantly Christian.

[143] National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*, *Department of Health, Education and Welfare*, 1978.

[144] Specifically, Title 45 of the Code of Federal Regulations.

[145] Ibid., Part B.

[146] Interview with Tom Beauchamp, 'Oral History of the Belmont Report and the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research', 2004 <https://www.hhs.gov/ohrp/education-and-outreach/luminaries-lecture-series/belmont-report-25th-anniversary-interview-tbeacham/index.html>.

research-oriented first draft of PBE. The first edition of PBE that would come the following year preserved much of the focus of the Report, but had its eyes set on bringing its ideas through the "often porous"[147] barrier between research and clinical medicine.

With each passing decade, the audience for the permeating biomedical ethics espoused by PBE grew larger. The research scandals that had previously inspired the creation of IRBs/Research Ethics Boards had now been joined by the controversies surrounding the quickly growing number of specialized medical technologies[148] in need of regulation. Before long, hospitals could rarely be seen operating without ethics boards that relied heavily on the words of PBE[149]. Beauchamp and Childress ensured the continuance of this reliance by frequently updating the text, always attempting to stay at the leading edge of the field. Unfortunately, these attempts did not include or encourage efforts to address the healthcare injustices still being faced by Indigenous populations[150].

Now that the historical underpinnings of Principlism and Indigenous relations have been made clear, we can do justice to an assessment of its impact in the clinical sphere and its colonial underpinnings. What follows in this chapter will detail Principlism as described by Beauchamp and Childress in their most recent edition of PBE[151]. As such, particular attention will be paid to their arguments about the common morality and each of the four core principles. Critiques regarding the strength of these arguments and their colonial ties (along with other relevant points about the shortcomings of Principlism) will be addressed in Chapter 3. To help assuage any lingering concerns about the lack of transferability or relevance of PBE to Canadian clinical care, it should be re-stated that Canadian clinical ethics documents reference Principlism as a

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[147] Beauchamp and Childress, 361.

[148] For example: respirators, hemodialysis, more effective means of organ transplantation, and the *many* advances in genetic testing/screening/treatment.

[149] As is usually the case, Canada's development in this regard was slower than it was in the United States (presumably because of how much less litigious our citizenry generally is); see Fatemeh Hajibabaee and others, 'Hospital/Clinical Ethics Committees' Notion: An Overview', 9.1 (2016), "History and development of hospital ethics comittees".

[150] In addition to the particulars of Chapter 1, a notable manifestation of this dismissive attitude is that the last Residential School in Canada was not closed until 1996.

[151] Bioethics is a discipline that is profoundly interested in what John Arras calls "an unusually self-conscious debate about its own methods" (p.1). This is not to suggest that all bioethics work has to do with revising the entirety of the discipline; in fact, most of it has nothing to do with this. What Arras is suggesting is that there is proportionately more "self-conscious" work in bioethics than in other disciplines. Beauchamp and Childress are two authors who are engages in such work. Correspondingly, assessing Principlism using the most recent edition of PBE is paramount to ensuring any absorbed minutia are not passed over and/or discussions are not about outdated arguments.

foundational framework[152]. Moreover, Beauchamp and Childress argue that a healthcare system operating with a "decent minimum" approach like Canada's (and unlike the United States') is an ideal form for healthcare delivery and practice[153], so the minor possibility of losses in cultural translation can be compensated for in the assessment of Principlism operating in its ideal setting.

Principles from Rules and Rules from Principles

The titular principles of PBE, while being the primary source of ethical guidance offered to clinicians[154], are not the ultimate end from which Beauchamp and Childress derive their moral intuitions. While it is correct to say that the principles each represent an aspect of healthcare morality[155], this does not mean that all the support behind the doctrine begins and ends there. The principles are expected to distill and clarify what "moral" means for healthcare in a general sense whilst also providing a backdrop to legitimize what acting "morally" in specific contexts can be. To do so without leaving themselves open to criticisms of moral relativism, Beauchamp and Childress strive to ensure that their core rationale stems from something beyond mere intuition. Specifically, they appeal to a set of rules – the "common morality."

The authors describe the common morality as a universally believed set of "valid rules"[156] about action and character from which all other moral theories are derived. Rules such as "do not kill", "do not punish the innocent", and carry yourself with "conscientiousness"[157] are all part of this set. Proving that all moral agents actually agree to the facets of the common morality is a near-impossible task[158], so their universality is presumed. This presumption is predominantly made on the grounds that the constituents of the common morality have historically operated as bastions for human flourishing and/or against the entropic chaos that all societies might

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[152] Canadian Nurses Association, 2; Canadian Medical Association, *Code of Ethics and Professionalism*, 1; Canadian Medical Association, *Equity and Diversity in Medicine*, 1-2.

[153] Beauchamp and Childress, 292-4.

[154] It should be noted that PBE is written more like a textbook than anything else. As such, there are large portions of the book where the arguments being forwarded are presented as a summary of a debate from multiple sides. Beauchamp and Childress do share their opinions and "pick sides" in many places, but there are some sections where the argumentative relevance to Principlism is more inferential than it is direct.

[155] Tom L Beauchamp, 'The "Four Principles" Approach to Health Care Ethics', in *Principles of Health Care Ethics*, ed. by R.E. Ashcroft and others, 2nd edn (John Wiley & Sons, Ltd., 2007), 3.

[156] Beauchamp and Childress, 3.

[157] This list is not comprehensive. A longer (also not comprehensive list) can be found on pages 3 and 4 of PBE.

[158] The logistics alone of asking *everyone* a question are staggering; see also Beauchamp and Childress, 449-53.

otherwise fall into[159]. For example, commitment to the moral rule "do not kill" gives people reason to respect (or create) laws that prevent untimely death – a very abrupt way to curb the potential for someone to have a decent life, and a very sensible rule to agree to. The universality of the common morality can also be simply intuited; its constituent rules about moral life just seem agreeable. Whichever presumption is made, it is the presumed *agreement of all moral agents* to be obliged to this set that justifies the validity of the common morality. In this way, the common morality is not an ethereal code of objective rationale waiting to be discovered; it is the actively held sense of what "moral" is in the global community.

This agreement criterion renders the aspects of common morality functionally indisputable. Since it is, by definition, a set of rules that everyone agrees on, any disagreement on what is morally universal "can be explained by biases or cultural distortions or [as] merely linguistic variations"[160]. Only fools would truly dispute the validity of the common morality because only fools do not grasp its intuitive agreeableness. This is not to say that the constituents of the common morality could not change over time, nor that the idea is completely beyond reproach[161]. Rather, it is simply a moral framework that, once established, provides a firmly unquestionable base upon which more complex ideas like principles can be built. Indeed, the common morality provides little more than a foundation when it comes to moral guidance.

Although they are valid and wide-ranging, the constituents of the common morality are content-thin[162]. Content-thin ideas, as opposed to content-rich ideas, are concepts that address a topic very broadly. Rather than giving didactic instructions for a circumstance to which an idea might apply, content-thin rules make generalized, often binary claims about how to conduct oneself. For example, a common morality rule such as "tell the truth" suggests that a morally committed agent will be acting morally if they tell the truth, immorally if they do not. While the rule is clear, it does not specify how much of the truth must be told, when it should be told, or if there are exceptions worth considering.

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[159] This fact is made true when conjoined with the assumptions that all human societies and their (morally committed) members: 1) want to flourish, 2) ascribe to and expect others to abide by moral commitments to allow for this flourishing, and 3) achieve flourishing (or at least avoid destructive chaos) in broadly similar manners; see Beauchamp, 7; see also Christopher Peterson and Martin E. P. Seligman, *Character Strengths and Virtues: A Handbook and Classification*- (Washington D.C.: American Psychological Association and Oxford University Press, 2004), 34-52.

[160] Veatch, 49.

[161] As will be explored in Chapter 3.

[162] Beauchamp and Childress, 5.

Principlism's Colonial Ties

Often when we are seeking specific, tractable guidance in healthcare, we do not appeal to binary platitudes like those in the common morality. Rather, we turn to what Beauchamp and Childress term particular moralities. Like the common morality, these moralities are sets of rules about moral action. Unlike the common morality, these rules are content-rich and are agreed upon and binding only to the communities by which they are crafted. In other words, they are rules by the (particular group of) people, for the (same group of) people. They are intended to address some course of action as it is to be committed within restrictive conditions in a manner consistent with the common morality. The CMA code of ethics is an excellent example of this. One of the responsibilities (i.e., moral rules) of this code is for physicians to "[l]imit treatment of yourself, your immediate family, or anyone with whom you have a similarly close relationship to minor or emergency interventions and only when another physician is not readily available; there should be no fee for such treatment"[163]. The rule gives a clear idea of to whom physicians should administer treatment, when it is appropriate to treat those who would otherwise not be treated, and how one should compensate the physician (or not compensate them). Although it is consistent with a common morality rule like, "rescue persons in danger"[164], this particular morality rule is clearly more useful to a medical professional.

At this point, one might wonder where the principles fit into this scheme. If particular moralities are often the most pragmatic appeal to make, why not just allow medical groups to independently operate under their own codes of ethics? They know how to best lead themselves, so why not let them do so? Indeed, it seems that a truly committed moral agent (who, by definition, subscribes to the rules of the common morality) would always express themselves in a suitably moral manner, so we need not worry about having some other factor (i.e., the principles) to keep things in line.

Where Beauchamp and Childress would protest this suggestion is in what counts as "suitably". Yes, it is true that an agent of the common morality would likely express *some* aspect of the universal set in their particular moral code, but this expression may come at the unnecessary expense of some other crucial aspect(s). Our common moral rules can offer conflicting advice (e.g., "tell the truth"[165] and "keep your promises"[166] often come up against

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[163] Canadian Medical Association, *Code of Ethics and Professionalism*, 4.
[164] Beauchamp and Childress, 3.
[165] Ibid.
[166] Ibid.

each other; I can promise to not disclose some piece of information but this promise conflicts with my obligations to tell the truth). Said conflict means that hastily made decisions will often miss important overarching factors of moral righteousness. As was made evident in Chapter 1, such haste is common in healthcare settings; indeed, healthcare systems have demonstrated very poor track records of moral conduct when fully left to their own devices. Accordingly, "suitably moral" decisions will not just be good enough for the healthcare providers making them, they will also be good enough for a greater sense of morality with all things considered. The principles help to encourage this consideration.

The principles also help to hold healthcare providers accountable to what is expected of them. Since the healthcare profession plays such a crucial and influential role in society, there are unique expectations about moral decisiveness for providers that do not apply elsewhere. For example, Beauchamp and Childress identify five focal virtues in healthcare[167] (with *care* itself being a "fundamental orienting virtue"[168]): compassion, discernment, trustworthiness, integrity, and conscientiousness[169]. These virtues are character traits universally agreed to be valuable to healthcare's design and delivery, so are part of the common morality – yet are not relevant to all disciplines outside of medicine, so are not required for all moral agents[170]. Factors like the focal virtues help to provide richness and discipline-relevant guidance to our understanding of the common morality. The principles are the most important of these factors.

Being distilled factors of the common morality, the principles simultaneously *come from rules* whilst *rules also gain authority from* the principles. The general, content-thin common morality rules inspire the broad-stroke moral tapestry that the principles make digestible and concise for healthcare settings. The specific, content-rich particular morality rules are accountable to the principles insofar as they must be consistent with their dictates as distilled from the common morality.

Each of the four core principles: respect for autonomy, nonmaleficence, beneficence, and justice represent rules of the common morality that are salient to healthcare. Some of these rules

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[167] Ibid., 33-45.

[168] Ibid., 37.

[169] My mentioning of the "focal virtues" here may seem unusually brief or irrelevant to the principles, but this is only because they are given a similar treatment by Beauchamp and Childress. These virtues are framed as being foundational to PBE's ethical framework, but exist almost entirely in the background for the remainder of the book. Later chapters of this work explore this further.

[170] They may be nice qualities for all moral agents to have, but are *not excepted or required* of all people.

are easily categorized, clearly informing the nature of a single principle (e.g., "do not cause pain or suffering to others"[171] is synonymous with a content-thin obligation to nonmaleficence), but more often, a rule can sculpt multiple principles (e.g., "do not punish the innocent"[172] primarily invokes the principle of justice, but also pertains to the principle of nonmaleficence through the implication of harm in the term "punish"). Should any relevant rules of the common morality change, the categories (i.e., principles) must alter themselves to meet this change[173]. For example, if a "new"[174] common morality rule, "do not cause pain or suffering to animals" came to be universally believed, this rule might alter the principle of nonmaleficence by requiring a reconsideration of who/what we understand "harm" to apply to. So long as no healthcare-relevant rule of the presently standing common morality is left uncategorized by at least one principle, Principlism has sufficiently represented the foundation of moral reasoning in medicine.

To ensure that the principles are representing what they are espoused to[175], Beauchamp and Childress have designed them to be specifiable. In their most basic form, the principles are content-thin and digestible, which makes them easy to agree on and refer to in the abstract. To know that this abstract agreement is helping the provision of healthcare, each of the principles is "specified" by series of rules and/or the accompaniment of virtues that nuance each principle beyond a single content-thin obligation (i.e., "be beneficent" or "act justly")[176].

The subsidiary rules and the virtues are intended to have "only a loose distinction"[177] from their parent principles[178]. All three modes of guidance are drawn from the common morality[179]; the rules and virtues are just a more content-rich expression of the ruleset. For example, a rule such as "do not intentionally cause harm to a patient" and the inculcation of the virtue of

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[171] Beauchamp and Childress, 3.

[172] Ibid.

[173] Beauchamp and Childress argue that such change is most likely to occur in terms of a rule altering its scope (i.e., a reconsideration of to whom/what a certain idea applies), but they also think that there is nothing ruling out the introduction of new rules to the common morality (p. 446-7).

[174] A rule about avoiding the harming of animals is not a novel idea, but an idea that is not yet considered a universally held belief about moral decency. Indeed, humans have caused animals to suffer in the name of our flourishing for millennia.

[175] I.e., a reasonably sufficient encapsulation of medically relevant points of the common morality, but not the common morality in its entirety; see Beauchamp and Childress, 444-5.

[176] Although each principle has their own sets of virtues and rules, Chapter 8 of PBE, "Professional-Patient Relationships" details the virtues of: veracity (pp. 327-37), privacy (pp. 338-46), confidentiality (pp. 347-52), and fidelity (pp. 353-70) as important subsidiary specifiers of the core four in general.

[177] Beauchamp and Childress, 14.

[178] For example, on page 33 of PBE, Beauchamp and Childress refer to each of the four core principles as "virtues".

[179] The principles do not represent the common morality any more accurately than do their rule/virtue specifications. The rules and virtues are just that, specifications; see Beauchamp and Childress, 455.

compassion jointly give a more specific idea of what it means to be nonmaleficent. Rather than simply being obliged to not cause harm, we can now grasp that the principle of nonmaleficence includes aspects of intentionality and acting compassionately. Moreover, because there is such a loose distinction between these aspects and the parent principle, we can – context-depending – use a rule like "do not intentionally cause harm to a patient" in place of the principle of nonmaleficence. This works similarly for all the other principles; with enough[180] rules and/or virtues, a clearer picture of each principle is formed[181].

To account for the possibility of the principles simply becoming re-wordings of the common morality, Beauchamp and Childress have importantly designed them as a plural deontology. In this deontology, each principle imposes an equally binding *prima facie* duty[182]. They are equally binding insofar as no duty to a principle is more important than another (e.g., a person's commitment to beneficence does not always take precedence over their commitment to nonmaleficence). Their duties are *prima facie* insofar as an obligation to them "must be fulfilled unless it conflicts with an equal or stronger obligation"[183]. Therefore, the moral duties prescribed by each principle must be adhered to unless some equally morally salient duty (i.e., another principle) overrides them. This is an important point to make because there are many circumstances in clinical medicine in which the most "moral" course of action is obfuscated by conflicting obligations. For example, a physician may have recently learned that one of their patients has a metastatic tumor. This patient, who is very averse to the idea of invasive procedures and prefers to not know about "bad news", does not yet know their diagnosis. The tumor(s) can only be treated through very harmful and invasive chemotherapies and surgeries, which leaves the physician with (at least) the following duties: respect the patient's autonomous desire to not want to hear about the diagnosis and/or refuse treatment for it, be nonmaleficent by

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[180] There is no ideal number of rules or virtues that any given principle should be associated with. For Beauchamp and Childress, so long as the specification is able to achieve "more concrete guidance"(p.17) than the principles can by themselves, then the rules/virtues have done their job.

[181] Although this increase in richness of content may align with a particular morality, this does not mean that the subsidiary rules and/or the virtues are particular moralities. Particular moralities could contain verbatim ideas from the subsidiary points of the principles (there is nothing preventing a particular morality from being nothing but virtue requirements), but particular moralities are more than this. They are intended to contextualize the ideas of the principles and/or apply new ideas that are still coherent with the principles, but have the added benefit of improving quality of care for the particular circumstances under which they are set to apply.

[182] This concept is borrowed from the work of W.D. Ross, but expanded upon throughout PBE; see Beauchamp and Childress, 15.

[183] Ibid.

avoiding the imposition of harm to the patient through treatment or neglecting to inform them of their situation, and be beneficent by providing treatment in the hopes of slowing or reversing the spread of the tumour(s). The principle of beneficence may take precedence in this case, leading to the progression of the invasive treatments despite the harm and infringement on autonomy they will inevitably cause. However, depending on the (here unestablished) minutia of this case, the principle of respect for autonomy or nonmaleficence could have also taken precedence.

This is how the duties detailed by the principles (and their subsidiary rules and the virtues) are always adhered to but need not always be carried out. Healthcare providers assess the circumstances of their patients with "all things considered"[184] and make extensive use of their "experience and sound judgment"[185] to – in cases where some (or all) of the principles conflict – adhere to the principle(s) most salient to said circumstances. Therefore, "[t]here are no absolute principles, rules, or rights"[186], but rather, a pluralistic set of obligations that must be balanced with one another[187]. Principlism holds clinicians to a *prima* facie duty to all the principles, but clinicians' *actual* moral duty is a matter of adhering to as many of the principles as possible[188].

How then do we ensure that this duty, pluralistic as it is, maintains its ties to the common morality while also being pragmatically useful? The medical world and the common morality can and do change; stagnant conceptions of "autonomy" or "justice" – and/or the overreliance on a particular principle – will quickly prove the paradigm ineffective. The authors' answer to this is to invoke John Rawls' concept of "reflective equilibrium"[189]. This is a process that is reflective insofar as it re-assesses the repercussions of a moral stance as taken, and it aims for an equilibrium in which all aspects of this moral stance are made coherent. For Principlism, this involves the mutual adjustment of the existing principles/rules in healthcare with our intuitions about what the common morality requires. As put by the Beauchamp and Childress, "[t]he goal of reflective equilibrium is to match, prune, and adjust considered judgements, their specifications, and other relevant beliefs to render them coherent … If coherence proves

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[184] Ibid.
[185] Ibid., 430.
[186] Ibid., 346.
[187] Ibid., 19-23; 430.
[188] Beauchamp, 7-8; Beauchamp and Childress, 15.
[189] Beauchamp and Childress, 430-42.

impossible to achieve, we must readjust some points in the system of beliefs in a renewed search for coherence"[190].

In PBE, this goal of "coherence" is more than just a lack of contradictions or inconsistencies. This would be *mere* coherence. Beauchamp and Childress believe that mere coherence is a poor metric for moral soundness because it aims to equilibrate what is, not what should be. A metric of mere coherence does not require a central foundation of steady moral terms, so any coherent idea set could be considered "moral" even if it clearly permits immoral actions[191]. As such, the reflective equilibrium emphasized in PBE primarily aims at the *convergence* of all levels[192] of the Principlist theory[193]; wherein the common morality acts as the foundations for critical reflections on and adaptation of subsidiary rules, virtues, and particular moralities. Coherence is still the ultimate goal of reflective equilibrium that sits atop this convergence, but "[a]chieving a state of reflective equilibrium in which all beliefs fit together coherently, with no residual conflicts or incoherence, is an ideal that will be realized only partially"[194]. This makes reflective equilibrium a supposed guarantor of moral decency that goes beyond the basic moral competence expected by most other biomedical ethics codes[195]. The principles must be useful and morally sound because PBE's reliance on reflective equilibrium demands it.

Taken together, the Principlist doctrine generally claims that the ideal clinician will be motivated by the jointly sufficient fulfilment of: having exceptional integrity to a character that is based in an alignment with the principles (i.e., a dedication to appropriate distillations of the common morality), being motivated to uphold to principles for the sake of virtuous principled conduct (i.e., being dutifully obliged to the principles insofar as they can be simultaneously acted upon), and maintaining a constant introspectiveness that results in morally coherent action (i.e., the application of reflective equilibrium).

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[190] Ibid., 440.

[191] To this point, Beauchamp and Childress reference pirates' "codes of ethics" as morality frameworks that were/are coherent but are clearly immoral (p.442).

[192] "All levels" here refers to PBE's insistence on *wide* reflective equilibrium (p.441), which essentially means that all aspects of a moral circumstance are included in the deliberative process. It has a wide, as opposed to a narrow, scope. As such, the common and particular levels of Principlism (and all of their subsidiary points) are subject to deliberation so that the principles may adjust according to its conclusions.

[193] Beauchamp and Childress, 440-1.

[194] Ibid., 441.

[195] Specifically, competence in the care-based virtues of compassion, discernment, trustworthiness, integrity, and conscientiousness; see Beauchamp and Childress, 35-44, 49-50.

Principlism's Colonial Ties

There are difficulties with some of these points, but an exploration of these difficulties will be withheld until Chapter 3. To fully understand the forthcoming critiques, a more thorough understanding of each principle is needed. After all, it means little to critique platitudes about the general nature of the principles (and their many, many influences) without seeking out specifications in PBE that could respond to these critiques. Therefore, the remainder of this chapter will detail each of the principles as they are described (and in the order presented) by Beauchamp and Childress and will use these descriptions to inform Chapter 3's critique of Principlism as a vehicle for colonialism.

Respect for Autonomy

The respect for autonomy principle stands out amongst its peers for several reasons. Most obviously, it is the only principle presented as a phrase. All the other principles in PBE have always been presented as single words, but this principle continues to maintain the inclusion of both "respect" and "autonomy" (or "persons" in some previous iterations) at its core. Therefore, Beauchamp and Childress believe that an understanding of both terms is necessary for understanding the moral obligations captured by this principle.

As the order of the terms in "respect for autonomy" suggests, respect is an idea that works *for* autonomy, but not the other way around. Respect, although important to the principle, is mostly just the means through which autonomy is upheld[196]. The term "respect" is etymologically comprised of the Latin prefix *re-*, "back" and the Proto-Indo European (PIE) root *spek*, "to observe". Like other words based in this root (e.g., spectacle, expect, perspective), respect has an element of passive *observation*. To respect something in this sense is to act in a way that watches, but does not interfere with, the chosen conduct of said thing. Phrases like "keep at a respectful distance" echo this idea, which Beauchamp and Childress refer to as the *negative* sense of respect. It is an obligation of non-interference which "requires that autonomous actions not be subjected to controlling constraints by others"[197]. Additionally, unlike other *spek* words, the prefix *re-* in respect also adds an element of active support. To respect something in this sense is to act in a way that helps said thing conduct itself in the manner of its choosing. It is

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[196] The argumentation for which largely borrows from the Kantian idea that treating people as ends, rather than mere means (i.e., an invocation of their autonomy), requires a particular (i.e., respectful) attitude from the treater; see Beauchamp and Childress, 105.

[197] Ibid.

to "go *back* to basics"; providing the psychophysical latticework from which someone can make informed and value-based decisions. This is what Beauchamp and Childress refer to as the *positive* sense of respect. In healthcare, this positive sense manifests itself through "disclosures of information and other actions that foster autonomous decision making"[198]. The combined use of the negative and positive senses of respect is what upholds autonomy in PBE[199]. It is an omnipresent awareness of a person's chosen conduct that aims to ensure no choices that someone may (legally and reasonably) make are obfuscated or made to have undesirably altered consequences. As such, these choices are the things being respected in the principle – the things that make up autonomy.

"Autonomy" etymologically consists of the Greek terms *autos,* "self" and *nomos,* "law". The word's present-day usage differs slightly from its historical/etymological origins[200] – now most often used to refer to a *person's* capacity to abide by their self-made "laws" without unjustified impediment[201]. These "laws" are the foundational beliefs that one uses to discriminate between and act upon superficial preferences that hold sway over how we act. For example, I may operate with a personal "law" that states that animal suffering is immoral and, when considering what to eat for dinner, will use this foundational belief to diminish my superficial preference for eating a meat product while strengthening my superficial preference for supporting vegan alternatives. The preferences that align more directly with my "laws" will be used as direct impetus for my actions. As such, this basic understanding implies that a person's unhindered choosing to act in accordance with their foundational beliefs constitutes autonomy[202].

Beauchamp and Childress' emphasis on choice slightly shifts their definition of autonomy away from this Kantian understanding. For PBE, autonomy is defined as "personal self-governance: personal rule of the self by adequate understanding while remaining free from *controlling* interferences by others and from personal limitations that prevent choice"[203]. This definition maintains the importance of unimpeded action but is careful to note that it is the act of

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[198] Ibid.

