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Principles of Bioethics for Christian Physicians: Autonomy and Respect

by

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Introduction

The impetus for the development of principles-based ethics in contemporary health care may have been the *Belmont Report,* a work of the federal government dealing with the protection of human subjects of research.[1] Subsequent researchers have further explored and commented on principles-based ethics to the degree that it can be stated with confidence that the prevailing theory of bioethics in current usage is based on variously defined sets of principles.[2] The de facto standard has generally come to be accepted as the *four-principles approach* advocated by Beauchamp and Childress in what has become a standard reference text in bioethics, *Principles of Biomedical Ethics* (1994).

The four principles espoused by Beauchamp and Childress are autonomy, non-maleficence, beneficence, and justice. The authors defend these principles on the basis that they "initially derive from considered judgments in the common morality and medical tradition that form (the) starting point in (their) volume."[3] However, their list of principles is not exhaustive. Other researchers have added veracity, confidentiality, integrity, utility, double effect, and respect, among others, to the list.[4]

In spite of some disagreement on a list of universal principles, the model of a principles-based bioethics, and particularly the *four-principles approach*, enjoys wide acceptance in both professional and academic bioethics communities.

However, in fairness to those who disagree with principles-based bioethics, this grounding of bioethics on "principles" is not without controversy. Clouser and Gert argue that the "principles of biomedical ethics" approach, what they call *principlism*, is

> ...mistaken about the nature of morality and is misleading as to the foundations of ethics. At best, "principles" operate primarily as checklists naming issues worth remembering when considering a biomedical moral issue. At worst, "principles" obscure and confuse moral reasoning by their failure to be guidelines and by their eclectic and unsystematic use of moral theory.[5]

This paper will seek first to briefly review the various principles that are widely commented upon in the bioethics community. Second and foremost, it will seek to examine and contrast the principles of autonomy and respect. The distinction between the two is important. Autonomy, widely viewed as the cornerstone of secular bioethical principles, is often used to justify procedures such as abortion, euthanasia, and right-to-die advocacy. The principle of respect, in contrast, attaches a greater proportional value to human life than to autonomy or privacy. An understanding of this distinction can be of value to the Christian bioethicist or physician faced with a clinical moral dilemma.

The Principles of Bioethics

While not meant to be a complete list, the following represents a review of the more widely accepted principles of bioethics in contemporary usage.

The principle of **beneficence** refers to acts performed for the benefit of others. It encompasses acts of mercy and kindness and the obligation to do good and avoid evil. Within the Christian tradition, a famous example of beneficence is found in the parable of the Good Samaritan. A key element of the parable is the ideal of a *positive* beneficence — that is, a positive obligation to provide benefit to others. There are some who argue that such a positive obligation does not exist. Instead, they say that beneficence is purely a virtuous ideal or act of charity, and thus persons are not morally deficient if they fail to act beneficently.[6] From the Christian perspective, of course, the teachings of Jesus are clear insofar as one's positive obligation to their neighbor.

Nonmaleficence is the moral imperative not to inflict harm or evil. It is related to, but differs from beneficence, in that nonmaleficence admonishes one in the negative, not to do harm. The principle of

beneficence involves a positive action toward preventing or removing harm.[7]

Nonmaleficence and beneficence are further related in terms of actions that involve determination of a *risk-to-benefit ratio* and the principle of *double effect.*

A common example of the concept of *risk-to-benefit ratio* would include the use of chemotherapy in the treatment of malignant tumors. The medication will cause some harm to normal tissues and to the patient, but the expected benefits ordinarily outweigh the risk or the degree of harm to the patient. In such situations, the "harm" caused to the patient is morally defensible.

