HEALTHY LIMB AMPUTATION, BIOETHICS AND PATIENT AUTONOMY

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This paper examines what, if anything, is morally problematic about the desire for healthy limb amputation. The paper begins with a brief survey of the empirical data concerning the desire to amputate a healthy limb, focusing on questions of characterisation and treatment. Subsequent to this, the paper focuses on two normative questions: is the amputation of a healthy limb in and of itself morally questionable *if* those persons requesting it are autonomous? And, are patients who desire the amputation of a healthy limb autonomous? With respect to the first question, I reject two possible objections to healthy limb amputation, namely the claim that it is repugnant, and that it might cause harm to others, thus showing there is nothing inherently objectionable to healthy limb amputation. With respect to the second question, I critique two opposing views of patient autonomy from the healthy limb amputation literature, in order to show that the nature of the desire itself may inhibit a person's autonomy.

Introduction

A key role of bioethics is to examine the extent to which certain clinical practices are ethically justified. Often this involves examining the nature of the relationship between health-care provider and patient, or questioning the ethical justifications of certain medical practices. An example of such a process is the debate concerning the amputation of healthy limbs. In the last decade we have become increasingly aware of a phenomenon whereby people desire the removal of a limb despite the fact that is a healthy, functioning part of their body. As medical practitioners and bioethicists turn their attention to this desire, it becomes apparent that there is plethora of unanswered questions, both normative and empirical. In recent years, what was once a secret and often unheard of desire, has announced itself to the mainstream. This is in part due to increased media attention, including a proliferation of related internet sites and forums, as well as popular culture references. While the general public is now more aware of the desire for the amputation

of healthy limbs, health-care providers, medical researchers and bioethicists have their work cut-out for them when it comes to understanding how such a desire arises and whether it is in any way morally objectionable to be removing healthy limbs from patients.

In considering the question of whether or not there is anything morally objectionable about healthy limb amputation, I will argue that there is nothing objectionable about the removal of healthy limb, in and of itself, provided the parties involved are autonomous with regard to the decision. After establishing this, I will then argue that it is far from clear that patients with the desire for amputation are in fact autonomous. In section two, I will outline the current state of play with regard to the kinds of empirical questions that remain unanswered, thereby showing that there is little consensus concerning the nature of the desire, that is, whether or not it is part of a disorder, and, if so, what treatments are recommended. In section three, I will argue that *prima facie* there seems to be nothing morally problematic about the removal of healthy limbs per se, given that the parties involved are autonomous and consenting. This then raises the question of whether it is an autonomous desire in the first place. In answer to this question, in section four, I consider two accounts of autonomy from the healthy limb amputation literature, and argue that they cannot adequately deal with healthy limb amputation.

What is the Desire for Healthy Limb Amputation?

The desire to have a healthy limb amputated[1] has perplexed bioethicists, medical practitioners and researchers alike. Is such a desire part of a medical condition or a disorder, or is it akin to

[1] Rather than referring to a particular condition or disorder I will refer to the 'desire for healthy limb amputation.' This is because it allows us to capture the nature of a patient's request or desire without having to commit ourselves to a medical characterisation of the desire. This is because medical professionals are divided on this issue and further empirical work needs to be undertaken before we can decisively attribute the desire to a particular disorder.

other forms of body modification such as cosmetic surgery? Questions like these have been the focus of much of the literature on healthy limb amputation. Indeed many questions of this kind remain unanswered, awaiting further empirical investigations. In this section I will show that there is no real consensus concerning the origin of the desire for healthy limb amputation. As we will see, psychologists, psychiatrists and neurologists are divided on the issue of characterising the desire for healthy limb amputation (Bayne 2005; Müller 2009). Despite such divisions, there is still work to be done in the field of bioethics regarding the ethical justifications for healthy limb removal, as we will see in the subsequent sections. For now though, we need to unpack some of the empirical findings that are offered as explanation of the desire for healthy limb amputation.