[199] Ibid.; Beauchamp, 4.

[200] That is, the Ancient Greeks used the term to refer to the sovereignty of nations, states, and political groups, whereas the term today is mostly used to refer to persons. This change in meaning is mostly due to the influence of Immanuel Kant's work.

[201] Justified impediment is anything that prohibits actions that infringe on other's abilities to live autonomously (or actions that go against existing just laws).

[202] A conception of autonomy developed by Immanuel Kant – ubiquitous amongst philosophers, less so elsewhere.

[203] This is definition comes from an article about Principlism written by Beauchamp (Beauchamp, 4). Although not directly lifted from PBE, this passage succinctly captures the core definition of autonomy in the book.

choosing itself, not choosing for a reason aligned with one's beliefs, that is the key metric of autonomy. As such, simply being able to act out a choice, even if it goes against one's own foundational beliefs, can still be autonomous. Beauchamp and Childress believe this sort of definition is of great benefit in the context of medicine. There are many medical cases in which people choose things that do not clearly align with their belief systems, yet these choices still appear autonomous. For example, even if I am fundamentally opposed to being a living organ donor, I may still autonomously choose to donate an organ when I find myself under novel circumstances (e.g., a loved one requiring an organ for which I am the only feasible match). It could be argued that these "novel circumstances" (e.g., a loved one suddenly experiencing renal failure) might be coercing or controlling me to donate an organ (e.g., a kidney); therefore, my decision to donate an organ cannot be autonomous. However, this argument negates the possibility of being surprised by certain decisions we make. No person acts entirely rationally and with perfect adherence to their own codes of conduct, but this does not make the decisions that fail to adhere to such codes nonautonomous. Doing something contrary to one's system of beliefs does not require having been forced into it, it just requires a (likely difficult) choice. Therefore, the concept of autonomy being upheld in medicine should be able to encapsulate these difficult choices and respect them accordingly.

Despite focusing on choices without a need to appeal to a person's higher-order beliefs, Beauchamp and Childress still need to establish what constitutes an autonomous choice. While there are many possible actions a person may choose to perform, these actions are not necessarily chosen by a competent actor nor are they necessarily proper choices even if the actor is competently autonomous. In other words, all choices are actions, but not all actions are choices. For example, an incompetent actor, such as a young child, can act out many things but it is not the case that these actions constitute true autonomous choices. We may refer to a child's actions as having been "chosen" in some sense, but this sense does not include autonomy. The child is incompetent because they lack an adequate understanding of the world that would allow them to truly choose how they want to act. This is why children cannot legally consent to many things[204]; they do not possess the (primarily mental) wherewithal to autonomously choose to consent to actions performed by or against themselves. Beauchamp and Childress therefore want to avoid defining autonomy as a protection of all actions that could be considered "choices" in some

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[204] Except in cases where "mature minor" status can be proven, which is done on a case-by-case basis.

nonautonomous sense. Accordingly, Beauchamp and Childress' definition stipulates that autonomous actions are choices made with: 1) intentionally planned courses of action and outcome, 2) adequate[205] understanding of the circumstances at hand, and 3) a freedom from factors that supress personal control[206].

According to Beauchamp and Childress, from PBE's principle of respect for autonomy we can derive positive and negative obligations towards person's intentional and understood choices. It captures and employs common morality rules with positive obligations like "tell the truth"[207] as well as rules with negative obligations like "respect the privacy of others"[208]. The principle of autonomy also makes use of specifying rules such as "obtain consent for interventions with patients"[209] and bears resemblance to the virtue of judiciousness[210] when considering evidence for person's competence for autonomous decision making. Accordingly, this principle approves of particular moral rules such as "[c]ommunicate information accurately and honestly with the patient in a manner that the patient understands and can apply, and confirm the patient's understanding"[211] and "[r]espect the decisions of the competent patient to accept or reject any recommended assessment, treatment, or plan of care"[212]. In the context of clinical medicine, the principle obliges healthcare providers to listen to and foster the choices of their autonomous patients. These obligations are only overridden when another principle takes circumstantial precedence (i.e., when respecting a patient's autonomy will inexcusably infringe on another principle[213]) or when there are reasonable grounds to consider a choice nonautonomous.

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[205] An indeterminate qualifier, "adequate" means different things in different contexts. Beauchamp and Childress discuss the ambiguity of this qualifier as it applies to understanding from page 130 to 136.

[206] The first criterion is binary while the second and third are held in matters of degrees; Beauchamp and Childress, 102-3.

[207] Interestingly, this rule is presented in the chapter as a specification of the principle, despite being presented earlier in the book as a common morality rule; see Beauchamp and Childress, 106, 3.

[208] Ibid., 106.

[209] Ibid.

[210] This term is not used in PBE. However, I believe it effectively captures the idea of the "sliding scale strategy"(p.115) that Beauchamp and Childress suggest should be employed to the standards of evidence clinicians use to determine patient's competence (p.112-18).

[211] Canadian Medical Association, *Code of Ethics and Professionalism*, 4.

[212] Ibid., 5.

[213] This helps to ensure that healthcare providers are not obligated to be completely beholden to their patients' choices. An autonomous patient could choose to sexually assault their healthcare provider, but this does not mean that the provider must capitulate with this choice. The choice to assault someone invokes a concern about nonmaleficence that would take precedence in this case; thereby ensuring the safety of the provider.

Principlism's Colonial Ties

Despite being open to appraisal on most fronts, Beauchamp and Childress are adamant that their depiction of respect for autonomy is often critiqued in bad faith. For example, the authors passionately claim at the beginning of their work that "respect for autonomy has no distinctly American grounding"[214], despite "long-standing misinterpretations"[215] (i.e., critical responses to PBE) that argue otherwise. They also state, in referencing their decision to present the respect for autonomy chapter before others in PBE, "the order of our chapters does not imply that this principle has moral priority over, or a more foundational status than, other principles"[216]. These claims act as pre-emptive responses to critiques of the respect for autonomy principle. Namely, they work against critiques claiming that the principle is overly focused on the individual (i.e., "American"), which leads to an unwarranted exemption to the equality of the four core principles. Similar precautionary caveats are not given in the other principle-based chapters.

Although Chapter 3 will delve more deeply into whether Beauchamp and Childress are correct in saying that their conception of respect for autonomy is not detrimentally individualistic or overbearing, it is worth mentioning their positions on the matter here. Doing so will not only help to set the stage for my own critiques of this principle, but also help to further clarify the scope of the principle (i.e., to whom/how many people it applies in any given case).

The concept of individualized autonomy may seem redundant. Autonomy is foundationally predicated on the goings-on of the self, so it seems that autonomy and individuality are inseparable. It is I, an individual, who chooses to act a certain way, not some external force(s). If my choices were made by external forces, then I would assuredly be under the influence of factors that suppress my personal control, which fails the third criterion of Beauchamp and Childress' autonomy framework. However, this is not the full picture. There are many cases in which our choices are made in large part by external forces. My choice to purchase a particular brand of shampoo is not the result of ethereal and rational calculus specific to me, it is the result of my exposure to alluring marketing programs. The aforementioned case about my choosing to donate an organ is the result of external pressures that run counter to my (hypothetical) deeply set aversion to organ donation. A patient's choice to seek out and make use of their clinician's services requires them to relinquish some of their personal control and place it in the hands of

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[214] Beauchamp and Childress, ix.
[215] Ibid.
[216] Ibid. 99.

someone they believe to be a qualified professional. These are all cases of external forces that can significantly suppress and/or alter one's choices, yet the decisions made at the behest of these forces are usually considered autonomous.

Beauchamp and Childress are quick to agree with this consideration. They note that "no fundamental inconsistency exists between autonomy and authority"[217] and it is very possible, if not always the case, that patients in clinical settings act autonomously despite some amount of external choice-influencing force. The "dependent condition"[218] of the patient relative to the authority vested in medical professionals guarantees that a patient is not fully free to decide whatever they want in medical contexts. If Beauchamp and Childress were so concerned with making autonomy individually focused – as their critics profess – it seems unlikely that they would admit to such facts. They would be better suited to dig in their heels and assert that patients make choices without any influence from their physicians. Doing so would help to position patient autonomy as a free-standing entity that is unique to each individual and worthy of protection as such. Since the authors do not do this, they are able to permit the idea that forces outside of the individual can influence a person without overriding their autonomy.

PBE also distances itself from individualized autonomy by providing a thorough discussion of the problems with individually-focused conception of informed consent[219]. Informed consent, as the name suggests, refers to a patient's choice to proceed with or refuse some medical treatment wherein said patient: is informed about the treatment (i.e., possessing an adequate understanding of the medical procedure(s) they may be subjected to (criterion 2 of PBE's definition of autonomy)), capable of consenting to it (i.e., possessing the capacity to intentionally choose (criterion 1 of PBE's definition of autonomy), and is free of coercive external forces (criterion 3 of PBE's definition of autonomy)). This is a direct call upon of the core tenets respect for autonomy principle. Persons incapable of informed consent[220] cannot act autonomously and persons who are capable of – but have yet to provide – informed consent have not had their autonomy respected.

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[217] Ibid., 103.

[218] Ibid.

[219] The presentation and elaboration of their ideas on informed consent take up roughly half of the respect for autonomy chapter.

[220] I.e., young children, as previously discussed.

Principlism's Colonial Ties

In their discussion, Beauchamp and Childress note that it is a regrettably common practice to reduce informed consent to a single element – disclosure[221]. That is, many medical groups will only require that a patient has had been made privy to information related to their health and/or a possible procedure to render informed consent possible. This is problematic not only because it neglects other important elements of informed consent[222], but because this neglect enforces an ideal of individualized autonomy. The individual patient's exposure to some sufficient amount of information is made out to be solely constitutive of a capacity for consent; the other external factors that may influence such consent need not be considered. Essentially, it only obliges healthcare providers to foster the second criterion of PBE's definition of autonomy – having adequate understanding of the circumstances at hand. The first and third criteria (capacity for and freedom to consent, respectively) are left up to the individual. This is reminiscent of victim-blaming business practices that rely heavily on the provision of "terms and conditions" documents. Subscription service W may (correctly) claim that they have the right to sell the personal information of their customer base because this proprietary relationship was detailed in the terms and conditions of their service, provided to the customers at sign-up. However, this claim neglects to acknowledge the (blatantly obvious) fact that almost no one takes the time to read or fully comprehend the minutia of such terms. Indeed, customers of W will likely be surprised to discover that they "consented" to their personal information being sold. W can ignore such surprise by claiming that it was the fault of the individual customers for not understanding the terms as they were presented. However, it is clearly the case that, despite having information relevant to their choices disclosed to them, placing most of the onus of autonomy on the individual has not allowed them to informedly consent. It should be the responsibility of W to ensure that its customer base understands its terms and can choose to accept them. Similarly, Beauchamp and Childress disagree with the assertion that "individual autonomy alone can account for the ethical importance of consent"[223] in healthcare. The respect for autonomy principle obliges an acknowledgement of the ways in which consent is determined outside of the individual. Anything less misses crucial aspects of patient autonomy.

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[221] Beauchamp and Childress, 121-9.

[222] PBE lists seven elements of informed consent (p.122): competence, voluntariness, disclosure, recommendation, understanding, decision, and authorization. Although disclosure is one of the most crucial of these elements, it alone is insufficient for the attainment of informed consent.

[223] Beauchamp and Childress, 118.

Altogether, Beauchamp and Childress avoid any explicit affirmations of individually focused autonomy. They argue that autonomy is about a person's choices, but the factors that influence these choices are not wholly within said person. Moreover, they posit that existing standards of autonomy are too narrow and individually focused. The authors are clearly in favour of improving autonomy, but never state that the principle or its improvements should take moral precedence.

Nonmaleficence

An obligation to nonmaleficence is one of the most well-established ideas in healthcare. Etymologically, the term consists of the Latin prefix *non-*, "not", the Latin root *mal*, "ill/wrong", and the Latin suffix *-ficus*, "doing". As such, the principle refers to a person's not doing (i.e., bringing about) maleficence; it is the avoidance of wronging/harming someone. Since healing – the primary goal of *health*care – is a process that requires the absence or reduction of harms, it is not hard to see why nonmaleficence is considered so important to medicine. Beauchamp and Childress note that this importance is so engrained in the common understanding of medical practice that many people incorrectly believe the Latin phrase *primum non nocere,* which roughly translates to "first, do no harm", is an integral part of the Hippocratic oath[224]. Although this phrase was never actually part of Hippocrates' oath (nor does the oath depict the beliefs and professional conduct of all healthcare providers[225]), it does correctly capture the general obligations to nonmaleficence that medical practitioners have recognized for millennia.

Beauchamp and Childress' definition of nonmaleficence strays from this apocryphal nugget of Hippocratic wisdom in a couple of ways; the first of which is expanding on the idea of "do *no* harm"[226]. Despite the intuition that harm should be avoided completely, the principle of nonmaleficence does not oblige healthcare providers to avoid all harms whatsoever. Rather, it

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[224] Ibid., 155.

[225] While many medical schools in settler North America require their graduates to swear to an oath (e.g., the classic Hippocratic oath, Louis Lasagna's "modern version" of the Hippocratic oath, or the World Medical Association's Declaration of Geneva), this requirement is far from universal in a geographical or temporal sense; see Shernaz Dossabhoy, Jessica Feng, and Manisha S Desai, 'The Use and Relevance of the Hippocratic Oath in 2015 - a Survey of US Medical Schools', *Journal of Anesthesia History*, 4.2 (2018); see also Rachel Hajar, 'The Physician's Oath: Historical Perspectives', *Heart Views*, 18.4 (2017).

[226] The authors weave expanding ideas throughout their chapter on nonmaleficence, but never explicitly state that they oblige healthcare providers to do something more nuanced than *no* harm. This nuance is made evident by the fact that a whole chapter is dedicated to the subject, but their general idea about the possibility of harm avoidance is worth noting here for the sake of clarity.

obliges these providers to *avoid as much harm as possible*. This less stringent metric is used because it is impossible to avoid all harms in a medical context. The primary reason a patient will seek out medical care is because they are experiencing some form of harm that they wish to eliminate/prevent. Irrespective of the speed and efficiency with which a provider can act, there will always be some risk for harm experienced by the patient and met by the provider[227]. Moreover, many medical treatments necessarily involve the imposition of harm for the sake of mitigating another (e.g., surgical procedures involve intentional bodily harm for the sake of ameliorating existing harm(s)). Further still is the case of palliative care, in which the harms a patient is experiencing cannot be eliminated, only lessened. To these ends, Beauchamp and Childress state that "to confine the practice of medicine to measures designed to cure diseases or heal injuries is an unduly narrow way of thinking about what the physician has to offer the patient"[228]. There may very well be cases in which a medical procedure eventually eliminates a patient's harms, but the avoidance of harm to the greatest degree possible is much more accurate to the physician's role as a nonmaleficent care provider.

PBE also distinguishes its principle of nonmaleficence from the "Hippocratic" tradition by making it a *prima facie* obligation, in line with the other core principles. Rather than positing that medical providers are obligated to "*first*, do no harm", they argue that there is a *prima facie* obligation to avoid harms[229]. This ensures that healthcare providers are not unduly focused on preventing harms since the incurrence of certain harms is morally permissible, if not unavoidable, in many cases.

Altogether, Beauchamp and Childress argue that the principle of nonmaleficence is not about obligations to "first, do no harm", but rather, to avoid harm when possible and only allow for the imposition of harms when they can be justified by the *prima facie* obligations of another principle[230]. This definition is particularly useful when deciding a patient's course of treatment. For example, a clinician operating under this principle would be morally permitted to decide that a patient with terminal cancer should undergo chemotherapy despite knowing that this treatment

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[227] For example, even if a patient is not attending a medical facility for some pressing malady, simply entering such a facility poses a risk for being subjected to harmful accidents and/or (more likely) institutional harms such as stereotype threats.
[228] Beauchamp and Childress, 191.
[229] The reasons for which have already been established in the *Principles from Rules and Rules from Principles* section of this chapter.
[230] Beauchamp and Childress, 158.

will result in significant bodily pain, discomfort – and in some cases – financial harm. Introducing these harms is justified on the grounds that the intervention will hopefully mitigate existing physical and/or psychological harms and provide a net benefit to the patient. Harm is avoided (i.e., nonmaleficence) through selecting the treatment option with the highest available ratio of benefit to harm (i.e., beneficence). On top of demonstrating that harm can be avoided in cases when it is also intentionally introduced, examples like these are illustrative of the many different forms of harm that the principle of nonmaleficence obliges the avoidance of.

Until this point, the nebulous term "harm" has been used to describe what the principle of nonmaleficence obliges clinicians to avoid. While it can be intuitively garnered that harms are antagonistic to the healing process and worth avoiding, there is a wide variety of things that meet these criteria. Indeed, Beauchamp and Childress note that there are many definitions of "harm" that range from broad and unwieldy to narrow and exclusionary[231]. The authors attempt to meet these definitions in the middle, defining harm as "a thwarting, defeating, or setting back of some party's interests"[232]. Beauchamp and Childress acknowledge that this definition can include a myriad of entities and/or conditions, but primarily concerns itself with "physical and mental harms, especially pain, disability, suffering, and death"[233], the maladies most frequently managed by healthcare systems.

Although the terms "thwart" and "defeat" mentioned in PBE's definition imply some degree of intentionality, not all harms are intentional[234]. For example, I am harmed if I am caught in an avalanche while hiking in the mountains because the (likely severe) physical destruction of my body resulting from the avalanche will set back my interest in living a life unencumbered by pain or disability. If I am a particularly passionate outdoorsman I may even go so far as to say that the avalanche has specifically harmed me by setting back my interest in completing the hike. However, we cannot rightly attribute intention to the avalanche's imposition of harm. Snow does not choose to fall from a mountain. As such, the avalanche's "thwarting" of my interests cannot be given moral attribution; it was not morally wrong for the avalanche to harm me, it simply harmed me. In healthcare, these are the sorts of harms that clinicians aim to ameliorate through appeals to the principle of beneficence. They are harms incurred through processes like "disease,

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[231] Ibid.
[232] Ibid.
[233] Ibid., 158-9.
[234] Ibid., 158.

natural disasters, bad luck, and acts of others to which the harmed person has consented"[235]. The principle of nonmaleficence does not require any action regarding these harms other than to avoid exacerbating them.

On the other hand, there are also intentional harms – harms that can be given moral attribution, being beneficent (right) or maleficent (wrong)[236]. Beneficent harms have already been alluded to in this section; they are the sorts of intentional harms that can be justified on the grounds of some other principle. For example, a physician choosing to amputate the foot from a patient with diabetes involves the intentional setting back of the patient's interests (e.g., an interest in having the ability to walk/stand without support), but this harm is justified as a means of mitigating the necrosis of the patient's leg tissue (a significantly worse harm). Maleficent harms are intentional and unjustifiable impediments to persons' interests. For example, a physician who elects to anaesthetize all their patients to the point of losing consciousness would be setting back their patient's interests (e.g., an interest in avoiding a loss of control over their own bodies) maleficently because there is no principled reason to impede patient interests in this way or to this degree. Accordingly, a nonmaleficent care provider will avoid such harms.

The overzealous anaesthetizing physician example also reveals an important addendum to the harms that healthcare providers are obliged to avoid – negligent harms. When the physician elects to anesthetize all their patients, they are not only *directly* inflicting undue harm on their patients by causing them to lose bodily control, but they are also negligently putting them at undue *risk* for harm[237]. If there is too much anaesthetic administered to a patient, the patient is at significant risk of incurring a future harm much greater than that which they were already experiencing. The physician, depending on the circumstances, could be imposing this risk intentionally or unintentionally. If the physician is aware of the possible harms that the anesthetic carries, they are intentionally imposing risk; if they are ignorant of or have forgotten these possible harms, they are unintentionally imposing risk[238]. Regardless of intention and/or circumstance, both cases present clear cases of maleficent negligence that is to be avoided.

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[235] Ibid., 158.

[236] Ibid.

[237] Anesthetic can result in significant damage to a person's body (e.g., lack of blood flow or oxygen intake, neurological damage, etc.), even when administered appropriately. As such, patients are usually only sedated when absolutely necessary.

[238] Unintentionally harming is distinct from the non-intentional harming described several paragraphs previously to this. Non-intentional harms have no aspect of decision wherein the harm could have reasonably been avoided. Unintentional harms come from a decision to not attend to something, a sort of "if you choose not to decide, you still

Avoiding these negligent harms, according to the principle of nonmaleficence, requires taking due care[239]. Beauchamp and Childress define due care as "taking appropriate care to avoid causing harm [or risks for harm], as the circumstances demand of a reasonable and prudent person"[240]. For PBE, this "reasonable and prudent person" is unbothered by the circumstances behind a failure to meet this appropriate level of care. Instead, they are focused on the consequences of failing to avoid harms. As demonstrated in the case of the negligent anaesthetizing physician, the precise circumstances that determined why the negligence occurred is irrelevant; the fact that undue harm was imposed is what matters to the principle. Beauchamp and Childress strengthen their resolve in this sentiment through their discussion of the distinctions often held between the concepts of: withholding versus withdrawing treatment, intended versus foreseen side effects, and killing versus letting die[241]. To the authors, all people who maintain that there are reasonable differences within any of these conceptual pairs are needlessly focused on making the imposer feel better about a harm they are inflicting (e.g., distinguishing killing from letting die only helps someone feel less directly responsible for ending someone's life). The principle of nonmaleficence does not determine any difference within any of these ideas. So long as due care is met (i.e., maleficent harms are avoided), the name given to a particular harm is irrelevant.

To get a clearer picture of the lines that demarcate foundational ideas like "maleficent" and "due", Beauchamp and Childress provide a list of specifying rules to the principle of nonmaleficence. This non-comprehensive list of rules, all of which take the form of "do not do X"[242], consists of: i) do not kill, ii) do not cause pain or suffering, iii) do not incapacitate, iv) do not cause offense, and v) do not deprive others of the goods of life[243]. Much like the principle from which they are derived, these rules are to be balanced in context, not taken as absolutes[244]. The effectiveness of these specifying rules can be illustrated by applying them to the colonial clinical encounters mentioned at the end of Chapter 1. For example, while it is obvious that Brian

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have made a choice" (Rush, *Freewill* (1980)) concept. Someone who unintentionally harms could have chosen to act in a way that would avoid this harm; someone/something who non-intentionally harms has no choice in the matter.

[239] Beauchamp and Childress, 160-1.

[240] Ibid., 160.

[241] There is a lot of interesting discussion had in this section of PBE. Unfortunately, elaborating on all of it here would distract from the topic at hand; see Beauchamp and Childress, 171-93.

[242] Ibid., 157.

[243] Ibid., 159.

[244] Moreover, these rules bear striking resemblance, if not verbatim similarities to aspects of the common morality, which leverages the "loose distinction" these rules have to principles, as mentioned in Chapter 2.

Sinclair's death was wrong and involved a great deal of harm, exactly what the "wrongness" was is in this case is less clear. If we apply the specifying rules, it is easy to see why this wrongness is hard to parse; the case fails to meet any of the obligations of the specifying rules. Mr. Sinclair experienced suffering (rule ii), was incapacitated due to negligent behaviour (rule iii), was deprived of the good that was medical treatment for his easily treatable bladder infection (rule v), and died due to the confluence of these factors (rule i). I think it is apparent that this encounter also caused offense (rule iv) to Mr. Sinclair, but it is not immediately apparent that he was offended on the night of his death[245]. All these specific rules were broken due to negligent behaviour on behalf of staff in the hospital where Mr. Sinclair passed. The principle of nonmaleficence dictates that all the harms incurred by Mr. Sinclair should have been avoided.

Taken as a whole, the principle of nonmaleficence stems from common morality obligations that require us to avoid unjustifiable harms. It captures and employs common morality rules like "do not kill"[246], "do not cause pain or suffering to others"[247], and aspects of "do not punish the innocent"[248]. Accordingly, particular morality rules such as "[n]ever participate in or condone the practice of torture or any form of cruel, inhuman, or degrading procedure"[249] are consistent with the principle of nonmaleficence.

Beneficence

Although nonmaleficence is one of the most well-established ideas in healthcare, beneficence could easily share this title[250]. As the previous section demonstrates, the principles of beneficence and nonmaleficence often operate in concert. Wherever some harms are being nonmaleficently avoided, the beneficent address of other harms is likely close by. This

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[245] Beauchamp and Childress also do not say much of anything about what "offense" means in the context of harm. I assume that the definition of "offense" being used in PBE is based on Joel Feinberg's seminal offense principle or some facsimile of it (i.e., being offended is equivalent to "the whole miscellany of universally disliked mental states [that may be] caused by the wrongful (right-violating) conduct of others", which excludes several physical and emotional maladies); see Joel Feinberg, *Offense to Others: The Moral Limits of the Criminal Law* (Oxford University Press on Demand, 1985), 1-2, 46. I make this assumption because their definition of harm is also near-identical to Feinberg's; see Joel Feinberg, *Harm to Others: The Moral Limits of the Criminal Law* (Oxford University Press on Demand, 1984), 36. As such, being offended is an undesirable affront to the self that impedes one's interests (i.e., causes harm) by making someone feel unpleasant.

