FEATURE ARTICLE

Understanding the Principle of Autonomy in Bioethics: Support for Conscience or Destroyer of Ethical Reasoning?

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Is Female Genital Circumcision Moral?

This practice among many peoples and in accord with some religious traditions in northern Africa affects hundreds of thousands of women. Initial awareness of this practice among the people and ethicists of the First World brought responses of abhorrence and condemnation. Subsequent debate tempered the negative reaction only moderately. Some argued for the importance of respecting local customs and beliefs despite the fact that embedded in such practices is the subordination and mutilation of women.

I begin with this issue because a well-meaning doctor once asked me whether or not he could perform female circumcision for a woman from another culture who was demanding it because her husband expected it. After rehearsing the usual arguments, the physician then played the trump card: "But she wants it and you ethicists are always telling us to respect the principle of autonomy for patients!"

In what follows, I would first like to explain how autonomy needs to be understood as a condition of moral choice, but has been misconceived as an independent principle of objective morality. Second, I will examine some of the consequences of not distinguishing objective principles from subjective conditions in determining moral courses of action. And, third, I will offer a reflection from out of the Catholic moral tradition that might help deal with this impasse.

Understanding the Principle of Autonomy

Undoubtedly, one of the sacred principles of medical ethics today, enshrined in the famous four principles of Beauchamp and Childress, is the principle of autonomy. "To respect autonomous agents is to acknowledge their right to hold views, to make choices, and to take actions based on their personal values and beliefs."[1]

In the context within which this principle was articulated, namely, the heavily paternalistic decision-making of doctors, the principle was used as a defense for patients and families against some of the drastic consequences that may accompany

potentially helpful or even life-saving medical interventions. Thus, for example, a patient faced with the possibility of bowel resection for colon cancer, followed by a chemotherapeutic regimen that gives, on average, an extra six months of life, could easily be convinced by an oncological surgeon—who incidentally makes his living doing surgery—to accept the surgery.

Patients, on the other hand, must look at what the bowel surgery will mean for them in terms of recovery time, use of a colostomy bag, and possible complications, as well as the statistically very probable debilitation that will accompany the chemotherapy. What the surgeon does not always communicate very clearly is that this patient is going to die, and that part of the question the patient faces is what is the 'best' pathway on one's journey of dying. Fortunately, many oncologists today are learning that offering palliative care as one of a variety of treatment options for some of the harshest cancers is the way to be most respectful of what these patients are going to experience and, therefore, of what their choices should be.

This example should give some insight into the meaning of the principle of autonomy. The principle does not give the patient the right to demand anything whatsoever of the doctor. Rather, the doctor presents a number of reasonable options (and it took time for doctors to realize that palliative care and, in late stages of the dying process, hospice care are reasonable options!) while the patient has the right to ask any questions that will help to clarify the options and their consequences. Ultimately, however, the patient is the one who will bear the potential benefits as well as the known and unknown burdens of the treatment. The final decision about treatment then rests with the patient.[2]

Part of this discussion, however, has troubled ethical thought, particularly in Catholic circles. When discussing ethical issues or an ethical problem, many ethicists seem to believe that there should be a right answer. Since the only other alternative is a wrong answer, there is a further assumption that ethicists should be able to reason through any particular case and give a more-or-less correct answer. Indeed, for some (Catholic and other) ethicists, there is a sense that this is the ethicist's job--to help people find the right answer so that they can live without sin.

As one who has been a clinical ethicist for years, it is very difficult for me, an outsider who has all the information about treatment options, say, for this patient with colon cancer, to figure out what the right decision is. Of one thing I am sure—I have my biases. I like to think that they are based upon my experience of walking and discussing with many, many patients about such decisions. Nonetheless, I will never know all the factors that go into *weighing* the various components comprising a moral decision.

Think, for example, of a 35-year-old who is diagnosed with colon cancer. She wants to live; she will likely try anything that

will give her a chance to beat the cancer. However, she then notes that the drugs not covered by insurance will severely harm her family's finances; and she realizes that her husband, who is not good with illness, will have an awful time with her deterioration; and she wants to spare her children a long, prolonged illness. Consequently, she refuses the surgery and the chemotherapy, choosing instead to change her diet, do meditation and follow an herbal treatment, knowing full well that this has even less chance of success than the medical interventions. She is weighing factors of which others are unaware—her own courage or lack thereof, an experience of an aunt who died from cancer, an eye on an insurance policy, the well-being of her family, and so on.

