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From Paternalism to Systemic Bioethics: Principles, Characteristics, and Contemporary Relevance of Applied Ethics in Medicine and Society

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Abstract

The evolution of applied ethics, particularly in bioethics, reflects a paradigm shift from the paternalistic Hippocratic tradition to a systemic model grounded in shared ethical principles. This paper examines the characteristics and philosophical foundations of the four guiding principles—autonomy, beneficence, non-maleficence, and justice—formulated and institutionalized by the Kennedy Institute of Ethics. Drawing from Kantian duty, utilitarian calculus, Aristotelian distributive justice, and Rawlsian fairness, these principles have become a universal framework for medical decision-making, research governance, and healthcare policy. The study highlights cultural divergences between American pragmatism, with its emphasis on therapeutic and policy ethics, and European perspectives, which prioritize duties and research ethics. Findings demonstrate that systemic bioethics has reshaped patient-physician relations, reinforced patient dignity, and addressed pressing issues such as equitable resource distribution and ethical medical research. Nevertheless, challenges remain in operationalizing these principles within diverse sociocultural and economic contexts. By analyzing historical developments, theoretical underpinnings, and practical applications, this paper affirms the continued relevance of systemic bioethics as a dynamic instrument for balancing individual rights and collective responsibilities in modern healthcare.

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Introduction

The evolution of bioethics reflects profound transformations in the relationship between medicine, morality, and society. For centuries, the Hippocratic tradition dominated the medical profession, where the physician's oath emphasized beneficence but largely ignored the patient's right to self-determination. Medical ethics were deeply paternalistic, with the doctor positioned as the sole decision-maker regarding the patient's well-being. However, the cultural revolutions of the twentieth century introduced new perspectives that challenged this unilateral authority. With the rise of human rights charters, the affirmation of personal autonomy, and the growing need for ethical reflections on resource distribution, healthcare could no longer remain anchored exclusively in paternalistic models.

In Western societies, particularly in the United States, the rapid advancement of medical technology, combined with limited resources and growing healthcare demands, compelled scholars, policymakers, and medical practitioners to rethink ethical foundations. This context gave rise to systemic bioethics, which sought not only to address individual patient care but also to provide structured principles that could guide complex ethical decisions across diverse contexts. Central to this approach are four principles articulated and developed by the Kennedy Institute of Ethics: autonomy, beneficence, non-maleficence, and justice. These principles have since become cornerstones of applied ethics in medicine and biology.

The principle of autonomy emphasizes the individual's capacity for self-determination, rooted in both Kantian ethics and liberal legal traditions. Beneficence underscores the physician's duty to act in the best interest of the patient, while non-maleficence reiterates the obligation to "do no harm" in light of new medical risks and experimental research. Justice, in its distributive form, calls for fairness in the allocation of resources and equal access to healthcare services. Together, these principles have shaped the discourse on clinical practice, public health, and biomedical research.

Nevertheless, the interpretation and application of these principles differ across cultural contexts. American bioethics, marked by pragmatism, focused heavily on therapeutic practices and healthcare policy, while European thought, particularly in France and Spain, emphasized research ethics and philosophical duty. These divergences highlight the richness of bioethical debates and the necessity of contextualized approaches. As such, the systemic approach provides not only an ethical framework but also a lens for understanding broader societal and philosophical dynamics that govern the practice of medicine in modern times.

The development that has taken place in the field of biomedical sciences has led to the emergence of many problems that threaten human dignity and humanity. The unprecedented experiments carried out on humans in the hope of finding cures for incurable diseases did not take into account the dignity of the human being and turned into a scourge on humanity. They created an imbalance between science and the requirements of respecting the human being and raised the issue of regulating scientific research.