The kinds of empirical questions that researchers are trying to answer can be divided into two general areas: Firstly, how do we characterise the desire for healthy limb amputation? And secondly, how should health-care professionals treat the desire? The first reported case of this desire was documented in 1785 (Lawrence 2006). Despite what would seem like a long history, it has only been in the last decade that medical professionals and the public more generally, have become aware that some people experience the desire for healthy limb amputation. Initially, people who experienced this desire were thought to be delusional or mentally ill (Lawrence 2006). This has since been shown to be false, with many people who experience the desire displaying no signs of delusion or mental illness (First 2005). The desire to have a limb removed is often long-standing; many people report being aware of the desire from childhood (2005). People experiencing this desire have also noted that the desire increases in intensity and urgency. In fact, some people even attempt to remove their limbs themselves which can lead to severe

injury or fatality (Bensler 2003; Elliott 2003). Anecdotally, people who experience the desire for healthy limb amputation tend to view the limb as alien, often claiming that they feel 'over complete' and cannot identify with the limb in question (Elliott 2003; First 2005; Müller 2009).

Research concerning the basis of the desire for amputation has moved in three general directions, which roughly correspond with research from psychology, psychiatry and neurology. Given the diversity of this research there is no real consensus as to how the desire for healthy limb amputation is characterised (Johnston 2002). In the late 1970s, mental health professional John Money characterised the desire for healthy limb amputation as a paraphilia known as apotemnophilia. Like other paraphilias, Money believed that the desire for healthy limb amputation was grounded in a sexual attraction to the idea of being amputee (Elliott 2003; Bayne 2005; Lawrence 2006). This characterisation has been disputed in recent times by various psychiatrists and neurologists who claim that many instances of the desire have no sexual basis (Müller 2009). Some researchers attribute the desire to the patient's upbringing, linking a person's desire to be an amputee to episodes of neglect and abandonment that occurred during their childhood (Bruno 1997; Elliott 2003).

In contrast to the psychological explanations of the desire for amputation, are the psychiatric explanations. Explanations of this kind have tended to characterise the desire as part of Body Dysmorphic Disorder or Body Integrity Identity Disorder (Bayne 2005; Müller 2009). The former of these is a condition whereby a person views part of their body as diseased, ugly and outwardly defective. The latter of these disorders entails a mismatch between a person's body and their representation of their body (Bayne 2005). The key difference between these disorders is

that sufferers of BDD see the limb as disfigured, whereas sufferers of BIID see the limb as being "not part of themselves." Experiencing part of the body as being alien to, and not part of, the person's true identity, has led to BIID being linked to Gender Identity Disorder (Lawrence 2006).

Neurological investigations of the desire for limb amputation have picked up on work done in psychiatry and attempted to identify the neurological basis of the mismatch between body and body-representation. Neurological research has seen the desire for limb amputation come to be attributed to peripheral injury to the limb itself, congenital defects in neuronal pathways, strokes, bleedings or tumours in the parietal lobe (Müller 2009). As with the psychological and psychiatric explanations of the desire for healthy limb amputation, there seems to be no agreed understanding of how the desire arises.

The second general area of empirical investigation that needs to be considered is that concerning recommended treatments. Given that there is no consensus as to the nature of the desire to amputate limbs, there is also no consensus as to appropriate treatment of the desire. Based on evidence gathered by medical professionals, it appears that traditional psychotherapy does not alleviate the desire (Elliott 2003; Müller 2009). Select research has indicated that anti-depressants can work in some cases, as can cognitive behavioural therapy, movement and music therapy (Müller 2009). There is even evidence that rinsing a patient's ear canal with hot then cold water has helped reduce the urge for amputation (Ramachandran 2007). Of course, there is also the option of amputation. Given that there is no agreement as to why people desire to have their limbs removed, it is unclear whether amputation actually cures a disorder or, whether it is simply

an extreme way of treating a symptom. Some researchers argue that amputation does not alleviate the desire and can lead to further desire for the amputation of multiple limbs (Müller 2009).