The principle of **double-effect** is derived from the work of the Catholic philosopher and theologian, St. Thomas Aquinas. According to this principle, some actions may have other than the intended effect. In some cases, these *unintended* effects may be bad or harmful. However, the action can be justified if the bad effect is the *unintended result* of the initial good act. The classic example in medicine is the pregnant woman who develops uterine cancer. The proper treatment may include removal of the uterus, which in turn will cause the death of the fetus. The death of the fetus is an unintended result of the properly indicated and beneficial surgery. As such, it is morally permissible.[8]

The principle of **veracity** deals with the obligation of the practitioner and the patient to deal with each other in honesty and truth. While it might seem obvious that the practitioner should deal truthfully with the patient, it should be just as clear that the patient has the same responsibility to be truthful with his or her physician. Truthfulness, aside from being an obvious moral obligation, has legal implications in terms of *disclosure* and *informed consent.* The doctrine of *disclosure* is the basis for the obligation of the practitioner to provide the patient with the amount and kind of information necessary to understand the nature of the condition and the various options that may be available. The doctrine of *informed consent* requires that before any risky or invasive procedure can be performed, the practitioner must inform the patient of pertinent details about the nature of the procedure, its purpose, potential risks involved, and any reasonable alternatives that may be available.[9]

Among the oldest principles of medical ethics is the promise made by physicians to keep confidential any information obtained in the course of treating their patients.[10] **Confidentiality** deals with the patient's legitimate expectation that the details of their private lives, health, and treatment will be kept confidential. This right to privacy is seen as critical to the doctor-patient relationship. Without it, the patient may feel the need to withhold information which may be necessary in order to receive proper medical care. However, confidentiality is not an absolute right. Under

certain circumstances, such as child abuse, physicians have a moral obligation (and in many instances a legal one) to report the suspected abuse to the appropriate agencies. Children are rightly to be viewed as vulnerable and in need of protection when their physical or mental health is threatened. In such cases, society's interest in the welfare of these children outweighs the patient's right to confidentiality.

Consequentialism is the moral theory that states that an action is good or bad depending on the balance of its good or bad consequences. Entire moral theories have been developed on the idea that an action should be judged by its consequences rather than the intention.[11] In this regard, when we are faced with a choice of more than one morally permissible act, it is the principle of **utility** that should guide us to choose the one that benefits the most people.

The principle of **justice** deals with *fairness*, that is, that persons receive what is their due. In health care, it is most often *distributive justice* that concerns us. It is the principle which governs the fair distribution of resources. Problems arise when resources become scarce. In the era of managed care and efforts to contain rapidly escalating costs, many ethicists have concerned themselves with questions of how to properly allocate scarce resources and access to *adequate* health care. The problem is especially difficult because of a myriad of complex issues such as the definition of *adequate health care*, and the government's role in the distribution of tax dollars which pay for much of health care in this country today.

Autonomy and Respect

Autonomy, concisely defined, is the right of self-determination. It allows for persons to determine their own course of action, or what interventions they will allow upon themselves. It has become an integral part of contemporary health care ethics, and has gained sacrosanct status in secular bioethics.[12] Consider the following statements:

> ...there are relatively few bioethicists who argue that respect for autonomy is not the preeminent value governing the actions of health care providers.[13]

> ...from the outset, the conceptual framework of bioethics has accorded paramount status to the value-complex of individualism, underscoring the principles of individual rights, autonomy, self-determination, and their legal expression in the jurisprudential notion of privacy.[14]

Modern interpretations of autonomy have been influenced by the philosophies of Immanuel Kant and John Stuart Mill. The perspective of Kant was that a rational being existed as an end in himself. As such, all persons have an unconditional worth, each having the capacity to determine his or her own destiny.[15] To not violate that autonomy was a fundamental moral obligation. This Kantian notion of autonomy seems to dominate current bioethical thought.[16] It is easy to see how this philosophical approach to autonomy can be used to defend such practices as abortion — upholding the woman's autonomy to choose and denying the personhood (rational nature) of the embryo/fetus. Likewise with proponents of euthanasia and assisted suicide who argue that terminally ill persons have the autonomous right to choose the time and manner of their death. This near absolute view of autonomy and self-determination finds support in the legal arena in relation to the concept of privacy.

Privacy, as a legal concept in the United States, is a relatively new notion arising from various legal decisions during this century. First called a "liberty interest," the U.S. courts later began to use the term "privacy" to refer to an individual's protection from interference in matters of personal choice. Although not specifically enumerated as a constitutional right, the decisions of the Supreme Court have upheld privacy as a constitutional right because it seemed (to them) to be implied within the Bill of Rights. While no doubt controversial in some cases, the Supreme Court has been consistent in supporting this view in essentially all of its decisions in the past 30 years. From the moral perspective, of course, it is the case of *Roe v. Wade* (1973) that serves as the pivotal event in support of autonomy at any cost.