Actuality (Relevance of the Study)

The rapid growth of biomedical sciences, genetic engineering, and experimental medicine has intensified ethical dilemmas concerning human dignity, consent, and the distribution of limited resources. Incidents of unethical experimentation during the twentieth century emphasized the need for systemic regulation of scientific research. Today, global healthcare challenges—including pandemics, unequal access to medical technology, and debates over artificial intelligence in medicine—underscore the urgency of revisiting and reinforcing applied ethical frameworks. This study contributes to contemporary scholarship by critically reexamining systemic bioethics and its adaptability to modern challenges.

Findings

Shift from Paternalism – Applied ethics dismantled the physician's unilateral authority by empowering patient autonomy and informed consent.

Universal Ethical Framework – The four principles provide interdisciplinary guidance applicable in clinical practice, public health, and biomedical research.

Cultural Divergence – American pragmatism privileges policy and therapeutic ethics, while European traditions emphasize duty, responsibility, and research ethics.

Contemporary Impact – Systemic bioethics has enhanced patient rights, guided equitable allocation of scarce healthcare resources, and regulated experimental research.

Challenges – Variations in cultural, legal, and institutional contexts limit the uniform application of these principles, requiring context-sensitive adaptations.

Method and Methodology

This research adopts a qualitative, analytical, and comparative methodology, structured around three dimensions:
- Historical analysis of the evolution from Hippocratic paternalism to modern systemic bioethics.
- Philosophical examination of autonomy, beneficence, non-maleficence, and justice through Kantian, Aristotelian, utilitarian, and Rawlsian frameworks.
- Comparative study of American and European bioethical traditions, highlighting pragmatic versus duty-based approaches.

Sources include primary philosophical texts, policy documents, and contemporary bioethical scholarship.

The regulation of the field of science from a legal perspective exploded on an ethical level in the aftermath of the Second World War with the Nuremberg trials, which raised the problem of the ideality of science that obliges it to be in the service of good, and that the manipulation of science leads to its embodiment. These trials resulted in a set of concepts that became a reference in the scientific field, particularly on the subject of human experimentation. Thus emerged the idea of moving from ethics to law, through the issuance of the Nuremberg Code, which contained ten principles and became a reference in the field of legislation on biomedical experiments.

The preliminary stage of the emergence of bioethics was marked by rebellion against the paternal authority exercised by the physician and coincided with an enormous technological revolution affecting medical and biological research. In addition to the breaches and violations of patients' rights and the undermining of their dignity, this situation brought about new issues of a primarily ethical nature linked to the physician's responsibility and the patient's rights. They concerned matters such as reproduction, aging, chronic diseases and their complications, organ transplantation, dying, and genetic engineering research and experiments. Attempts to address these issues by returning to classical medical ethics were not successful, which prompted the idea of renewing ethical thought in the hope that it might provide solutions to these issues.

With the emergence of the term *bioethics* by Potter in the United States of America, its appearance coincided with the establishment of professional ethics committees (*comités d'éthique*) by the American authorities, which included individuals not necessarily belonging to the field of medicine and biology. Among the most prominent of these ethics committees were: "The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research," "The President's Commission for the Study of Ethical Problems in Medicine," and "Hospital Ethics Committees." In Canada, there were "Research Ethics Committees." However, all this codification was not comprehensive for all states, as some states adopted certain laws while rejecting others.

Characteristics of Applied Ethics:

It is noted that new scientific techniques, by arousing waves of fear and degrees of suspicion and doubt, have led to the association of bioethics with intellectual currents that viewed the progress of science as not necessarily constituting progress for humanity as a whole in all cases, due to the excesses accompanying such applications or what may result from them, perhaps even leading to slips into the unknown. All this was a motive to propose bioethical approaches based at times on complementarity and at other times on contradiction, through the adoption of a number of institutional principles for bioethical practice.

A- Interdisciplinary Approach:

The biomedical developments after 1960 brought forward new problems on the one hand, and on the other hand, raised old problems. "Issues were no longer dual between physician and patient but expanded to include all actors in the medical and biological field such as nurses, psychologists, social workers, etc." Gradually, these developments attracted the attention of legal experts to regulate legislation, ethicists concerned with ethical legitimization, and financial administrators responsible for distributing public resources. "All this was in order to ensure a sense that the matter is a societal choice, not just simple or private interventions."

