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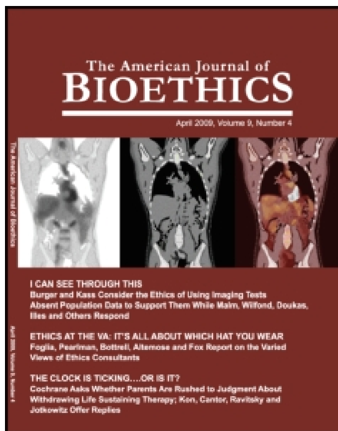

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Two Types of Autonomy

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Two Types of Autonomy

J. S. Swindell, Baylor College of Medicine

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Although I agree with Sabine Müller's (2009) conclusion that we should first seek to find alternatives to amputation for patients suffering from Body Integrity Identity Disorder (BIID), I disagree with one of the major premises that she uses to argue for her claim. Müller argues that patients with BIID are likely not autonomous when they request that the limb be amputated. Müller's argument that BIID suffers are not autonomous is flawed because she conflates philosophical conceptions of autonomy with the conception of autonomy that is operative in the context of medicine.

Müller (2009) argues that autonomous action requires intention, insight, and absence of externally controlling or coercive influences; and she goes on to argue that autonomous action requires free will, which (drawing on Kant) is the will that is determined by an agent's "rational" judgment, or at least (drawing on Frankfurt) is the will that the agent in some sense approves of upon reflection. She then argues that BIID patients do not have a free will when they request amputation because their thinking is obsessive. The philosophical notions of autonomy that Müller employs (e.g. Kant and Frankfurt) are quite different from the conception of autonomy that is operative in medicine.

The conception of autonomy that is operative in medicine serves the function of warding off unjustified paternalism. In the context of medicine, the concept of autonomy is seen as a patient's right to make decisions among medically reasonable alternatives so long as the patient is able to 1) understand the condition and the risks and benefits of the proposed treatment plan; 2) appreciate that the relevant prognosis and risks apply to her; 3) engage in a process of reasoning and weighing the pros and cons; and 4) arrive at a decision and communicate that to the medical team. Various instruments have been developed (most notably the MacArthur Test for Competence to Consent to Treatment (MACCAT-T)) to formally measure these abilities, which are clinically labeled "decision making capacities" (Grisso and Appelbaum 1998).

The concept of autonomy that is operative in philosophy is much different. In the philosophical context, autonomy is an ideal for persons to aim for that involves a certain relationship among their internal states (e.g. that their motivations are ones that they in some sense endorse). There are various philosophical conceptions of what sort of internal relationships (among desires, motivations, beliefs, reasons, etc.) are required for autonomous choice and action. For example, Harry Frankfurt (1998) argues that what is required is that the agent "identify" with the motivating desire; Michael Bratman argues that what is required is that the agent view the motivating desire as "reason-giving" in light of the normative content of the agent's self-governing policies; and John Chrisman argues that what is required is that the agent be satisfied with the process that led to the motivating desire becoming a motivating desire (Taylor 2005). Needless to say, philosophical notions of autonomy are complex, and they are very different from the notion of autonomy that is used in medicine.

The distinction between these two types of autonomy is important, for it is not as if we do or should force patients to act on only their rational or endorsed preferences. Nowhere else in society do we force persons to act only on their endorsed decisions. Imagine the case of a dieter who has a desire to eat a piece of cake, and decides to eat the cake even though upon reflection he does not want his desire to eat the cake to move him to action—he is just being weak of will. Society does not stop this man from eating the cake in an attempt to force him to act autonomously (i.e. in accord with his endorsed desires). Even in cases of more serious consequence (although obesity of course has serious consequences), we do not force persons to act autonomously in the philosophical sense of autonomy. Imagine a case of a person who has a desire to have unprotected sex with an HIV+ person every night, and decides to do that even though upon reflection he does not want to be moved by his desire for sex because he knows that there is a chance that he will contract HIV. While society may have a responsibility to make sure that this man is properly informed about the risks, society has no right to interfere and force this man to act autonomously (i.e. in accord with his endorsed desires).