Despite questions of characterisation and treatment requiring further empirical investigation, we can still use what is known about the desire to inform bioethical debate. It would be irresponsible for bioethics to wait until more is known about the psycho-physical basis of healthy limb amputation, because it is already presenting health-care workers with an ethical dilemma. People are presenting to emergency wards with injuries or demands that stem from a fixation on amputation. So, rather than waiting to see what psychological and psychiatric evidence alone can tell us about the desire, we can begin to answer some of the normative questions that have already been raised by this desire. In the next section I will show that, *prima facie*, it seems that there is nothing inherently wrong with the removal of a healthy limb, provided that the decision to undergo amputation is made autonomously. The upshot of this is that healthy limb amputation becomes morally problematic in cases where the patient is not autonomous. In section four, I will question what autonomy entails, and suggest that, given what little empirical evidence we have, patients presenting with amputation fixations may not actually be fully autonomous.

Healthy Limb Amputation (per se)

In considering whether or not the amputation of healthy limbs is morally problematic we can move in two general directions. The first direction is to question whether or not the amputation of a healthy limb is, in and of itself, morally problematic in cases where participants have freely and autonomously decided to participate in the practice. This will be the focus of this section. If we grant for argument's sake that both the person desiring the amputation and the surgeon are

autonomous, the following question arises: what, if anything is morally objectionable about removing healthy limbs? As we will see, it seems that there is nothing morally objectionable. This means that, *prima facie*, healthy limb amputation is acceptable. The second direction we can take is to examine whether patients who desire healthy limb amputation are autonomous in the first place. This will be the focus of the following sections, as I contend it is the lack of autonomy that can render healthy limb amputation morally problematic.

The desire for the removal of healthy limbs is rare, and for many of us, perhaps unusual. Patients admitting to emergency wards with self-inflicted injuries, or requesting amputation, raise very real ethical questions concerning how health-care staff should respond to such requests. There exists anecdotal evidence of patients threatening to remove their own limbs if surgeons refuse to perform the requested surgery (Elliott 2003). Where James L. Nelson argues that bioethical examinations of gender reassignment surgery are few and far between (Nelson 1998), I would suggest that the same can be said for amputees by choice. Unlike other topics in bioethics like abortion, euthanasia and reproduction, the phenomenon of healthy limb amputation has yet to develop its own thorough bioethical treatment. As we will see in the next section, this has led to some rather thin discussions of patient autonomy. For now though, I will examine whether or not there is anything wrong with healthy limb amputation per se, in situation where both the patient and the surgeon are acting autonomously.

One possible reason for doubting that the amputation of healthy limbs is morally permissible is derived from an intuitive response one might have to such a desire by virtue of its rareness and unusualness, namely that the removal of healthy limbs is in some way repugnant. This objection

is raised and rejected by Tim Bayne and Neil Levy (2005). In questioning the moral acceptability of healthy limb amputation, one might argue that the removal of a healthy functioning limb that displays no signs of deficiency or disability is, in essence, repugnant. However, as Bayne and Levy correctly point out, this kind of objection is problematic because repugnance has previously been associated with practices that are not morally problematic, such as tattooing, piercing and masturbation (Bayne 2005). Given that feelings of repugnance can often be attributed by some people to practices that are not morally problematic, we cannot simply assume that, because certain practices elicit a sense of repugnance, the practice must therefore be morally problematic (2005).

Another possibility for rejecting the removal of healthy limbs per se is that it causes harm to other, non-consenting people. Examples of non-consenting parties would be children and other family members. An argument of this kind is problematic, as it threatens to stigmatise disability by assuming that disability can reduce the quality of life of non-consenting parties. As Annemarie Bridy argues, if we are going to respect a person's autonomy then this should extend to their autonomy to choose disability over being able-bodied (Bridy 2004). If we reject the amputation of healthy limbs on these grounds, then it seems that we would be debasing the quality of life that children are able to enjoy in the care of people with disabilities. At the very least, this means that we have to be very careful in rejecting healthy limb amputation outright, as it may have implications for how we think of disability.