[246] Beauchamp and Childress, 3.

[247] Ibid.

[248] Ibid.

[249] Canadian Medical Association, *Code of Ethics and Professionalism*, 2.

[250] Beauchamp and Childress, 230.

accompaniment happens so frequently that many people have suggested that the two principles should be combined into a single concept[251]. Hippocrates was not one of these people. Even though *primum non nocere* was never part of his oath, Hippocrates still gave explicit instructions about the avoidance of harm and its relation to other obligations. Specifically, as Jay Katz notes, "the original Greek version of *primum non nocere* … commanded not, as does its Latin adaptation, 'above all, do no harm," but rather 'in the diseases we must seek two (facts): to be useful or not to damage'"[252]. In other words, the Hippocratic oath required healthcare providers to recognize that usefulness (i.e., obligations to the principle of beneficence) and the avoidance of damage (i.e., obligations to the principle of nonmaleficence) are distinct entities, each of which are central to medicine. Beauchamp and Childress mostly agree with this sentiment, differing only insofar as they believe that the medical providers are obliged to be useful (i.e., beneficent) *and* avoid harm (i.e., be nonmaleficent), not to be useful *or* avoid harm[253]. Consequently, PBE argues that the principles of beneficence and nonmaleficence are of equal importance, but they have unique obligations.

The term "beneficence" is an antonym of "maleficence". It is etymologically comprised of the Latin root *bene*, "well" (the opposite of *mal*, "ill/wrong") and the Latin suffix *-ficus*, "doing". Accordingly, the term refers to a person's doing (i.e., bringing about) wellness; it is the active promotion of someone's health. Unsurprisingly, obligations of this sort are also foundational to the ethos of *health*care. Some health-promoting obligations need to be committed to; else the entire discipline of healthcare loses its purpose. Medical professionals who lack a commitment to such obligations (and/or unjustifiably prioritize other concerns) are rightly considered to be charlatanic. However, this does not mean that healthcare requires all medical professionals to be zealots of beneficence. It is a *prima facie* binding principle that can be overcome. Moreover, in the same way that the principle of nonmaleficence does not require all harms be avoided, the principle of beneficence does not require that health be promoted to its furthest extent. Some

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[251] For example, the CMA posits a series of "fundamental commitments to the medical profession" (p.2), which include a "commitment to the well-being of a patient" that is comprised of avoiding harms and promoting health. This series also includes commitments to respect for persons and justice. In essence, this is the CMA's harkening to Principlism (i.e., "well-being of a patient" is equivalent to the combination of nonmaleficence and beneficence, "respect for persons" is equivalent to respect for autonomy, and "justice" is equivalent to justice); see also Beauchamp and Childress, 155-8.

[252] Jay Katz, *The Silent World of Doctor and Patient* (New York: New York Free Press, 1984), 94.

[253] As Beauchamp notes, "[t]he physician who professes to 'do no harm' is not usually interpreted as pledging never to cause harm, but rather to strive to create a positive balance of goods over inflicted harms" (p.5).

elaboration on what constitutes a health-promoting act will be useful in understanding why this is the case.

According to Beauchamp and Childress, obligations to beneficence are fulfilled through "preventing harm, removing harm, and promoting good"[254]. Preventing harm promotes health by proactively ensuring that risks for the incurrence of harm are kept to a minimum. Essentially, this mode of beneficence is the active stymieing of the negligent harms mentioned in the *Nonmaleficence* section. For example, a nurse not washing their hands between patient visitations – a negligent harm that imposes risk for staff, patients, or care materials becoming disease vectors/hosts – can be prevented through enforcing strict guidelines regarding the frequency and quality of staff handwashing. Removing harm is more direct than this. It promotes health by actively seeking to eliminate an existing problem. For example, a clinician prescribing antibiotics for a patient's bacterial pneumonia helps to directly resolve the harm(s) related to this infection. Promoting good refers to all other beneficent acts that do not involve harms. Typically, these promote health by building on existing goods. For example, a physician promotes the health of their patient by encouraging them to make regular appointments to "check-up" – a good that builds upon the limited goods a patient receives when only visiting their primary physician for emergent health concerns. As is especially apparent in this last mode of beneficence, there is seemingly no end to the extent to which we can promote health. So long as there is some preventable or removable harm and some goods to build upon, one can always be acting more beneficently.

As already alluded to, although it is true that nearly all circumstances leave room for someone to act more beneficently, this does not mean that this room should always be filled. That is, it is unnecessary to oblige healthcare providers to benefit each of their patients to the greatest extent possible. Such lofty goals are impractically idealistic; there are some benefits that are impossible to obtain. For example, it is impossible to guarantee that every patient a clinician sees can be cured of all their ailments. Irrespective of how much harm reduction and preventative medicine a care team throws towards a patient, the patient will still inevitably suffer some harm that is intractable by current medical science. There are also some benefits that are obtainable, but obtaining them would place unreasonable burdens on healthcare systems. For example, it is possible to require that all persons entering a hospital wear a hazmat suit, or pad every wall a

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[254] Beauchamp and Childress, 157.

patient may bump into, or guarantee each patient at least 2 hours of face-to-face time with their physicians per appointment, but these would all clearly exceed reasonable expectations under the current funding and labour scheme of healthcare. Accommodating such benefits is too costly.

To help garner a more precise measure of what counts as "costly" (so as to judge the point to which beneficent obligations extend), PBE suggests the use of cost-benefit and cost-effectiveness analysis[255]. In both forms of analysis, the "cost" of any action is understood as the combined force of the possible probability and magnitude of harm[256]. Cost-benefit analyses measure this harm and its opposed benefits in monetary terms, while cost-effectiveness analyses do this in terms of enumerable health metrics (e.g., quality-adjusted life years (QALYs), prevalence/incidence of illness, etc.). In either case, actions that are deemed to have a net risk (i.e., more enumerable risk than enumerable benefit) are deemed costly and impermissible; actions deemed to have a net benefit (i.e., more enumerable benefit than risk) are deemed reasonable and permissible. Such is the utilitarian calculus of the beneficent medical professional; providing as much enumerable benefit as possible until the enumerable cost of doing so becomes too burdensome.

However, these calculations do not account for all the considerations required to adhere to the duties to beneficence. Estimations of probability/significance of harm can differ drastically between parties, even when presented with the same data. For example, Canada and the United States, two countries with similar (if not identical) access to data on the costs and benefits of the circumcision of newborns with penises, have different guidelines on the permissibility of the procedure. Canadian frameworks deem the procedure too risky to justify its existence under beneficent obligations, but American frameworks deem the procedure's benefits to outweigh the possible risks[257]. Does the principle of beneficence oblige the circumcision of newborns with penises? Cost-based numerical analyses alone cannot tell us. Therefore, beneficent obligations must also be shaped by other, more personal ideas. According to Beauchamp and Childress, these ideas consist of special relations and reciprocity.

Special relations refer to interpersonal and/or institutional connections that uniquely bind a person to act beneficently for the sake of another specific person. These specific benefactors

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[255] Ibid., 250-2.
[256] Ibid., 243-4.
[257] Ibid., 244.

include children, friends, and other people who depend on us[258]. The physician-patient relationship is a special relation because it binds the physician to benefit a specific person who depends on them – the patient. Standing in opposition to this are general relations, in which people are bound to act impartially beneficent for the sake of people at large. According to PBE, the common morality "recognizes significant limits to the scope of general obligations of beneficence" [259]. As wonderful as it would be if every person was generally beneficent[260] (i.e., impartially preventing/removing harms and promoting good for the sake of all people), an obligation of this kind is too demanding[261]. Accordingly, it is the beneficent obligations of special relations (i.e., patient relations) that bind clinicians; general beneficence only overrides these duties in very limited circumstances[262].

To explain why such relationships should matter to us, the authors turn to the concept of reciprocity. Specifically, they argue that a clinician's obligations of beneficence are not about being kind/philanthropic, but about paying back a debt. The healthcare industry is indebted to society and the people within it, regardless of if they are patients or not[263]. Taxes and special interest groups allow for healthcare workers to be trained, supplied, and make a living. Moreover, the knowledge and experience gained by interacting with patients is an invaluable resource in the constant improvement of medical practice[264]. Medical professionals, like any other professionals, provide services "rooted in a moral reciprocity of the interface of receiving and giving in return"[265]. This reciprocity driver is uniquely potent in medicine due to the relatively high value of exchange that takes place through the medical sphere (i.e., the

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[258] Ibid., 219.
[259] Ibid., 220.
[260] Ibid., 46-51, 218-9.
[261] This is in opposition to some Utilitarian theorists like Peter Singer, who argue that beneficence obliges equalizing opportunity and sacrifice amongst all moral entities on a global scale; see Beauchamp and Childress, 219-20.
[262] These limited circumstances are what can be called "rescue cases." Simply put, if a person to whom a clinician otherwise holds no special relation to needs rescue, they are obliged to help them. More specifically, a person "needs rescue" if they are experiencing significant risk for (or actual) harm; the clinician is obliged to beneficently aid this person if a spontaneous cost-benefit/cost-effectiveness analysis deems it reasonable to help this person; see Beauchamp and Childress, 244.
[263] William F May, 'Code, Covenant, Contract, or Philanthropy', *Hastings Center Report*, 5.December (1975), 31-3.
[264] Beauchamp and Childress, 229.
[265] Ibid.

saving/preservation of life and monetary transfer)[266]. Clinicians owe it to their patients to benefit them as much as possible because such benefits would not be possible without them.

Altogether, the principle of beneficence obliges healthcare providers to actively promote the health of their patients as much as possible, given the probable costs of doing so. It is *prima facie* binding in the same manner as the other principles, but is uniquely central to the practice of medicine insofar as it directly addresses the specific, emergency, and reciprocal duties that the discipline owes to its patients. Oftentimes, such as in the case of the CMA, codes of ethics will reflect this centrality by espousing general commitments to beneficence with little in the way of specification (i.e., "always act to benefit the patient and promote the good of the patient" [267]). The principle captures and employs common morality rules such as "rescue persons in danger"[268], "nurture the young and dependent"[269], and "prevent evil or harm from occurring"[270]. It also includes specifying rules such as "remove conditions that will cause harm to others"[271] and "help persons with disabilities"[272]. Particular morality rules such as "[p]rovide whatever appropriate assistance you can to any person who needs emergency medical care"[273] are also covered by this principle.

Justice

Exactly what the principle of justice obliges healthcare providers to do is "controversial and difficult to pin down"[274]. The etymology of the term "justice" is fairly straightforward; it is a modernization of the Latin word *iustitia*, "equity/righteousness". To be just is to be *iustus*, equitable and righteously in accordance with an agreed upon moral framework. As straightforward as the term is, its definition reveals little. There are many different moral frameworks to which someone can accord, and there are equally many determinations on the

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[266] Verna J Kirkness and Ray Barnhardt, *First Nations and Higher Education: The Four R's - Respect, Relevance, Reciprocity, Responsibility*, *Knowledge Across Cultures: A Contribution to Dialogue Among Civilization* (Hong Kong, 2001).
[267] Canadian Medical Association, *Code of Ethics and Professionalism*, 4.
[268] Beauchamp and Childress, 3.
[269] Ibid.
[270] Ibid.
[271] Ibid., 218.
[272] Ibid.
[273] Canadian Medical Association, *Code of Ethics and Professionalism*, 4.
[274] Beauchamp and Childress, 266.

precise obligations of "equity". Beauchamp and Childress opt to embrace this complexity and structure their principle of justice upon the conglomeration of several different theories.

Common to all theories of justice is what is known as the formal rule[275]: "equals must be treated equally, and unequals must be treated unequally"[276]. This rule is the sole member of the first of two tiers of specifying rules within the principle of justice. Justice is generally about being equitable, and the formal rule specifies that being equitable has something to do with treating like cases alike. More importantly, this rule differentiates the normative term, "equity" and the descriptive term, "equality". Specifically, it reveals that equality – the state of being the same – is integral to being equitable, but the reverse is not true. It is impossible to treat equal things alike if I do not understand what makes them equal[277]. However, it is very much possible for things to be equal without any influence from equitable actions. For example, two infants born with the same congenital heart defect may have an equally low chance of surviving past their first year, but this equality does not hinge on anything having to do with equity[278]. The infants' equal chance of survival is purely descriptive. However, determining that each infant should be treated with an equal amount of care to help increase this chance of survival[279] has everything to do with their equality. Without this equality, the formal rule could not dictate that the two infants need to be treated equitably.

As universal as the formal rule is, it is not particularly instructive for medicine. Namely, it does not identify what the rule means by "equal". It could be referring to an extremely strict definition of equality under which two (or more) patients must be identical in nearly every regard (e.g., sameness in size, genetic predispositions, diet, socioeconomic status, etc.) to be considered worthy of equitable care. This definition has the benefits of ensuring that each patient is owed the exact type and amount of care they deserve, but is also idiosyncratic to a degree that would

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[275] Beauchamp and Childress use the term "formal principle" when describing this concept (as well as the "material principles" of justice mentioned later). The term "rule" will be used here in place of "principle" to avoid confusing these ideas with the four core principles and because I believe the term "rule" is more accurate to the specification role that these ideas play.

[276] Beauchamp and Childress, 267.

[277] I could, purely by coincidence, happen to act equally towards equal things, but this is different from *treating* equal thing equally. The word "treat" implies some degree of understanding behind and intentionality towards the circumstance.

[278] The existence of the heart defect and its low survival rate may have to do with some unjust systemic factor(s) (e.g., the area in which the infants are born does not have access to the surgical equipment required to treat the condition). However, the point being made here is that the equality of these two infants is not unjust.

[279] Moreover, infants who possess drastically lower or higher chances of survival should be treated with correspondingly distinct levels of treatment (i.e., treating unequal cases unequally).

be impossible implement in practice. Human diversity nearly guarantees that all patients are unequal in some regard, making generalizable treatments or advice impossible under this definition. On the other hand, the formal rule could also embrace an extremely lax definition of equality under which two (or more) patients need only share one or two characteristics (e.g., being a living member of *homo sapiens*) to be considered worthy of equitable care. This definition has the benefits of ensuring that all patients are guaranteed the same basic level of care, but is also generalized to a degree that makes tailored care impossible. Under this definition, any treatment given to a patient above the shared equitable minimum must also be given to all other patients, which is an extremely inefficient way of distributing limited medical resources. PBE's principle of justice attempts to find the happy medium between these extreme definitions by making use of the particulars in its conglomeration of theories.

These particulars are described in the second tier of specifying rules – the material rules of justice[280]. In essence, this series of rules explicates the essential standards used to define the terms "equal" and "unequal" as they are used in the formal rule. Said standards are drawn through the invocation of six popular theories of distributive justice: Utilitarianism, Libertarianism, Communitarianism, Egalitarianism, Capability theories, and Well-being theories[281]. Despite apparent contradictions between aspects of these theories[282], Beauchamp and Childress insist that "[n]o obvious barrier prevents acceptance of more than one of these [rules] as valid"[283]. Indeed, they believe that "[i]t is likely that there has never been a political state or a world order fashioned *entirely* on one and only one of the six theories of justice"[284] that they discuss. As such, the authors argue that each of the six material rules are important and comprehensible specifiers of the principle of justice. These rules, as "notably abstract"[285] summations of their parent theories are: "1) To each person according to rules and actions that maximize social utility [derived from Utilitarianism], 2) To each person a maximum of liberty and property resulting from the exercise of liberty rights and participation in fair free-market exchanges [derived from Libertarianism], 3) To each person according to principles of fair

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[280] Beauchamp and Childress, 266-70.

[281] More accurately, this list is only four theories in total. Capability and Well-being theories are updated versions of Egalitarianism – as will be shown later in this section (despite the authors' reluctance to admit it); see Beauchamp and Childress, 277.

[282] Which is the source of the aforementioned controversy inherent to the principle.

[283] Beauchamp and Childress, 270.

[284] Ibid., 281.

[285] Ibid., 270.

distribution derived from conceptions of the good developed in moral communities [derived from Communitarianism], 4) To each person an equal measure of liberty and equal access to the goods in life that every rational person values [derived from Egalitarianism], 5) To each person the means necessary for the exercise of capabilities essential for a flourishing life [derived from Capability theories], and 6) To each person the means necessary for the realization of core elements of well-being [derived from Well-being theories]"[286].

The first four material rules are derived from what Beauchamp and Childress refer to the "traditional theories"[287]. They are traditional insofar as they were the "most widely discussed theories of justice"[288] in the latter parts of the twentieth century, but their traditional status does not make them outdated or unimportant.

Rule 1 defines equality based on net utility, the core of Utilitarianism[289]. In this, people are defined as equals based on the summation of their beneficial and harmful experiences (as individuals or as a collective). People (or societies) who have significantly more beneficial experiences than others have significantly higher net utility. The opposite is true for people/societies who have significantly less beneficial experiences and/or more harmful experiences. As such, equity is determined by ensuring that the ratios of experienced benefit/harm are treated according to their severity whilst also trying to maximize utility in everyone's net ratio[290]. This concept was already mentioned in the *Beneficence* section; it is the same driving force behind cost-benefit and cost-effectiveness analyses. Justice is done through maximizing benefits and minimizing costs.

Rule 2 defines equality based on the "unfettered operation of fair procedures and transactions under conditions of law and order"[291], the core of Libertarianism[292]. In this, people are defined as equals based on their liberty (i.e., personal freedom determined by the ability to participate in a free market of property right transference without interference from other persons). Those who have significantly more or less liberty than others are unequal and

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[286] Ibid.
[287] Ibid., 271-7.
[288] Ibid., 271.
[289] The Utilitarian theory discussed in PBE appeals primarily to the work of John Stuart Mill and Jeremy Bentham.
[290] Beauchamp and Childress, 272.
[291] Ibid., 273.
[292] The Libertarian theory discussed in PBE appeals primarily to the work of Robert Nozick.

deserving of unequal treatment. As such, equity is made possible through the pursuit of guaranteeing everyone's unencumbered procedural engagement in the free market.

Rule 3 defines equality based on a person's engagement with "the moral and political commitments found in communities and their traditions and practices"[293], the core of Communitarianism[294]. In this, people are defined as equals based on the strength of their commitment to, and reciprocated commitment from, their communities. Those who have significantly more or less reciprocal connection are unequal and deserving of unequal treatment. As such, equity is made possible by finding ways to reduce the influence of individual rights in favour of promoting the benefit of groups as a whole.

Rule 4 defines equality based on "liberty"[295] and "fair opportunity"[296], the cores of Egalitarianism[297]. In this, people are defined as equals if they possess the same amount of freedom to pursue their own interests and the same socially-granted capacity to pursue social goods/positions. Those who have significantly more or less liberty and/or ability to pursue these goods are unequal and deserving of unequal treatment. However, egalitarians concede that some amount of inequality is acceptable and does not warrant unequal, equity-based treatment in cases where the inequality "benefits everyone"[298]. As such, equity is made possible through pursuing personal and social equality for all people in some areas, but not others.

Contemporary egalitarians disagree on what exactly must be made equal for just distribution. Where traditional Rawlsians argue that social justice is accomplished by ensuring equal opportunity to goods/positions, "modern"[299] theorists argue that the equalization of the means necessary for the: 1) "exercise of capabilities essential for a flourishing life"[300] – Rule 5, stemming from Capability theory[301] - or, 2) "realization of core elements of well-being"[302] – Rule 6, stemming from Well-being theory[303] – are more important. The capabilities of Rule 5 can

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[293] Beauchamp and Childress, 276.
[294] The Communitarian theory discussed in PBE appeals primarily to the work of Daniel Callahan.
[295] Beauchamp and Childress, 274.
[296] Ibid., 275.
[297] The Egalitarian theory discussed in PBE appeals primarily to the work of John Rawls and Norman Daniels.
[298] Beauchamp and Childress, 275.
[299] Ibid., 277.
[300] Beauchamp and Childress, 270.
[301] The Capability theory discussed in PBE appeals primarily to the work of Amartya Sen and Martha Nussbaum.
[302] Beauchamp and Childress, 270.
[303] The Well-being theory discussed in PBE appeals primarily to the work of Madison Powers and Ruth Faden (who is Tom Beauchamp's wife…).

be thought of that which allows us to be able to live our lives pursuant to our personal goals. The well-being of Rule 6 is much the same, but posits it is better to be healthy/well than to be capable of it.

Beauchamp and Childress see particular value in Rules 5 and 6 because they "attend closely to the value of health"[304], and are based not only in Rawls, but also in Aristotelian theory – both of which are key theoretical inspirations for the Principlist scheme[305]. Rules 5 and 6 are "modern" because they focus on the active living of an independent person. This is opposed to a focus on the resources people make use of as a member of a civilization, which is the centre of the other four "traditional" theories mentioned earlier[306]. The focus on active living as a person, rather than a citizen, also allows for an extension of the ideals of justice beyond the walls of a metropole, towards greater humanity.

According to PBE, the "intelligent use"[307] of these six material rules helps to provide guidance about the provision of care whilst adhering to the multi-faceted concerns of healthcare. To "make available high-quality health care for all citizens while protecting public resources through cost-containment programs and respecting the choices of patients and clinicians"[308], at least some of these rules must be considered at any given time. As such, the principle of justice obliges healthcare providers to consider all the material rules when deciding the type and degree of care they are administering to their patients. It is a difficult balancing act, but it promises to ensure that each patient is treated with what they need because they need it, nothing else.

The argument could be made that this system of rules is unfeasible, acting as reasonable "models, but not truly practical instruments"[309]. After all, Principlism already obliges healthcare providers to consider the balancing of each of the four core principles and their minutia; balancing the six material rules within the principle of justice (each of which are content-thin) on top of the balancing of the principles is unlikely to result in much in the way of well-reasoned action. If it does, this action will likely take too long to come to fruition. Although Beauchamp

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[304] Ibid., 270.

[305] Egalitarian theories are more directly influenced by Rawlsian theory, but these "new" theories have the benefit of combining Rawls and Aristotle, making them more directly aligned with Beauchamp and Childress' argumentation throughout PBE.

[306] They note that the modernity of capability and well-being theories does not make them better theories than their traditional counterparts (p.271); however, PBE clearly favours these more modern concepts.

[307] Beauchamp and Childress, 280.

[308] Ibid.

[309] Ibid.

and Childress disagree with this assessment[310], accepting its conclusions would not be devastating to the principle of justice. Indeed, the principle of justice is a useful tool not only because of what it explicitly obliges of clinicians, but also for what it does not.

Quite obviously, the principle of justice does not oblige healthcare providers to act unjustly. According to the formal rule, injustice occurs when a provider fails to treat equal things equally and unequal things unequally. According to the material rules, injustice occurs when a provider defines just distributions by any metric other than utility, liberty, community, or equality of opportunity/capability/well-being. Taken together, this means that a healthcare provider's provision of just care should not stem from some other "irrelevant properties"[311] that fall outside the purview of the material rules. Relying on such properties is a failure to act equitably; a failure to accord with the principle of justice. For example, it is unjust to treat Indigenous patients differently (i.e., unequally) from settler patients solely based on "race" because none of the material rules dictate that an individual's "race" is a metric for determining equality (or lack thereof). The same can be said for other properties such as gender/sex, "linguistic accent, ethnicity, national origin, and social status"[312]. As such, even if a healthcare provider fails to perfectly balance and accord with the six material rules of the principle of justice, being aware of what they do not permit at least ensures that harmful and unreasonable definitions of equality are not being employed. If there is any unequal treatment between patients of different races, it must be defensible on grounds of one or more of the six material rules, nothing else.

Altogether, the principle of justice captures and employs common morality rules such as "obey just laws"[313] and "do not punish the innocent"[314]. Much like the rules mentioned by the principle, these common morality norms oblige against unjust behaviour. From these, the principle of justice gives positive obligations regarding what this "sense of equality" should be through its specifying rules. Particular morality rules that accord with the principle of justice borrow from both frames of reference. For example, responsibility 1 in the CMA's professional code of ethics simultaneously prohibits determining equal merit on non-material grounds and promotes equitable treatment if they are based in "legitimate" material rules: "[a]ccept the

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[310] Ibid.
[311] Ibid., 281.
[312] Ibid.
[313] Ibid., 3.
[314] Ibid.

patient without discrimination (such as on the basis of age, disability, gender identity or expression, genetic characteristics, language, marital and family status, medical condition, national or ethnic origin, political affiliation, race, religion, sex, sexual orientation, or socioeconomic status). This does not abrogate the right of the physician to refuse to accept a patient for legitimate reasons"[315]. Similar ideas are captured by responsibility 43 (explicated in Chapter 1) and responsibility 44, "[c]ontribute, individually and in collaboration with others, to improving health care services and delivery to address systemic issues that affect the health of the patient and of populations, with particular attention to disadvantaged, vulnerable, or underserved communities"[316]. The only cases in which these obligations to justice are overridden is when another principle takes circumstantial precedence.

