

Preface

In the course of this book, I will foreground a number of cases in which the supposedly objective way of portraying autonomy has been in fact applied in rather different ways in relatively similar cases of enforced medical treatment occurring in the Western world. More specifically, I will focus my attention on the US, the UK and Italy.

The current approach used in bioethics, and more specifically medical ethics, gives a prominent role to the notion of autonomy when dealing with sensitive issues related to the patient's future. This central notion of autonomy was necessary for the construction of the premises of the ethical revolution that shook the Western medical world after WWII.

As a response to the atrocious medical experiments carried out by German and Japanese doctors, the Western world wanted to ensure greater protection for the patient such that he might be better able to defend himself from treatment forced upon him in the name of [pseudo] science. This was achieved via the implementation of the notion of informed consent, through which the decisional power of the patient increased drastically, the results being seen on many occasions in direct improvements to the possibility for affirmation of autonomy, freedom of choice. In recent years, however, the nature of such improvements has been called into question.

A second foundational element of the role of autonomy in Western bioethics has been one particularly important shift in medical ethics over the past 20 years: the patient–doctor relationship has moved from a paternalistic model—whereby doctors were expected and entitled by law to enforce on patients their judgement on the presumption of “knowing best”—to a new system where a patient's authority over her body is central. This qualitative change to the patient's decisional power has in itself increased the (quantitative) weight of autonomy in specific bioethical controversies. Gradually, society has modified its perception of autonomy in medical contexts, moving from a concern with the best possible option for the patient—for whom any deviation from this path only served to further negate his autonomy due to a putative lack of competence—to an increasing respect for the

patient's autonomy on condition of sufficient proven competence. The growing acceptance of the patient's will as a sufficient moral justification for ensuring, or withdrawing, treatment has created a number of controversial cases in relation to the patient–doctor relationship.

Thus, as a starting point I will consider the current Anglo-American legal system—whereby the notion of respect for patient's autonomy has increasingly gained more relevance vis-à-vis the previous paternalistic approach that was dominant in the patient–doctor relationship. Paternalism had assumed that physicians were to be allowed to interfere with a person's freedom of action, a person's autonomy, on the grounds that it is for the good of the person, her liberty thus being legitimately restricted.

The growing number of debated cases of refusal of medical treatment and its denial on the grounds of impermissibility in the name of the patient's best interest has underlined the need for our attention to be refocused on the actual disappearance of paternalism from bioethical debates.

The crucial switch in power relations is characterised by an acknowledgement that—under satisfactory conditions of competence—the patient is the best judge for providing—or rejecting—informed consent over a medical procedure concerning her. Prior to this conception of “patient knows best” there existed a dogmatic view of doctors as the best judges by definition. After all, what can the patient be expected to understand about the procedure that she may or may not decide to undergo? Eventually, it was realised that doctors are as imperfect as any other professionals, and though generally more informed than their patients, doctors can fail just as every other human being engaging in any practical activity can. The *a priori* justification of valuing the nobility of having chosen a profession where an irreversible mistake can be noticed was no longer satisfactory. The more this knowledge of fallibility spread in society, the less people were willing to trust doctors, resulting in a need, gradually expanded, for an increase in the patient's decisional power, or, in more technical terms, in greater respect for her autonomy.

This reform brought innovations in the capability of the patient directly to shape her [medical] destiny. This was seen as a positive change in biomedicine but also more broadly in society, because, despite often being underestimated, the inter-connection between “medical politics” and “real politics” is direct enough to allow one to influence the other in significant ways.

It is on these grounds that this work should be considered: through the analysis of the unconvincing application of the notion of autonomy in some specific cases, it is my intention to broaden our perspective on how we should evaluate an inconsistent use of this central concept.

