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The Four Fundamental Principles of Bioethics: Their Need and Relevance for Today

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Abstract: Before formulating any comprehensive or common understanding for the moral arguments that have been surrounding the end of life decisions for terminally ill patients. The world has been forced to witness, make decisions and care or leave the sick to die on their own. Ethical decisions and conduct have torn the world between reality and theory.

The world turning into a medical warzone as the Covid-19 pandemic causing catastrophic dilemmas witnessing the unprecedented number of critical patients that are requiring urgent treatment. The ethical questioning of whom should be provided with treatment or who should be left out has never been questioned as much as today. The calamity has

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left medical workers, patients and their families in a deep and harrowing sense of dysphoria. The ripples of dire suffering of physical, emotional and mental have been felt in almost all parts of the world. The current situation has induced humanity to act in ways that they would have never believed themselves to behave in.

In these critical times, an infected human being is negated due to the uncertainties that surround the virus as it threatens a contagion outbreak leading to the fear of death.

In these uncharted waters, medical personals have been reduced to observers wherein they are learning and trying with great intensity to be as moral as possible. The need for the principles of bioethics has never been felt as acutely as today.

Let us get an understanding of the principles of bioethics in the event of treating patients – autonomy, allocation of resources and justifying actions.

Keywords: Autonomy, Beneficence, Non-Maleficence, Justice, Principles of Bioethics

What is bioethics? What are its basic principles? The principles of bioethics form the fundamental values and the central role in any biomedical decision, research and actions that are taken. “Bioethics is not only limited to biomedical ethics but to everyday life as well, regardless of culture or region” (Tyler, 2010: 96). The common goal is often described as actions for the benefit of the larger part of society, however, when it comes to ethical situations the count of people or society is not the leading factor, it is only about doing right or wrong.

The principles of bioethics were formulated due to the upscale of the modern development of science and research so that in any given event of medical trials the lives of people should not be comprised. “It is within such a moral chaos that health care policy must be framed and safeguarded” (Tristram, 1996: 6).

Bioethics is a conscious act of understanding human behaviour when put into a medically challenging situation. Exploring the depths of why certain decisions are taken or made during the effort in the treatment or caretaking of a patient. Beauchamp & Childress have brought about an awareness in their writing that it becomes quite a challenge making it difficult within the realms of biomedical ethics to maintain a balance of the four principles (Tyler, 2010: 98).

Most human beings carry out their mundane activities unknowingly according to these principles as they are also the underlying fabric of human moral actions. Before the pandemic, the understanding of these principles was narrow in the field of medicine, psychology, philosophy and few other disciplines. However, unawares to most the world is witnessing the pragmatics of the principles of bioethics.

The Four Principles of Bioethics

Van Rensselaer Potter studied the four principles of bioethics in his book *Bioethics: A Bridge to the Future* (1971), “bioethics as a bridge between science and humanities” (Eckenwiler & Cohn, 2007: 4). Potter was influenced by the article “Bioethics the science of survival” (1970) by Aldo Leopold, a land ethicist and conservationist. Thus, it was with both Potter and Leopold that the term bioethics was born.

The fundamental principles of bioethics arise from the actions of human tendency which is descriptive in nature that ought to be the pathway for comprehensive amalgamation of treating patients with utmost morality. Thus, we can rightly say that bioethics is carrying out one’s moral duty, not as a means to an end, but an end in itself. (Matthew, 2011: 29).

Alas, the prescribed form of ethics has an innate approach of being deontological. (Boyle & Sumner, 1996: 4). Deontology as propounded by Immanuel Kant (1724-1804), is the act that

ought to be carried out as a categorical imperative, which implies that according to the bioethical principles all patients ought to be treated in the same manner. As Kant's universal law, "Act only according to that maxim by which you can at the same time will that others should act upon it" (Warnock, 1964: 308). To act in a manner that is driven by morality is a means whereby signifying subtly that, "Kant elaborates an ethics of respect for persons" (Tristram, 1996: 105). This respect ought to be meted out not only to those that are hale and hearty but also those that are vulnerable, sick and dying.