Chapter 3: Addressing and Redressing Principlism

Principlism, like any other ethical paradigm, is not without its detractors. Many theorists – principlists and other "-ists/-ians" alike – have offered critiques and revisions of the famous four[317]. These critiques tend to argue that: PBE excessively focuses on autonomy, its conception of autonomy is too individually focused, or the framework works better with a different number of principles (if the principles work effectively at all)[318]. As this chapter will demonstrate, Principlism has not fully shaken these issues, especially when dissecting its colonial ties.

This chapter will focus on illustrating the specific nature of Principlism's difficulties as they apply to the permittance and/or encouragement of colonial clinical medicine. The first section of the chapter, *Addressing Principlism*, details the difficulties with each of the main argumentative aspects of PBE in the same order they were presented in Chapter 2. Despite its critical tone, this section intends to illustrate that – despite each of its aspects requiring amendment of some kind – the paradigm can be made better. The second section of this chapter, *Redressing Principlism*, notes some prominent attempts that have been made at ameliorating the colonial permissiveness inherent in the paradigm. Although these attempts were not designed to amend Principlism directly, they still demonstrate some "decolonizing" ideas that a proper reconstruction of

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[315] Canadian Medical Association, *Code of Ethics and Professionalism*, 4.
[316] Ibid., 7.
[317] Several of these "principlists" have inspired critiques in this work. They include but are not limited to: W.D. Ross, Bernard Gert, Dan Clouser, John Arras, Robert Veatch, and Howard Brody.
[318] See Arras; see also Veatch.

Principlism should adopt (and others that should be avoided). Chapter 4 will then take all the points made here to argue the particulars of said proper reconstruction.

Addressing Principlism

The burden of illness experienced by Indigenous persons – although ultimately the result of colonialism as a whole – is not significantly helped by current Principlist ideas. For example, the CMA and CNA both cite the four core principles as foundational inspirations for their codes of ethics[319] and also encourage problematically underperforming versions of "decolonization"[320]. Beauchamp and Childress could respond to these concerns by stating that these "particular moralities" have developed colonial issues from other sources; that PBE's influences are purely of the beneficial sort. However, even if this response is taken to be true, this does not mean Beauchamp and Childress' paradigm is free from serious oversights. If Principlism does not directly espouse and encourage colonial ideals, it can still fail to adequately fight against them. As Chapter 1 demonstrates, this sort of indifference towards the perpetuation of colonial medicine is *the* major factor in the inequitable treatment of Indigenous persons today. Indeed, it is this indifference where PBE also masks most of its colonial ties.

The Common Morality

As explained in the beginning of Chapter 2, the "famous four" principles: respect for autonomy, nonmaleficence, beneficence, and justice[321], were originally designed as tools to bridge the successes of "ethically sound" medical research into the clinical sphere. They, with certain additions, were essentially copies of the Belmont Report's principles with a clinical twist. As such, the justification for their existence came from the same source as the Belmont Report, a *single line* stating that the principles are plucked from "those [principles] generally accepted in our cultural tradition"[322]. I think the inadequacy of this vague claim speaks for itself.

Since the third edition of PBE, this justification has (thankfully) been made more robust. The four principles are now considered to be drawn from the common morality – a set of content-thin moral rules that all moral agents ascribe to. As such, the four core principles are no

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[319] Canadian Nurses Association, 2; Canadian Medical Association, *Code of Ethics and Professionalism*, 1; Canadian Medical Association, *Equity and Diversity in Medicine*, 1-2.

[320] See the *"Decolonizing" Saviours* section in Chapter 1.

[321] In their respective forms at the time.

[322] National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, Part B.

longer argued to be *generally* agreed upon or part of *our* cultural tradition, but rather, derived from a *universally* valid conception of morality. The legitimacy of the principles is therefore bound to their distilling of this supposedly universal sense of moral conduct. If PBE's depiction of the common morality is missing some medically relevant aspect of this universality, then the entire Principlist doctrine comes into question.

Near the end of their book, Beauchamp and Childress elect to bring up such questionability on their own. The authors state that the common morality, as it stands today, "is not where it should be"[323]. Specifically, they claim that the current set of rules in the common morality *should* include, but has yet to involve, an explicit rule about equal moral considerability[324] (hereafter, EMC) – some moral dictate that specifies the grounds on which exclusionary behaviour based in "irrelevant properties"[325] should be prohibited. Put differently, the authors believe that there is currently no universally agreed upon rule detailing what exact properties of a person count as "irrelevant" when considering their moral worth. As such, there is supposedly no universal agreement upon a rule detailing that something like colonial oppression – which grants moral considerability based on the property of settler proximity – is immoral.

This is a rather strange claim for Beauchamp and Childress to make (besides the fact that colonial oppression is not immoral according to the common morality). If the authors can posit that an EMC rule *should* be in the common morality, then their support for this claim must be backed by reasons to think that such a rule *should* be universally agreeable. However, its exclusion from the common morality clearly proves that such reasons are lacking. From where then do these reasons come from? Why would they bother to acknowledge them at all if they cannot grant an EMC rule a place in the common morality?

Since the authors are beholden to the common morality being determined by universal agreement, suggestions about what *should* be in it must come from some external reflection. Perhaps they and we all believe that it is rationally justifiable to have an EMC rule, but this rationality does not entail agreement. It is also possible that Beauchamp and Childress simply borrowed the idea of an EMC rule from some particular morality and are suggesting that it should be made more important. Either way, these external sources are not allowed to share in

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[323] Beauchamp and Childress, 447.
[324] Ibid., 447-50.
[325] Ibid., 281.

Principlism's limelight because they are not the same as universal agreement. PBE's strict distillation of the principles from a source of such agreement requires that an EMC rule cannot (yet) be part of the framework. Certainly, the authors' discussion suggests that they do not want this to be the case; but this does not change the fact that an EMC rule is left out. Surprisingly, Beauchamp and Childress still insist that Principlism can guard against irresponsible discrimination[326] nonetheless.

As briefly mentioned at the end of the *Justice* section in Chapter 2, Beauchamp and Childress acknowledge that irresponsible discrimination is immoral. The formal rule of justice requires that equals be treated equally and persons who differ by some impertinent property does not keep them from being equals. They even give a list of possible properties in this vein that includes things like ethnicity and social status[327], both of which bear clear relations to something like an EMC rule. Similar allusions to EMC-like properties can be seen in the principle of beneficence, wherein the authors dedicate an entire subsection to "Historical Problems of Underprotection"[328]. These sorts of oppositions to poorly founded moral considerability have been central to the core principles since the beginnings of the paradigm, even before shifting to a justification in the common morality[329].

Put succinctly, this all means that Beauchamp and Childress argue that there are good reasons to think that irresponsible discrimination is bad, but these reasons do not yet come – nor have they ever come – from a dedicated rule in the common morality. Their primary reason for thinking this is that there are many discriminatory practices "widely regarded in many customary moralities as tolerable and perhaps even thoroughly justified"[330]. As such, there is not universal agreement on what counts as an "irrelevant property" in a potential EMC rule. For example, there are several cultures in the world that refuse to allow persons assigned female at birth to run for political office because of a belief that they are better suited for housework and childcare. These cultures believe such refusal is sensible because the alternative – allowing any person of

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[326] I.e., discrimination based on irrelevant properties.

[327] Beauchamp and Childress, 281.

[328] Ibid., 198.

[329] The names of the principles have changed slightly, as have their specifications. However, PBE has yet to consider changing the number, relationship, or foundational definitions of the principles. Although Beauchamp and Childress profess that "the best strategy [for Principlism] is to appreciate the contributions and the limits of various principles, virtues, and rights, which is the strategy we have embraced since the first edition and continue throughout this edition" (p. ix), the principles have seen little in the way of change, which suggests that the authors believe that the "famous four" are as close to bioethical bedrock as we can get.

[330] Beauchamp and Childress, 447; see also Beauchamp and Childress, 80.

any gender/sex to pursue any job – will end up harming society by way of unchecked incompetence and underqualification in the workplace. At the same time, there are several other cultures that generally accept such deterministic beliefs as discriminatorily irresponsible.

So where else might Beauchamp and Childress draw their inspirations for their proposed anti-discrimination stance if not from rational reflection? The only other possible source must be a particular morality. I would think that such a morality would be wide-ranging, such as the United Nations conventions or Canada's Charter of Rights and Freedoms. Despite being particular moralities, the influence of these frameworks suggest a great deal of agreement, even if it is not universal. Principlism therefore might act in stride with such moralities' conceptions of appropriate moral considerability, even if it cannot share in their rationale.

Clearly, this method is only as effective as the particular morality it relies upon. Indeed, it is extremely unsatisfactory to have to rely on particular moralities to uphold EMC rules. This is not to say that documents like the Charter of Rights and Freedoms are ineffective *per se*, but there are many inescapable factors that mitigate their potency. History has shown that governments are not keen on enforcing anti-discrimination because these same governments often stand to benefit from discrimination. What better way is there to colonize a continent than to convince the settler population that the native inhabitants are to be feared and avoided? Indeed, the colonial enterprise is built on profitable discrimination that utilizes properties that are not only irrelevant, but largely made up. As Chapter 1 demonstrates, the "characteristics" often used to distinguish Indigenous persons from settler colonizers are self-fulfilling prophecies born out of oppression. The more Indigenous persons resist this oppression, the more settler colonizers cite the resistance as evidence of reason to discriminate against Indigenous persons. Settler colonizers do not want to admit this oppression exists or is immoral, because doing so means they have to forego the policies that allow them to enjoy an undeserved abundance of flourishing at the expense of someone else. Only under large public pressure, fueled by opinion on the *morality* of governmental practice, do effective policies come to be.

Given these difficulties, Beauchamp and Childress could have turned to another avenue for EMC justification. Were they less committed to social agreement being a direct source of the principles of biomedical ethics, they could simply argue that the common morality need not have an explicit EMC rule because the current ruleset already covers its obligations. Beauchamp and Childress argue that this same concept can be applied to things like slavery. PBE's current depiction of the common morality (as evidenced by the description of the four core principles) clearly prohibits slavery without needing to explicitly distill a common morality rule like, "do not enslave other persons" or "do not treat people as mere means"[331]. The obligations distilled by the principle of respect for autonomy almost cover the concerns about slavery by themselves[332].

Had they pursued this sort of approach, there is arguably similar coverage for a possible EMC rule. This subsection has already alluded to how the principles of justice and beneficence hint at considerability obligations. However, there are also more specific common morality rules that can illustrate this point. For example, the common morality rule "tell the truth", a rule categorized by the respect for autonomy principle, helps to illustrate the importance of veraciously recognizing and espousing the differences (or lack thereof) between people. A beneficence-related rule such as "prevent evil or harm from occurring"[333] would then cover the more general definitions about EMC, helping to determine what constitutes an "evil" appraisal of difference amongst patients and oblige healthcare providers to avoid acting on these because they lack substantive truth. Therefore, by adhering to the rules espoused by the existing principles, healthcare providers must also be successfully treating humans with sound EMC obligations in mind.

I think it is clear that this approach, even if it had been used in PBE, is not as complete as simply having an EMC rule would be. It also relies on the use of particular moralities to determine that ideas like "truth" and "harm" can apply to groups of people and/or institutions. In places like Canada, the particular moralities that tend to bind our medical communities today can allow us to see such determinations; however, this would not be the case in all contexts. The principles are still beholden to making EMC considerations optional at best.

Despite all of this, Principlism has yet another tool to save itself. However, Beauchamp and Childress have stubbornly avoided employing it. If we want to find the specifics we need to engage an anti-colonial EMC rule, we can do so with the effective application of reflective equilibrium. This process, which – in the authors' own words of support – requires the effort to "readjust some points in the system of beliefs [i.e., Principlism] in a renewed search for coherence"[334] between its points seems to have not been followed through. The recognition that

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[331] In line with the Kantian idea of "respect" mentioned in the *Respect for Autonomy* section of Chapter 2.
[332] Beauchamp and Childress., 447-8.
[333] Ibid., 3.
[334] Ibid., 440.

something should be, but is not, in the common morality should send up immediate indications that we need to reflect on the Principlist paradigm and amend it accordingly. However, PBE opts to merely say that this is a problem – a familiar pattern of a colonial culture that perpetually acknowledges, but refuses to engage with anti-colonial/decolonizing ideals.

We do not have to look far to find the specifics we need to engage an anti-colonial EMC rule if we employ reflective equilibrium effectively. Many of the specifics are implied by Beauchamp and Childress and have already been discussed in this work. A possible phrasing of an EMC rule in the common morality (should the idea of a common morality be amended to allow for such a rule) is "do not discriminate deservedness of moral consideration for irrelevant reasons". The rule would specify that "irrelevant" metrics refer to "race", gender/sex, socioeconomic status, and religious affiliation. These metrics cannot be used to determine what someone is owed, which ensures that every person is given equal opportunity to flourish in the way(s) they so choose. As such, only properties such as one's species, cognitive capacities, agency, sentience, and relationships count as possible "relevant" metrics for determining a being's moral status[335].

One could argue that my specified list of "irrelevant" properties for the EMC rule is inadequate. This could be due to the lack of agreement on a particular metric and/or because the list is woefully short and misses many other important discriminatory issues. However, I do not consider either of these concerns unique to the EMC rule. In the same way that the common morality rule "do not kill" operates perfectly fine, despite their being debate on what exactly "killing" is (some possible definitions include: ending any life, ending the life of someone prematurely or without good reason, and allowing someone to die under your care), an EMC rule can operate without much difficulty, despite not being comprehensive on what counts as an "irrelevant" property. The common morality rules are all content-thin and should be expected to lack a great deal, the EMC rule is no exception.

Beyond its exclusion from PBE, it is also worth directly mentioning that the common morality supplies other norms that could provide EMC-like attitudes; virtues that go beyond those currently explored in PBE. Indeed, Beauchamp and Childress have been remarkably stingy in the number of universally admirable virtues that they consider important to biomedical

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[335] These metrics are explored further in the *Respecting Autonomy* subsection of this chapter.

ethics[336]. Although they only mention them offhandedly, I think it is clear that virtues like trust and humility[337] are key to the attitudes missing in PBE. A trustworthy clinician bolsters EMC through a building of rapport with the patient. Specifically, a rapport in which the patient can confidently enter decision-making processes without fear of being irresponsibly cared for or discriminated against. As Beauchamp and Childress note, "[n]othing is more valuable in health care organizations and contexts than the maintenance of a culture of trust"[338]. However, Beauchamp and Childress primarily only recognize the usefulness of trust in the respect for autonomy principle[339].

Like trustworthiness, humility is not simply a virtue of particular communities; it has been regularly and universally considered morally excellent throughout human history. A humble clinician bolsters EMC through an avoidance of vanity and complacency. Humility requires a constant vigilance about one's place in their environment and the part they play in shaping it. As such, humility is valuable because it directly guards against the willful ignorance of irresponsible discrimination. Interestingly, Beauchamp and Childress do not mention the importance of this virtue at all in PBE, which lends further credence to their culpable negligence regarding the inclusion of EMC norms in their framework.

Respecting Autonomy

Beauchamp and Childress believe that their principle of respect for autonomy – as they have argued for it – does not take moral precedence over the other core principles[340]. Moreover, they believe that their depiction of the principle is not excessively individualistic[341]. The truth of both beliefs is imperative to the success of the Principlist doctrine. If respect for autonomy is given priority over its peers, then it is no longer *prima facie* binding, but permanently binding. While this shift would certainly help providers to balance their obligations to the principles (i.e., always adhere to obligations of respect for autonomy before all else), it unjustifiably demotes nonmaleficence, beneficence, and justice to lower-tier obligations. An excessively individualistic focus in respect for autonomy is also destructive to Principlism because it neglects the crucial

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[336] Consider their brief address of the five focal virtues and/or their general leaning away from extoling virtues inside of discussions about the principles.

[337] The importance of these virtues will be explored more thoroughly in Chapter 4 and in the next section of this chapter, *Redressing Principlism*.

[338] Beauchamp and Childress, 40.

[339] Ibid., 327.

[340] Ibid., 99.

[341] Ibid., ix, 99, 118.

relational aspects of real-world autonomous choices. Respecting autonomy means little if the autonomy that healthcare providers are obliged to respect is only a sliver of what patients have/use to make choices about their health.

Although Beauchamp and Childress are directly critical of the narrowly individualistic autonomy standards abound in healthcare practice today, they are also hesitant about defining autonomy through relationships, over and around the individual. Falling between these positions, PBE ends up with a principle that is less individualistic than standard practice, but much more individualistic than relational definitions. Unfortunately for Beauchamp and Childress, this middling position does not free the principle from concerns.

In the sections immediately preceding the respect for autonomy chapter, Beauchamp and Childress explore the concept of moral status. This exploration is crucial to the principles in general because it lays out the ways by which we determine whose choices are worthy of respect and to whom we should be nonmaleficent, beneficent, and just. More pertinent to the principle of respect for autonomy, this exploration begins by undoing the authors' insistence against their promotion of individualism, thereby poising the respect for autonomy principle to follow suit.

PBE states that the "relevant" criteria necessary for an entity to be rightly called morally considerable are[342]: membership with the human species, the cognitive capacity for self-guidance and adjustment, moral agency, sentience (although this only allots *some* degree of moral status), and relations to morally obligated agents in the world[343]. The joint fulfilment of these criteria (to some sufficient degree[344]) defines a person – a being with interests and instilled with rights that other moral agents have obligations towards. While these criteria and this definition of personhood are relatively uncontroversial, PBE, controversially, does not treat each criterion equally.

Beauchamp and Childress give the four criteria that focus on the individual much more import than the relational criterion. Unlike the individual-based criteria[345], the relational criterion is thought to "not supply a necessary [or sufficient] condition of moral status"[346]. Supposedly,

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[342] These are not criteria determining irrelevant characteristics for *equal* moral considerability (i.e., an EMC rule), but just the bare minimum of what makes something morally considerable.

[343] Beauchamp and Childress, 71-80.

[344] Not all the criteria are met on binary terms of possession. For example, different people are differently capable of self-guidance. As such, some of the criteria are met by achieving some reasonably sufficient minimum.

[345] "Individual-based" itself being contentious. Is *membership* with the human species not a relational property?

[346] Beauchamp and Childress, 80.

this point is founded in the fact that relationships tend to overpower or muddy the presence of the individual criteria. This vague implication can be seen in the authors' claim that the relational criterion is "unsustainable as an account of moral status if it rejects, neglects, or omits the insights in the previous four theories, which recognize moral status on the basis of qualities (cognition, sentience, etc.) that can be acknowledged independently of relationships"[347]. On its own, this claim does not demonstrate any preferential treatment to other criteria – after all, we should expect that any member of a jointly sufficient set that rejects/neglects/omits crucial aspects of its peers should be considered "unsustainable". However, recognizing the fact that this note of concern is given *only* for the relational criterion indicates the authors' reluctance to acknowledge relationships' moral legitimacy[348]. The criterion becomes an addendum instead of an integral piece of moral recognition.

One could argue that this addendum status makes sense. We should not think that a person who has a dozen close friends (i.e., a "high" relation status with other morally obligated agents) is more of a person than someone who has no close friends (i.e., a "low" relation status with other morally obligated agents). A person is a person is a person, friends or not. While our treatment of the person with more close friends might make a bigger splash in the pool of moral agents[349], this does not mean the person with no close friends makes no splash at all. Ergo, it should be the splash (i.e., the individual criteria), not its size (i.e., the relational criterion) that matters. However, even Beauchamp and Childress recognize that this argument is flawed, particularly in healthcare.

As briefly mentioned in the *Principles from Rules and Rules from Principles* section of Chapter 2, Beauchamp and Childress acknowledge that health*care* is predicated on a *caring relationship* between a provider/institution and a patient[350]. More specifically, this caring relationship is defined by the five focal virtues[351] – character traits that we *socially recognize* as being parts of exemplary *people* (who, in turn, can be patients and/or providers). As such, while relationships may not determine someone's *degree* of personhood – as the last paragraph

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[347] Ibid. 79.

[348] And/or a short leash for the concept in the hopes that it will "trip up" in practice.

[349] That is, treating the person with many close friends poorly will have ripple effects on said close friends.

[350] Beauchamp and Childress, 36.

[351] And, as I will later expand upon, the virtue of humility.

suggests – they are foundational to determining the *existence* of personhood, without which healthcare could not occur.

The authors are clearly aware of the importance of relationships yet choose to downplay their role in morality. This decision is strengthened in their depiction of the principles.

The respect for autonomy principle is presented in a way that not only pushes relationships to the periphery, but also speaks against their influence. When discussing cases in which autonomy is threatened, Beauchamp and Childress state that "a person of diminished autonomy is substantially controlled by others or incapable of deliberating or acting on the basis of his or her desires and plans"[352] wherein "controlled" is understood to mean being coerced, persuaded, or manipulated[353]. To minimize instances of diminished autonomy, the principle obliges healthcare providers to avoid engaging in/with coercive, persuasive, or manipulative relationships. However – while a person *may* have diminished autonomy because they are under someone else's control – the authors do not consider whether a person's relations with this "controlling" force could also bolster autonomy. The authors attempt to accommodate this consideration by noting that, "not all influences exerted on another person are controlling"[354], but they venture no exploration into whether these non-controlling influences can be beneficial. As I mention in the *Respect for Autonomy* section of Chapter 2, Beauchamp and Childress also believe that "it is very possible, if not always the case, that patients in clinical settings act autonomously *despite* some amount of external choice-influencing force"[355]. Evidently, they correctly believe that there are "forces" (i.e., relations to persons and/or the institutions to which they belong) outside of the patient that will inevitably influence their decisions, but they are steadfast in these influences being impediments or unimportant to the true desires of the autonomous agent.

To the authors' credit, PBE does contain brief acknowledgements of "family-centred models" of decision making[356] "enriching" Principlism's concept of autonomy[357]. However, it is unclear how this enrichment is manifesting beyond off-handed mentions. Moreover, even if these

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[352] Beauchamp and Childress., 99.
[353] Ibid., 137.
[354] Ibid.
[355] Emphasis added.
[356] Leslie J. Blackhall and others, 'Ethnicity and Attitudes Toward Patient Autonomy', *JAMA: The Journal of the American Medical Association*, 274.10 (1995).
[357] Beauchamp and Childress, 107.

models were truly altering the respect for autonomy principle, the models mentioned in PBE are far from cutting-edge theories on relational decision matrices[358].

Consequently, Principlism's conception of relationships is very narrow. PBE acknowledges that there are many special relations in healthcare[359] and these special relations are crucial in determining the unique nature and binds of the principles[360]. However, these special relations are of a very specific kind and are only between individuals. The authors argue that "many loving and caring relationships, with various kinds of beings, do not confer moral status on those beings. No matter how much we love our children's closest friends or a neighbor's pet, they do not gain moral status by virtue of our relationship to them. Nor does the lack of such a relationship indicate a lack of moral status"[361]. I think is relatively straightforward to see that not all our relationships are loving, caring, or singularly focused like this. We have many other sorts of relationships to the world and its constituents that determine moral status and autonomy and should be positively respected as such. For example, if I am an employer, I may neither love nor particularly care for my employees, but this does not mean that I do not have a relationship with them that determines each other's autonomous capacities. Their employment shapes how they see the world and their choices within it, and it is my job to ensure that this relationship is strong. More generally, not all loving and caring relationships are about particular individuals having feelings for other individuals. We have relationships to our communities, to our ancestors, and to the world[362].

According to Viola Cordova[363], "any person who is not part of a community, or who does not see herself as part of a community, or behaves as if she is not part of a community is no person at all – she is merely humanoid"[364]. In other words, Cordova believes that person's moral worth and capacity for autonomy is necessarily tied to their relationships with the people *and*

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[358] For instance, the work mentioned in footnote 348 (the study referenced in PBE for "family-centered model" information) conflates the terms "autonomy" and "informed" throughout (a common fallacy mentioned in the *Respect for Autonomy* section of Chapter 2 of this work) and focuses more on specific relations than it does the concept of interpersonal relations in general. More on what counts as a "cutting-edge" theory of relations and autonomy can be found in the Relational Autonomy subsection of *Redressing Principlism* later in this Chapter.

[359] For example, the entire eighth chapter of PBE is dedicated to the professional-patient relationship.

[360] Beauchamp and Childress, 219-20.

[361] Ibid., 80.

[362] Jonathan H. Ellerby, 'Aboriginal Bioethics', *The Cambridge Textbook of Bioethics*, 2009, 385-6.

[363] Viola F. Cordova, *How It Is: The Native American Philosophy of V. F. Cordova*, ed. by Kathleen Dean Moore and others (Tuscon: University of Arizona Press, 2007).

[364] Welch, 213.

world, including the institutions around them. I think that this is an accurate view of how and why our choices/autonomy matter. Autonomously made decisions mean little if there are no other people to be impacted by a person's choices (or lack thereof). Having friends, family, acquaintances, strangers (who I do not presently hold relations to but could at some point depending on my actions), ties to organizations, and connections to the land around oneself gives meaning and influence to choices. For example, my choice to purchase locally grown produce (should I be able to afford such a choice) is made meaningful because it invokes relationships to local farmers who depend on my patronage, a greater community of ecologically-minded persons who disagree with factory farming, the land on which the food is grown, and the members of my household who enjoy the food I choose to purchase. Without these relationships, my decision to "buy local" is meaningless, I have simply made a choice for choice's sake.