In bioethics there exists a tendency to assess autonomy (or competence) as the function we can—or cannot—have within a given system. My idea is that we must reconceptualise our way of understanding the principle of autonomy by abandoning the mental state that puts a barrier between the sphere of bioethics—and biopolitics as a result—and the broader political scheme within which certain interpretations can be questioned. In understanding the inadequacy of such a premise in current debates, we must be ready to dissolve it progressively by the acceptance of its

anachronism. As it will be shown through a number of specific cases that pertain to both bioethical and political debates, autonomy should be seen as a shared term that reinforces the connection between the two fields. This questioning our own stance on many delicate issues is a necessary means to avoid a situation in which the inconsistency present in the two spheres of justice (political and bioethical) produces such unhappiness—through the biased use of autonomy as a tool functional to power and not to individuals—that the very groundwork of the current Western society could be shaken by a violent outburst of anger towards authorities, the state and the status quo more generally. If we are to defuse this tension, we are thus required to provide a less drastic change (operated within the current system), yet we need also to realise the urgent need for innovative examination of the role granted to autonomy in Western society.

In order to reveal the central goal of the present investigation, I will attempt to cover a range of different cases exhibiting a certain commonality yet also varying along other important axes. This will allow for the gradual broadening of the reader's perspective, ultimately demonstrating the interconnection of all of the specific cases (related by the use of autonomy as their basic principle of justification) and their political contexts.

In Chap. 1 of this book, I will explore standard accepted versions of the notion of autonomy in Western contexts (particularly those of Kant and Mill), considering as well the interconnected parallel notions of competence and biopolitics. A fundamentally important aspect that should be understood from the beginning is that, when referring to the incoherence of the application of the notion of autonomy in this work, I will not aim to point out a tension between the Kantian and Millian versions, as I do not contend that one is exclusive of the other. I am aware that these two conceptions could be used in parallel without undermining the consistent application of the wider notion. My critical analysis of how autonomy is subject to contingent interpretations will instead be centred upon a malfunctioning use of its definition according to Kant's description. It is within that version of autonomy that I will foreground the incoherence to which I refer.

To give my critique a more precise and detailed frame of reference, in the subsequent three chapters I will focus my attention on four specific contexts in which the concept of autonomy (and its related sub-definition of competence) has been applied in an inconsistent and therefore questionable manner. In concluding Chap. 3 I will provocatively sustain that in future cases resembling those considered, the medication of mentally ill death-row prisoners scheduled for execution should be avoided as it would be the only way to ensure a more coherent way of applying the principles that we—as a society—claim to defend. The reasoning behind such a provocation will bring into the equation the direct relevance of politics in defining our ways of dealing with this bioethical case. Finally, Chap. 5—with its reference to Guantanamo—will make the connection between bioethics and politics even more evident.

Having realised the structural limits of the individual-centred version of autonomy that governs the bioethical and political world, as well as all the problems related to its misuse as a natural reaction preserving the very system that we live in,

we have the moral duty—and we should have the political wisdom—to reshape the autonomy discourse towards a more communitarian conception that will help us deal with future cases. In order to ensure the relevance of this book in progress towards this end, however, some important premises to my work must be made.

First of all, I am aware of the fact that each of the cases considered could produce sufficient material for a book of its own. However, I urge the reader to understand that despite its intriguing appeal at theoretical level, the option of expanding the analysis further for each case would have led the book to sacrifice breadth in favour of depth given the practical constraints of this work; while focusing on a single case also represented a valid option, this would not have allowed for a wider evaluation of the role of autonomy. The payoff is the ability to consider what is common to these different (and yet sufficiently similar) situations.

Indeed, this relates to the main objective of this work: to reconnect the discussion over autonomy taking place in the field of bioethics to its political context, interrogating the current conviction that bioethical cases should be evaluated as a separated field altogether.

In this respect, I think it would important for the reader to understand how this book developed into its current form, as the research process itself has undoubtedly played a central part in the shaping of the work.

Initially, my research was centred upon Anorexia Nervosa and the debate over the acceptability of refusal of naso-gastric treatment by patients suffering from this unique mental disorder. My perception of the problem was that if we accept that autonomy is the evaluating factor upon which we should base the moral and legal permissibility of an action, all we had to do was to establish if anorexics are autonomous. As will be explained in Chap. 2, this debate is related specifically to the assessment of the presence of competence and/or capacity (the terms with which we connote autonomy in medical contexts), two related concepts whose definition is problematic in itself.

However, what became gradually more obvious to me was that, if I wanted truly to understand what made cases of Anorexia Nervosa so controversial, focusing the argument only on the assessment of competence as the way of resolving its controversial status would have provided only a temporary answer.