The fundamental principles of bioethics are built on being respectful of decisions made, carrying out acts that will benefit the sick, causing no harm and being just. Thus, it also makes it a requisite for workers in the discipline of medical ethics. Treatments provided to patients are to be based on these four principles of bioethics: autonomy, beneficence, non-maleficence and justice.

The four principles of bioethics are: autonomy, beneficence, non-maleficence and justice.

Autonomy

During the rule of the Greek empire, autonomous acts were considered to be the rights of the leaders. Leaders made decisions for themselves, without any interference from other kingdoms or emperors. An autonomous decision is based on self-determination and not on the injunction of an authoritative body. Perhaps one can exclusively determine it as self-rule.

The expression autonomy was first found in the Nuremberg code that arose from the Nuremberg trials that

ended on 19th August 1947 (Weindling, 2001: 37-71). This code came into effect due to the medical and experimental atrocities committed by the Nazis on human subjects. The International Military Tribunal at Nuremberg was presented by five scholars that constituted from the four allied nations namely the United States of America, the United Kingdom, the Soviet Union and France over the war crimes in Germany. It was a means to prosecute and punish the wrong and hateful crimes that were inflicted by the Nazi regime. With this trial, the international court of crimes codified the rules for any future research and trials on human subjects. The mandate of permission ought to be sort and documented by researchers, autonomous decisions to be made by the subjects themselves.

During modern times the word autonomy is heard in most disciplines, especially, within the realms of deciding on available choices for human beings during treatments or surgeries. Autonomy is about the self-governance of rational beings. Autonomy is now understood as a right to freedom and to be able to choose the best from the available choices. According to Kant “autonomy flows from our natural capacity to reason out” (Laceulle, 2018: 160-161)

Autonomous decisions are normally considered what we hold as priorities or that the person deems best for themselves. But, can an act be called an autonomous act of reason if one does not have complete information. We can still consider it as the same since the one that is carrying out the act is under the assumption that they have been told everything.

Autonomy may be overridden at times when patients are not aware of themselves due to a comatose state or mentally competent persons, the family might consider what the patient would have wanted or they will decide on the current economical and medical situation. “Normally, the autonomy of the patient is considered.” According to Beauchamp and

Childress's argument "respect for autonomy has priority over all other principles" (Kanniyakonil, 2007: 63).

Oral cancer is one of the most prevalent cancers in India which accounts for 30% of the cancer disease (Thavarool et al., 2019: 15). "Oral cancers are common in South Asian countries due to the consumption of tobacco, alcohol and betel leaves" (Montero & Patel, 2015: 491-508). The number of male cancer patients is higher than female patients in India, females suffering from the disease is lesser due to the lower usage of tobacco products and alcohol.

A pragmatic case was witnessed first-hand of the autonomy for an oral cancer patient where respect to continuing treatment as per the wishes of the patient even though the surgery was futile. The male patient aged 62 suffering from oral cancer was in a counselling session with a palliative surgeon on the prognosis of a surgery that he wanted to undergo. The cancer had grown into the jaw bone due to which the jaw had broken and needed reconstruction. As the patient was in the advanced stage of cancer, he was advised by a number of surgeons that there was a high possibility that the infection will spread even after surgery. There was one surgeon that was very optimistic about the surgery and the prognosis of the treatment and this brought hope for the patient. The patient's family was worried that the surgery might be futile and may have adverse effects. The family sought help to counsel the patient against the surgery. The advice given to the family was profound, they were told that they had to respect what the patient desires and will have to go through the surgery since the patient is well aware of the benefits and risks. The patient, in this case, said, "I don't want to lose myself to this disease without fighting."

The autonomy of the patient was given utmost importance as he was in a mentally competent state and was well aware of the entire process.

Autonomy has never been placed as high as it is today. With science and medicine spoiling us with a wide variety of choices, sometimes making it difficult for us to understand what is morally right anymore? Undermining our own capacity at times further blows out our confidence to make autonomous choices. Patients and sometimes families as well, are incompetent as they do not have the knowledge or a clear understanding of the medical status of their sickness. This then leaves the responsibility to further explain the pros and cons of the treatment and prognosis by physicians.