Having considered some possible objections, it seems that it is difficult to develop an argument that healthy limb amputation, where it involves autonomous agents, is morally objectionable. In

fact, as we will see, philosophers Bayne and Levy argue that, provided a patient gives informed consent and the surgeon is willing, healthy limb amputation should be permitted (Bayne 2005). The upshot of this section, then, is that provided the person requesting the amputation is autonomous, it would be paternalistic to deny them the amputation of the healthy limb as such an amputation does not seem to be morally problematic.

Up to this point, we have been assuming that the person with the desire is autonomous with respect to that desire. However, what if there is something about that desire and the way in which it arises that impairs a person's autonomy? It is this question that I contend gets to the heart of whether or not the amputation of healthy limbs is morally acceptable. In the next section I examine two accounts of autonomy from the literature of healthy limb amputation and argue that they are ill-equipped to handle such a complex and ill-understood desire.

Healthy Limb Amputation and Autonomy

So far we have seen that there is little consensus about how best to characterise the desire for healthy limb amputation. We have also seen that, *prima facie*, there is nothing inherently wrong with the amputation of healthy limbs. If there is nothing inherently morally problematic with healthy limb amputations, then we can turn our attention to the conditions under which people desire their limbs to be removed, the context in which such decisions are made and whether these enhance or impair the patient's autonomy. In this section I will argue that discussion of autonomy in the literature on healthy limb amputation is too narrow and unable to deal with the complexity of the desire and the ways in which it might manifest in different people. By looking at two hypothetical examples, derived from different possible empirical explanations of the desire, I will

argue that we need to re-characterise autonomy in order to better deal with such examples. The upshot of this is that in cases where the patient's autonomy is impaired, healthy limb amputation is not morally permissible. For now though, we need an understanding of what autonomy is and how bioethicists have dealt with it in the literature on healthy limb amputation.

Since its inception in the latter half of the twentieth century, bioethics has been concerned with examining health-related practices in an effort to minimise paternalism and to enhance the liberties of patients who are rendered vulnerable by ill-health or health-care practices themselves (Dodds 2000). In so doing, bioethicists, like their counterparts in related fields such as philosophy and law, have emphasised the significance of respect for personal autonomy in medical decision-making. Ultimately, autonomy is about an individual being able to live their own life according to their own idea of what a good life entails (Mackenzie 2008). In other words, it involves self-determination and self-rule (Buss 2008), and is closely associated with personal identity. In order for each person to be autonomous, other people must respect that person's autonomy. Respect for autonomy can also be extended to the state, institutions and health-care professionals. One plausible means of grounding respect for the autonomy of other people lies, as philosopher Kim Atkins proposes, in the idea of epistemological humility (Atkins 2000). Atkins argues that autonomy is important in clinical ethics because of the 'subjective character of experience'. The subjective character of experience refers to the experience of 'what it is like to be me'(Atkins 2000). Given that we cannot know what it is like to be someone else, we ought to respect their authority over their actions and decisions (2000). Grounding respect for autonomy in epistemic humility is even more important in cases such as healthy limb amputation because it is such a rare and unusual desire that most individuals cannot imagine what it would be

like to have a desire of that kind, or appreciate the subjective experience of an individual with that desire. On this basis, and in keeping with mainstream bioethical discourse, health-care practices ought to allow for and respect personal autonomy, and therefore an individual's authority over their life.

