Autonomy is (Largely) Irrelevant

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Autonomy is (Largely) Irrelevant

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Sabine Müller claims that Tim Bayne and I, in our article on Body Integrity Identity Disorder (BIID) (Bayne and Levy 2005), “deduce from the principle of respect for the patient’s autonomy that elective amputations are ethically permissible if the patient is not psychotic and well-informed” (Müller 2009, 36). She apparently accepts the validity of the deduction, but since she denies that BIID sufferers are autonomous, she also denies that elective amputations are ethically permissible. I will argue that Müller is multiply mistaken. She is mistaken in her interpretation of our article. Autonomy was only one of three grounds we offered for the permissibility of elective amputation—although it is, arguably, a sufficient condition of the permissibility of elective amputation, it is not a necessary condition. She is wrong, secondly, in her account of autonomy. And she is wrong, finally, in her contention that BIID sufferers are not autonomous. Despite these mistakes, Müller makes some valid points, which warrant caution with regard to the use of elective amputation. Nevertheless, it still seems likely that amputation should be regarded as a permissible therapy for BIID.

I begin with Müller’s (2009) conception of autonomy. She advances a broadly Kantian account, according to which an agent lacks autonomy when there is a contradiction in their will. This account of autonomy is controversial among philosophers, and with good reason. Müller claims that on this account, “drivenness, hypnosis, brainwashing, conformism, obedience, lack of self-control, obsession, and addiction” are not autonomous (2009, 36). But this account of autonomy is controversial, in part, because it entails that at least some of these conditions are autonomous. We can show this by following Müller and spelling out the account using Frankfurt’s (1971) split-level theory. On Frankfurt’s theory, an agent is autonomous with respect to a first-order desire if the agent identifies with this desire. There are, as Frankfurt conceded, problems with spelling out this notion of identification in the way he did in the article that Müller (2009) cites, but let that pass: Assume it is the case that when an agent has a second-order volition that a particular first-order desire be her will, that agent is autonomous with respect to that first-order desire. Then autonomy depends on the coherence of first- and second-order mental states, not on their causes.

Suppose I have a particular desire as a result of hypnosis. In that case, I am autonomous with respect to that desire if and only if I have a second-order volition that that first-order desire be my will. Nothing in the fact that I possess the desire because I am hypnotized rules out my having such a second-order volition. A clever hypnotist might not only bring it about that I have a particular first-order desire; he might also bring it about that I am autonomous with respect to that desire, by hypnotizing me to have the relevant second-order volition. What goes for hypnosis appears to be true for all the other items on Müller’s (2009) list. Many have seen this very fact as an insurmountable obstacle to Frankfurt’s (1971) account, though Frankfurt himself is untroubled by it.

Müller (2009) thus misunderstands her own official account of autonomy. Turn now to the question whether on this account BIID is nonautonomous. Müller thinks that it is. She attributes to the BIID sufferer the following mental states: a first-order desire (the desire for amputation) and a second-order volition (a desire not to have an amputation desire). But (leaving aside the fact that this mental state is not a second-order volition at all, since it does not concern whether the first-order desire be the agent’s will) we have no reason to attribute to all BIID sufferers seeking an amputation a mental state with this content. They do not have the desire that they lack the amputation desire; they have the narrower second-order desire that their amputation desire be satisfied. Since that is the case, Frankfurt’s account entails that they are autonomous with respect to their desire: they have a second-order volition that that first-order desire be their will, and that is sufficient for autonomy on his account.

Some of Müller’s (2009) claims suggest that despite her protestations, she has a different conception of autonomy, one that is more substantive than Frankfurt’s procedural account. She makes much of the claim that BIID is either a delusion or held with obsessive intensity. On two occasions, she claims that all psychiatrists who have investigated it have concluded that one or both of these are true. She cites as her source for this claim an Australian Broadcasting Commission (ABC) website devoted to my article with Tim Bayne (Skatssoon 2005). But nowhere in that website is the claim Müller attributes to it made (the only psychiatrist cited is Michael First (2004), who explicitly denies that BIID are suffering from a delusion or any other pathology of belief). In the documentary Complete Obsession (2000), the examining psychiatrist found one of the two BIID sufferers to be competent. Müller’s (2009) claim is therefore entirely unwarranted. Indeed, it cannot be the case that BIID sufferers are delusional: they may have no relevant false belief at all, never mind a delusional belief. They do not deny that the affected limb is theirs; they appear not to misperceive it. They
just (truly) affirm that they do not regard it as part of their ideal body.

Neither on Frankfurt’s (1971) account nor on a substantive account are BIID sufferers necessarily nonautonomous. But what if they were? Contra Müller’s (2009) reading of our article (Bayne and Levy 2005), we did not claim that autonomy was a necessary condition of the permissibility of amputation, only (at most) a sufficient condition. We discussed two others grounds of permissibility, and they retain their force. The first was the harm minimization argument, according to which we ought to accede to requests for amputation if we have good reason to believe that so doing will prevent sufferers from taking matters into their own hands, with potentially disastrous consequences. Second, we argued that amputation might be justified on therapeutic grounds: the harm of amputation may, in some or many cases, be less than the ongoing harm caused by the suffering that BIID patients experience.

It is important to notice that neither claim depends on the notion that BIID patients are autonomous. Either or both could justify amputations for clearly delusional individuals; say, for schizophrenics with the delusion that their leg was evil. Instead, both depend on empirical claims regarding the balance of harms. Although Müller’s (2009) claims regarding autonomy are false, they are also irrelevant to these powerful arguments.

However, some of her remarks do warrant caution with regard to the use of elective amputation, either to minimize harms or as a therapy. Our claims rested on the further claim (advanced somewhat cautiously) that no other, less drastic, treatment was available or could be expected to be available in the near future. It remains the case that no other treatment is available, but there is a therapy that is worth exploring, as Müller (2009) points out. Following Ramachandran and McGloch (2007), Müller (2009) suggests that BIID might arise from right parietal dysfunction. If this hypothesis is correct, transcranial magnetic stimulation (TMS) or deep brain stimulation (DBS) might be used to sensitize and enlarge the underlying somatosensory maps.

I think that TMS, as well as the use of vestibular stimulation, also suggested as a therapy by Ramachandran and McGloch (2007), are worth exploring. (DBS, in contrast, is arguably more dangerous and drastic than amputation and does not have therapeutic potential for BIID, given available techniques). However, these therapies are highly speculative: not only is the right parietal dysfunction theory an unconfirmed hypothesis; in addition, we have little reason to hope that any remission brought about, say, vestibular stimulation will be any longer-lasting than the remission brought about vestibular stimulation in neglect cases (Cappa et al. 1987). Given the extent of neuroplasticity, longer-lasting, even permanent, benefits cannot be ruled out. It is incumbent on neurologists and neuroscientists to explore these techniques rapidly, as well as to work toward a better understanding of the causes and consequences of BIID, but the likelihood remains that amputation will remain the most practicable treatment in the medium term. Note, finally, that if one of these treatments proves effective, autonomy will suddenly become much more relevant: BIID sufferers will then face a choice of treatments, and it will matter greatly, if they choose amputation, whether their choice is autonomous.

REFERENCES