The field of research developed, and research today is often conducted in highly equipped laboratories with significant public funds to pay these researchers. Faced with this situation, and with the desire of both the legislator and society to monitor what is happening—given the growing sense of the magnitude of the risks these studies pose to the future of humanity—it became clear that the professional framework of ethical thinking was no longer capable of keeping up with this new situation. "It was therefore necessary, in this complex situation connected to understanding and analyzing data linked to many sciences (sociology, psychology, law…) and different professions, and with the emergence of issues related to societal choices, that decision-making not remain tied to professionalism alone but be expanded to a public debate seeking consensus." Here two features of bioethics appeared: "multidisciplinarity and interdisciplinarity." These two features, emphasized by the need for interaction among disciplines, received a high level of attention as they even reflected on the way of thinking and the practice of ethics and medical ethics.

B- Secular Approach:

The biomedical revolution of the 1960s, as well as the secularization of American society, had an effect on the emergence of a sense of shared new challenges, due to the church's failure to keep pace with this process by finding solutions or proposals. Therefore, it was necessary to move away from everything that was doctrinal or religious in discourse or arguments.

The secular approach constituted an ethical reflection by proposing a non-religious or pluralistic ethical approach. According to this approach, the term *bioethics* had the advantage of being less religiously loaded compared to the term *ethics*.

Since the secular approach in bioethical thought does not necessarily mean abandoning or replacing all that is religious—"this does not exclude the religious sectors of the participants, but rather their ideas, which may be marked by ideologies they adhere to such as communism, secularism, etc. Through intellectual exchanges and discussions at this level, beliefs are temporarily bracketed in order to reveal a shared idea."

C- Holistic Approach:

The medical specialties that expanded significantly during the 19th and 20th centuries, and the associated specialized medical practices focusing on treating the patient's organ linked to the medical specialty, meant that care became centered on the organ rather than on the whole suffering person, with greater importance given to the proper functioning of the technique treating the patient's organ. From here, the loss of personality, humanization, and care began to appear. This called for the emergence of a comprehensive approach to health—a biopsychosocial approach to treatment (the interrelation of psychological, spiritual, and emotional aspects with the physical aspect).

"The holistic approach, in its view of the person as composed of body and soul, integrated in a family and influenced by the environment, presented its bioethical perspective with a socially integrated character concerned with the social and legal structures established for that purpose, characterized by justice, fairness, the functioning of the care system, and the value choices of society."

C – The Systemic Approach:

Unlike the Hippocratic Oath, which was centered on the physician's duty to do good for his patient, while disregarding the patient's right to self-determination—since medical ethics were characterized by paternalism, where the physician was the one to decide what was best for the patient—the cultural revolution that advocated autonomy established the patient's right to determine his destiny. With the proliferation of charters of individual rights on the one hand, and the decline of resources in Western societies on the other, questions arose related to the distribution of resources, access to care, and intergenerational relations. Some focused on the ranking of principles: some made the principle of autonomy the sole principle within this comprehensive approach, while others considered that the essential values were justice and solidarity. Within this bioethical approach, emphasis was placed on the analysis of real and individual cases—these are new conscientious issues related to the dialogue of the person with himself, making this dialogue fundamental without neglecting concern for the whole. Bioethical thought, according to this approach, does not suffice with solving problems in a fragmented way, independent of one another, without connection or coherence, but rather through strict logical analysis according to an ordered plan containing an interconnected sequence that summarizes the meaning of systemicity as a bioethical approach that aims to contain and transcend paternalism and issues of conscience.