While there is widespread agreement about the importance of autonomy, there is little consensus in the philosophical literature as to the requirements for autonomy and the conditions under which people meet these requirements (Mackenzie 2008). As mentioned earlier, the desire for healthy limb amputation is very rare and has only recently become a focus of bioethical debate. Consequently, few ethicists and medical professionals have written on the subject. There are, however, two examples from the literature that emphasise patient autonomy and propose that the permissibility of healthy limb amputation depends on the patient autonomously deciding to have a limb removed. These versions of autonomy are Tim Bayne and Neil Levy's autonomy as informed consent (Bayne 2005), and Sabine Müller's use of Frankfurt's identification account of autonomy (Müller 2009), both of which offer different requirements for autonomy.

Invoking an account of autonomy that relies of informed consent, Bayne and Levy state that:

> Where a wannabe has a long-standing and informed request for amputation, it therefore seems permissible for a surgeon to act on this request (Bayne 2005, p.79-80).[2]

According to this claim, the amputation of a healthy limb is acceptable if the patient can demonstrate that their desire for amputation has a long history and that they have been informed

[2] 'Wannabe' is the term Bayne and Levy have adopted to refer to people who desire the amputation of a healthy limb.

of the procedures and risks involved. Bayne and Levy motivate this position by stating that a patient's version of a good life should be respected in all health-care related decisions (2005, p.80). Implicit in their position is the view that, in order to be autonomous, the patient must be rational. Since empirical investigations have shown that people with this desire are rational, then there is nothing about the desire that can undermine the person's autonomy. This means that on Bayne and Levy's view, autonomy is achieved by virtue of the patient giving their informed consent. As we will see in the next section, this view of autonomy is problematic. For now though, we can contrast this discussion of autonomy with Müller's use of Frankfurt's account of autonomy.

Unlike Bayne and Levy, Müller does not endorse amputation of healthy limbs. She does, however, argue that a patient's autonomy needs to be respected in medical decision-making. Müller claims that a patient's autonomy must be respected with regard to choosing from available medical treatments. She then argues that it is far from clear that amputation is a medical treatment (Müller 2009). The issue of whether or not amputation is a valid medical treatment will depend on whether or not the desire for healthy limb amputation can be attributed to a disorder, and if it can, what kind of disorder. While questions of treatment are important, our current focus is on the conception of autonomy that Müller endorses. So, if we grant for argument's sake that amputation is a valid medical treatment available to an autonomous patient, we must consider what, according to Müller, is characteristic of an autonomous patient.

Müller endorses Harry Frankfurt's identification account of autonomy or free will. According to this view, a person is autonomous if their first-order volitions cohere with their second-order

volitions. A first order volition is a desire for certain objects or conditions. A second order volition is a desire that pertains in some way to our first order desires (Frankfurt 1971). In order for an agent to be autonomous, their first order volitions must accord with their second order volitions. This coherence is attained by the agents critically reflecting on and identifying with these volitions. The example that Müller offers is a smoker who desires a cigarette (2009). This desire is a first order volition. The smoker's second order volition could be either to continue being a smoker or to quit being a smoker. If the smoker's second order volition is to quit, but they continue to smoke in spite of this, then on the view that Müller endorses the smoker would not be autonomous because their first and second order volitions would be in tension. This sort of account of autonomy is known as a procedural theory of autonomy because it holds that the right procedure, such as identification with and accord between first and second order volitions, is necessary and sufficient for autonomy (Mackenzie 2000).

So far, we have seen that a patient's autonomy is a central concern in health-care practice and we have seen two ways in which it has been invoked in discussions concerning the moral permissibility of healthy limb amputation. In the following section I will argue that Bayne and Levy's version of autonomy as informed consent, and Müller's identification theory of autonomy are insufficient accounts of autonomy, and resultantly, are unsuited to the unusual and ill-understood desire for healthy limb amputation.

