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The Evolution of Autonomy

Abstract

There can be little doubt that, at least in the Western world, autonomy is the ruling principle in contemporary bioethics. In spite of its triumph however, the dominance of the concept of autonomy is being increasingly questioned. In this paper, I explore the nature of autonomy, how it came to displace the Hippocratic tradition in medicine and how different concepts of autonomy have evolved. I argue that the reduction of autonomy to “the exercise of personal choice” in medicine has led to a “tyranny of autonomy” which can be inimical to ethical medical practice rather than conducive to it.

I use the case of Kerrie Wooltorton as an illustration of how misplaced regard to patient autonomy can lead to tragic consequences. An analysis of autonomy based on the work of Rachel Haliburton is described and applied to the role of autonomy in a recent bioethical debate – that arising from Savulescu’s proposal that conscientious objection by health-care professionals should not be permitted in the NHS. In conclusion, I suggest Kukla’s concept of conscientious autonomy as one promising pathway to circumvent both the limitations and adverse effects of the dominance of current (mis)understandings of autonomy in biomedical ethics.

In the *British Medical Journal* in 2003 Professor Ruth Macklin (2003.p1419) famously suggested that “dignity is a useless concept” in medical ethics, being nothing other than a “vague restatement of other more precise, notions.....to invoke the concept of dignity without clarifying its meaning is to use a mere slogan” (Macklin. 2003; 1419). Macklin goes on to suggest that ‘autonomy’ is one word that could be substituted for “dignity”. A decade later, I would suggest that far from being a more precise term than dignity, autonomy itself and certainly by itself is arguably a useless concept in medical ethics and will explain why I have recently come to this conclusion.

The Cautionary Case of Kerrie Wooltorton

On the 17th Sept 2007, Kerrie Wooltorton arrived in the A and E department of the Norfolk and Norwich University Hospital, having attempted to take her own life by drinking antifreeze. She had a

previous history of self-harm and had been labelled with the *bête noire* of psychiatric diagnoses – a personality disorder. She had poisoned herself on several previous occasions but this time was different. She produced a note stating that “I would like no lifesaving treatment to be given “only “medicines to help relieve my discomfort, painkillers, oxygen etc”. She was adamant on repeated questioning that “the letter says what I want”. The psychiatrist who saw her deemed that she did not lack mental capacity to make this decision, nor was she eligible to be sectioned under the Mental Health Act. The doctors took the view that the note constituted an advance directive and was therefore legally binding.

Therefore, Kerrie’s expressed wishes were honoured and two days later she died from ethylene glycol poisoning. Both bioethicists and lawyers of course subsequently went into overdrive, mostly arguing over legal niceties concerning whether the medical staff did or did not in fact have power under the Mental Capacity Act 2005 or the Mental Health Act 1983 to intervene. There was much less attention given to asking fundamental questions about the meaning of personal autonomy and its relation to others. In Kerrie’s case at least one other – her father- was “angry that the hospital did not treat her when she was dying. He blames the doctors for her death.”

Consultant physician Alexander Heaton, when asked by the coroner what would have happened if he had intervened, replied: ‘It’s my duty to follow her wishes.’ So in accordance with the principle of respect for autonomy – the touchstone of contemporary medical ethics, he and his colleagues left her to die. She was aged 26.

How could it be that doctors who once would have instinctively responded in accordance with the Hippocratic precept of “First do no harm”, let a young woman die in this way? It seems it is not only

babies but adults too whose lives are endangered by being thrown out with the Hippocratic bathwater.

‘A Thoroughly Noxious Concept’: Defining Autonomy

Perhaps it was cases like Kerrie’s, that prompted the feminist philosopher Sarah Hoagland, to dub autonomy “a thoroughly noxious concept” (1998: 144), the sociologist David Smail to call it an “illusion” (2005:44), and even the well-known Kantian scholar Onora O’Neill to personify it as “a naked Emperor of questionable legitimacy” (2003:1). For many, autonomy has become, rather like football, their religion. Barrister Charles Foster in his recent book, refers to the ‘cult of autonomy’ (2009) and William Gaylin one of the cofounders of the Hastings Center condemns what he calls the “uncompromising and rigid worship of personal autonomy” as “naïve, out of touch ... and ultimately, philosophically and morally untenable” (1996:45).

So how then did we reach the point of sacrificing human life, or at least watch human life sacrifice itself, on the altar of autonomy?

One of Ruth Macklin’s primary arguments with dignity is the problem of defining what we mean by it. This is a genuine difficulty but is no less the case with autonomy.

Gerald Dworkin considers autonomy a ‘slippery concept’ containing many nuances including “Liberty (positive or negative) dignity, integrity, individuality, independence, responsibility and self-knowledge, self-assertion, critical reflection, freedom from obligation, absence of external causation and knowledge of one’s own interests” (Dworkin G 1988:6).

