# *From the Editors*

In addressing ethical dilemmas in healthcare, many American bioethicists have become comfortable with, and sometimes even smug about, both principlism and the primacy of the principle of autonomy. Principlism is an approach that, in part, analyzes ethical dilemmas in terms of at least four ethical principles. Often the principles clash. It is held that resolution of cases and problems can be effected through sophisticated "balancing" of those principles, weighting them differently in each case according to their relative merits. The earliest and best proponents of this view of bioethics were Tom Beauchamp and James Childress in *The Principles of Biomedical Ethics* (4th ed., New York: Oxford University Press, 1994).

The primacy of autonomy within that balancing procedure came more and more to be viewed as a condition of possibility of ethics itself, a position argued and formulated best by H. Tristram Engelhardt, Jr. in *The Foundations of Bioethics* (New York: Oxford University Press, 1988). Engelhardt views autonomy as a condition of possibility of ethics in a pluralistic society. He posits that in a pluralistic environment nothing can be assumed. The starting point of all "peaceable discussion" then, and the only *a priori*, must be respect for the individual's own self-determination as he or she comes to the table for the discussion and resolution of an issue. No one position can predominate over another without consensus of equal partners in the dialogue. The lack of consensus described by Engelhardt casts a wide net over all assumptions, even those that Pellegrino and Thomasma, in their series of books on philosophy of medicine (Oxford University Press), have argued are *a priori* for the accomplishment of the healing goals of medicine: equality of treatment and its consistency, irrespective of race, religion, social class; respect for persons; and beneficence, that is, acting in the best interests of the patient.

Clinicians and other bioethicists have become increasingly critical of both principlism and the primacy of autonomy, claiming that principlism does not respect the particularities and emotional, personal, professional, and cultural content of ethical cases and dilemmas. It is too abstract. Also, the primacy of autonomy is foreign to the fundamental principle of beneficence in medicine. This criticism has led to today's widespread dissatisfaction with autonomy-based ethics, and to growing discussion of alternative bioethical theories such as virtue ethics, narrative ethics, situation ethics, feminist ethics, caring ethics, and the like. It is hard to predict where this discussion may end. Most certainly it will lead to a refinement of principlism more adapted to the demands of the twenty-first century.

Add to this discussion the vigorous questioning of the American cultural content, and it is clear that a more international and culturally sensitive bioethics

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must emerge to foster truly cooperative work on important bioethical and ethical concerns throughout the world. Perhaps the greatest challenge will be to search for a rights-based bioethics that could be accepted transculturally, even by those traditions that stress community over individualism, and/or protest against a rights- rather than responsibility-based ethics.

Our own conviction is that communitarian ethics must rejuvenate bioethics discussion that has become too complacently reliant on standard analysis in terms of autonomy. There is much to be learned from approaches that move beyond a clinical ethics based on autonomy; and in this issue's Special Section, we explore current critiques of autonomy-based ethics from an international perspective, the place of persons in the community of values, and how far the envelope of concern should be extended, especially with regard to vulnerable populations.