Not only would it be ethically problematic to force patients to behave autonomously in the philosophical sense, it would be practically impossible as well. It is not as if we ever could ensure that patients have a certain relationship among their internal states (e.g. endorsement of their first order desires, or as Frankfurt calls it, wholehearted identification with one's first order desires) when they inform us of their medical choices. Frankfurt himself has admitted that in his autonomy theorizing, he is interested in metaphysics and not practical ethical questions. He says, "If this were a question of public policy, if we were trying to decide how to conduct our judicial system or our system of rewards and punishments, it would not be terribly useful to talk about wholeheartedness..." (Frankfurt 1998, 39). And this is because we can never really know whether a person wholeheartedly identifies with the factors that motivate her choice, for we cannot get inside another person's head, so to speak.

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So, it may be the case that our BIID sufferer is not making an autonomous choice (in the philosophical sense) when she requests amputation, but all that is needed for her choice to be respected in the medical context is 1) that she is informed and has decision making capacity; and 2) that her choice is among the medically reasonable alternatives. Hence, two lines of argument against amputation in BIID that might be pursued are 1) that the BIID patient lacks the ability to understand, appreciate, deliberate, or communicate (i.e. lacks decision making capacity); or (2) that amputation is not a medically reasonable alternative. Either line of argument against amputation in BIID should be evidence based. In other words, in order to argue that BIID patients lack decision-making capacity, formal assessments of capacity should be performed by psychiatrists with the assistance of tools such as the MACCAT-T. Similarly, arguments against amputation in BIID that are based on the premise that amputation is not a medically reasonable alternative should also be evidence based. That is not to say that values such as patient beneficence will not play a role in that argument, for surely they will; but arguers should take care to make sure that claims about the benefit that would or would not occur from amputation be evidence based. In sum, there are arguments to be made against amputation in BIID (e.g. uncertainty about the benefits of amputation and uncertainty about the availability of less harmful alternatives), but that the sufferers are not autonomous in the Kantian or Frankfurtian sense is not one of them. ■

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The Relevance of Identity in Responding to BIID and the Misuse of Causal Explanation

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The primary reason cited for wanting amputation of healthy limbs is that "the amputation would correct a mismatch between the person's anatomy and sense of his or her 'true' self" (First 2005, 922). In his study of 52 people with the desire for amputation, First found that 63% cited the realization of their identity as the primary reason for wanting the amputation, while 73% reported identity realization as either a primary or secondary reason. It is surprising, therefore, that Müller (2009) almost entirely neglects the significance of the question of identity in her discussion of the ethics of offering surgical amputation to treat Body Integrity Identity Disorder (BIID). She writes, "the definition of BIID as an identity disorder in analogy to the gender identity disorder is only a descriptive classification but no explanation" (36). It is clear from the context that by "explanation," Müller means scientific causal explanation, which she means to contrast with a clinical description of the characteristics of the condition. Müller goes on to make a second claim that "[t]he consequence of the controversy about the causes of BIID is a controversy about its therapy" (36)—in other words, Müller thinks that the ethical debate over the appropriateness of surgical amputations as a treatment for BIID stems from a lack of scientific clarity about the etiology of the condition.

Müller (2009) is mistaken on both of these counts. In drawing a dichotomy between clinical description and scientific explanation, Müller leaves out the question of how our conception of a condition as an identity disorder relates to our normative understanding of that condition. The characterization of BIID as an identity disorder is not only a matter of clinical description but of characterizing the desire for amputation as a part of the patient's identity or self.[1] The ethical controversy over the treatment of BIID stems at least

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1. In this commentary, I use the terms self and identity interchangeably to denote those personal characteristics which define who a person is, in a practically significant sense (Schetchman 1996).