Agich more briefly states, “The ideals implicit in (autonomy) include independence and self-determination, the ability to make rational and free decisions and the ability to identify accurately one’s desires and to assess what constitutes one’s own best interests” (1990:12).

Beauchamp and Childress define autonomy positively:- “an extension of political self-governance by the individual; personal self-rule of the self while remaining free from both controlling interferences by others and personal limitations, such as inadequate understanding, that prevent meaningful choice” (1989:68) and negatively:- “Autonomous actions should not be subjected to controlling constraints by others” (1994:125) and they take great pains to distinguish the principle of autonomy from the principle of *respect for autonomy*.

When it comes what is needed to exercise autonomy, many would settle for such key common features as appropriate mental capacities and independence (both of which pose obvious multiple problems in the context of medicine). However Joseph Raz in “*The Morality of Freedom*” (1988) insists as well on the presence of an ‘adequate range of options’ which are ‘morally acceptable’ from which to choose. It is important to note that Raz’s view differs from the general understanding of autonomy that predominates in healthcare. The latter focuses on an individual realising their capacity to make choices, and merely requires that these choices be informed and free from coercion. The existence of morally acceptable options from which to choose is assumed but not usually addressed or subjected to conscious analysis and reflection. With all the focus being on independent choice, often it is the validity (or lack of) informed consent, rather than a range of morally acceptable options to give consent for, that becomes the sole criterion for whether autonomy is being exercised or not.

In addition to this emphasis within Razian autonomy, others distinguish between actual autonomy and ideal, decisional autonomy and executional, emotional and behavioural, individual and relational and so on. With all these distinctions, small wonder that Dworkin laments, “The only features that hold constant from one author to another are that autonomy is a feature of persons and that it is a desirable quality to have’ (Dworkin G 1988:6). O’Neill wryly comments that “this is hardly an exacting claim, yet I doubt whether it is correct on either point. There are lots of writers –they include many feminists, virtue ethicists and communitarians – who doubt that autonomy is always of value. There are others including various determinists and behaviourists who think that it is an illusion” (O’Neill 2002:22). She cites Hill’s view that “Kant never predicates autonomy of persons, but only of principles and willings: Mill predicates autonomy of states but not of persons” (Hill in O’Neill 2002:22).

Autonomy – A Divided Concept

I would argue that *if* the difficulty in defining dignity means it must be a useless concept this must be to be even more the case for autonomy since it could be considered philosophically schizoid, having at least 2 mutually contradictory historical strands to which O’Neill and many others draw attention. I want to briefly outline the distinctive features of these two types.

Firstly Kantian autonomy, which is so overshadowed by the later Millian form that bioethics students seem to have real difficulty in grasping its essential nature. For Kant, human freedom rests in the ability to be governed by reason and to be motivated by reason alone. Kant referred to this as the autonomy of the will, contrasting it with the heteronomous will directed by external causes, other than

reason. The autonomous agent in Kantian terms then, is one able to overcome the promptings of external agents such as desire or emotion, if they are in conflict with reason. As Scruton (2001 PAGE) succinctly puts it “Because autonomy is only manifest in obedience to reason, and because reason must guide action always through imperatives, autonomy is described in the *Groundwork of the Metaphysics of Morals* as ‘that property of the will which is a law unto itself’. It is also the ground of the dignity of human nature and every rational creature’.

O’Neill rightly considers however that contemporary admiration for personal autonomy owes far more to John Stuart Mill than to Kant: although many of those admirers crave and claim Kantian credentials. Interestingly she claims that Mill hardly ever uses the word autonomy himself and when he does use it, it is in passing reference to cities or states and never to individuals. The reason for this, she suggests is that Mill saw the word as too closely allied to Kant’s non-naturalistic views of freedom and reason which Mill emphatically rejects (p30). It is subsequent commentators on Mill, rather than Mill himself who have expressed his concepts in terms of autonomy.

Mill’s version of autonomy within a naturalistic frame sees individuals as not merely choosing to implement whatever desires they happen to have, but taking charge of those desires as the expression of her or his own nature. As Mill writes in *On Liberty*, “The free development of such individuality is one of the leading essentials of well-being” (1859 Page). On this basis, Mill asserts his famous dicta that “there is a limit to the legitimate interference of collective opinion with individual independence” and that “the sole end for which mankind are warranted individually or collectively in

interfering with the liberty of action of any of their number, is self-protection.”