Principles of Applied Ethics Thought:

Bioethical approaches established a set of principles, and the Kennedy Institute of Ethics was a pioneer in proposing a systemic approach within the framework of medical and biological ethics, based on fundamental principles that serve as a reference for physicians and researchers in the field of life sciences. These four principles are:

A – The Principle of Autonomy:

The content of this principle is the patient's ability to make decisions for himself in all matters that concern him, which entails surrounding him with all the information related to his health condition and the consequences of any decision he makes, and protecting him from all forms of pressure that may affect his choice. Among the requirements of this principle is treating persons as independent actors and protecting those who lack autonomy, such as the mentally impaired and children, by shielding them from the consequences of imposed decisions by any authority, and by striving to meet the needs of patients.

Theoretically, some researchers trace this principle back to Kant's concept of moral duty, others to J. Stuart Mill's utilitarian approach, while some give it a legal basis in John Locke's political philosophy. This principle was embodied in American reality and enshrined by the legislative system, upon which judicial bodies based their rulings, from the premise that "every individual is master of his life and his decisions," in application of the general rule that enshrines human autonomy.

B – The Principle of Beneficence:

Medicine has been linked to beneficence since ancient times and was enshrined by religions. Among its requirements is doing what is good and beneficial for individuals, balancing between harms and risks on the one hand, and benefits and interests on the other. The concept of beneficence has been subject to many interpretations, as it entails refraining from causing harm and achieving the greatest possible benefits while avoiding the greatest possible harms. Tom Beauchamp and James Childress, in their book *Principles of Biomedical Ethics*, proposed that this principle expresses both the increase in what brings comfort and benefit in the positive sense, and the comparison between potential benefit and avoided harm in the negative sense. Meanwhile, Edmund D. Pellegrino and David C. Thomasma, in their book *For the Patient's Good*, gave greater value to this principle, which imposes several obligations on the physician, such as not harming the patient, the duty of selflessness, and acting for the utmost interest of the patient.

However, the difficulties in interpreting the concept of beneficence are mainly related to its connection with the physician's paternalistic guardianship. If under the Hippocratic Oath the physician decided on behalf of his patients, this is rejected under the new thought. Moreover, critics of old American medicine argue that it is difficult to accept beneficence if associated with charity and donation, as this implies the existence of an authority concerned with the weak. This makes it hard to accept in a society based on equality, as it conflicts with autonomy. In addition, American society does not embrace solidarity and mutual aid within social institutions, on the grounds that the field of business, including medicine and health, has no place for emotions. This perhaps explains the particular system that governs organ donation in American society.

C – The Principle of Non-Maleficence:

With the growing ability of physicians to treat diseases that were until recently incurable, demands for health services increased, especially in the United States, and thus treatment costs rose. This led to the creation of social insurance systems to cover the needs of workers in the second half of the 20th century, which were later revised to include vulnerable groups in society (elderly, poor...), reflecting concern for fairness and preventing the exploitation of the weak. In this context, debates arose over the exploitation of prisoners, residents of shelters, the disabled, and poor women in need of obstetric and nursing care, in addition to the issue of fair distribution of resources and organ transplants. These were hotly debated topics, where principles and plans were proposed to ensure optimal justice in accessing difficult treatments and distributing them among members of American society.

This explains why the U.S. government turned to distributive justice at the expense of social justice as a common good. The Belmont Report confirms this, and distributive justice also received contributions from Joel Feinberg, Tom Beauchamp, and James Childress.

D – The Principle of Justice:

The idea of distributive justice goes back to Aristotle, but the American interpretation cannot be separated from the social contract theories of J.J. Rousseau and T. Hobbes. Hence, bioethics was incorporated into American political philosophical debates. This is confirmed by the attention given to John Rawls, who gained wide admiration when he proposed his *Theory of Justice* in 1971.

