No harm, no foul? Body integrity identity disorder and the metaphysics of grievous bodily harm

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Abstract
Sufferers of body integrity identity disorder (BIID) experience a severe, non-delusional mismatch between their physical body and their internalised bodily image. For some, healthy limb amputation is the only alleviation for their significant suffering. Those who achieved an amputation, either self-inflicted or via surgery, often describe the procedure as resulting in relief. However, in England, surgeons who provide ‘elective amputations’ could face prosecution for causing grievous bodily harm (GBH) under section 18 of the Offences Against the Persons Act 1861. Whether such a therapeutic intervention should be classified as GBH depends on the presence of harm, as, without harm, it is hard to argue that GBH has occurred. However, there is no agreed-upon definition of what constitutes harm. Such a definitional absence then begs the question, what is harm? It is this question which this article addresses, using the provision of healthy limb amputation in cases of BIID as an example. Drawing on metaphysics, this article will seek to clarify three separate contemporary models of harm: the counter-temporal, the counterfactual, and the non-comparative. Each model will be applied to the scenario of a surgeon carrying out a BIID-induced, therapeutic, healthy limb amputation, and in each, how harm may, or may not, be understood to have been caused will be explored. It concludes that an unexamined conception of harm is ill-equipped for employment in suspected cases of GBH when it is unclear whether harm has been caused and that a better-informed understanding of harm is required in cases where there is potential disagreement, be that in instances of BIID or a myriad of other borderline scenarios.

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Introduction

John Stuart Mill wrote that the only purpose for which the power of a civilised state could be exercised over its citizens was to prevent them from causing harm to others.1 If a person wanted to harm themselves, the state should not intervene as ‘[o]ver himself, over his own body and mind, the individual is sovereign’.2 This justification for minimal state intervention was termed the ‘harm principle’ and is one of the founding doctrines of liberal political and legal theory.3 Given this theoretical pedigree, and because the law is one of the fundamental forms by which the state exercises power over its citizens, it is unsurprising that the concept of harm makes repeated appearances in various legal traditions, including in English law.4

However, despite its prevalence, no conclusive definition of ‘harm’ exists, nor does a standardised legal interpretation of the term. This definitional and interpretational discretion gives offences that have harm as a critical component of their actus reus an indeterminate quality; what one may consider harm another may not.5 This fluctuating trait does not present an issue in circumstances where the presence of harm is undisputed. However, when contention exists over whether an individual harmed another, this lack of a definitive conceptualisation can prove to be confusing and, for those who fall foul of such ambiguous phrasing, highly problematic.

This article will examine one such instance where the question of what constitutes harm is central, that being the legal status of the provision of healthy limb amputation in cases of body integrity identity disorder (BIID).6 Specifically, this article will explore whether a surgeon providing such a therapeutic intervention, in an incident of BIID, has

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1. J.S. Mill, On Liberty (Cambridge: Cambridge University Press, 1859).
2. Op. cit., p. 18.
3. J. Feinberg, The Moral Limits of the Criminal Law: Harm to Others, Volume I (Oxford: Oxford University Press, 1984), pp. 14–16.
4. V. Tadros, Wrongs and Crimes (Oxford: Oxford University Press, 2017).
5. For an interesting, albeit sobering, account of the problem of the indeterminacy of harm in English law, see G. Birchley, ‘Harm is All You Need? Best Interests and Disputes About Parental Decision-Making’, Journal of Medical Ethics 42(2) (2016), pp. 111–115.
6. The term BIID was coined in 2005 by Michael First in an effort to both highlight the phenomenological symptoms of being in the wrong body, as experienced by those with the disorder, as well as invoke a comparison to gender identity disorder. Prior to 2005, and in some select contemporary publications, the condition goes by several other labels including Amputee Identity Disorder, Klingsor syndrome, Xenomelia and Apotemnophilia. This article will use the term BIID as it is the most widely applied label by clinicians, researchers and those with the condition.
caused harm to that individual, and consequentially, whether they have committed the offence of causing grievous bodily harm (GBH) with intent under section 18 of the Offences Against the Persons Act 1861 (OAPA 1861).