Rachel Haliburton in her lucid and thought-provoking new work *Autonomy and The Situated Self*, likens comparing these two concepts of autonomy as like comparing apples and oranges. She claims the common view that utilitarianism focuses on consequences and Kantianism on intentions, rather than being the main *cause* of the difference between them is the *result* of more fundamental differences. (2013: 61)

Contours of Kantian Autonomy

Haliburton elucidates these differences through exploring the peculiarities of both concepts in turn. Concerning the Kantian self she suggest “many of its features could just as easily have been created by a writer of science fiction as by a philosopher” (2013:63). Kantian autonomy lies in the rational capacity to determine what the moral law is and to follow it for its own sake. As long as my actions arise from a Good Will, their consequences are utterly irrelevant.

“The moral worth of an action does not lie in the effect which is expected from it ...For all these effects could be brought about through other causes and would not require the will of a rational being, while the highest and unconditional good can be found only in such a will” (Metaphysics of Morals 20). This requires of course that even generally positive feelings such as sympathy, loyalty and care must be set aside in preference to Kantian duty.

Several consequences arise from this:-

1) *Only rational beings have value*

Within the world of medicine, this means that we can experiment on animals in any way we like but it also means that the new-born and the patient with advanced dementia can also be treated in exactly the same way. Conversely, contemporary philosophers have wondered if Kant would respect the autonomy of an android or other thinking computer?

2) *Our instinctive ways of moral thinking are invalidated*

Consider a woman who lives all her life alone on a small pension who has not contributed to society at all but has always done her duty and compare her with a highly successful doctor who decides she will take early retirement to go and work in Sierra Leone because it makes her feel much better about herself and she saves thousands of lives. For Kant the first is a moral success and the second a moral failure because the Good Will even if it achieves nothing “it would sparkle like a jewel in its own right as something that has its full worth in itself...Usefulness or fruitlessness can neither diminish nor augment this moral worth. “ (*Metaphysics of Morals* 13)

3) *Consequences are not simply less important than intentions, they are meaningless.*

If in the case of Kerrie Woolterton considered earlier Dr Heaton had indeed as he stated “done his duty” in Kantian terms, then Kerrie’s death is morally irrelevant

4) *Moral rules are discovered not made*

All Kantian selves, if they reason correctly will arrive at the same moral conclusions and these will be absolute truths. Just

as there can be no square circles, there can be no occasion on which it is right to lie.

A Utilitarian Understanding of Autonomy

Turning next to the utilitarian self, we discover a kind of distorted mirror image of the Kantian self. For the utilitarian, the moral goal is to increase the overall amount of happiness and decrease the overall amount of pain both in her own life but also in all sentient beings.

For the utilitarian self therefore,

1) Intentions are not simply less important than consequences, they are morally meaningless.

“He who saves a fellow creature from drowning does what is morally right, whether his motive be duty, or the hope of being paid for his trouble;” (Mill 2001:18)

2) The morality of actions must be adjusted according to particular circumstances

Because there are no absolutes, depending on the circumstances a lie might be wrong but to save a life or even simply to prevent hurt feelings, a lie might be right.

3) Moral action is dependent on particular feelings or intuitions.

The moral grounding of maximising happiness and minimising pain comes through observation and experience. As Mill states, the merits of utility “can only be determined by practiced self-consciousness and self-observation assisted by observation of others.” However whilst this may be possible in terms of our

own lives, the moral obligation to increase global happiness comes at a much higher price to the self and few are prepared to pay it.

4) *Moral truths are developed educationally rather than discovered*

It is as we understand the world more clearly and shape society through political and social action and see which policies work best that we determine what maximises overall happiness and minimises overall pain. Indeed such was Mill's faith in the power of education he believed it would not only increase benevolence to all human beings but "to the whole sentient creation".

5) *Sentient beings have value*

As Jeremy Bentham famously expressed it - the question that identifies objects toward whom moral obligations exist "is not can they reason? Nor can they talk but can they suffer?"

Autonomy in the Real World

Although at first glance it may seem easier to understand and identify the utilitarian self rather than the Kantian self with the "real world" we inhabit, I think Haliburton is right to point out the utilitarian world view is also very odd.

It is a world where we are morally bound to care about the pleasures and pains of the whole world as well as our own. Furthermore if Kantian criteria are too exclusive for moral citizenship- ruling out babies for example, then the problem with the utilitarian alternative is that it allows in a vast crowd that may be difficult to define. This

leads to difficult questions. If we allow dolphins in, do we exclude porpoises? “If moral personhood provides the dividing line between what we can eat and what we can’t must the utilitarian self always be a vegetarian?” (Haliburton ?

Finally in a world of QALYs and trolley bus thought-experiments, we have grown so used to the idea of being able to quantify pain and pleasure that we have become immune to how odd this idea is. As JJ Smart’s (1973) famous trolley’s dilemma illustrates, it leads to a situation where no action, not even murder, is inherently forbidden as long as the books balance (or else can be cooked) in favour of increased overall happiness.