Problems for Autonomy as Informed Consent and as Identification

While I share the view that personal autonomy is central to the question of whether or not healthy limb amputation is morally objectionable, I contend that the two aforementioned accounts of

autonomy, namely Bayne and Levy's informed consent and Müller's identification account, cannot adequately deal with the desire for healthy limb amputation. Both accounts suffer from a similar problem, in that they offer too narrow an account of autonomy. This means that they cannot deal with the complicated and ill-understood desire for healthy limb amputation. In order to demonstrate their inadequacies, I will introduce two hypothetical examples of people with a desire for healthy limb amputation, derived from two possible medical explanations of the desire. While these examples are not taken from medical journals or case reports, they are informed by medical research insofar as the desire for amputation can be attributed to several of the causes that have been suggested by medical professionals who have investigated the origins and nature of such a desire. Before I introduce and explain these examples, I will canvass some convincing objections to Bayne and Levy's, and Müller's, accounts of autonomy that are taken from the literature on autonomy more generally.

Informed consent is a cental concern in medical practice. Indeed, in cases where informed consent cannot be achieved, special measures are required in order to determine whether or not the health-care professionals should proceed with the proposed intervention. Situations like this often arise in cases of mental impairment or immaturity. The assumption is that mental illness and age can undermine an agent's ability to give informed consent, and therefore their autonomy. By characterising autonomy in terms of informed consent, Bayne and Levy are effectively claiming that the only thing that can impair a person's autonomy is a lack of information. As philosopher Susan Dodds argues convincingly, more factors can impair autonomy than a lack of information, making informed consent too narrow a requirement for autonomy (Dodds 2000). Dodds argues that characterising autonomy as informed consent alone is premised on the

assumption that decision-making takes place in a vacuum and, consequently, that such a view does not acknowledge the variety of other sources that can impair and influence a person's autonomy (2000). Such other sources might include family members, the nature of the medical condition itself, or events in the person's past that have been oppressive or abusive and therefore threatening to the person's sense of self and self-value. In other words, an adequate view of autonomy is one which acknowledges that person does not make decisions and act in a vacuum.

Similarly, the account of autonomy that Müller endorses has also been charged with being too narrow, and thus unable to deal with the way in which a variety of sources can undermine a person's autonomy. Identification accounts of autonomy have been subject to strong criticism on the grounds that they do not account for the variety of different ways in which autonomy can be impaired (Wolf 1987; Benson 1991). Central to Frankfurt's theory of autonomy is that, through a process of critical reflection, an autonomous agent can identify with their actions because both their first order volitions and second order volitions cohere. The typical objection to this theory is that it overlooks the fact that the process of critical reflection and identificaiton can be influenced by such external sources as oppressive socialisation or traumatic experiences that inhibit a person's autonomy (Benson 1991). As with Dodds' criticism of informed consent, Frankfurt's theory is not sufficiently sensitive to the fact that people do not act and make decisions in a vacuum.

So far we have seen that Bayne and Levy's, and Müller's accounts of autonomy are problematic, following common criticisms from the philosophical literature on autonomy. I now want to show the force of these criticisms by demonstrating that the two accounts of autonomy cannot deal

convincingly with two hypothetical examples of the desire for healthy limb amputation. Early in this paper I discussed the variety of explanations offered by medical researchers concerning the desire for healthy limb amputation. Two of the possible explanations, namely that the desire arises from a history of childhood neglect, and that the desire arises from a mismatch between the person's actual body and their cognitive representation of their body, will serve as hypothetical examples for our present purposes. Firstly, I will focus on the childhood neglect explanation. In this first example, a person consults health-care workers at a local hospital, requesting that his limb be amputated, despite its proper functioning. For arguments sake, I will assume that a proven explanation of this desire is that it has arisen as a result of the patient's childhood, during which they experienced severe neglect and mistreatment from their parents. If we apply Bayne and Levy's account of autonomy, namely informed consent, then provided that the patient is informed of the risks and processes involved in the amputation, they are making an autonomous decision to have their limb removed. Similarly, if we apply Müller's account of autonomy, then the patient is autonomous if the desire for amputation is a first order volition that coheres with a second order volition to be an amputee. So, on both accounts of autonomy from the literature, the patient is autonomous with regard to the desire for amputation. However, this seems to be problematic; there seems to be something influencing the desire that is not captured by either account of autonomy. While the patient may be able to understand the information the surgeon provides, and while the patient's second and first order volitions might cohere, there is no acknowledgement that the desire stems from a situation in the patient's past that has led them to view themselves differently, affecting their sense of self worth and their capacity to make autonomous decisions. If, hypothetically, medical professionals reach a consensus that the desire for healthy limb amputation stems from a history of rejection and abandonment during childhood,