Autonomy and privacy seem so intimately related that Beauchamp and Childress offer respect for one's autonomy as the primary justification for the right to privacy. Having done so, they quickly admit that objections to this view do exist. Although they choose not to pursue or discuss those objections further, they do state that "*one possibility... is to emphasize a broader conception of respect for persons that includes both respect for their autonomy and respect for their dignity*" (italics added).[17] This statement of theirs seemingly offers a foothold for those who would argue against that notion of an absolute autonomy which is so prevalent today. Carl E. Schneider, in his book *The Practice of Autonomy*, sums it up this way: "...now that the law has installed an armory of devices to promote patients' autonomy, bioethicists and lawyers need to undertake the grubbier but rewarding work of asking what people actually want, how they actually behave, and what changes are actually possible."[18]

Other persuasive arguments can be made against autonomy as the fundamental bioethical principle. One is that the patient's autonomy and

decision-making skills may be routinely compromised by illness. According to Pellegrino and Thomasma:

> The patient autonomy model does not give sufficient attention to the impact of disease on the patient's capacities for autonomy... Ill persons often become so anxious, guilty, angry, fearful, or hostile that they make judgments they would not make in calmer times... These primary characteristics of illness alter personal wholeness to a profound degree. They also change some of our assumptions about the operation of personal autonomy in the one who is ill.[19]

Another argument against autonomy is that in order to respect the autonomy of a patient, the practitioner may have to compromise his or her own autonomy. For example, the patient's wishes may be contrary to the morality or value system of the physician.[20] Further, a patient's wishes may be at odds with their responsibility to the society at large. As an example, a patient may choose not to be vaccinated against a disease which presents a danger to the community even though the risk (of vaccination) to the patient himself is low.[21]

A most compelling argument against the autonomy model is given by Nancy Rhoden. Individuals do not exist as totally independent and self-sufficient decision-makers. According to Rhoden, persons cannot be self-governing and self-reliant in isolation from others. People exist within a framework of personal and social relationships. These relationships partly define who the self is and affect the meaningful expression of autonomy.[22]

While supportive of autonomy, the philosophy of John Stuart Mill offers some further insights as to the weaknesses of autonomy. He was more concerned about the individuality (autonomy) of persons in shaping their lives. He argued that persons should be permitted to develop according to their personal convictions, as long as they do not interfere with a like expression of freedom by others; but he also insisted that we sometimes are *obligated to seek to persuade others when they have false or ill-considered views* (italics added).[23] This view that autonomy may be relativized, especially in situations involving respect for human dignity, has served as an impetus for some authors to consider another principle as more fundamental in bioethics.

The main concept in the principle of **respect** is the idea that every human being has inherent dignity and worth. While not generally considered mainstream in contemporary secular bioethics, the principle of respect enjoys a considerable amount of support among many researchers. As early as 1979, the *Belmont Report* enumerated *respect for persons* as one of the three principles that it recommended as the basis of ethical decision-making in medicine.[24] Robert M. Veatch proposes a set of six

"substantive" principles which includes *respect for life* and *respect for persons*. Although he also includes the principle of autonomy in his list, he defines it as "the moral necessity of treating one another as autonomous members of the moral community free to make choices *that do not violate other basic ethical requirements* (italics added).[25]

A comprehensive treatment of the principle of respect is found in the work of Beabout and Wennemann, *Applied Professional Ethics: A Developmental Approach for Use with Case Studies* (1994). It is of interest that while they do not consider the concept of *respect for persons* to be essentially religious in character, they have found that many (students) from diverse traditions identify with it very strongly.[26] They go on to say:

> The principle of respect for persons will help religious people knit their central moral beliefs into the fabric of a common public morality befitting professionals. The moral life ought to be made of whole cloth. The study of applied professional ethics that focuses on moral principles should not be carried out in a vacuum. The challenge of such a study is to help develop a balance between the diverse personal interests, social roles and moral principles encountered by professionals.[27]