The same importance of non-individualized relationships holds true for healthcare professionals, who enter a relationship with the expectations of their highly esteemed and highly scrutinized profession. A keen observation by Oakley and Cocking is made along these lines, "in discussions of the sorts of things which doctors might legitimately refuse to do on grounds of their personal *conscience*, there is an implicit assumption in play that what is being permissibly refused is towards the periphery of the practice of medicine"[365]. In other words, whenever a doctor is said to be acting "conscientiously" – a term that, for PBE, seems like idealized "autonomous" acting – this term is actually being used to imply that the doctor is acting against the relationship that doctors are expected to hold with the expectations of their profession (and the many, many people who mold those expectations). Indeed, the doctor who does not see themselves as part of the medical community is no doctor at all.

This relational perspective is not limited to the decision-making aspects of autonomy. It also impacts expectations on the kinds/degree of respect that autonomy commands. For example, M. Therese Lysaught believes that "respect is a rich, multivalent concept, fleshed out thickly in the context of different *relationships*"[366]. Others argue that respect is as much about "nurturing

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[365] Justin Oakley and Dean Cocking, *Virtue Ethics and Professional Roles*, 2nd edn (Port Melbourne, AU: Cambridge University Press, 2003), 82.

[366] Emphasis added. M. Therese Lysaught, 'Respect: Or, How Respect for Persons Became Respect for Autonomy', *Journal of Medicine and Philosophy*, 29.6 (2004), 666.

relationships"[367] as it is attending to persons' "personal authority or dignity" [368]. To see why these ideas also ring true, we need to see how Principlism fails to capture the full scope of what counts as "respect".

PBE dictates that there are negative and positive obligations of respect, each of which determine the permissible actions that an individual moral agent (i.e., a healthcare provider) can make towards another individual agent (i.e., a patient)[369]. The negative obligations are passive, requiring non-interference with individuals making decisions; the positive obligations are active, requiring the actor to provide some sort of psychological or physical aid for individuals making decisions. Because PBE is so focused on interpersonal interactions in healthcare, these obligations are very small-scale. Specifically, they require healthcare professionals to be cognizant of not stepping on toes and leaving patients the space to be as they need to be. However, there is more to respect than simply allowing patients to choose how they are treated. Comprehensive respect is much more involved and relationally entangled.

Stephen Darwall (in a publication that came out *prior* to the first edition of PBE) gives an excellent overview of this more involved scope. Darwall argues that "respect" refers to "two rather different kinds of attitude"[370]. The first is "*recognition respect*", which is the attitude that Principlism is concerned with[371]. This form has to do with "a disposition to weigh appropriately in one's deliberations some feature of the thing in question and to act accordingly"[372]. Clearly, this definition is broad, but this is intentional. There are a great many things we can display recognition respect for[373] and, as such, a great many features of things and ways to act in accordance with them. The important takeaway is that this form of respect in PBE and healthcare more generally is about *recognizing* features of a person and navigating around/for them. Put succinctly by Darwall, "to have recognition respect for someone as a person is to give

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[367] National Ethics Advisory Committee, *Getting Through Together: Ethical Values for a Pandemic* (Wellington, New Zealand, 2007), 31.

[368] Ibid.

[369] See the *Respect for Autonomy* section of Chapter 2 for further details.

[370] Stephen L. Darwall, 'Two Kinds of Respect', *Ethics*, 88.1 (1977), 37 (III).

[371] "It is just this sort of respect which is said to be owed to all persons" (Darwall, p.38 (III)); see also, "One rather narrower notion of recognition respect conceives of it as essentially a moral attitude. That is, some fact or feature is an appropriate object of respect if inappropriate consideration or weighing of that fact or feature would result in behavior that is morally wrong. To respect something is thus to regard it as requiring restrictions on the moral acceptability of actions connected with it. And crucially, it is to regard such a restriction as not incidental, but as arising because of the feature or fact itself" (Darwall, p.40 (IV)).

[372] Darwall, 37 (III).

[373] Darwall gives examples of "the law, someone's feelings, and social institutions" (p. 38 (III))

appropriate weight to the fact that he or she is a person by being willing to constrain one's behavior in ways required by that fact"[374].

The second form, "*appraisal respect*", is the attitude that Principlism is sorely lacking. This form exclusively concerns itself with "persons or features which are held to manifest their excellence as persons or as engaged in some specific pursuit"[375]. In other words, it is a form of respect that has to do with engaging a person and/or their virtues or skills in an appreciative manner. Even more simply, it is an *appreciation for a person's character*. As such – unlike recognition respect – this form of respect does not necessarily impose any constraints on behaviour. As the words 'virtue' and 'character' suggest, this form of respect has to do with *good people*, not just people, simpliciter.

How then does Principlism promote recognition respect and fail to address appraisal respect (and why is this a bad thing)? On top of the many, many instances of moral behaviour guidance (i.e., recognition respect), PBE also discusses many instances of moral ideals, supererogatory duty fulfillment, and exceptional persons in medicine (i.e., appraisal respect). However, *who* this discussion is directed at matters greatly. Of all the praiseworthy persons/characters discussed in PBE, the patient is never one of them. On the surface, this makes sense. The providers in a healthcare relationship are supposed to be held to a higher standard than the patients. Moreover, patients are not the target audience for PBE, so appraising (or even guiding) them in the book makes little sense. Patients need not be held to a standard at all, they are there to be cared for, not do the caring. It is obviously nice if patients are kind, compassionate, and humble, but these are simply ideals.

I am certain that most persons, when thrust into the role of a patient (healthcare professionals included), are not the perfect embodiment of virtue. This only further stands to suggest that we need not be overly concerned about appraisal respect for patients. However, this lack of immediate concern does not mean that patients deserve no appraising whatsoever. Even the most elitist physician is beholden to the fact that they and their peers will likely be patients at some points in their lives. If they can be appraised as providers, then they can and should be appraised as patients; they are the same person in either scenario[376]. People without medical

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[374] Darwall, 45 (VI).

[375] Ibid., 38-9 (III).

[376] Despite playing a different role in the patient-provider relationship in each scenario, they still hold each relationship as a part of their personhood. One does not cease being a nurse when they go in for a yearly physical.

expertise should be no different. Providers need not even consider all patients as morally praiseworthy. Indeed, the only sort of appraisal respect needed from providers is appraisal respect about their patient's *character as self-evaluators*. The simple appraisal of the fact that patients are good at evaluating what they need is hugely important to altering their status as people *worth* helping. Not only this, but it helps to encourage a culture of humility amongst providers. It is clear how the opposite – presuming that patients are *only* to be recognized as moving sacks of flesh that tell you what you can/cannot do – can be swept up into colonial policies, permitting the indifferent and inhumane treatment of persons in the name of "respect".

Beauchamp and Childress' reliance on recognition respect does just this. Patients, while described in PBE as incredibly important to healthcare, are more like detached things than they are people worthy of treatment that will embolden their character. One clear example of this is when the authors describe the validity of threats to patients: they claim that a "subjective response in which persons comply [with the demands of their provider] because they *feel* threatened even though no threat has actually been issued"[377] does not count as an infringement on autonomy. Put differently, if a patient feels unsafe in the system in which their healthcare provider operates, it is that system that gets to decide if that was a real threat or merely a "feeling". The patient's very real sense of threat is only a valid concern if the *issuer of the threat* deems it to be so – a disrespectful act and an epistemic injustice.

This is not to say that everything a patient says/feels must be accepted and accommodated for. However, a patient claiming that the hospital they are in feels unsafe is something that should be addressed, whether the providers can see a threat or not. Principlism's defaulting to the medical professional misses this obligation. It renders threats like structural violence near invisible and dehumanizes patients in a way that insinuates they are incapable of evaluating their environment – two familiar-sounding hallmarks of colonial medicine.

The patient and the provider are both valuable evaluators of healthcare procedure – bound to each other in an intimate relationship and to their greater relational networks in varying degrees of intimacy. As explained in the *Beneficence* section of Chapter 2, these relationships are predicated on reciprocity. This reciprocity is mostly met by the exchange of privilege and payment for the provision of services, but it can be met more thoroughly by allowing appraisal respect to flow from providers to patients, not just vise-versa, as it does now. If patients are

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[377] Beauchamp and Childress, 137.

expected to revere medical professionals, so too should medical professionals revere their patients, even if it is for different reasons.

Taken together, respecting a person's autonomy is about more than what PBE claims. It requires an understanding of people as relational nexuses worthy of both recognition and (at least the potential for) appraisal respect. Some relationships are controlling and need to be mitigated, but many more relationships are foundational to a person's desires and way of life. As such, ameliorating a patient's illness – "a manifestation of the body and soul in search of harmony or balance"[378] within this relational framework – depends on acting to help the patient within their network of support, not cut them out of it. Put well by Baylis et al., "[w]hen called upon to make important decisions we often do not arrive with a clear, well-ordered set of values that can be rationally applied, but rather feel our way to a decision in conversation with others who help us to determine who we are and what we stand for"[379]. These conversations that we *feel* our way towards are worthwhile and to be taken seriously from all sides, even if they lack the rigid dictates of colonial medicine.

"Autonomy is not found in an extra-corporeal individual carrying a bag full of rights as a safeguard against the world. Instead, autonomy is articulated by an embodied self, through relationships with others"[380], which includes interactions with healthcare. Considerations for a more relational conception of autonomy as well as its shortcomings will be explored more thoroughly in the *Redressing Principlism* section of this Chapter.

Being Nonmaleficent

It is difficult to argue that the principle of nonmaleficence is fraught with colonial concerns. The principle effectively articulates the need to avoid direct harms like those of the Joyce Echaquan case[381] while also warning against the permittance of negligently caused indirect harms[382] (i.e., some harms of indifference). Not only do these points protect against harms incurred within the healthcare system, but they also serve to bolster trust in the system, thereby limiting the number

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[378] Lux, *Medicine That Walks*, 18.

[379] F. Baylis, N. P. Kenny, and S. Sherwin, 'A Relational Account of Public Health Ethics', *Public Health Ethics*, 1.3 (2008), 201.

[380] Belinda Bennett, 'Posthumous Reproduction and the Meanings of Autonomy', *Melbourne University Law Review*, 23.2 (1999), V.

[381] See the *Nonmaleficence* section in Chapter 2.

[382] Beauchamp and Childress, 159.

of vulnerable persons driven away from an essential good like medicine[383]. PBE is clear that the imposition of undue harms (or risks for harm), irrespective of the person(s) facing them, is wrong and should be avoided as such.

Beauchamp and Childress also take a strong stance against healthcare that operates as a means to help providers avoid the "unbearable searchlight of complicity"[384] mentioned in the *"Decolonizing" Saviours* section of Chapter 1[385]. That is, the Principlist approach is committed to the belief that healthcare providers should take responsibility for *all* cases in which they harm patients, complicit or otherwise. Being passively agreeable to, complicit in, or directly involved with harming someone are all behaviours worthy of moral reprimand. Patient harm – not the provider's exact influence/intention towards it – is what matters most.

This idea can be seen through the authors' strong opposition to the distinction between intended and foreseen consequences in medical decisions, otherwise known as the "doctrine of double effect"[386]. The doctrine posits that medical interventions with harmful consequences[387] are more permissible if these harms are merely foreseeable than if the same harms are intended. Beauchamp and Childress sensibly argue that this sort of distinction only serves to absolve responsibility from the provider. There will always be harmful consequences in medical decisions; using the language of "intention" only obfuscates these harms and how they can be avoided. A physician's claim that they did not intend to paralyze a patient from the waist-down during surgery, despite foreseeing it, means little. The fact that the physician and patient were able to tolerate the paralysis as a possible harm of surgery (presuming this risk was known to both parties) is much more meaningful. The harm is identifiable and whether or it can/should be avoided is clear. Similarly, claims that healthcare providers do not intend to exacerbate possible intergenerational trauma faced by Indigenous patients should not absolve them of wrongdoing. More correctly, these providers should be held responsible to recognizing the avenues of action through which such exacerbation can be minimized.

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[383] Elizabeth McGibbon, Josephine Etowa, and Charmaine McPherson, 'Health-Care Access as a Social Determinant of Health', *Canadian Nurses Association*, 104.7 (2008), 23-5.

[384] Tuck and Yang, 9.

[385] PBE does not make this stance to refute colonialism or to be responsible for people's participation in it *per se*. However, the core of this commitment does imply that colonialist participation rightly counts as harmful.

[386] Beauchamp and Childress, 167-9.

[387] That are justified by the overriding benefit such interventions will provide.

Principlism's Colonial Ties

So where do things go wrong for this principle? The first stumbling block can be found in the individualist spillovers from respect for autonomy[388]. As mentioned in the *Nonmaleficence* section of Chapter 2, Beauchamp and Childress define harm as, "a thwarting, defeating, or setting back of some party's interests"[389]. In terms of autonomy, this means that harms are impositions on a person's autonomously garnered interests. Unsurprisingly – considering what I have already said about PBE's depiction of autonomy – Principlism argues that relationships hold little bearing on how such interests can be impeded. The authors note that when a patient incurs harm "it is incorrect to say that the harming is wrong merely because we have an established laboratory, clinical, or social relationship with either individuals or populations. We behave wrongly because we cause gratuitous and unnecessary risk, pain, or suffering, which would be so whether an established relationship exists"[390]. Although the preceding subsection of this work has already demonstrated why this claim is shaky at best, PBE also manages to undo this idea when discussing non-physical harms.

This undoing is made in one of PBE's two explorations of Indigenous-specific health concerns[391]; an exploration of a study about treatment planning in a Navajo population[392]. Through interviews with Navajo patients, providers, and leaders, the study demonstrates that many members of this community are opposed to advanced care planning because they feel that receiving morbid diagnostic/prognostic news from their provider can "shape their reality" in an unfavourable way[393]. That is to say, the dissemination of "negative information" between patients and providers is considered harmful and oppressively controlling (i.e., persuading and/or manipulating). From this, Beauchamp and Childress conclude that providers need to be

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[388] Most of what is discussed in this and the next 4 paragraphs is written in the Respect for Autonomy chapter of PBE, but I find these excerpts more relevant to nonmaleficence.

[389] Beauchamp and Childress, 158.

[390] Ibid., 80.

[391] In a book that discusses upwards of 80 specific cases in-text (in addition to making use of countless other footnotes, references, and hypotheticals) it might be expected that only 2 of said cases specifically refer to studies directed towards a group of people that make up a relatively small proportion of the overall population. However, even if we generously assume that PBE only discussed 50 other cases in comparable depth to the two Indigenous cases mentioned, these cases would still only make up 4% of the total cases discussed, which hardly scratches the low end of most proportional population estimates for Indigenous persons in the United States and Canada. Considering the book's overall goal is to provide guidance on morally righteous decisions in medicine from the basis of common understandings of what is "moral", one would expect the employed ideologies and/or research to be more proportionally drawn from all sources, if not more heavily reliant on sources that have been historically oppressed by "righteous" decisions in medicine.

[392] Joseph A. Carrese and Lorna A. Rhodes, 'Western Bioethics on the Navajo Reservation: Benefit or Harm?', *Journal of the American Medical Association*, 274.Sep 13 (1995), 826–29.

[393] Beauchamp and Childress, 107.

cognizant of the fact that there are many actions that can be inadvertently persuasive or manipulative, and that this cognizance helps to bolster patient *autonomy*. Interestingly, Beauchamp and Childress fail to mention what the *study* recommends providers do to avoid these inadvertent *harms*[394]. Study participants viewed autonomy and safety as being encouraged by way of *hózhoojí nitsihakees* ("thinking in the Beauty Way") and *hózhoojí saad* ("talking in the Beauty Way")[395]. Here, patients ascribe a positive obligation upon healthcare providers to recognize that their relationship to the patient requires a unique affect about conduct; an affect that utilizes the patient-provider relationship to bolster (i.e., "Beautify") the patient's health in ways other than cold prognostications.

These Navajo patients argue for this positive obligation because they recognize that relationships determine the nature of harms. If I (someone who is not medically certified) told a stranger that they have terminal cancer, there is a chance that this would be upsetting to them, but it is much more likely that this stranger will dismiss me entirely or seek the opinion of a professional. However, if said professional tells this person the same thing, there is suddenly a very real potential for harm. The patient-provider relationship makes the act of diagnosing a patient potentially wrong, the diagnosis is meaningless and harmless without it. This is not to say that the harm(s) of terminal cancer are non-existent without a patient-provider relationship, but rather, that the degree and sorts of harms associated with such an illness (or any illness) change completely within one. By opening the door to relationships through the discussion of this study, yet choosing to omit the source material's conclusions about engaging these relationships, Beauchamp and Childress clearly show a willful individualistic leaning.

The other difficulties with the principle of nonmaleficence have to do with its distinct lack of admonishments against colonialism. As mentioned already, although the disproportionate burdens of illness handed out by healthcare systems and faced by Indigenous persons[396] are not entirely attributable to PBE, this does not mean that Principlism is effectively addressing these issues. Indeed, there is a lack of effect, which stems from what appears to be an erroneous assumption that harms against Indigenous people and colonialism are the same thing.

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[394] Beauchamp and Childress only note that "[t]hey [the Navajo patients] expect instead a 'positive ritual language' that promotes or restores health" (p.107).

[395] Carrese and Rhodes, 828.

[396] Tara Horrill and others, 'Understanding Access to Healthcare among Indigenous Peoples: A Comparative Analysis of Biomedical and Postcolonial Perspectives', *Nursing Inquiry*, 25.3 (2018), 3-4; Thomas Harding, 'Cultural Safety: A Vital Element for Nursing Ethics.', *Nursing Praxis in New Zealand*, 29.1 (2013), 4–11.

Principlism's Colonial Ties

As mentioned in Chapter 1, it is incorrect to claim that colonialism is "anything that is bad for Indigenous people". The spread of pathogens like smallpox from settler populations to Indigenous populations was harmful and did *contribute* to the advance of colonial policy, but this harm was not by itself, colonial. If it were, the eradication of smallpox would have dealt a significant blow to the colonial state's power, which it did not. Similarly, an Indigenous patient who experiences a stroke in hospital does experience a harm, but this harm is not itself colonial. Avoiding these harms does not guarantee an avoidance of colonialism.

Colonialism is a sort of harm, though PBE does not express it as such. The harms that Beauchamp and Childress are concerned with in the principle of nonmaleficence are largely intentional and interpersonal. Terms like "judgemental error"[397] are much more frequently used to describe mistakes in the avoidance of direct patient harm, while the possibility of systemic oppression and/or complicity is hardly addressed. Colonialism happens to occupy this systemic blind spot, thereby escaping the current obligations of the principle of nonmaleficence.

Very few healthcare providers will admit that they are racist or intend to promote a colonial regime. However, these same providers intentionally promote colonialism nonetheless. They do this by reframing colonial oppression as an unavoidable fact of nature, rather than something that can be changed[398]. It is an intentional misrepresentation of a harmful mindset as unintentional – something not bound by the principle of nonmaleficence. Recall my avalanche example from the *Nonmaleficence* section of Chapter 2. In this example, I claim that the principle of nonmaleficence has no obligations towards stopping an avalanche. Even though we could simply avoid the risk for harmful avalanches altogether by never hiking in the mountains, the principle of nonmaleficence would not require such a thing. Avalanches are intention-less systems of nature that cannot be avoided, presuming that hiking in the mountains is also unavoidable. Similarly, any harms resulting from "disease, natural disasters, [and] bad luck"[399] are largely unavoidable and impose no nonmaleficent obligations. This is how colonialism is viewed[400]. It is considered an unintentional imposition of harm because living life without it is simply

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[397] Beauchamp and Childress, 172.

[398] See my discussion on the cycle that entrenches these sorts of ideas in the *Colonialism & Indigeneity in Canada* section of Chapter 1.

[399] Beauchamp and Childress, 158.

[400] For example, the TCPS 2 claims that structural inequalities that disadvantage Indigenous persons are "seldom intentional, but nonetheless real" (Canadian Institute for Health Research, B).

incomprehensible; it is as natural as people hiking in the mountains. By viewing colonialism in this unintentional, inevitable light, settlers can justify a failure to avoid its impacts.

Even if colonialism is not viewed this strictly as an inevitability, it can at least be viewed as partially unavoidable. For example, the signing of the Numbered Treaties could be misconstrued as Indigenous people consenting to harms from the Canadian government[401]. Someone could also consider colonial harms relics of the past that cannot be ameliorated. Both examples present an air of unintentionality. Obviously, both views also misunderstand the actual nature of colonialism – an active mindset that is allowed to flourish because it takes advantage of Indigenous persons through coercive or directly harmful relegation against them. PBE does not warn against such misunderstanding.

One could argue that this is not fully charitable to PBE. As I mention in Chapter 2, "[s]o long as due care is met (i.e., maleficent harms are avoided), the name given to a particular harm is irrelevant". As such, it should not matter how people misconstrue colonialism, it is clearly harmful and should be avoided accordingly. Beauchamp and Childress are also critical about social ignorance that would lead to my aforementioned sort of colonial misrepresentation. Specifically, they point out the importance of avoiding implicit bias and stereotype threats because they are extremely detrimental in determining a patient's health[402]. However, this is a recognition of *social* harms/justice, not the true *systemic/structural* nature of harms such as colonialism[403]. Nonetheless, we could attempt to construct colonialism as a sort of negligent harm, which is tractable by the principle of nonmaleficence.

Colonialism is the relegation of Indigenous people to the margins of society, and this relegation would constitute a deprivation of goods to life, an explicit rule of the principle of nonmaleficence[404]. Healthcare providers negligently permit this harm by being willfully and/or unwittingly ignorant of the actual nature of colonialism. Presuming that colonialism cannot be undone neglects the measures a clinician can take to reduce risks for harm against Indigenous people, even if they are slight reductions. For example, even if a physician views colonialism as a relic of the past, this does not absolve them of the duty to ensure that the transgressions against Indigenous people in the past do not present themselves again. I think this depiction of

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[401] Harms that are consented to also impose no nonmaleficent obligations; see Beauchamp and Childress, 158.
[402] Beauchamp and Childress, 89-90.
[403] Indeed, despite their recognition of these *social* harms, they never phrase them as being systemic or structural.
[404] Beauchamp and Childress, 159.

colonialism as a negligent harm is also convincing. However, this does not mean that the nonmaleficence principle suddenly possesses an anti-colonial obligation.

The fact of the matter remains that Beauchamp and Childress do not oblige healthcare providers to avoid colonialism "as much as possible". Rather, they only oblige providers to avoid colonialism as much as the current colonial structures allow. To truly avoid as much harm as possible, irrespective of the harm in question, two things must be understood: 1) the full extent of the harm and 2) how to avoid it. For example, a plastic surgeon is considered well-equipped to avoid as much harm as possible in cases of skin grafting because they possess the requisite knowledge of what can go wrong in such a procedure and the expertise to know how to avoid these wrongs. Unfortunately, the same cannot be said for most healthcare workers and colonialism; the full extent of mindset and the ways it can be avoided are not well understood by clinicians[405]. Medical practitioners are forced to reduce colonial harms within a colonial structure that does not tell them how. There is currently not enough in the way of medical education that criticizes and illustrates the shortcomings of colonial healthcare and PBE does not oblige us to fix this. However, the sheer scale of colonialism also makes understanding its full extent nearly impossible. Indigenous life within colonial influence is so complex that it is unreasonable to expect every provider to know everything about the possible harms related to it, even if they are well-educated in colonial history[406].

To rectify these issues, the principle of nonmaleficence should place a greater emphasis on the virtue of humility. The full extent of humility's effectiveness will be elaborated in Chapter 4, but it is worth briefly addressing here. As mentioned in *The Common Morality* subsection of this chapter, humility is a key virtue of decolonizing and anti-colonial healthcare because it opposes willful ignorance. Adherence to the virtue requires a sense of modesty about what a provider truly knows, does not know, and cannot know. When applied to the harm avoidance obliged by the principle of nonmaleficence, humility helps providers understand the full extent of colonial harms and how to avoid them. This understanding would not be attained by isolated

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[405] Allana S.W. Beavis and others, 'What All Students in Healthcare Training Programs Should Learn to Increase Health Equity: Perspectives on Postcolonialism and the Health of Aboriginal Peoples in Canada', *BMC Medical Education*, 15.1 (2015), 155; Lloy Wylie and Stephanie McConkey, 'Insiders' Insight: Discrimination against Indigenous Peoples through the Eyes of Health Care Professionals', *Journal of Racial and Ethnic Health Disparities*, 7 May 2018, 1–9.

[406] Yet another reason why the harm-reduction, anti-colonial approach is achievable for a project like this thesis, but a decolonial goal is far from reach.

introspection, but rather, a direct call to involving more Indigenous persons in policy making and on-the-ground clinical practice. Ideally, any patient care (with an Indigenous patient or otherwise) will be informed by Indigenous knowledge. We are all colonized[407] and we all must know how to avoid the harms of colonialism. The true extent of this knowledge can only be gained from work with experts, the Indigenous patients who experience these harms.