To grasp the depth of the issues at stake, I had to increase the challenge to case-specific analyses and move the investigation to more structural questions regarding autonomy and its role in Western bioethics. The decision to broaden the coverage of my research allowed me gradually to question my initial idea of the assessment of competence in Anorexia Nervosa as a sufficient guide to the permissibility of medical treatment (or its refusal).

Firstly, I encountered a case involving schizophrenia and capital punishment (exposed in Chap. 3) that quite drastically contrasted with the common idea of forcing medical treatment on a person to keep them alive, as in this case the notion of autonomy was used to justify enforced medical treatment to kill—albeit indirectly—the person that should supposedly have benefited from the treatment.

This strikingly different way of defining how we as a society should decide to respect autonomy provoked further questions in me. I came increasingly to doubt

the absolute to which we refer when talking about autonomy, understanding that ultimately it is its interpretation (related to human beings within a predefined political structure and thus subject to power relations) that really makes a difference between being forced to stay alive and being allowed to die.

For this reason, in Chap. 4, I decided to broaden even further the spectrum of the cases, taking into account a number of comparable situations where respect for the patient's autonomy had been inconsistent and in Chap. 5 I chose to engage with perhaps the most representative and challenging case of our time in relation to the issues considered.

The need to consider these cases was vital to the strengthening of the validity of the critical analysis engaged in up to that point: after having introduced the reader to the complexity of conceptions of autonomy in Western bioethics through the contrast of enforced treatment in cases involving mental illness (and thus competence), I realised that considering contexts in which the lack of mental competence was less of a central issue might underline even more clearly the fact that the real entitlement to use one's autonomy is a function of its political acceptability.

This biopolitical strand of the book (through a reading of the similarities and differences of the cases) allowed me to point out that—contrary to the tendencies of much of the American bioethical community—bioethics cannot, and should not, be considered as a different field from the rest of philosophy. And, most importantly, we should not think that the autonomy to which we refer when debating a certain given practice or policy is not affected by the political context in which it develops, takes place and becomes a bioethical reality.

As already noted in passing, due to the structural limits of scope associated with a book, not every tangential point worthy of attention could be exhaustively explored, and for this reason I unhesitatingly acknowledge that (as in every research project) my choices as to what is relevant and what is not are open to challenge and to criticism. Given the intention of this work to link various subjects not commonly considered in such close proximity, there is at once a greater risk of undervaluing certain dimensions of the problems tackled and building in structural faults from the outset. Nonetheless, I believe that I have managed to produce a coherent and linear argument that is not jeopardised by the necessary underdevelopment of certain peripheral topics.

Some final clarifications should be made before proceeding into the main body of the book. Firstly, I have voluntarily chosen to use—even in cases of major authors—a limited number of sources from which to derive quotations and direct references. The reason behind this decision is the conviction that applying a more balanced and equal representation of the work of both the more and the less well-known philosophers used herein will prevent the reader from becoming distracted by the potential inputs that each of them might have had if moved into a more central role. My priority is rather to ensure that none of the sources applied in this context obfuscates the central argument of this work.

Hence, the use of Foucault, for example, is limited in terms of utilisation both of space and of literature, but there are two reasons for this. The space given to his

work is limited because I did not want to make this book a Foucauldian one, but only to use some of his more valuable insights in support of my project of reconnecting bioethics to its philosophical roots. Foucault proved very useful and apt in this enterprise, yet I did not want the book to be absorbed by his ideas.

That is why—especially in Chap. 4—I refer mainly to one text of his. Without wanting to deprive him of his well-deserved renown nor deny the validity of his broader analysis of power relations, my intention was to treat him as all of the other authors used in the book are treated. That is, using their ideas only where they serve to develop the work towards its intended trajectory.

Lastly, I want explicitly to affirm that the interchangeability of “she/her” and “he/him/his” is also intentional. This decision might not satisfy every reader in stylistic terms, but it is the most convincing way for me to ensure that the book remains gender neutral without depriving the individuals considered within (sometimes not directly named but still existent) of their humanity.



<http://www.springer.com/978-3-319-22652-1>

Guantanamo and Other Cases of Enforced Medical
Treatment

A Biopolitical Analysis

Garasic, M.D.

2015, XVI, 100 p. 1 illus., Softcover

ISBN: 978-3-319-22652-1