This article will present the argument that it may not be appropriate to charge a surgeon, who carries out a therapeutic, healthy limb amputation, with causing GBH with intent, not because of an entitlement to a medical exception from this charge as afforded under *R v. Brown*,\(^7\) as has been the approach explored in the literature so far,\(^8\) but rather because no harm was caused in the first place. While this article does not seek to provide an absolute definition of harm, nor to advocate for one account over another, it will challenge the common-sense interpretation of harm commonly employed in English law. It will argue that a more considered and reflective understanding of harm is needed. This is to provide clarity for not only those surgeons faced with an individual afflicted with BIID, but also in a multitude of other borderline harm infliction cases, including elective sterilisation,\(^9\) ‘radical’ body modification\(^10\) and even male circumcision.\(^11\)

First, this article will provide an account of the current jurisprudential attitude towards harm as it concerns the body. It will provide critical examples from the case law in which the concept of harm has been overlooked or assumed to be axiomatic, specifically in contrast to the other conceptual components of GBH; those being ‘grievous’ and ‘bodily’. Next, it will give a brief account of the potential and actual problems caused by the law not having an explicit understanding of harm. Following this, a brief introduction to BIID will be given. This introduction will draw attention to the two cases of elective amputation carried out by the surgeon, Robert Smith. The examination will highlight the uncertainty concerning whether a surgeon carrying out a BIID-driven therapeutic, healthy limb amputation causes harm, and thus whether they satisfy the *actus reus* and *mens rea* requirements for the commission of an offence under the OAPA 1861.\(^12\) Finally, this article will employ three metaphysical accounts of harm as interpretational devices clarifying whether those individuals, who undergo a healthy limb

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\(^7\) *R v. Brown* [1993] 1 AC 212.

\(^8\) R. Smith, ‘Body Integrity Identity Disorder: A Problem of Perception?’, in A. Alghrani, R. Bennett and S. Ost, eds., *Bioethics, Medicine, and the Criminal Law. Vol. 1, The Criminal Law and Bioethical Conflict: Walking the Tightrope* (Cambridge: Cambridge University Press, 2013), pp. 71–87; J. Johnston and C. Elliott, ‘Healthy Limb Amputation: Ethical and Legal Aspects’, *Clinical Medicine* 2(5) (2002), pp. 431–435; A. Bridy, ‘Confounding Extremities: Surgery at the Medico-Ethical Limits of Self-Modification’, *The Journal of Law, Medicine & Ethics* 32(1) (2004), pp. 148–158.

\(^9\) Faculty of Sexual & Reproductive Healthcare (FSRH), *Male and Female Sterilisation* (London: Royal College of Obstetricians & Gynaecologists, 2014).

\(^10\) *R v. BM* [2018] EWCA Crim 560.

\(^11\) *Re B and G (children) (No. 2)* [2015] EWFC 3.

\(^12\) The *actus reus* of a section 18 offence can be broken down into the following: (1) unlawfully (2a) wound, or (2b) cause any GBH (3) on another person. The *mens rea* of a section 18 offence can be broken down into the following: (1) maliciously (2a) with intention do some grievous bodily harm or (2b) with intention to resist or prevent the lawful apprehension or detention of any person.
amputation, are harmed in a manner deserving of consideration according to section 18 of the OAPA 1861.