There may be times that a physician might lead one on to make a particular decision in favour of what might be feasible to the hospital or the health institution. The physician might act in a paternalistic manner, without the awareness of the patient, the patient may be coerced into making a decision, which he has hardly or no knowledge of. (Hodson, 1977: 61-69).

Here, we can consider it as the patient's decision alone, however, one may argue that it may not be a rational one. But, we can still consider it as a completely autonomous decision taken by the patient as he/she might have been provided with selective information by the treating physician but according to the patient, it was a completely informed decision.

Informed consent, according to Beauchamp and Childress, is based upon "competence, disclosure, understanding, voluntariness and consent" (Scaria, 2007: 87).

Competence: "Our legal system endorses that all patients are competent enough to make reasoned decisions unless they are deemed to be otherwise" (Leo, 1999:131-141). The decision made must be solely that of the patients, without any influence or external pressures whatsoever.

Disclosure: A patient that is sick will only share their innermost fears with a doctor if they know their information is respected by not divulging their symptoms to anyone unless discussed and agreed upon. On the other hand, the doctor needs the patient to be truthful and give the exact and complete symptoms of their illness, so the doctor can diagnose correctly and provide or advise the right treatment required as per diagnosis (McLean & Mason: 2003:2). There is an unsaid bond that builds over time between a doctor and a patient. Both the doctor's and the patient's trust are built upon how much information is disclosed to the other.

Understanding: To begin with, when patients are diagnosed with a sickness the patient should be made to understand their illness. The key to getting treated is by sharing all the information with the doctor, there are times that a patient might hold back information that they think is embarrassing or out of character. Holding back any information may slow down the process of being treated. Getting to know the procedures and how they will affect the prognosis of the disease is a step towards making informed decisions. On the other hand, the medical practitioner ought to work as a disciplinarian along with other nurses, medical technicians and caretakers (Gillett, 2004: 40). The Hippocratic Oath condemns the procedure of advising or administering any drug that brings about death; the oath states, "I will give no deadly medicine to any one if asked, nor suggest any such counsel." If any of the patient's information or privacy is violated the medical practitioner is required to be dismissed. The patient's permission needs to be requested by the doctor in case the doctor needs to discuss any medical information with another medical worker, physicians can get verbal consent but it is evidently legally acceptable if it is documented.

Voluntariness: According to Beauchamp and Childress, voluntariness is “as being independent of controlling influences exerted by others, discuss coercion and persuasion” (Hewlett, 1996: 232-237). In any event of a medical procedure or treatment, the consent of the patient is required. However, there might be situations that the consent of the patient cannot be taken like in an emergency situation of an accident where the patient might not be in a conscious state or an unforeseen situation arises during surgery. The surgeon and the team might need to make on the spot table decisions in the operation room, to save the patient’s life in such a situation; the team cannot waste precious moments to seek permission as every moment might be crucial for the survival of the patient during a procedure. However, after the procedure, the information needs to be discussed with the patient and the family by giving them clarity and understanding as to why the procedure was necessary.

Consent: The notion of consent is based upon the time when a decision is made with having complete knowledge of the situation. (Campbell & Higgs, 1982: 12-14). In other words, the information provided to a patient is all about facts. Sometimes physicians might decide for themselves that they can leave out information that might be complicated for the patient to understand or might lead to more questions or doubts. The complete onus needs to be taken by the doctor to explain the details of the treatment and the prognosis of the disease and treatments thereafter. Once this step by step process is taken care of by the doctor, the patient in all awareness decides for or against the treatment, this is called consent.

Beneficence

“Beneficence is defined as an act of charity, mercy, and kindness with a strong connotation of doing good to others

including moral obligation.” (Kinsinger, 2010: 44-46). When it comes to the medical practitioner, it becomes the fundamental ethical act to consider the well-being of the patient. Every medical therapy that is performed ought to benefit no one else besides the patient. “It is firmly established that a doctor cannot impose a treatment on an unwilling patient even though he or she is convinced it is the right treatment and even though the patient’s refusal may result in his or her death” (McLean & Mason, 2003:23).