In order to fully appreciate the preeminent nature of respect for persons as a moral principle, Beabout and Wennemann review the work of the developmental psychologist Lawrence Kohlberg. Kohlberg theorized that there was a recognized pattern of development in reasoning. At *Level One*, the child is primarily interested in himself. Rules are obeyed out of fear of punishment, or the expectation of a reward. The primary criterion used for moral decision-making at this level is self-interest. At *Level Two*, the emphasis shifts away from oneself to concern for one's society. This is called the "conventional" level of moral judgment, since decisions are based on conformity to the conventions of one's society. Not everyone moves into this level. But those who do move into Level Two obey rules because they are part of the society. Conformity is seen as important, as is concern for fulfilling one's role in society. At *Level Three*, the emphasis shifts away from the norms of one's society to a universal perspective that recognizes impartial moral principles. This highest level is called the "post-conventional" level, since moral judgments are made based on universal moral principles that transcend any particular social conventions. Kohlberg claims that not everyone moves into this level, and rarely do so before the age of eighteen. At this level, there is a concern for some universally applicable moral standard: for example: the principle of respect for all human beings as individuals. Good is done because it is a matter of conscience to apply a logical, universal standard such as the principle of

respect. The principle of respect for persons is a self-chosen criterion of moral decision-making. Further, it can function as a criterion for evaluating the conventions of societies, including one's own.[28]

In their book, Beabout and Wennemann present a list of seven principles for moral decision-making: respect, non-malevolence, benevolence, integrity, justice, utility, and double effect. They point out, however, that all are derived from the foundational principle of respect for persons. They define this principle as:

> In every action and every intention, in every goal and every means, treat every human being, yourself and others, with the respect befitting the dignity and worth of a person.[29]

It is their position that all other (moral) principles are subordinate to and consistent with respect when considered in a hierarchical order with respect as the fundamental principle.

It would seem clear that a bioethics based on a fundamental principle of respect for persons would not be supportive of many of the practices that contemporary society tolerates on the basis of personal autonomy.

Conclusion

This paper has sought to briefly introduce the concept of principles-based bioethics, and to concisely review the more widely accepted principles in contemporary usage. More importantly, its purpose is to compare and contrast the principles of autonomy and respect, and how they might influence a more Christian perspective when faced with ethical dilemmas in health care.

Finally, it should be mentioned that principles-based bioethics are but one aspect of a comprehensive approach to health care ethics that must ultimately integrate them with values, duties, moral norms, casuistry, and, especially for the Christian physician, virtue ethics.[30]

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4. Raymond S. Edge and John Randall Groves, *Ethics of Health Care: A Guide for Clinical Practice* (Albany: Delmar, 1999) 43-9.

5. K. Dan Clouser and Bernard Gert, "A Critique of Principlism," *The Journal of Medicine and Philosophy*, 15:1990, 219-36.

6. Beauchamp and Childress, 261.

7. Edge and Groves, 46.

8. Several conditions are necessary for the principle of double-effect to be applicable. These include: 1) the initial act must be morally good, or at least morally neutral, 2) the good must not follow or be the result of the secondary bad or harmful effect, 3) the bad or harmful effect must not be intended. It can only be accepted or tolerated as a consequence of the good act, and 4) the good must outweigh the bad.

9. Edge and Groves, 104-7.

10. Monagle and Thomasma, 74.

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16. Morris, 3.

17. Beauchamp and Childress, 410.

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19. Edmund D. Pellegrino and David C. Thomasma, *For the Patient's Good: The Restoration of Beneficence in Health Care*, (New York: Oxford University Press, 1988), 14-5.

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22. Nancy Rhoden, "Litigating Life and Death," *Harvard Law Review* 102 (1988): 375-446.

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25. R. M. Veatch, *A Theory of Medical Ethics* (New York: Basic Books, 1981) 327-30. The author defines the principle of respect for life as "the moral necessity of avoiding actively and knowingly the taking of morally protected life." He defines the principle of respect for persons as "the moral importance of producing good for one another and treating one another with respect, dignity, and compassion insofar as this is compatible with the other basic principles to which we are bound."

26. Beabout, 4.

27. Beabout, 4-5.

28. A concise review of Kohlberg's model of moral development is presented in Beabout and Wennemann 23-5. See also Lawrence Kohlberg, *The Psychology of Moral Development* (New York: Harper & Row, 1984).

29. Beabout and Wennemann, 50.

30. A comprehensive treatment of character and virtue ethics from a Christian perspective is found in Edmund D. Pellegrino and David C. Thomasma, *The Christian Virtues in Medical Practice* (Washington, D.C.: Georgetown University Press, 1996).