Being humble in this way would dismantle the monopoly that colonial medicine holds. This is not particularly good for proponents of Principlist paradigm – who have a vested interest in maintaining the framework's power over clinical medicine – but redistributing this power is necessary for decolonization. This hints at why Beauchamp and Childress do not include such a virtue in PBE. Programs of humility like those I have mentioned already exist, but Principlism's support for them would go against its colonial ties. Some such programs are the cultural safety paradigm (which will be discussed more thoroughly in *Redressing Principlism* at the end of this Chapter) and the Educating for Equity (E4E) program[408], which seeks to inform specific medical professions about employing anti-colonial strategies to patient care[409].

Altogether, the principle of nonmaleficence is not terribly problematic. If the principle can extend its understanding of intentional harms to include systemic/structural violence, this will go a long way. From here, the principle can actively encourage the involvement of Indigenous knowledge translators as a means of better avoiding colonial harms. Many particular moral codes already demand such epistemic humility[410] and PBE should do the same.

Being Beneficent

The principle of beneficence is more directly aligned with anti-colonial thought than any of the other "famous four". If colonialism is viewed as a negligent harm, as described in the previous subsection, then the principle of beneficence requires an active stymieing of this harm. This stymieing comes in the form of preventing harm (i.e., stopping colonialism from having an impact in medicine), removing harm (i.e., eradicating colonialist policy in healthcare), and promoting good (i.e., encouraging anti-colonial and Indigenous-centric policy). Unlike the other

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[407] Tuck and Yang, 17.

[408] Lindsay Crowshoe and others, *Educating for Equity (E4E): Alberta Systems Integration*, 2018.

[409] Although I truly believe that E4E is an effective program, I am likely biased in this appraisal. I was part of the team that developed, assessed, and extended this program in its beginning stages (alas, not all undergraduate work garners authorship).

[410] Ala Hojjati and others, 'Educational Content Related to Postcolonialism and Indigenous Health Inequities Recommended for All Rehabilitation Students in Canada: A Qualitative Study', *Disability and Rehabilitation*, 2 October 2017, 8-10; Crowshoe et al.; Canadian Medical Association, *Code of Ethics and Professionalism*, 7.

core principles, these obligations present clear and definite requirements against mindsets like colonialism.

Beneficence also does not suffer from colonial concerns pertaining to an overriding of the other principles, though it may appear to. When discussing beneficence, Beauchamp notes that "[n]o demand is more important when taking care of patients: the welfare of patients is medicine's context and justification"[411], which seems to suggest that it takes priority over the other principles. History also suggests this sort of primacy. Throughout Canadian history, settler healthcare workers have presumed they were benefitting Indigenous people by "civilizing" them. An over-inflated sense of beneficence (among other things) ran these providers into being presumptuously paternalistic. Care decisions were framed as being "for the good of the patient" without considering the obligations of the other core principles that help determine what this "good" is (or who should make the decisions). However, PBE is very clear that this sort of exclusively beneficent mindset is not ideal. Indeed, Beauchamp and Childress are careful to note that paternalistic action, although not always wrong, needs to be managed carefully.

Beauchamp and Childress define paternalism as "the intentional overriding of one person's preferences or actions by another person, where the person who overrides justifies the action by appeal to the goal of benefiting or of preventing or mitigating harm to the person whose preferences or actions are overridden"[412]. Put differently, paternalism is acting towards a person in a manner that goes against their desires for the sake of beneficence. PBE distinguishes between two types of paternalism: hard and soft. Hard paternalism, which the authors consider to be wrong in almost all cases, is acting to "prevent or mitigate harm to, or to benefit, a person, even though the person's risky choices and actions are informed, voluntary, and autonomous"[413]. In other words, this form of paternalism aims to save someone from themselves. To condone an act of hard paternalism is to reject the rationale of a patient's autonomous choice and is correspondingly only permissible in obvious cases of self-harming. Soft paternalism, the form Beauchamp and Childress endorse[414], is the act of "preventing substantially nonvoluntary [harmful] conduct"[415]. This form of paternalism excludes the consideration of autonomy; "[e]ven

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[411] Beauchamp, 5.
[412] Beauchamp and Childress, 231.
[413] Ibid., 232.
[414] In applicable cases, not always.
[415] Beauchamp and Childress, 232.

if a person's desires, intentional actions, and the like are not substantially autonomous, overriding them can be paternalistic"[416]. As such, soft paternalism is about saving people from things outside of their control, but within/affecting themselves. Condoning acts of soft paternalism is relatively easy because they presume the patient to be at the mercy of some force outside of their autonomous control, but within the care provider's control (to some extent). Neither form of paternalism is differently beneficial; what distinguishes the forms is their degree of infringement on autonomy. Hard paternalism is wrong because it infringes on autonomy, soft paternalism is acceptable because it is only invoked when there is a lack of substantial autonomy to be infringed upon.

There are some difficulties with justifying paternalism in this way, but they mostly have to do with the issues of Principlism's concept of autonomy that was discussed in the *Respecting Autonomy* subsection of this chapter. Beauchamp and Childress consider hard paternalism wrong because it impacts an *individual's* choices. However, hard paternalism is more correctly wrong because it is a failure to effectively engage the relationships of the patient; namely, the patient-provider relationship. Hard paternalism does disrespect autonomy, but this disrespect is not applying to some ethereal sense of individuated desire, it is applying to the relationships that form autonomy.

Going beyond paternalism, the few other colonial issues facing the principle of beneficence are shared with the principle of nonmaleficence. However, they have slightly different justifications. For example, being humbler and more open to the idea of educating medical practitioners about colonial harms is crucial, but it is crucial because this knowledge will give providers the tools to prevent harm, remove harm, and promote good. It is an education for the active opposition of colonialism, rather than the avoidance of it.

For the principle of beneficence, this humble education comes in the form of a better understanding of the reciprocity that healthcare owes to Indigenous persons. Knowing exactly what Indigenous patients have provided and continue to provide medicine will go a long way in bolstering this principle's ability to be anti-colonial. Without these exactitudes, healthcare providers are left to rely on generalizations about Indigenous life that are inaccurate and lead to more ready-to-hand justifications for undue paternalism. For example, there is a pervasive stereotype that most Indigenous people have chronic alcoholism, a condition that Beauchamp

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[416] Ibid., 231.

and Childress' describe as leaving individuals "unlikely to reach adequately reasoned decisions"[417]. If medical practitioners do not have the humility to look past this stereotype, the default view of Indigenous patients begins at a place of "unlikely" autonomy. Indigenous people are considered less autonomous and more in need of beneficent intervention, or at least, in need of a specific type of harm reduction for a harm that may not be present[418]. This sort of logic can also occur from facts about the world that are poorly understood. For example, it is a fact that suicide rates among Indigenous persons are higher than those in any other demographic in North America[419], and this fact can be used to justify paternalistic behaviours to compensate for a presumed lack of mental wherewithal in Indigenous populations. Educating providers about how these circumstances are not inevitable facts of nature, but the product of oppressive colonial medicine, can only help to instill a truer sense of why clinicians are obligated to act beneficently.

To give further reason to support this humility, we can turn to the nature of the "special relations" that Principlism claims define the limits of beneficent obligations. Although most of PBE describes these relations as being between independent individuals, Beauchamp and Childress recognize that the principle of beneficence does stretch beyond this. When discussing cost-benefit analyses of the prescription of opioids, the authors state that "it is important, but insufficient, to evaluate the probable benefits … and risks… for individual patients. It is also necessary to evaluate the benefits and risks to others in a patient's household and in their community"[420]. I believe that this can be taken further. The special relations that define beneficence should not be understood as a covenant between two individuals, but the meeting point of two elaborate networks of relationships. Patients represent entire communities and systems of persons at the behest of sociopolitical forces, providers represent medicine as a discipline, also at the behest of these sociopolitical forces. The power within the patient-provider relationship is found in just how deep these networks go when dealing with the health of a

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[417] Ibid., 232.

[418] Some examples of treatments for harms that are erroneously presumed present are given by Beauchamp and Childress on page 284.

[419] Brenda Elias and others, 'Trauma and Suicide Behaviour Histories among a Canadian Indigenous Population: An Empirical Exploration of the Potential Role of Canada's Residential School System', *Social Science and Medicine*, 74.10 (2012), 1560–9.

[420] Beauchamp and Childress, 247. As presented here, this quote is missing some parenthetical passages (as indicated by the ellipses). These passages were removed because of their specificity to opioids, which are an important issue, but would confuse the reader if included in this paragraph.

person. As such, the beneficent care provider will indirectly prevent harm, remove harm, and promote good for the members of a patient's network and they should be cognizant of this.

Being Just

It does not take much searching to find inequity between settler and Indigenous populations. As many laudable goals of medical equity and equality as there are – including those espoused in PBE – these goals are rarely achieved[421]. Indigenous people remain worse off than their settler counterparts in a myriad of ways. This discrepancy between a nebulous ideal of equity and the inequity in the world could be attributable to several things: policy lag (the phenomenon of policy taking time to "catch up" with theory), some healthcare practitioners are less morally conscientious than others, and these factors often combine to result in a lack of infrastructural/economic support for anti-colonial practice. As problematic as these items are, they do not bear the whole responsibility for a lack of equitable care. PBE's principle of justice also comes up short of anti-colonialism.

Conveniently enough for Beauchamp and Childress, these shortcomings are not devastating to their principle of justice. As explored in "The Common Morality" subsection earlier in this chapter, for issues surrounding equal moral considerability (EMC) – matters of justice often pertaining to colonialism – Principlism uses particular moralities, not the common morality. The common morality should, but does not have universally agreed upon standards about EMC, so the authors are left to hope that the particular moralities that operate in tandem with Principlism will have such standards. In Canada, we have several ethical frameworks that can and do recognize the immorality of irresponsible discrimination[422], even though their effectiveness is debateable. As such, PBE is almost entirely off the hook for any problems these frameworks face in this regard. Colonial failings related to moral considerability are attributable to Canadian healthcare policy, not Principlism.

Ignoring that this is an easy way to shirk responsibility[423], this does not mean that the principle of justice is not also problematic in other ways outside of EMC issues.

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[421] See Josée G. Lavoie, 'Medicare and the Care of First Nations, Métis and Inuit', *Health Economics, Policy and Law*, 13.3–4 (2018), 280–98 for an in-depth analysis of the discrepancies between ideals of sovereignty and supported payment promises for the "14th health care system" in Canadian-Indigenous healthcare.

[422] For example, the Charter of Rights and Freedoms and the CMAs Code of Ethics and Professionalism.

[423] As also mentioned earlier in this chapter.

Principlism's Colonial Ties

Some of the colonial difficulties in the principle of justice – much like its peers – are based in its focus on persons, rather than systems. That is, each of the rules within the principle draw attention to the fact that people require just treatment, but the systems in which these people live are considered manageable as distinct entities of lesser importance. This is not to suggest that a truly anti-colonial conception of justice requires ignoring people in favour of ameliorating systems. It is people that we interact with in the clinical sphere and people who ultimately benefit from appropriate action. However, the systems that these people depend on and/or are restricted by need to be addressed as much as the people are and as part of these people. Without this address, structures of colonial medicine are allowed to persist whilst healthcare practitioners are under the impression that they are acting justly simply by weeding out unjust interpersonal interactions.

Although PBE's rules of justice focus on the treatment of a person at the expense of the appropriate address of a system, not all the principle's rules (if any of them) do so in an ignorantly pernicious way. The formal rule of justice – "equals must be treated equally, and unequals must be treated unequally"[424] – is a claim about the treatment of persons. Acting in accordance with this rule requires that an actor be able to compare persons to others and treat each in kind, whatever the systemic circumstance. However, it does not explicitly assert that the equal treatment of equals requires a diversion away from systemic barriers to this treatment. The rule could be understood to imply the opposite (i.e., to have the ability to treat people in certain ways, said ways must be made permissible by the systems under which they are to occur). The fact that a systemic address *may* be implied by the formal rule is acceptable so long as the material rules – which Beauchamp and Childress use to specify the formal rule – are clear that such an implication should be there. Unfortunately, this clarity is missing.

According to Beauchamp and Childress, all six material rules are important to medicine and should be considered as such. The "intelligent use"[425] of these six rules – knowing when to emphasize certain rules and deemphasize others – is possible and necessary for the just provision of healthcare. However, it is not immediately clear that each material rule is given equal weight (or that it should). PBE gives much praise to Capability and Well-being theories for their

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[424] Beauchamp and Childress, 267.
[425] Ibid., 280.

modernity[426] and focus on health[427]. It should not be surprising that Principlism also gives more merit to these theories than the other four "traditional"[428] theories of justice, several of which draw explicit attention to the relations people hold. Granted, neither Capability or Well-being theories preclude the involvement of relationships in their understanding of what makes someone "capable" or "well", but they also do not draw explicit attention to the social world as the metric of success as "traditional" theories like Utilitarianism or Communitarianism do. Therefore, the emphasis on individualized material rules suggests a colonial leaning towards justice based in ameliorating individual suffering. This leaning, for reasons already discussed at length, allows for the ignorance of socially oppressive structures.

Despite all this, Beauchamp and Childress can largely disregard these concerns on the grounds that the material rules, as they are applied through equal moral considerations, are to be balanced as particular moral frameworks see fit. Whatever theories the authors might lean on most heavily is irrelevant because the actual distribution of resources (and more importantly, the actual determination of who is considerable for said distribution) will be handled by whichever combination of theories a particular community has good reason to think will achieve effective and ethically decent healthcare.

Nonetheless, I think that it is important to establish that some of the material rules are better suited for anti-colonial purposes and should be employed as such. Specifically, I will suggest that giving more weight to the Communitarian rule – "[t]o each person according to principles of fair distribution derived from conceptions of the good developed in moral communities"[429] – is a valuable first line of analyzing what justice should be in healthcare settings for Indigenous and settler Canadians. This sort of framework will ensure that relations, the true core of personhood and autonomy, are put before all else. Once these relations are understood and managed, any other material concerns of justice can be addressed. It could be argued that my suggestion dangerously restricts the complexities of justice, which I would agree to if the new focus I am suggesting was drawn to any of the other material rules. However, Communitarianism is uniquely suited to encompassing all other theories of justice. As Beauchamp and Childress note, "Communitarians see principles of justice as pluralistic, deriving from as many different

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[426] Ibid., 277.
[427] Ibid., 270.
[428] Ibid., 271-7.
[429] Ibid. 270.

conceptions of the good as there are diverse moral communities"[430]. The other five material rules are much more concerned with defining justice in a singular way. As such, making communities the first focus of justice should not preclude or deemphasize any considerations of justice without merit.

Beauchamp and Childress also take time in the Justice chapter to discuss the importance of eliminating oppression, but – because of their reliance on particular moralities for these areas – do not explore the ways by the healthcare system (and their significant contributions to it) can be reconstructed appropriately. This leaves the door open to very simplistic interpretations of what anti-oppression work should be. Most concerningly, the idea that eliminating oppression, by itself, is a morally righteous thing to do. However, this misses the complexity of our world; wherein oppressive systems, as inhumane as they may be, are integral to the ways of life of many people. It would be wonderful if this were not the case, but we cannot ignore the fact that systems like colonialism are foundational to what it means to live in today's world. Simply getting rid of such systems without a plan for transition (in the case of decolonization, returning power to Indigenous communities) presumes that people will be able to thrive without the structures that have hitherto shaped their lives. PBE makes no effort to suggest transition or replacement strategies to this end.

This was the same failure of the White Paper of 1969 (mentioned in the *Handshakes and Papers* section of Chapter 1). To achieve the (first) Trudeau government's goal of equality between Indigenous persons and settlers in Canada, the Paper, if passed, was designed to abolish all existing legislation about systemic barriers to Indigenous persons (i.e., the Indian Act, the Numbered Treaties, etc.) and start afresh. However, this suggestion was panned by from nearly all sides because it completely ignored the colonial systems of oppression (and the corresponding few dictates of Indigenous sovereignty) that created the concerning inequality in the first place. Eliminating these policies would not make Indigenous people equal to settlers, it would only leave a power vacuum for some other, less regulated, also colonially oppressive system to take its place. By ignoring the importance of the systems that shape Indigenous peoples lives, the blameworthiness for Indigenous persons' difficulties to flourish could be placed squarely on them. Beauchamp and Childress tread dangerously close to the same territory without a more direct assertion about appropriately amending systems of oppression.

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[430] Ibid., 276.

Principlism's Colonial Ties

It could be argued that comparing PBE's principle of justice to the 1969 White Paper is unfair. Just because Beauchamp and Childress do not give explicit instructions about how to ease from an oppressive system to a non-oppressive one does not mean that they do not believe in transitioning between systems of power. As mentioned in the *Justice* section of Chapter 2, there is much to be found in what the principle of justice does not say. For example, any "irrelevant properties"[431] – distinguishing features of persons that are not explicitly outlined by the six material rules – should not be used to define metrics of equality. Oppression, being borne out of discriminatory behaviour that almost exclusively uses these irrelevant properties, is therefore delegitimized as a means of creating inequality. People will be slowly discouraged from participating in and supporting systems of oppression because their commitment to the principle of justice requires them to act in non-oppressive manners.

However, Beauchamp and Childress also make it evident that, while they consider systemic oppression a harmful thing, it is not taken to be a primary concern. For example, they state that, "[s]ome disparities in health care may result from implicit biases, even though the causal links may not be as direct as sometimes supposed"[432]. In this claim, they are distancing themselves from the idea that systems and people are inextricably tied. The "implicit biases" – framed by oppressive systems like colonial medicine – that cause people to act irresponsibly discriminant *may* be problematic, but are not as concerning as overtly oppressive people[433]. The systems can be dealt with on their own; the people are where concerns should lie. Beauchamp and Childress go on to say that "constraining situations" (i.e., circumstances wherein "a person feels controlled by the constraints of a situation, such as severe illness or lack of food or shelter, rather than by the design or threat of another person"[434]), which are entirely determined by systemically oppressive factors are "sometimes misleadingly termed coercive situations"[435]. By claiming this,

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[431] Ibid., 281.

[432] Ibid., 284.

[433] The subsection in which racial disparities (included in the "some" mentioned in the previous quote) are covered – "Redressing Racial, Ethnic, Gender, and Social Status Disparities in Health Care" – mentions at least seven healthcare areas in which there are implicit biases around race, but chooses to focus heavily on the systems of renal transplantation, wherein some targeted policies have shown some degree of racial equalization. Supposedly, this proves that "developing an equitable policy of organ allocation and distribution is challenging" (p.286); I fail to see why this is a useful conclusion or how it adds to the "confusion" around causal links between implicit biases and health outcomes. The authors *immediately* distract from this by limiting their foregoing discussions to "economically disadvantaged" (p.286) persons, ignoring intersecting racial concerns almost entirely for the remainder of the chapter (institutional injustice is briefly mentioned on p.299, but not with race involved).

[434] Beauchamp and Childress., 287.

[435] Ibid.

they can entirely remove systemic issues from the reach of principles like respect for autonomy, which deals only with interpersonal coercion, persuasion, and manipulation. Systems become their own realm of concern outside of the principles, supposedly free from noticeable influence on people. This supposition is clearly wrong.

Again, we can see the importance of the inculcation of humility in anti-colonial healthcare. Providers currently erroneously presume that they know what is best for their patients, but often lack the appraisal respect or relational focus to actually know this. Being humble enough to understand that they are misguided is only possible when there are alternatives to dogmatic understandings of the world. These non-dogmatic alternatives are found in the minds of the oppressed and their communities. Anti-colonial justice requires attention to these minds.

Redressing Principlism

The previous section demonstrates that Principlism's colonial ties present themselves through a failure to incorporate an EMC rule in the core of the paradigm, a misguided and individualized sense of obligations to persons, and a need for an expanded application of humility in each of the principles. Perhaps unsurprisingly, the most prominent anti-colonial efforts of the last quarter century have targeted similar issues. Although few of these efforts were designed to redress PBE specifically, their insights are nonetheless valuable in understanding what can be done to create a Principlist-specific anti-colonial strategy.

To this end, what follows will address two of the most successful efforts at redressing healthcare ethics in an anti-colonialism-adjacent manner. I refer to these efforts as "redressing" because both attempts – while having facets that are well-suited to amending Principlism – do not ultimately accomplish a reconstructing of the paradigm. The first effort, relational autonomy, attempts to more accurately define "autonomy" in the social world and use this relationally-minded definition to inform obligations that go beyond the strictly interpersonal. The second ameliorative effort, cultural safety, incidentally focuses on the other shortcomings of Principlism; it attempts to draw attention to the value of EMC rules and the virtue of humility. The shortcomings identified in what follows will be illustrative in why and how Principlism can be reconstructed directly, as will be argued for in Chapter 4.

Relational Autonomy

Relational autonomy is a theory that aims to shift the focus of "autonomy" from the limited conception of the independent individual to a more holistic sense of interconnected decision matrices that people act within[436]. Consequently, the theory argues that relationally-founded choices, rather than idiosyncratic decisions, are the true object of the respect for autonomy principle. This focus helps to illuminate the fact that patient decision-making is as much up to an individual's preferences as it is the preferences of their support network[437] and clinician with whom they are interacting[438]. Chapter 2 and earlier parts of this Chapter detail why this concept makes sense. People's preferences are embodied in and through their relations with the constituents of the world. These relations are neither one-sided nor arbitrary; they are reciprocal engagements of parties with the intention of exchange of goods, knowledge, or support.

In essence, relational autonomy is most things that individualized autonomy is not. The social world is considered a constitutive and causal aspect of autonomy[439] as opposed to an addendum that threatens to impose upon it. Without the social world, our decisions mean little of anything; or if they do, their meaning is likely to impede future decision-making significantly. For example, my relationship to an ophthalmologist allows me to take part in deciding if I need corrective eye surgery. This relationship is important because an ophthalmologist, knowing significantly more about eye health than myself, can help me comprehend what it would mean for my embodied existence to undergo the risks of surgery and what benefits I could expect should things go well. Without this relationship, I cannot know what my decisions mean and can do little to act on them without causing more harm to my own interests (i.e., attempting and inevitably failing to perform surgery on myself).

For the individualized autonomy crowd, these social claims may read as being overly inclusive regarding what a decision involves. One could look at the previous examples as demonstrating that relational autonomy has to do with acknowledging the social world as a

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[436] Carlos Gómez-Vírseda, Yves De Maeseneer, and Chris Gastmans, 'Relational Autonomy: What Does It Mean and How Is It Used in End-of-Life Care? A Systematic Review of Argument-Based Ethics Literature', *BMC Medical Ethics*, 20.76 (2019), 5, 9.

[437] Or perhaps more correctly, that an individual's preferences *are* (the amalgamation and curation of) the preferences of their support network.

[438] Jennifer K. Walter and Lainie Friedman Ross, 'Relational Autonomy: Moving beyond the Limits of Isolated Individualism', *Pediatrics*, 133.1 (2014), s16.

[439] Natalie Stoljar, 'Informed Consent and Relational Conceptions of Autonomy', *Journal of Medicine and Philosophy*, 36.4 (2011), 377-8.

restriction upon autonomy proper[440]. The social world does not constitute or cause our decisions, our decisions are forced into constraints that are laid out by the social world. This seems apparent in socially oppressive forces such as colonialism. Unlike an ophthalmology consultation, colonialism restricts Indigenous lives in such a way that autonomy becomes a matter of black and white decisions, rather than a spectrum of choice. As such, it seems that relational autonomy draws focus away from the core of personhood that is autonomous choice in favour of including that which impedes personhood.

While it is true that the social world is "restrictive" in this way, this does not make it any less constitutive of autonomy. Labelling social factors as being restrictive on choice implies that choice and social factors are distinct things. It presumes that people can willingly choose to distance themselves from unwanted social factors like colonialism. This is clearly untrue. As such, social factors integral in autonomous decision-making. By encouraging this integral recognition, relational autonomy hopes to encourage healthcare providers to give more credence to extended world in which patients make autonomous choice, which would make Indigenous patients' oppression more directly concerning.

Beauchamp and Childress are aware of relational autonomy. They accurately describe the theory as being "motivated by the conviction that persons' identities and choices are generally shaped, for better or worse, through social interactions and intersecting social determinants such as race, class, gender, ethnicity, and authority structures"[441]. Although most of PBE's considerations towards relational autonomy have to do with end-of-life care[442], the authors clearly understand that there enough merit to the theory to warrant its discussion. Noting the other (rather non-committal) inclusions of relationships in other parts of PBE[443], it is curious as to why PBE's concept of autonomy is so individualized. Social relations do not limit one's ability to intentionally plan their actions or understand their world. It could be argued that the social world, and therefore relational autonomy, suppresses personal control to some degree, but this is only true if "control" is considered an individualized concept.

Why then has relational autonomy failed to embed itself in the core of PBE? A simple answer might be to just appeal to authorial stubbornness, but I do not find this very convincing.

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[440] Ibid.

[441] Beauchamp and Childress, 104.

[442] Implying that relational autonomy is a special case of autonomy, not a replacement for individualized autonomy.

[443] See Chapter 2 and the earlier sections of Chapter 3.