then it seems problematic to permit the amputation on the basis of informed consent or even the coherence of first and second order volitions. A less problematic option would be to encourage treatment that promotes the patient's autonomy by helping the patient come to terms with their childhood and improving the patient's sense of self worth. Ultimately, we need an account of autonomy that can address the way in which external and social factors can influence our capacity for autonomy.

For the second example, I will assume for the sake of argument that medical researchers have established that the relevant desire arises from a mismatch between the patient's body and their cognitive representation of their body. According to Bayne and Levy, the patient would be autonomous with respect to this decision if they consented to an amputation after being informed of the processes and risk involved. For Müller, the patient would be autonomous if their first order volition was in accordance with their second order volition. As with the first example, these accounts are not sensitive to the way in which the disorder might arise, or the different factors that can influence a desire. If part of the mismatch or disorder meant that sufferers experienced intense urges for amputation, then on Bayne and Levy's, and Müller's views the decision to amputate has been made autonomously. Again, something about this seems to be problematic. If a symptom of the disorder is an intense and obsessive urge for amputation, then it is likely that the patient's autonomy is impaired by the condition itself. Neither Bayne and Levy's, nor Müller's, versions of autonomy can address this. This is especially problematic where successful treatments are available that can reverse or alleviate the mismatch without resorting to the irreversible option of amputation.

The idea behind these two examples was to show that there is something important and helpful missing from Bayne and Levy's, and Müller's, accounts of autonomy. I should note, however, that I do not wish to commit myself to a particular medical explanation of the desire for healthy limb amputation as this is an empirical question, and one best left to medical research. The point of using these examples is to show that the source of a person's desires can impair, or at the very least influence, their autonomy, and that, accordingly, we need an account of autonomy that is sensitive to this. Informed consent and hierarchical coherence cannot adequately address the way in which a variety of different factors influence a person's medical decision-making. Informed consent and coherence might be necessary, but they are not sufficient (Mackenzie 2000). The upshot of this is that we need a richer account of autonomy and that if, on such an account, a patient was not autonomous with respect to their desire for amputation, then the amputation would be morally objectionable.

Conclusion

So, is the amputation of healthy limbs morally objectionable? As we have seen there seems to be nothing morally problematic with the amputation of healthy limbs per se, provided that the parties involved have consented autonomously: neither repugnance, nor the possibility of harm to others renders the amputation of healthy limbs morally problematic, provided the patient is autonomous. However, it is far from clear that patients requesting healthy limb amputations are autonomous with respect to that desire. The accounts of autonomy from Bayne and Levy, and Müller, are ill-equipped to solve the problem. Neither account enables us to appreciate the ways in which a person's past, their current situation or even the medical condition itself can influence and impair that person's autonomy. Given that there is no consensus on the cause of such a desire

it is not clear that people requesting amputations are acting autonomously. The amputation of healthy limbs is not morally permissible if the patient consenting to the amputation has not made the decision autonomously, as it is a serious invasion of bodily integrity (Johnston 2002). And as I have argued, it is far from clear that people who experience this desire are in fact autonomous. This is of course subject to future empirical investigation concerning the source of such a desire. The upshot is that, when considering whether or not a person is autonomous with respect to their desire for healthy limb amputation, more than just informed consent and coherence of first and second order volitions is needed. If the patient is not autonomous, then other treatments ought to be sought after.

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