According to Daniel Callahan, assisting euthanasia in any form by a doctor goes against the very fundamental goal of medicine and the capability of the physician-in-charge of treating the patient with or without a terminal disease. (Gula, 1994: 33-36). Medicine and the integral role of the doctor commenced with the only aim of assisting or taking care of patients to rid a patient of their disease. Treatment was sorted by patients to free them of their pain. Killing or allowing to die was not the normative way of ending the suffering of an incurable disease by a physician (Gula, 1994: 33-36).

We can categorize beneficence into two acts – altruism and obligation.

Altruism: The word altruism, was first coined by Augustus Comte, in his work ‘System de Politic Positive’ (1851), a combination of the Latin word *alter* with *ui* that literally means ‘to this other’ (Scott & Seglow, 2007: 1)

Altruism to quite an extent is doing to others what you would want to be done to you. This thought process has a subtle aspect of a religious connotation to it; from the Bible, “Therefore, whatever you want men to do to you, do also to them, for this is the Law and the Prophets”

Obligation: Some actions may be called obligatory as we find it necessary to only do what is required even if it may not be what we want. We have only duties of beneficence that derive from specific roles and assignments of duty that are not a part of ordinary morality can be said to fall under obligatory acts. (Beauchamp, 2019).

If we continue to do everything with the thought of benefit all benevolence will be lost.

However, can we say that this might edge onto acts that have an extrinsic motive? Taking a cue from Kant's universal law of the categorical imperative if one acts only to be returned with the favour sometime in the future, it cannot be called a moral act. (Scott & Seglow, 2007: 21). Most acts are done after adequate reasoning. There can be acts that are done spontaneously if there is a person trying to cross the road and suddenly trips. A person nearby will, without thinking spring into action to help either to stop the person from tripping or might help them to get back on their feet. In such a situation there is no time for reasoning or giving a thought. It is the innate behaviour of human beings to act accordingly when it comes to at the spur of the moment. There is no time for considering the decisions we make. Human society to an extent is quite altruistic in nature. The actions that require reasoning, give a human being an opportunity to think about the deed they might carry out. These acts can be considered moral or immoral. This also leads to a biased or an unbiased thought while doing something for each other. (Vine, 1992: 73-103).

Non-Maleficence

The first ancient maxim of treating patients is not to harm anyone, "First do no harm" (Pence, 1990: 168). Negation of unrealistic prognosis should also be avoided, as there are times that physicians give complete assurance that the disease will be taken care of. If the disease still prevails then it can cause

not only physical harm but also psychological harm. “Physicians and nurses are confronted repeatedly with conflicts between respecting the freedom of patients and doing what is in their patients’ best interests” (Tristram, 1996:103). Patient’s autonomy will be overridden if they are not competent and would not want to be tied down to a bed for medical procedures, it will be beneficial here for a physician to carry out the procedure as long as it is causing no harm to the patient.

A physician can yet be questioned on the ethics of such a procedure, only because a patient is incompetent can a physician continue treatment as they cannot decide for themselves. According to ethical values, persons are to be treated as equal to competent persons and not discriminated against on their capacity of rationality.

Justice

This implies justly allocating resources: A term never felt more relevant than ever before the Covid-19 pandemic. Right now, the medical and political fraternity is reeling under pressure and trying with great difficulty to reason out, for whom to provide treatment or to be left out. Situational and time constraints are making it extremely hideous to allocate resources in a justified manner. According to UNICEF, “The disease caused by the Novel Coronavirus first identified in Wuhan, China, has been named Coronavirus Disease 2019 (COVID-19) – ‘CO’ stands for corona, ‘VI’ for Virus, and ‘D’ for Disease” China, one of the developed countries of the world was rudely awakened to the disease that left them gasping on how to combat the issue. The Chinese government did take unprecedented steps to curb the spread of the disease. Then the virus set out to spread its drastic effect worldwide. Sending the entire world into uncharted territory, not

foreseeing how life could come to a standstill even for the economically affluent nations.

Along with this came ethical issue for the allocation of medical resources to patients that needed treatment.