Before moving onto the main body of the argument, a quick point of framing must be made. The actus reus of an offence under section 18 of the OAPA 1861 can be fulfilled via two avenues: either by an individual intentionally causing GBH to the victim or by an individual intentionally wounding a victim. This article will examine the former of these avenues. The reasoning for this being that wounding, as a legal concept, has a clear definition; that being a break in the continuity of the skin.13

This precise legal definition gives the charge of causing GBH via wounding a clear applicational boundary. If the continuity of the skin remains intact, regardless of the severity of internal wounds, then a charge of GBH via wounding is not applicable.14 If it were not for this explicit definition, the term wounding could be interpreted in a variety of different ways and according to a variety of different conceptualisations. As such, it would be subject to the same interpretational issues which the concept of harm is. Thus, this article can be seen as a first step towards giving the concept of harm, as employed in GBH, the same clarity which has been afforded to the concept of wounding and, as will be illustrated in the next section, the other conceptual components of GBH.

Part 1: Current attitudes to the harm component of GBH in English law

The question of what harm is ipso facto has been explored in the philosophical literature since Mill’s employment of the term,15 most notably in Joel Feinberg’s four-part series The Moral Limits of the Criminal Law.16 This area of work has been fuelled, in part, by Mill’s failure to specify what he means by harm.17 However, despite this interest in the literature, there has not been the same perceived need in the law to clarify the term ‘harm’ ontologically, nor to assist juries in their interpretation of harm, or what its necessary and sufficient conditions are.

This lack of conclusiveness is resultant from the typically unquestioned presence of harm in the majority of cases. There has not been the same call to examine what ‘harm’ means because it is usually apparent, and the law preoccupies itself with categorising harm according to severity and type. Arguably then, for those individuals who are in a position to decide whether harm has been inflicted by one person onto another, as would be the case for a surgeon charged with GBH as a consequence of providing a therapeutic, 13. Moriarty v. Brookes [1834] EWHC Exch J79; JJC (A Minor) v. Eisenhower [1984a] Q.B. 331.
14. [1984a] Q.B. 331.
15. M. Rabenberg, ‘Harm’, Journal of Ethics & Social Philosophy 8(3) (2015), pp. 1–33.
16. Feinberg, The Moral Limits of the Criminal Law: Harm to Others; J. Feinberg, The Moral Limits of the Criminal Law: Offense to Others, Volume II (Oxford: Oxford University Press, 1985); J. Feinberg, The Moral Limits of the Criminal Law: Harm to Self, Volume III (Oxford: Oxford University Press, 1989); J. Feinberg, The Moral Limits of the Criminal Law: Harmless Wrongdoing, Volume IV (Oxford: Oxford University Press, 1990).
17. P.N. Turner, “‘Harm’ and Mill’s Harm Principle’, Ethics 124(2) (2014), pp. 299–326.
healthy limb amputation, it is expected that such an arbiter will employ an intuitive understanding. Put simply, they will know harm when they see it.

This assumption of the implicit understanding of the nature of harm is articulated explicitly in the case of *DPP v. Smith*\(^ {18}\) in which the question of whether the *mens rea* of intent to murder is a subjective or an objective test was considered. The defendant claimed that he could not be convicted of murder because he did not possess the required *mens rea* of intention to kill or to cause GBH. In the course of the *Smith* judgment, Viscount Kilmuir LC stated that:

> I can find no warrant for giving the words “grievous bodily harm” a meaning other than that which the words convey in their ordinary and natural meaning. “Bodily harm” needs no explanation, and “grievous” means no more and no less than “really serious.”\(^ {19}\)

According to Viscount Kilmuir, the word harm, at least when referencing the body, has a natural meaning which is easily accessible, understandable, and contextually appropriate. Consequently, the term needs neither consideration nor explanation. It would seem reasonable to assume then that an unexamined idea of harm is sufficient to be of use in a legislative and judicial capacity. That is, what people typically mean by harm is adequate for use in the law. This assumption of a natural and self-explanatory idea of harm is further employed in the case of *R v. Brown and Stratton*.\(^ {20}\) This case considered what constitutes grievous in the context of GBH. It was stated that judges should not attempt to define GBH for a jury. Instead, whether something constitutes a charge of GBH should be left for a jury to decide.