We have become so familiar in thinking about autonomy in Kantian and utilitarian terms that the two become fused like conjoined twins. We can’t apply one without thinking about the other at least as a foil or a rival. They have become part of the very fabric of how bioethical dilemmas are explicated but because both intentions and consequences are important there is continual tension in the bioethical frame that is more likely to rip the moral fibres than resolve the problem.

Within the pull of the tensions of this dichotomy, we have forgotten how strange it would appear to the pre-enlightenment philosophers. Neither paradigm has for example any place for virtue or God or care or community. The focus of both of them is on individuality and equality and locks them ultimately into an unresolvable conflict.

I again agree with Haliburton in her central thesis that because bioethicists are torn between the worlds of the utilitarian and Kantian selves, they have gravitated towards the concept of autonomy as a way to avoid the moral impasse. In the process Kantian autonomy has been given a liberal gloss “in which the ideal

of what it is to flourish as an autonomous being is tied to our capacity to determine for ourselves what gives meaning and value to our lives.” (Haliburton 2013:71) This alone is all that is required. No one else need share our chosen values and there is nothing outside of ourselves (save possibly the harm principle) which we need to take into account.

Fundamentalist Autonomy

We see a very clear example of this kind of autonomous fundamentalism in a 2006 paper by Julian Savulescu. The article entitled *Conscientious objection in medicine* caused outrage at the time with interestingly not a single supportive letter in the flurry of dozens of responses that ensued. One physician opined “After 30 years of reading the BMJ, Savulescu’s article was the first to make me feel physically sick” So what exactly had Savulescu said that produced such widespread emesis among BMJ readers?

A few direct quotes will give you the flavour:

“When the duty is a true duty, conscientious objection is wrong and immoral. When there is a grave duty, it should be illegal.”

“A doctors' conscience has little place in the delivery of modern medical care.”

“This (paternalism) has been squarely overturned by greater patient participation in decision making and the importance given to respecting patients' autonomy.”

“If we do not allow moral values or self-interest to corrupt the delivery of the just and legal delivery of health services, we should not let other values, such as religious values, corrupt them either.”

“Values and conscience should not influence the care an individual doctor offers to his or her patient. The door to “value-driven medicine” is a door to a Pandora's box of idiosyncratic, bigoted, discriminatory medicine.”

I have previously commented on this article elsewhere (Stammers 2006) but would here draw attention to the fact here that not only would Savulescu's demands lead to universal over-ruling of the doctor's conscience on any matter but that very conscience is a part of what constitutes the autonomy of both doctors and patients. When Savulescu refers to the importance of respecting the patient's autonomy, he is referring only to the individual autonomy of the utilitarian self. There is no trace of allowance for Kantian or even Razian autonomy, though there is more than a touch of the aforementioned craving of Kantian credentials present in the article.

Just as Savulescu rejects the paternalistic Hippocratic values of the past as being made obsolete by utilitarian autonomy, the tragedies of the Woolterton case and others like it are leading to more comprehensive and clinically appropriate considerations of autonomy, many of which such as relational autonomy originate from feminist writers such as ...

I conclude however with a mention of Rebecca Kukla's recent article on conscientious autonomy – a thick concept of autonomy which deserves to be better known. Kukla maintains that in many medical situations in which patients find themselves, self-determination is neither a helpful nor appropriate goal. She suggests that conscientiousness is an alternative normative notion which is more apposite. This relates to commitment to uphold values and ideals formed by and forming our consciences. Like Kantian autonomy, conscientious autonomy is manifested in actions that express fidelity

to goals and ideals to which the agent is responsibly committed but unlike Kantian autonomy, they are not derived from pure reason. Monitoring one's blood pressure or blood sugar are hardly categorical imperatives but are the sorts of expression of conscientious autonomy, Kukla has in mind.

Secondly the autonomous will is in Kukla's view a dangerously inappropriate place for the sources of principles that bind her to health care. Conscientious autonomy can involve commitment to norms from various sources including (*pace* Professor Savulescu) those prescribed by those whose authority we accept.

Kukla goes on to make further distinctions but the point I want to emphasize here is that she is one of many at the frontline of clinical care showing that the personal, individualistic concept of autonomy like the paradigm of paternalism that preceded it, is beginning to show its age. The 'triumph of autonomy' trumpeted by James Childress is beginning to sound like premature triumphalism and the tyranny of such autonomy is beginning to be broken. Is autonomy now evolving from a self-centred individualism to a more inclusive communitarian approach? Kerrie Woolterton's fate would suggest it needs to.

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