Pierre Boitte believes that the principle of justice "entails a social obligation to ensure equal access to all health services and also to certain social support benefits..." It is noteworthy that these principles, formulated in the United States and inspired by several philosophical currents, were dominated by pragmatism, due to differences in cultural and social structures. Meanwhile, European bioethical thought was linked to the field of research ethics. For example, the French National Consultative Ethics Committee focuses on research ethics, in contrast to American bioethics, which emphasizes therapeutic ethics (*Ethiques Thérapeutiques*) and health policy. This is what the Spanish humanist physician Diego Gracia pointed out when he said: "The Latin European model is very different from the American one... The European model is based on the principle of duty, and European philosophy believes that it is always possible to speak of absolute principles as the foundation of ethics. The most famous example is Kant's categorical imperative, which calls for treating people as ends and not as means... The individual has absolute duties prior to autonomy... The most important of these duties are the duty of non-maleficence, which is an absolute principle, and the duty of justice, in the sense of treating everyone in the same way..."

In conclusion, these bioethical principles, although originally intended as guiding values for healthcare professionals in their dealings with patients, became the primary reference framework for later theorization. They enabled practitioners to use a common language and terminology in many instances. However, when analyzed, these principles appear vague and subject to varying interpretations, even among healthcare professionals and theorists. Nonetheless, the principles of bioethical thought set out in the Belmont Report had the merit of restoring dignity to the patient through the principle of autonomy, encouraging healthcare professionals to provide the best care through the principle of beneficence, reminding practitioners of the risks of harm and undue inducement to patients through the principle of non-maleficence, and finally, reassuring society—especially vulnerable groups—about their access to healthcare and services through the principle of justice, while also raising awareness among members of society that some individuals are in need of such care.

Conclusion

The systemic approach to bioethics represents a turning point in the history of medical ethics, moving away from paternalistic traditions toward frameworks that recognize patient rights, individual autonomy, and social justice. By grounding medical practice in four interrelated principles—autonomy, beneficence, non-maleficence, and justice—bioethics has provided healthcare professionals with conceptual tools for navigating complex moral challenges. These principles are not merely abstract ideals; they have become operational guidelines that shape laws, institutional policies, clinical decisions, and public health strategies.

Despite their enduring importance, these principles remain subject to debate and reinterpretation. The principle of autonomy, while empowering patients, can conflict with collective responsibilities and social solidarity. Beneficence and non-maleficence, once tied to the paternalistic authority of physicians, now require delicate negotiation between professional expertise and patient choice. Justice, as distributive fairness, raises unresolved questions about equity in access to healthcare, the ethics of organ donation, and the allocation of scarce medical resources. Such tensions reflect not the weakness but the dynamism of bioethics as a field that must continuously adapt to evolving medical technologies, demographic shifts, and cultural values.

The divergence between American and European approaches further demonstrates that bioethics cannot be reduced to a single universal model. Whereas the American orientation highlights pragmatism, therapeutic ethics, and health policy, the European tradition insists on research ethics, moral duty, and absolute principles such as

Kant's categorical imperative. These variations, rather than undermining bioethics, enrich it by showing the diversity of moral reasoning and the multiplicity of social contexts in which medicine is practiced.

Ultimately, the systemic approach has transformed the physician-patient relationship, ensuring that healthcare is no longer conceived solely as a unilateral act of charity but as a dialogue grounded in dignity, respect, and fairness. It has also elevated public awareness of ethical responsibilities within healthcare systems, reminding societies of their collective obligation to protect the vulnerable and to secure equitable access to medical services. While challenges remain, the legacy of these principles is evident: they continue to inspire ethical reflection, strengthen the human dimension of medicine, and safeguard the balance between scientific progress and moral responsibility.

Ethical Considerations

The study adheres to established academic integrity and publication ethics standards. No human participants or experimental data were involved. The article relies exclusively on secondary sources and publicly available scholarly works. Ethical reflection was applied in interpreting diverse cultural perspectives with sensitivity and balance.

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Conflict of Interest

The author declares no conflict of interest related to the research, authorship, or publication of this article.

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