Theoretically, an ethicist should be able to analyze all these factors and give an opinion about their rightness or wrongness and, therefore, the rightness or wrongness of a particular choice. But to totally objectify the decision—and this is my concern with theoretical ethics—to make this a case study, is to betray something of the soul-searching, relational, conscience-centered deciding that actual people undertake. In this sense, the principle of autonomy is extremely important for our society and our church. The principle respects the autonomous right of each person, properly informed and with true voluntariness, to make those treatment decisions, the consequences of which they are going to suffer. Their decisions can be discussed; they can be disagreed with by those who weigh things differently. But, ultimately, the principle of autonomy becomes a respect for the individual conscience of the decider.

Given this, it is critical that medical professionals be clear in the choices they offer their patients/clients/residents. When they have informed them or given them opportunities to inform themselves as fully as possible and they make a choice, then that choice needs to be respected. But if they request something that has not been offered because it is not medically appropriate or reasonable, medical professionals are under no obligation to fulfill that request. This is important ethical advice for medical professionals.

Muddying the Waters Around Autonomy

When a Somali woman asks for female genital circumcision, when the dying patient asks for a shot of potassium chloride to stop his heart, when a married father of one requests a vasectomy, or when a young woman wants an abortion, one of the most prominent arguments in developed countries today is that a) this is the person's autonomous right, and b) there are many different moralities and thus, to refuse this autonomous choice is to impose one morality upon another.

The fundamental problem with this moral stance is a confusion between "choosing the good" and "freedom of choice." As expressed in the latter version of the principle of autonomy, the primary argument is "I want it." There is hardly a

self-respecting ethicist in the world that would consider this an unchallengeable moral argument. Children want all kinds of things; their parents wisely refuse and, in some cases, refuse even the possibility. Are parents imposing their morality? Yes, but perhaps it is more than simply *their* morality. Perhaps they understand something about what is good for the child. Parents may not get it all right, but they are not abandoning parental guidance for their children because of some principle of autonomy. Good parents do, however, allow more and more autonomous choices for their children as they grow and mature. They do so because they can see that, subjectively, the child is more and more capable of choosing the good without simply being directed to by authority.

What is the good? Answering this question is what we are always arguing about. Is it good for a woman to have female genital circumcision? A married man to have a vasectomy? A dying person to ask for euthanasia? These things cannot be good just because somebody "chooses" them! And even when ethicists argue that this is part of the moral adjudication of an issue, they then turn to reasons for the goodness of the choice.

Someone might interject that "there are people who want euthanasia," suggesting that perhaps there are a number of different kinds of morality, and one morality should not trump another. However, this is to do away with any form of moral reasoning except the most mundane. As long as somebody can come up with some reason for a particular position, then whoever holds that position has a right to his or her morality! This confuses moral norms with personal choice. One can commit suicide, whether the action is judged right or wrong. Should one commit suicide is a moral question—not just for the one who can do it, but for all of society.

If the principle of autonomy demands that even a marginally justifiable practice be accepted by a doctor, then it is important to realize what this implies. What has been accepted by the individual is now accepted by the society for whom the doctor is a representative voice. Is every doctor then obliged to provide this treatment as part of comprehensive medical care? Is society now obliged to provide this treatment because some people want it? In some very profound sense, the answer is yes. The actual practice becomes a justification of its morality.

Now, in actual fact, the principle of autonomy, when used in this manner, becomes the trump card that ends moral debate *and* societal choice. Ironically, autonomy, used in this manner, is only invoked when the contentious issue seems irresolvable. Nonetheless, no one would invoke autonomy for adolescents who want to commit suicide. No one would invoke autonomy as a justification for having a harem. No one would invoke autonomy to conclude that mutually degrading sex leading to death was moral. And yet, one can almost hear some people thinking, "Well, almost no one…"

because there are always some who will try to justify almost anything that human beings can do.