Both authors of PBE have demonstrated a keen desire to update and improve their work by taking on and adapting to criticism. It could also be the case that relational autonomy is too radically different from what currently exists in PBE. This too seems unlikely. As the "Respecting Autonomy" subsection earlier in this Chapter mentions, relationships are foundational to Principlism (even if the principles often contradict this). Beauchamp and Childress also describe "relational or associational privacy" as a *fundamental* form of privacy[444] and quote the very relation-centred phrase "errors are caused by bad systems, not by bad people"[445] as being from the *commendable* work of leaders[446] of the "patient safety movement"[447]. Despite the authors not fully committing to these ideas throughout their book[448], incorporating relational autonomy does not seem like too much of a stretch. However, I do not think that we should assume that forcing relational autonomy into PBE would result in universal benefit. The theory, as good as it is, is not the silver bullet of anti-colonialism.

There are several issues with using relational autonomy as an anti-colonial substitute for "autonomy" in the current PBE principle. The first and most obvious is that relational autonomy was not designed expressly for anti-colonialism or decolonization. Overlapping arguments about relational connections in the theory and in North American Indigenous philosophies that inspire decolonizing ideas are mostly a matter of coincidence. This coincidence happens to speak in favour of some aspects of anti-colonialism, but it is not a primary goal. Shay Welch argues that a more accurate conception of autonomy that benefits Indigenous people would "promote the highest degree of self-determination and independence"[449] whilst being rooted in "intense social

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[444] A form of privacy that "includes the family and similarly intimate relations, within which individuals make decisions in conjunction with others" (Beauchamp and Childress, p. 338). Granted, this depiction of "relational privacy" still limits itself to specific kinds of special relations, not relations in general; however, it does demonstrate that Beauchamp and Childress recognize that people make decisions as part of their relational matrices.

[445] R D Truog and others, *Talking with Patients and Families about Medical Error: A Guide for Education and Practice*, Talking with Patients and Families about Medical Error (Johns Hopkins University Press, 2011). p.vii The quotation is from the Foreword by Lucian L. Leape.

[446] Technically speaking, the quote is from a Foreword, which was authored by someone other than the primary authors (i.e., "leaders") of the referenced book on patient safety, but I do not think Beauchamp and Childress were so concerned with the specifics in their commendation of the driving ideas of the movement.

[447] Beauchamp and Childress, 334.

[448] For example, page 334 immediately follows the quote on systems with the phrase, "[n]evertheless, it is important to remove professionals deficient in personal character, knowledge, or skills who make or are likely to make medical errors"; a starkly individualist perspective that minimizes the importance of systemic error (only for Beauchamp and Childress to commend the patient safety movement two paragraphs later).

[449] Welch, 203.

interdependency"[450]. Although this is similar to relational autonomy, it is more nuanced than a pure focus on the social world.

Another issue with relational autonomy is that recognizing the social world does not guarantee an obligation to it. In other words, it brings attention to issues adjacent to colonialism, but does not command action towards them. I think it is accurate to say that most people are cognizant of the importance of the social determinants of health (even if they do not know the concept by this name). A nice illustration of this can be seen in the claim, "we live in a society" – often used to mock people who espouse grand claims about politics with little to no thought behind them. The insult demonstrates that even the most dim-witted person can notice the fact that people's lives are indelibly linked to the social world. It simultaneously demonstrates that making such a claim does nothing to suggest how we are to go about acting upon this realization. Relational autonomy is much the same. It is not fully clear what a clinician is to do about the social reality of a patient since they only work with individuals. I believe it is very much possible to construct obligations surrounding this social awareness, but relational autonomy does not presently have such obligations ready and able to replace those already present in PBE.

The last issue with relational autonomy is that it, by itself, does not draw the focus of PBE away from autonomy. Even if relational autonomy is preferable to the principle currently in place, relational autonomy does not give other anti-colonial principles (i.e., the inclusion of EMC rules) more stringent obligations. Certainly, relational autonomy would resolve some overlapping issues of individual focus in the other three principles explored in Chapter 2, but it does not resolve the currently lacking obligations towards the restructuring of healthcare.

None of this is to say that I think relational autonomy is a bad idea. There is "a curious contrast between the rich array of theoretical critique of individualistic notions of autonomy and the paucity of alternative forms of autonomy in practice"[451] and relational autonomy is one of the few attempting to go beyond critique. To this end, I think relational autonomy is a very effective first move. Where other works (including this one) primarily just critique individualized autonomy without a measured replacement, relational autonomy dares to make change.

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[450] Ibid.

[451] Edward S. Dove and others, 'Beyond Individualism: Is There a Place for Relational Autonomy in Clinical Practice and Research?', *Clinical Ethics*, 12.3 (2017), 162.

However, more than just a change to autonomy is needed to release PBE from its reliance on colonialism.

Cultural Safety

Cultural safety is a healthcare paradigm that hopes to inspire EMC and humble medicine. Unlike relational autonomy, which acts as a replacement for an existing principle, cultural safety adds to the Principlist framework. Cultural safety does not impose distinct, *principle-like* obligations that are drawn from the common morality and circumstantially balanced, but rather, holds healthcare providers to an *ever-present* set of obligations (or a refined understanding of existing obligations). Roughly speaking, these obligations (as the name of the paradigm suggests) are based in making healthcare interactions as safe as possible for cultural minorities. The nuances of how the paradigm defines "safe" are what make it distinct from the address of harm already mentioned throughout PBE. It fleshes out the idea of "harm" to include structural harms, which enriches the principles of nonmaleficence and beneficence in doing so.

Despite being a relatively new concept, the foundations of cultural safety go back many years. Indeed, the movement towards cultural safety has followed in step with the development of Principlism[452]. Cultural safety is the current leading theory along a continuum of efforts that have attempted to improve relations between patients of minority groups and healthcare providers[453]. At the least effective end of this continuum lies the well-known paradigm, "cultural awareness". Cultural awareness is essentially a step above what might be called "cultural ignorance". The cultural awareness paradigm simply obliges healthcare providers to be cognizant of possible differences between the cultures to which they belong and the cultures to which their patients belong. It does not require that these differences are engaged in any meaningful way. As such, the culturally aware clinician will be able to identify differences in culture and ideology but is likely unable to do anything about bridging these differences. As is hopefully apparent, this does not work for decolonization or anti-colonialism; "the enemy of solidarity is not difference but the lack of engagement with difference"[454]. To engage these acknowledged differences, the paradigms of "cultural sensitivity" and "cultural competency" were developed. These paradigms

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[452] McCallum and Perry, 98.

[453] Eric Smith, 'Safely Embracing Culture: The Adequacy of the Cultural Safety Paradigm in Canadian and American Indigenous Healthcare', in *Minorities in Canada: Intercultural Investigations*, ed. by Miklós Vassányi and others (L'Harmattan, 2021), 252.

[454] Katie Boudreau Morris, 'Decolonizing Solidarity: Cultivating Relationships of Discomfort', *Settler Colonial Studies*, 7.4 (2017), 467.

require that healthcare providers not only recognize cultural differences between themselves and their patients, but also strive to have meaningful interpersonal engagements in clinical settings. Cultural sensitivity dwells more on generating this meaning by being inoffensive, while cultural competency focuses more on creating open and meaningful discourse. The culturally competent clinician is therefore more likely to be able to enact anti-colonial healthcare than the culturally sensitive clinician. Cultural safety takes another step in this direction.

Unlike relational autonomy, cultural safety was designed with the express purpose of aiding anti-colonial efforts. It is a paradigm made by Indigenous persons[455], for the benefit of Indigenous persons. Cultural safety obliges providers practice of holistic, humble, and responsive healthcare[456]. The idea of holism could be thought to include the extended web of personhood mentioned in relational autonomy[457]. Humility and responsiveness have to do with provider's obligations to understanding the influence of culture on health and decision-making, and that patients are more knowledgeable about this influence than their providers (as things currently stand). This means that "safe" health spaces are those that are free of stereotype threats, distrust, and indifference towards patients. Put differently, culturally safe healthcare is expressly non-discriminatory. This address of non-discrimination – an element overlooked in the common morality through an absence of an EMC rule[458] – is why the cultural safety paradigm is the current gold standard of Indigenous-settler healthcare[459].

On its face, cultural safety appears to compensate for many of the colonial shortcomings of Principlism. It is non-discriminatory, humble, and capable of incorporating a relational concept of personhood. Cultural safety has also seen much more widespread acceptance than relational autonomy[460], which one would think makes it well-suited to an anti-colonial restructuring of

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[455] The roots of the paradigm trace back to a small group of Māori nursing students. Although the Māori native land is New Zealand, not Canada, there are several similarities between the Indigenous groups of New Zealand and Canada that make the paradigm applicable here. However, there are also some key differences that make its application less than ideal; see Smith.

[456] Elana Curtis and others, 'Why Cultural Safety Rather than Cultural Competency Is Required to Achieve Health Equity: A Literature Review and Recommended Definition', *International Journal for Equity in Health*, 18.174 (2019), 12-3; Smith.

[457] Erica Gabrielle Foldy and Tamara R. Buckley, 'Reimagining Cultural Competence: Bringing Buried Dynamics Into the Light', *Journal of Applied Behavioral Science*, 53.2 (2017), 272-5, 279-82.

[458] See *The Common Morality* from the *Addressing Principlism* section in Chapter 3.

[459] Curtis et al., 1–17; Matthews, 834.

[460] As evidenced by the fact that the CMA recommends cultural safety and humility in its code of ethics (several times) (Code of Ethics and Professionalism, 4-6), but only refers to the importance of patient-provider relations, not the relationships of patients.

PBE. However, the paradigm has yet to show true change for several reasons. Firstly, the concept has proven nebulous in practice. That is, there is a general lack of understanding on what being "culturally safe" means[461] for healthcare professionals, which leads to varied and blindly advocated practice. As is probably evident in the description of the paradigm I have provided, there are some very lofty ideals in cultural safety, many of which are open to a great deal of interpretation. For example, does including relational autonomy as a form of autonomy suffice for being "holistic" or does this require some other conception(s)? I cannot say.

The cultural safety paradigm has also generally failed to engage the relational matrices at the core of personhood[462]. Instead of promoting an understanding of colonialism and Indigeneity as they interact with clinical medicine, the paradigm has tended to encourage an insatiable thirst for ethnographic knowledge about Indigenous life[463]. That is, the paradigm is usually interpreted to only oblige providers to gather facts about Indigenous patient's health, not fully understand how/why this health is the way it is. Because providers are aware of their lack of Indigenous knowledge, the paradigm encourages them to act on this awareness and seek out said knowledge. However, this allows healthcare providers to think themselves absolved of wrongdoing, if not promoting more effective care without requiring actual change on the side of the provider[464]. Beauchamp and Childress bolster this knowledge over understanding idea in their support of the "learning healthcare system"[465], which they briefly describe as being a system that binds providers and patients to their beneficent obligations of reciprocity through the ever-present flow of knowledge about patient life. In both PBE and cultural safety, the laudable goals of understanding colonialism are turned into a perfunctory checklist of fact collection.

The phrasing of "cultural safety" also has some difficulties. Although the word "safe" is relatively innocuous, when combined with the word "culture" it carries paternalistic sentiments about acting for the patient's own good. The "cultural" patient (i.e., member of a minority group)

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[461] Lauren Brooks-Cleator, Breanna Phillipps, and Audrey Giles, 'Culturally Safe Health Initiatives for Indigenous Peoples in Canada: A Scoping Review', *The Canadian Journal of Nursing Research = Revue Canadienne de Recherche En Sciences Infirmieres*, 50.4 (2018), 210-11.

[462] Audra Simpson, 'On Ethnographic Refusal: Indigeneity, "Voice" and Colonial Citizenship', *Junctures: The Journal for Thematic Dialogue*, 0.9 (2007), 67–80.

[463] Robert Sanson-Fisher and others, 'Indigenous Health Research : A Critical Review of Outputs over Time', *The Medical Journal of Australia*, 184.10 (2006); Eileen Pittaway, Linda Bartolomei, and Richard Hugman, '"Stop Stealing Our Stories": The Ethics of Research with Vulnerable Groups', *Journal of Human Rights Practice*, 2.2 (2010).

[464] Tuck and Yang, 10.

[465] Beauchamp and Childress, 229.

is presumed unsafe at most times and the provider must ensure that this lack of safety is ameliorated. Being culturally safe gives an "appearance of equanimity"[466] from which healthcare providers are impartial benefactors to the patient populous. A healthcare provider is seeking to know more about racism, and so must protect their patient from it. This can include a degree of introspectiveness from which a provider sees themselves as part of the problem, but this avoidance of harm can only go so far without an understanding of what to do to positively benefit the patient (see the subsection *Being Just* earlier in this Chapter). In essence, the paradigm blankets Principlist concerns and allows people to say that they are "culturally safe", but the actual manifestations of this state of being are not significantly different from the pre-existing concerns borne out of Principlism.

These shortcomings are not without the possibility for improvement. Indeed, the continuum upon which cultural safety sits does not have a definite end. I have argued elsewhere that this indefinite nature can be used to encourage more effective paradigms such as "structural competency"[467], which encourages an introspectiveness about institutional misunderstandings, rather than individual ignorance[468]. While I maintain that a paradigm of this kind would help lead to positive change, it can only address issues with Principlism indirectly. Being culturally effective will always be a secondary priority to being an effective healthcare provider, as defined by influential texts like PBE, until being culturally effective is an inherent part of what this definition is.

Chapter 4: Reconstructing Principlism

Thus far, this work has demonstrated the colonial shackles that Principlism has yet to shed. This final chapter aims to use this demonstration as the basis for a reconstructed framework for PBE that can meet the pressing need for an abandonment of colonial leanings. Before I can do this, however, it is worth re-iterating why I believe such a reconstruction is worthwhile.

Each of the first three chapters have centred on discussions of colonialism, Principlism, or the confluence of the two. As discussions, these chapters have aimed to achieve an earnest

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[466] Janet Lee Mawhinney, 'Giving up the Ghost, Disrupting the (Re)Production of White Privilege in Anti-Racist Pedagogy and Organizational Change' (University of Toronto, 1998), 103.
[467] Jonathan M Metzl and Helena Hansen, 'Structural Competency: Theorizing a New Medical Engagement with Stigma and Inequality.', *Social Science & Medicine (1982)*, 103 (2014), 126–133.
[468] Smith, 262.

understanding of these topics in hopes of finding ways to amend their respective issues. Moreover, these amends have been presumed possible – merely requiring the alteration of some of the core constituents of Principlism. Why should we think that this is correct? I have thoroughly illustrated the ways by which Principlism fails Indigenous persons, so why not abandon PBE entirely and begin from scratch?

Principlism is worth keeping, albeit in a restructured form, for a few reasons. The first has to do with its entrenchment in healthcare. Even if PBE were beyond saving and worth completely removing from our collective consciousness, doing so is much easier said than done. The tendrils of Principlism are far-reaching and currently influence most corners of colonial medicine; detaching these tendrils is likely to be a long, arduous process. However, if we leverage this entrenched influence and use it as a vessel for more effective healthcare, although not a *decolonial* method, we should expect to see a reduction of harms against Indigenous persons. Furthermore, as mentioned in the "Being Just" subsection of Chapter 3, even if Principlism could be removed easily, failing to execute a plan that ensures Indigenous-led initiatives would fill the space left by its removal will only result in more unregulated oppression. Such plans have proven successful before[469], but I do not hold out hope that they will be accepted as true institutional upheavals anytime soon. Lastly, my being a settler limits what I can accomplish in terms of activism. I cannot be the head of a decolonization effort because I am the thing standing in its way. What I can do, however, is help to oppose colonialism in Canadian healthcare by adjusting one of its most foundational frameworks.

Of course, my suggestion for a reconstruction only works if Principlism can be changed in the manner I am alluding to. Slavery was entrenched in North American discourse for centuries, but this did not mean that the best approach to eliminating slavery was to keep it, but in a less pernicious form; slavery is a practice without the possibility for good. Although I have already demonstrated some methodological obstinance on the part of its authors, I do not think PBE is unassailable in this way. Beauchamp and Childress have made many genuine amendments to meet their critics partway[470] without losing the paradigm's identity or influence. Their supposed emphasis on reflective equilibrium also helps with this sort of openness to change without losing

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[469] For example, Canada's Bill C-92 (recently made law), which allows Indigenous communities to plan and operate child and family service centres as they see culturally and jurisdictionally fit (unlike what used to be the case, where the provincial and/or federal governments ran all these facilities by their own settler rules and regulations).

[470] Arras.

track of the core completely[471]. It is impossible to fully remove colonialism from Principlism, but I believe that the reconstruction that I propose is important and foundational enough to be worth considering as a stepping-stone in society's progress towards decolonization.

The first section of this chapter, *Adjusting the Core*, will make use of my critiques in Chapters 2 and 3 to summarize what I believe to be a more effective and anti-colonial version of the four core principles. The second section, *Act Humbly*, will argue that a fifth pillar should be added to the Principlist framework to truly fight against its current permittance of colonialism.

Adjusting the Core

My previously mentioned adjustments to Principlism's core have all hinged on a greater understanding of patients' and healthcare personnel's social existence. The reflective deliberation required for recognizing an EMC rule, embracing relational concepts of autonomy and appraisal respect, understanding systems as architects and vectors for harm, a direct obligation to amend systems at a systems level, and a greater embrace of humility in healthcare provision all speak to this need. Restructuring the paradigm to accommodate for such extensive aspects of clinical care is no easy task. The structural plot will need to be based in something that is relatively simple and intuitive whilst demonstrating clear impacts on the principles, without merely being appendices or ad hoc edits on the existing text. I believe that part of such a strategy is found in reconceptualizing the principles and their specifiers as virtue-based rules.

This reconceptualization initially presents as a simple re-wording of PBE's core into virtuous dictates (hereafter, "v-rules")[472]: "respect for autonomy" becomes "act respectfully"[473], "nonmaleficence" becomes, "act nonmaleficently", "beneficence" becomes, "act beneficently", and "justice" becomes, "act justly". However, there is a much more foundational shift behind these re-wordings. Said shift involves moving away from the binary deontological platitudes of the common morality espoused in PBE and instead embracing a common morality based

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[471] However, it is clear that the authors' employment of reflective equilibrium (or the method itself) is either ineffective or too slow to be able to recognize the need for anti-colonialism. For an in-depth appraisal of the mertis of the reflective equillibrium process in general, see Thomas Kelly and Sarah McGrath, 'Is Reflective Equillibrium Enough?', *Philosophical Perspectives*, 24.Epistemology (2010).

[472] Such a linguistic alteration has merit on its own. As mentioned in the introduction of this work, "moral progress often depends as much on finding (or fashioning) the right words as on applying the right principles" (Arras, 17). The named summation of an ethical argument can make or break its potential for convincing the public. A (morally prescriptive) rose by any other name would not, in fact, smell as sweet. If the healthcare community is not behaving in a righteous way, having "right" conceptualized differently may correct such behaviour.

[473] More on how the "autonomy" is subsumed as a subsidiary v-rule later.

primarily on virtue and character. Accordingly, I posit that the common morality is best understood as *the character traits that moral agents universally agree to be righteous* – particularly for its aspects pertaining to healthcare[474].

When I consider the sorts of things all moral agents agree on, I find it natural to first turn to children. Although children are not usually considered moral agents (given their lack of development/experience), they are a (mostly) unfiltered reflection of humanity. As I have argued for in the "Respecting Autonomy" subsection of Chapter 3, our selves are determined by the people/world around us. Consequently, despite some of children's behaviours being linked with their lack of development, many more are related to the information they absorb and what we explicitly tell them to think/say. Children do and think what they take in from their relational network much like adults, but do so with less forethought or regard for social mores, making them excellent displays of human moral intuitions/agreements.

When children are upset or disagree on something, they often say things like "that's not nice!" or "you're mean!" – phrases that clearly invoke a sense of faulty *character* on the part of the agitator. In my experience[475], it is rare to find comments like these outnumbered by "you broke the rules!" or "that isn't allowed!" – phrases about deontological rule following. Some might consider this observation to simply be a matter of children's inarticulate nature; it is easier to say "mean" than it is to cognate a phrase like "you have broken the ____rule, and that upsets me." However, adults also exemplify speaking in this "inarticulate" manner. Being upset about a person's character – even if their character is not rightly the issue at hand – is incredibly common in adults. For example, me calling the person who cuts me off in traffic an "asshole" seems to come from my displeasure with their failure to be more virtuous, even though the act of cutting me off does not really indicate anything about them as a person. Perhaps more importantly, *most people would agree* that my calling someone an asshole in this scenario is justifiable; cutting someone off is a rude and dangerous act worthy of reprimand. Therefore, whether it be children or unfiltered adults, it seems clear to me that humans naturally express and

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[474] Since Beauchamp and Childress claim there is a "loose distinction" between the principles, rules, and virtues of their paradigm (and the common morality expressed in PBE already has recognized virtues), there is little re-working of the concept needed to make my proposed shift work. So long as attention is paid to maintaining the existing checks and balances at the other levels of the paradigm, virtues can be made its primary consideration.

[475] Which I would say is extensive; having worked as a nanny, camp counselor/director, tutor, or driver for children of all ages throughout my life.

agree on what makes a person's *character* good or bad, agreement on rules is subsidiary to this. As such, the common morality should be expressed as an agreement on virtuous dispositions.

Even PBE recognizes that virtues are inescapably useful moral guides[476]. Early in their book, Beauchamp and Childress refer to the core principles as "other virtues"[477] that are outside of the five focal virtues of care[478]. The authors also describe virtue ethics as "the most venerable type of moral theory"[479] in healthcare without using similar approbative language for the other moral theories they discuss. Indeed, an appeal to virtue is even more clear in medicine than the general cases mentioned in the last paragraph. Do I and other moral agents agree that my doctor should abide by a rule like "do not kill"? Certainly. However, when considering what I want and/or expect from my doctor (i.e., what I and other moral agents agree should qualify as a "good doctor"), my first thought is not "I hope they do not kill me." Rather, my thoughts are more akin to "I hope they are a good listener" or "I hope they are compassionate". Thoughts like these, alongside the demonstration that healthcare is predicated on five focal *virtues*, clearly show that healthcare ethics is based in the development of good character. These concepts can be accounted for and integrated much more cleanly than in PBE if virtue is made the primary consideration of the common morality.

The v-rule form of the new "principles" preserves the content-thin, binary nature of the virtue-based common morality while also pulling an explicit focus of complex virtue to the paradigm's primary source of ethical guidance. In my humble opinion, this reconstructed core is a better distillation of my conception of the common morality than the principles are of theirs. The messy transitions and demarcations between rules, principles, and virtues in PBE are done away with; instead, the entire paradigm is comprised of v-rules that differ only in the thinness of their content and the number of v-rules they encapsulate. To clarify exactly how this works, it is now prudent to dig further into what exactly v-rules are.

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[476] Beauchamp and Childress, 37.

[477] Ibid., 33. Here they refer to the core virtues as "respectfulness, nonmalevolence, benevolence, [and] justice", but also interestingly include truthfulness and fidelity alongside this list – two virtues they explore in a separate chapter from the core virtues – as if they share the same standing as the previous four.

[478] The core principles have also been explicated as virtues elsewhere; see Justin Oakley, 'Virtue Ethics and Bioethics', in *The Cambridge Companion to Virtue Ethics*, ed. by Daniel C. Russell, 1st edn (Cambridge, UK: Cambridge University Press, 2013), 200, 202, 203-4.

[479] Beauchamp and Childress, 416.

Principlism's Colonial Ties

Rosalind Hursthouse describes v-rules as simultaneously embodying prescriptions (e.g., "act honestly, charitably, justly"[480]) and prohibitions (e.g., "do not act dishonestly, uncharitably, unjustly"[481]). Unlike virtues in a more general sense, v-rules do not immediately call upon their subjects to embody a (sometimes obscure) state of being. Rather, they just require that some agent is or is not doing some particular action. Eventually, by practicing this virtuous conduct in this way, it becomes second nature for an actor to align themselves with a virtuous state of being. In this way, v-rules are essentially the virtue ethicists' response to claims that virtues are too nebulous or inadequately action-guiding[482]. As much as these rules may *seem* to be "the wrong sort of rule"[483] – rules that are "evaluative"[484], lacking objective immutability or conciseness to be grasped by the uninitiated[485]– they are no more obtuse than the terms of other moral rules. For example, as mentioned in *The Common Morality* subsection of Chapter 3, the term "innocent" in the supposedly objective and universal rule, "do not punish the innocent" means different things to different people. A more virtue-laden term like "honestly" is also contextually interpreted in this way, but this is not a strong reason to think that the rule "act honestly" is uniquely nebulous. What matters most is not the exactitudes of the v-rules' terminology, but that these rules educate people in how to act (or at least aspire to act) in the same ways as a person with a virtuous character would, and so become more virtuous in the process. Ergo, my approach converts PBE's principles into rules about virtue, whose function is to help healthcare providers develop the virtuous dispositions required for ethical and anti-colonial healthcare.

Turning the principles and their subsidiaries into v-rules allows for a more active, holistic embodiment of moral goodness without losing much (if any) of the specifying content already present in the paradigm. The distilled aspects of the common morality – the "principles" and their specifiers – keep their capacities for clarifying what we mean when we idealize virtues of "respect" or "justice", but now – as v-rules – directly harken to a sense of *being* moral. A person who is deemed moral by their virtue must *be* a certain way. An obligation to act nonmaleficently is a direct calling for healthcare providers to embody the idea of nonmaleficence, rather than

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[480] Rosalind Hursthouse, 'Normative Virtue Ethics', in *How Should One Live?: Essays on the Virtues*, ed. by Roger Crisp (Oxford University Press, 1998), 25.