In the month of February 2020, Chinese doctors were put to test by deciding on life and death decisions for 1000 patients that needed to be put onto ventilators as they had only 600 mechanical ventilators available (Elegant, 2021).

Italy one of the countries to have been hit dreadfully with the Covid-19 virus until 14th, May 2021. Italy has seen 4,139,160 patients that were infected, deaths were at 1,23,745 and those that recovered were at a staggering number of 3,669,407 (Worldometer). According to a document by Crisis Management of Turin on March 14th 2020, if there are any emergency situation patients over the age of 80 years, they will not receive intensive care treatment. This situation will come into effect only and only if there is a grave shortage of health resources. “No one is getting kicked out, but we’re offering criteria of priority,” said Dr Petrini, Director of Bioethics Unit, Italian National Institute of Health.

The question that raises concerns in a pandemic outbreak is that, is this the right time to behave principled? How does an allocator of resources divide the available resources in a justified manner?

As humanity is facing a kind of medical war, the physicians are working under a practical and psychological strain that is draining them out and also killing some. The one thing that doctors are not supposed to do is the management of resources, they are taught to treat everyone alike, and they learn not to become God. In situations such as this, doctors are becoming Godlike, as it is left to them which patient will be treated. Those that are treated have the attitude that a doctor can treat

them due to the advancement in medicine and the updated medical facilities.

“In the present bioethical discussion, moral concern mainly focuses on particular persons; it does not focus on human beings, as such” (Gordijn, 1999: 347-359).

Situationally the main concern right now is to try and treat everyone alike. If the situation turns significantly graver than the present, and the number of patients escalates to a number more than the available resources, there will be a distinction made based on age. The younger and stronger will be given a higher preference since their chances of survival is greater. As the treatment will be cost-effective, in the manner that there will not be any wastage of resources on the elderly as it might not benefit them as much as the younger patients. One might call this maximizing the health benefits and resources available for the general population. Therefore, normative ethics investigates this decision of distributing resources impartially in regular and emergencies. Fair distributions embody a bioethical methodology in complex decisions.

A patient above 80 years and a patient that is 45 years require a mechanical ventilator, without thought the younger one will receive the treatment. The 80-year-old is considered to have completed their time of living while the 45-year-old has yet to live their life, hence, the younger patient gets preference over the elder. Nevertheless, it is a tough call for physicians to choose between two patients on whose life needs to be preserved. The main principles of policymakers are to distribute resources mindfully, however in situations as such interventional treatment, automatically have a fallout with the most vulnerable segment of society; the elderly. (Baltussen & Niessen, 2006: 14) By providing treatment to the one that has a

higher chance of living is said to be utilizing resources in the most optimal manner.

The concept of the person in such situations is based on the parameter of age. The elder the patient the lesser he/she is a person? If the elderly are continued to be treated as they are right now in this pandemic situation, there will be an adverse effect on the average age of elderly people worldwide. This effect will be visible as we see that by 2020, there will be nearly 2 billion people over the age of 60. (Noronha, 2016: 260). Only time will tell us if the complex choices that are made during the adverse crises of the current times are morally right or wrong.

Conclusion

Bioethics emerged from the field of ethics, questioning the usage of technology and inventions by humans on humans and animals. The principles of bioethics are the touchstone of morality in medicine and research. It encompasses the normative ethics in times when human beings have alternative choices to choose from. Although it is a relatively new theory in the field of moral conduct of the 1970s, however, it is rapidly finding its hold as an interdisciplinary study as well. The ethical choices within the field of medicine are very complex sometimes leading to situations that are very challenging and highly pressured leading to overwhelming outcomes that are detrimental. Decisions made during the treatment of patients may be ambivalent, however, these principles make sure that there is a conscious effort to carry out only that which is moral and will benefit the patient or persons in maintaining the respect of the individual at all given times. Learning bitter lessons from the atrocities that were inflicted previously, one cannot bring those back from the dead or unhurt them but the principles are a means of showing them that “we are sorry” and

all steps are taken in making sure that no one ever gets hurt again intentionally.

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