Are we therefore trapped in a relativistic world where "You've got your morality, and I've got mine"? I do not believe that society in fact does operate in this manner. We have many moral stances and positions that are never questioned. We do have a pretty solid idea of the good in most of what we do in medicine, business, the raising of families, and other areas. So, why is this principle of autonomy so problematic?

I would like to suggest that it is problematic because we have tried to establish it as a *principle* of objective morality when, by its very nature, it is a *condition* of subjective morality. When the good is clear, the informed, educated, and virtuous conscience will choose the good. When the good is not so clear and is mixed with some bad consequences or side-effects, as often happens in life, the individual human being (in the context of family and society) is challenged to understand the moral issues, recognize the principles, weigh the consequences, and follow his or her conscience in choosing the best, or at least better, path.

In brief, the principle of autonomy, correctly understood, is essential to the actual choosing of the good. The principle of autonomy, interpreted as little more than an expression of the will, can be destructive of morality.

Insight from the Catholic Moral Tradition

The question for ethicists is how to walk the fine line between outlining moral positions that help individuals to choose what is good, while at the same time respecting the often incredibly complicated reality of human decisions about the good which in turn requires individuals to follow their conscience. One can turn to medical ethics and to the Catholic tradition (where when the matter is not clear, there is freedom of conscience) for guidance here. We can in fact find a paradigm for the process of moral decision making at the bedside of patients.

First, ethicists need to recognize the good that is being offered. That is easier said than done in the world of medicine. If a person's appendix bursts, there is little option other than invasive surgery to save the person's life. However, in cancer treatment, as well as in most other interventions, there is always a balance of good being offered along with side effects or burdens that also have to be taken into account. In other words, there is almost always a weighing of benefits and burdens.

Second, I believe ethicists have to be very careful about pre-defining moral situations, which often happens with phrases such as "intrinsic evil" or "absolute moral prohibitions." The advantage of these designations is that they mean an action cannot ever be morally justified and one thereby attains certainty at least in what cannot be done. Having said this, it

is important to point out that in Catholic health care absolute prohibitions are often moderated by principles that deal with tough or borderline cases, principles such as that of Double Effect, or even the distinction between Ordinary and Extraordinary Means. Third, academic ethicists need to be careful of trying to pre-determine every particular case. The circumstances do make a difference. Ethical argument and principles do give the virtuous health care provider the guidance generally needed to make ethical decisions. One such guide, however, is knowing when and where patients have the right to make their own decisions about treatment.

Finally, we need to remember that ethics is a communal endeavor with consequences for individual human beings. While the social goods (often supported by power) can denigrate individual freedom and responsibility, the way to balance such tyranny is not to give the individual a veto over any moral rule that does not suit him or her. It is to find the relationship between moral principles or guidelines and the applications that are a work of practical reason. The two cannot be polar opposites or one loses either freedom or morality. The balance is found when we choose the good to the best of our ability and do not allow a personal veto through some individualized notion of autonomy. If female genital circumcision is not a good for this woman or for any women, then her requesting it does not make it right.

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References

[1] Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics*, 6th edition (New York/Oxford: Oxford University Press, 2009), p. 103. Further: "The principle of respect for autonomy can be stated as a negative obligation and as a positive obligation. As a *negative* obligation: Autonomous actions should not be subjected to controlling constraints by others. This demand asserts a broad, abstract obligation that is free of exceptive clauses such as 'We must respect individuals' views and rights so long as their thoughts and actions do not seriously harm other persons'" (p. 104). The extreme individualistic perspective given this principle by these authors is striking. Obviously, the issue becomes very complicated in the abstract. What I am arguing in this paper comes from the way in which the principle is used in practical medical thought.

[2] Bioethics in North America seems to presume that there is something called an "autonomous moral decision-maker." In my experience, such persons, as patients, seldom exist. Patients are themselves vulnerable, frail, frightened, and often lonely. Hence, they make decisions within conversations held with family, significant friends, and medical personnel. It is a legal fiction, a very helpful one, which makes the patient the decision-maker. However, caregivers must be careful to see the patient in the context of his/her family and social world.