[481] Ibid.

[482] Oakley, 205; Hursthouse, 25.

[483] Hursthouse, 25.

[484] Ibid., 26.

[485] Ibid., 26-7.

simply being aware of it and trying not to go against it – such as in the case of Principlism. Healthcare providers have less space to leverage the ambiguity of v-rules in this framework because all levels of specificity are obliging them to embody the rule, not merely be cognizant of it. Although v-rules have the same end goal as aspiring to virtues in general, presenting them in this active voice gives them a power and accessibility that other moral conceptions lack.

The other benefit of turning all levels of Principlism into v-rules is its resolution to a primary concern of other virtue ethics theories. Namely, the problem of enumeration – the observation that there are seemingly infinite virtuous character traits (especially when considering how circumstantial conditions can vary) and that an unending list of ethical pillars is practically useless for moral guidance[486]. Indeed, large-scale ventures to compile an adequate list of human virtues, such as "the Virtues Project"[487], contain too many virtues to reasonably expect anyone to attempt to embody them all. However, this problem can be solved by creating a hierarchy of v-rules, wherein some virtues are cardinal, while others are subordinates. We may have infinitely many subordinates (i.e., particular moralities), but the cardinals (i.e., the core "principles") remain limited. This is a much more manageable framework and PBE has already done us the courtesy of laying it out for us, *prima facie* binds and all.

Removing ourselves from these justificatory abstractions, I propose that the reconstructed core should be presented as follows[488]:

The first[489] cardinal v-rule shall be "act respectfully"; the virtuous mean between the excessive vice of vicariousness and the deficient vice of indifference[490]. It will continue to encapsulate positive and negative obligations of behaviour towards persons, as the respect for autonomy principle does; however, it shall demote "act respectfully towards other's autonomy" to a specifying v-rule. In doing so, the attitude of respect is cardinally obliged to be directed not

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[486] Daniel C. Russell, 'The Enumeration Problem', in *Practical Intelligence and the Virtues* (Oxford University Press, 2009), 145-7.

[487] Virtues Project International Association, 'The Virtues Project - Discover the Virtues', 2021 <https://virtuesproject.com/virtuesdef.html> [accessed 5 February 2023].

[488] This depiction excludes a direct mention of the prohibitive v-rules that would oppose each of the described prescriptive cardinal rules. The exclusion is not intended to suggest that the prohibitive rules (i.e., the rules warning against vicious behaviour) are any less important – in fact, they share cardinal status with their prescriptive opposites – however, they are not presented in the body of the text for the sake of sentential flow.

[489] "First" here only refers to the order of presentation, not that "act respectfully" is more important than the other cardinal v-rules.

[490] In being vicarious, one lives a life that is too much in the proverbial shoes of others – thereby losing oneself in the process. In being indifferent, one gives too little consideration to the other people around them – as Chapter 1 demonstrates, this indifference has disastrous consequences.

only towards individual people, but also towards the networks from which they develop their sense of self. To further ensure this broader-scaled attention, this new cardinal v-rule allows for the inclusion of a specifying v-rule such as "act respectfully towards the milieu" – which directly calls healthcare providers to attend to the physical and social world in which they and their patients exist. It is a sort of extrospectiveness, obliging providers to consider and work with what is beyond their immediate surroundings. To ensure "respect" is embodied fully, two specifying v-rules such as "act with recognition respect" and "act with appraisal respect" should also be considered key to this cardinal rule.

Although the other common morality rules captured and employed by the original principle would be preserved in v-rule form (i.e., "act truthfully", "act respectfully towards other's privacy", and "act judiciously"); more importantly, this new cardinal rule would also accommodate one of the five focal virtues – conscientiousness. The conscientious clinician is a respectful clinician because said conscientiousness requires attending to the patient *appropriately* – with relationships in mind; it is a *consciousness* about the patient, not merely *knowing* them as an individual. By adding "act conscientiously" to the specification matrix of "act respectfully" (and absorbing the other four focal virtues, as will be done in the coming paragraphs) the focal virtues remove themselves from the prefatory sections of Principlism, instead becoming true foundations of bioethical guidance, as they should.

Taken together, this cardinal v-rule promotes a behavioural profile less aligned with autonomy, and more focused on something akin to "konomy"[491] (from the Greek term *koine nomos*, "a law borne from common understanding") – being a moral actor that is always cognizant of their behaviour's impacts not because of infringement on liberties, but because of their relational ties. This not only makes for better, more true-to-life provision of care, but also aligns with the anti-colonial concept of autonomy suggested in the *Redressing Principlism* section of Chapter 3: a concept that "promote[s] the highest degree of self-determination and independence"[492] whilst being rooted in "intense social interdependency"[493].

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[491] Alain De Broca and others, 'Explicitation de Deux Caractéristiques Fondamentales Des Soins Palliatifs. La Diachronie et La Konomie', *Medecine Palliative*, 11.1 (2012), 10–16.

[492] Welch, 203.

[493] Ibid.

The second cardinal v-rule shall be "act nonmaleficently"; the virtuous mean between the excessive vice of overprotectiveness and the deficient vice of malignance[494]. It will continue to embody a sense of avoiding negligent, maleficent, and undue risks for harms, but more easily references the non-absolutist ideas about the common morality v-rules that inspire it. As explored in Chapter 2, rules like "do not kill", "do not cause pain or suffering to others", and aspects of "do not punish the innocent" all *sound* like good things to always abide by, but healthcare contexts often require going against them for the sake of other *prima facie* obligations. Specifying v-rules like "act empathetically" and "act mercifully" serve well as distillations of these absolute common morality dictates. Beauchamp and Childress are content to give an air of non-absolutism, but still rely on binary rules to clarify their principle; the v-rule adjustment avoids this by baking in the grey areas inherent to virtue directly. The focal virtue of "compassion" also fits nicely under this cardinal rule as the specifier "act compassionately"; being compassionate is an excellent way to exemplify a desire to avoid unjustifiable harms.

Much like "act respectfully", it is key that this cardinal rule attends to the systemic and social aspects of the world. It will be shown later that my proposed fifth cardinal v-rule manages much of this attention, but for the time being, a specifying v-rule like "act beautifully" may suffice. Such a v-rule encapsulates the sense of beauty referenced in the *Being Nonmaleficent* subsection of Chapter 3, *hózhoojí nitsihakees* and *hózhoojí saad* – being beautiful in both thought and communication[495]. That is, not being beautiful in a way that is aesthetically pleasing, but bolstering to the lines of communication that hold the patient-provider relationship together.

The third cardinal v-rule shall be "act beneficently"; the virtuous mean between the excessive vice of predictiveness and the deficient vice of callousness[496]. It will continue to embody a sense of preventing/removing harms and promoting health, while also being fertile ground for the absorption of other focal virtues mentioned in PBE. For example, "act

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[494] In being overprotective (i.e., being too harm-avoidant) one allows *no* harm to befall the patient – preventing the continuance of important procedures and/or setting unreasonable standards of care. In being malignant, one lives a life that ignores the need to minimize the incurrence of harm to others – a clear antithesis of healthcare's goals. These two vices collectively make up the "maleficence" opposed by nonmaleficent virtue (see Chapter 2 for how maleficence is comprised of avoiding intentional and/or negligent harms (i.e., non-malignance) and minimizing, but accepting some harms (i.e., non-overprotectiveness)).

[495] Carrese and Rhodes, 828.

[496] In being predictive, one focuses too heavily on the cost-benefit ratio of certain procedures – thereby being bogged down by analysis and not considering the aspects of benefit outside of hedonistic calculus. In being callous, one ignores the special relations between persons and the health promotion duties these relations impose – thereby negating the reciprocal relationship between patient and provider and dismantling the foundation of healthcare.

discerningly" – capturing the focal virtue of discernment – applies to beneficence insofar as a discerning character is key to making the cost-benefit analyses that determine the level of care that a patient can and should receive. Further, "act trustworthy" – capturing the focal virtue of trustworthiness – specifies beneficence by standing against hard paternalism, instead obliging healthcare providers to engage the patient-provider relationship such that both parties can consent to and place faith in the benefits of a certain care procedure[497]. "[N]othing is more valuable in health care organizations and contexts than the maintenance of a culture of trust"[498] and the idea of beneficence is immeasurably valuable to medicine – it is what gives *health*care things to do. It should therefore come as no surprise that "act trustworthy" fits so snuggly in the "act beneficently" frame.

The principle of beneficence is the least problematic of the famous four, so its difficulties need only minor adjustments in this restructuring. For example, a specifying v-rule like "act accountably" helps to encompass the importance of the reciprocal relationships explained in Chapter 2, but also does more than cover sorts of relationships mentioned by Beauchamp and Childress by being broad enough to cover an accountability to all healthcare stakeholders.

The fourth cardinal v-rule shall be "act justly"; the virtuous mean between the excessive vice of incontinence and the deficient vice of rapaciousness[499]. It will continue to embody the formal rule of treating like things alike, but also calls more direct attention to the material rules surrounding communitarian theories of justice, as I suggest in Chapter 3. Although part of this attention could come from specifying v-rules like "act loyally" or "act devotedly" (in reference to a loyalty/devotion to humankind, not a specific group of people), most of the work is done for me by simply melding with the current zeitgeist. The word "justice" in Canada today is almost inextricably tied to the phrase "social justice" – calls to action against systems, groups, and/or social strata. We are concerned less about justice for individual persons[500] and more so about what case examples mean for group equity. This is opposed to the depiction of justice in PBE, which is more concerned with bad-faith actors than the systems that breed them (see the *Being*

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[497] Put differently by Beauchamp and Childress, "[t]o be *trustworthy* is to warrant another's confidence in one's character and conduct" (p. 40).

[498] Beauchamp and Childress, 40.

[499] In being incontinent, one does not consider the best means of distributing social capital or material goods, nor do they hold onto such things – thereby leaving the community's wellness up to chance. In being rapacious, one lives a life too concerned with holding social capital and/or material goods – thereby preventing the community from ever having the chance to be well.

[500] Though this certainly is still a concern and many individuals are used as representatives of groups.

Just subsection of Chapter 3). As such, I think many persons' thoughts about being "just" have to do with the alteration of systems, which communitarian theories also have a large focus on. PBE seems to intentionally lead the reader away from this intuition.

I admit that this puts a lot of faith in healthcare providers getting the "right" interpretation. Acting justly is complex and nuanced. PBE needed six "separate" theories to cover it adequately, so arguing that people are just going to fall on a communitarian-first interpretation is a bit of a stretch. However, much like "act respectfully" and "act nonmaleficently", I believe that my forthcoming fifth cardinal v-rule will help to set the mood. If all five of my proposed v-rules are treated as *prima facie* obligations, they will influence each other's interpretations. Much in the same way respect for autonomy currently influences the other principles to be individualistic, my fifth cardinal v-rule will influence its peers to be more relationally minded.

One may reasonably ask at this point if my adjustments truly count as a restructuring at all. Indeed, it may appear that all I have done is change some words and put argumentative fluff around it. If we suppose this to be true, I think it should still matter *how* I am shifting the verbiage in my restructuring. Beauchamp and Childress also explore – in abstract – the idea of having their principles be presented as virtues using similar rationale as my own. They claim that the principles' virtue equivalents are as follows[501]: respectfulness for autonomy, nonmalevolence, benevolence, and justice. These alterations capture the active sense of character essential for virtuous behaviour, but do not necessarily instill the obligations to relations, EMC, or humility required for a decolonizing project[502]. The virtuous presentation is more of a façade than it is a true embodiment of and shifting towards effective virtue; the principle of justice does not even change verbiage. However, in my restructuring, changes like the subsuming of "autonomy" into disparate subordinate v-rules in "act respectfully" directly bring an active presence in the social world to the forefront. Agents of this moral framework must attend to things beyond an erroneous concept of individualized self.

For those not fully convinced by this, a further contention of misplaced supererogation could hold true. While we clearly all agree that being exceptionally virtuous is praiseworthy, it does not seem true that we all agree that we must all strive to be so exceptional. As such, the common morality does not oblige supererogatory behaviour. However, if the common morality is based in

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[501] Beauchamp and Childress, 415.
[502] As argued for throughout Chapter 3.

virtues, there is an unavoidable looming expectation of striving to be morally exceptional. Principlism's version of the common morality does not have this issue because its constituent rules are about the minimums of moral expectation. Ergo, my shifting of the common morality and corresponding distillation of the cardinal v-rules expects too much.

While I cannot deny that my reconstruction has the looming presence of aiming for excellence, I do not think that this is a devastating feature. Healthcare workers should not all be expected to become saints; however, without the presence of measures of excellence, we will fail to effectively recognize it when it happens. As the paradigm currently stands, the only reason to think that the supererogatory fulfillment of moral obligations is commendable is that Beauchamp and Childress go out of their way to discuss its importance in tangential sections of PBE. Accordingly, Principlism gives much more attention to admonishing moral failure than it does commending moral success. However, we know that we *can* all recognize and aspire to excellence, so why not also include it as an integral part of our ethical analyses?

Here is where the effective deployment of v-rules becomes so powerful. It would be wonderful if we could oblige everyone to be perfectly virtuous, but this is an impossibly optimistic expectation. Because v-rules are more rigid than virtues, simpliciter, but less strict than deontological rulesets, we can maintain a sense of base obligations while still holding in the back of our minds that we *could* do better. As such, persons operating under v-rule paradigms have no difficulty recognizing morally outstanding behaviour, it is part of the framework. Persons using Principlism or deontological ethics must find some other way of describing the wonder they feel when seeing moral excellence. Even if we presume that the presence of this possible excellence weighs on people (i.e., the fact that we may never be perfectly moral could discourage some actors from trying) in a way the principles may not, these v-rules are intended to be applied to healthcare professionals; the people that we expect to be capable of understanding and acting on difficult concepts about caring for others, such as these v-rules. We do not expect the same out of talk show hosts or stock brokers because these people do not have lines of work that require careful action towards other people. By having v-rules, we give enough requirements for moral adequacy, but also put nothing in the way of moral excellence. This is essential to effective healthcare today and leaving room for better, decolonized healthcare tomorrow.

Principlism's Colonial Ties

Perhaps I am being antithetical in suggesting that "V-rule-ism" – a name that is not nearly as catchy as "Principlism"[503]– is a superior paradigm, but I believe the benefits of this restructuring have been sufficiently demonstrated. However, by itself, this restructure is not adequate. It is still missing something that draws it closer to anti-colonialism and helps to round out its obligations to a social presence. For this, I suggest adding a fifth cardinal v-rule.

Act Humbly

The words "humble" and "humility" are used many times in the latter half of this work. It should therefore come as no surprise that I believe humility is key in turning the current 4-pillar approach into something that can work anti-colonially. None of the cardinal virtues described thus far have been able to draw clear pertinence to an EMC rule, nor have they been able to cleanly accommodate the final focal virtue, integrity. Therefore, I believe the best remaining option is to let in a fifth cardinal v-rule.

Although adding a new pillar to the framework may seem like dangerous territory – given PBE's forty years of having only four principles – the number of items in Principlism's core has no argumentative power. Put well by Veatch, "although four is a convenient number lodged about midway between the single-principle theories and those that produce longer lists, there is no theoretical or 'principled' reason why the number should be four"[504]. Indeed, there are many settler[505] and Indigenous[506] moral frameworks that successfully balance more than four principled duties. All that stands in the way of adding a cardinal v-rule is a demonstration that this addition is distinct and important enough to be counted separately.

Humility etymologically comes from the Latin word *humilitas*, meaning "lowness" or "insignificance". Correspondingly, the cardinal v-rule, "act humbly" obliges healthcare providers to adopt a sort of meekness. More specifically, it obliges healthcare providers to recognize themselves as meek in some, but not all ways; as professionals who – while skilled and useful –

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[503] Or "virtue ethics" for that matter.

[504] Veatch, 49.

[505] For example, Howard Brody's 5 principle theory, W.D. Ross' 6 principle theory (which was a large inspiration for Principlism), Robert Veatch's 7 principle theory, and Bernard Gert's 10 principle theory; see Veatch, 49.

[506] For example, the Seven Grandmother Gifts or the Inuit Quajimajatuqangit; see Jaro Kotalik and Gerry Martin, 'Aboriginal Health Care and Bioethics: A Reflection on the Teaching of the Seven Grandfathers', *American Journal of Bioethics*, 16.5 (2016), 41-2; John Borrows, *Law 's Indigenous Ethics* (Toronto: University of Toronto Press, 2019), 1-23; Francis ivesque, 'Revisiting Inuit Qaujimajatuqangit: Inuit Knowledge, Culture, Language, and Values in Nunavut Institutions since 1999', *Etudes Inuit Studies*, 38.1–2 (2014), 121; see also Welch, 207 for a collection of several pluralist Indigenous philosophies.

do not hold purview over all matters of their patient's health. The Canadian Medical Association – in listing humility as one of the five "virtues exemplified by the ethical physician"[507] – describes the character of the humble healthcare provider well, "[a] humble physician acknowledges and is cautious not to overstep the limits of their knowledge and skills or the limits of medicine, seeks advice and support from colleagues in challenging circumstances, and recognizes the patient's knowledge of their own circumstances"[508].

Such obligations may seem out of place for a virtue-based framework. The virtuous dispositions are intended to be aspirational, not suppressive. Healthcare providers should aspire to reach their full potential and capacity for helping others; but humility only seems to stymie it. However, this is exactly why the v-rule is so useful here. Where previous colonial failings have been based in paternalistically excessive or indifferently deficient treatment of Indigenous patients[509], humility encourages a mindset about healthcare that recognizes what it can and (more importantly) cannot do. It is the cardinal obligation to step back, rather than overstep; to be precisely as involved as one needs to be, not viciously more or less.

This may not sound too different from the other cardinal v-rules. Indeed, all the v-rules are about being in the mean between two vicious extremes. The negative obligations of "act respectfully" even sound very similar to "act humbly": if a clinician is acting respectfully by not unduly interfering with their patient's decision-making, they appear to be acting with a sort of meekness – a humility.

However, these negative obligations do not encapsulate "act humbly" because of the parties to which they are directed. Where respect obliges *extrospection* – to know of and act with the entities beyond one's immediate vicinity, humility obliges *introspection* – to know of and act with oneself[510]. Importantly however, this knowledge also extends beyond the individual. Since humans are such relationally-bound creatures, knowing oneself also requires an attention to the milieu/network of one's own life. Where respectful extrospection attends to the milieu of others, humble introspection attends to the milieu about oneself.

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[507] The degree to which the CMA actually commits to the importance of virtues is debateable, especially when noting that they are more indebted to Principlism than anything else; however, I have used their definition here because I believe it is thorough and accurate, even if not always employed.

[508] Canadian Medical Association, *Code of Ethics and Professionalism*, 2.

[509] See Chapter 1

[510] Of course, there is overlap here – since oneself is determined by their relations to others, being introspective requires a knowledge of other entities. However, this overlap is unavoidable and hardly unique. For example, the obligations contained within "act nonmaleficently" and "act beneficently" overlap constantly.

Of course, there will often be overlap in these considerations by nature of what relationships are. For example, by simply having a relationship to someone else, any respectful and/or humble attentiveness will inevitably make oneself the subject of reflection. A respectful physician will extrospectively understand their patient's social network and in this understanding, come to realize that they – as the patient's physician – play a significant role in determining their patient's sense of self. Should the same physician also be humble, they will introspectively understand that they play this role, while jointly recognizing that the aforementioned patient also plays a role in determining their sense of self. This is how "act humbly" instills an obligation to relationships; it requires healthcare providers to see themselves *relative* to the world and people that make them who they are (and who they are not).

This obligation to relations through an obligation to oneself is also why this cardinal v-rule relates to EMC concerns. To "not discriminate deservedness of moral consideration for irrelevant reasons" requires a mindset of kinship with one's peers. Understanding what counts as an "irrelevant" metric of difference first requires someone to consider what makes them similar to other people. For example, children – who are keen to point out things that seem "weird" to them – may, upon first seeing a stranger of a different skin tone, think of this stranger as fundamentally different and/or less than they are. However, if given the opportunity to get to know said stranger, children will come to realize that this person is not too dissimilar from themselves; that relevant discriminatory criteria are not based in skin tone. This is why exposing children to a wide variety of people, cultures, and opinions is so crucial; it teaches them to consider what *truly* makes people "bad" or "good". The "act humbly" cardinal v-rule has this same effect. It guards against unwitting irrelevant discrimination by obliging healthcare providers to intimately know how they and their patients relate.

"Act humbly" captures and employs these obligations through one of its specifying v-rules, "act considerately". Being truly humble is incongruous with believing that metrics such as "race", socioeconomic status, or gender/sex make someone more worthy of moral consideration. A healthcare provider introspecting to a level in which they *consider* themselves and their patients to be part of many relational matrices, and who is also *considerate* towards preserving such matrices, is humble. By recognizing that all people who have relationships (i.e., all people) are worthy of moral *consideration*, the shackles of irrelevant discrimination criteria loosen significantly.

The other cardinal v-rules do not require such understandings of similarity. Being respectful, nonmaleficent, beneficent, and just all hinge on the knowledge of what makes people different, and how such differences can be engaged in beneficial ways[511]. I can respect people by understanding that their decisions are different from my own, I can be nonmaleficent and/or beneficent towards people by knowing the harms that other people might incur, and I can be just towards other people by recognizing persons' differences in social/material capital. These difference-based attitudes are not bad things, but they are not the complete picture. By combining these attitudes with the embracing of similarity in "act humbly", we can capture the full scope of ethical engagement. The fact that we are all colonized[512] is true not only because of its introspective recognition of humanity's relational binding through a history of violence and indifference towards Indigenous persons, but also because we do not all experience colonialism in the same way. The other four cardinal v-rules are necessary to extrospectively and effectively acknowledge these experiences and devise ways to best nonmaleficently, beneficently, and justly engage with them.

On top of completing the scope of the other cardinal v-rules, "act humbly" also completes the encapsulation of the five focal virtues. Specifically, it encompasses the focal virtue of integrity – here converted to "act with integrity". Beauchamp and Childress correctly describe integrity as having two parts: 1) cohesiveness with oneself and 2) being stalwart for a greater sense of morality[513]. To be cohesive with all aspects of oneself – and be able to adjust these aspects to be so – requires the highest levels of introspection. Put differently, one cannot act with integrity without being humble enough to recognize their failure to do so. A person could certainly claim to have integrity by steadfastly refusing to acknowledge their flaws and "sticking to their guns" at all times, but this is clearly an unhelpful form of the disposition. Virtuous integrity comes from humbly working through the many conflicts that arise from strongly held beliefs, a fact that Beauchamp and Childress are also keenly aware of[514]. Acting with integrity in the right way is a humble pursuit of considering oneself as relative to others.

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[511] It could be argued that humility is also an engagement with difference, seeing that it involves deference to some *other* knowledge that is beyond the purview of a moral agent. However, the core of humility comes from understanding not just that there *are* different skills/ideas in the world to be engaged, but that these different skills/ideas are *worth* engaging. Finding this worth comes from an understanding of similarity; an equal standing between patient and provider in the healing process – despite the different roles they have in the relationship.

[512] Tuck and Yang, 17.

[513] Beauchamp and Childress, 41.

[514] Ibid., 42

Principlism's Colonial Ties

Taken as a whole, the cardinal v-rule "act humbly"; the virtuous mean between the excessive vice of arrogance and the deficient vice of obsequiousness[515], captures and employs common morality v-rules like "do not discriminate deservedness of moral consideration for irrelevant reasons" (turned to "act considerately"), "tell the truth"[516] (turned to "act truthfully), and "keep your promises"[517] (turned to "act with integrity"). It also includes specifying rules such as "act with fidelity" (which is also a common morality virtue[518]) and "act with honesty". Particular morality rules such as "[a]ccommodate a patient with cognitive impairments to participate, as much as possible, in decisions that affect them"[519] and "[c]ultivate training and practice environments that provide physical and psychological safety and encourage help-seeking behaviours"[520] also fall under this umbrella.

I acknowledge that this project is far from the first word on anti-colonial healthcare and it is certainly not the final word in decolonizing medicine. Principlism is not innocent in the continuance of colonial clinical care, but it is also not beyond fixing. Although this fixing is only capable of short-term moderate goals, it at least stumbles in the right direction – where settlers such as myself will hopefully give space for Indigenous voices to decolonize.

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[515] In being arrogant, one wrongly believes themselves to be superior to others in some way or another – thereby ignoring the truth of humankind's equality found in our interrelatedness, which serves to sever these relations. In being obsequious, one gives themselves up to the whims of others too readily – thereby losing a voice in the relational networks to which they belong and losing value as an interrelated human being.

[516] Beauchamp and Childress, 3.

[517] Ibid.

[518] Ibid.

[519] Canadian Medical Association, *Code of Ethics and Professionalism*, 5.

[520] Ibid., 6.

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