This deferral to the common knowledge of juries, when it comes to evaluating harm, was endorsed further in *R v. Golding*.\(^ {21}\) In this case, during an appeal, the question of whether the qualities of permanent or dangerous were necessary for harm to be considered grievous was considered. The appeal was rejected and the conviction upheld with a decision that “[u]ltimately, the assessment of harm done in an individual case in a contested trial would be a matter for the jury, applying contemporary social standards.”\(^ {22}\) Once again, in case law, an examination of harm is not mandatory. Merely employing one’s intuitions, informed by coeval and common social standards, suffices.

It should be noted that while the nature of GBH in the aforementioned cases was explored, this analysis focused on the severity of harm caused and not what harm was in-and-of-itself. Consequentially, the debate which these cases precipitated should be understood predominantly as a reference to degree and not type. The harm component of GBH was not challenged nor questioned, but rather the categorisation and theoretical boundaries of what constitutes grievous harm were.

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18. *Director of Public Prosecutions v. Smith* [1961] A.C. 290.
19. Op. cit., at 334.
20. *R v. Brown and Stratton* [1998] Crim LR 485.
21. *R v. Golding* [2014] EWCA Crim 889.
22. Op. cit., at 64.
A similar compartmentalised evaluation of GBH was demonstrated in *R v. Ireland and Burstow*.23 This case, rather than explore the grievous aspect of GBH like the cases mentioned above, challenged the conceptualisation of the ‘bodily’ component of GBH by exploring whether psychological harm could be considered ‘bodily harm’, and consequentially, under the consideration of the OAPA 1861.24 The decision was that ‘an offence of inflicting grievous bodily harm under s 20 of the 1861 Act could be committed even though no physical violence was applied directly or indirectly to the body of the victim’.25 This ruling, while drastically altering the applicational boundary of the offence of GBH,26 once again did not challenge what is to be understood as harm. It merely extended the remit of GBH to beyond the physical body into the psychological realm, albeit with specific parameters.27 The phenomenon of harm itself was still to be understood in line with its ‘natural’ definition; that is, any harm is self-evident.

Case law, then, has not shied away from critically examining or reconceptualising the theoretical components of GBH in its entirety but merely a single aspect of it, that being harm. Understanding why this oversight exists is beyond the remit of this article. However, it is likely linked to a combination of the common assumption that harm is self-evident and not in need of as much deliberation as that of harm’s severity or locality, as well as the fact that harm is often uncontested; in most criminal cases, the presence of harm is straightforward. However, such an oversimplified concept of harm, one that assumes that the nature of harm, as well as its existence, is derivable from ‘face-value’ judgments, presents considerable challenges in cases where the question of whether harm has even occurred is central. It is to this problem which this article now turns.

**Part 2: Why clarity of harm is needed**

Even if one concedes that the legal conceptualisation of harm is indeterminate and reflexive, this is not the same as accepting that such fluid employment of the term is itself problematic. One could argue that a legal system can effectively employ an undefined concept of harm in a manner which still produces ‘good’ law, ensuring the protection of both individuals and the broader societal good. However, this article holds that this is not the case and that an undefined and non-critical concept of harm is one which does indeed give rise to inconsistent and theoretically confused legal structures.

The central reason why this article holds that the use of an unexplored concept of harm is problematic in judicial decision making comes as a result of the applicational boundaries which the term confers, or to be more precise, the lack of such boundaries. The term harm can potentially be used as a way of prohibiting actions and activities which can be seen as undesirable, immoral, or even perverse; extending the reach of the

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23. *R v. Ireland and Burstow* [1997] AC 147.
24. Offences Against the Persons Act 1861.
25. [1997] AC 147 at 156.
26. F. Boland, ‘Psychiatric Injury and Assault the Immediate Effect of *R. v. Ireland, R. v. Burstow*, Liverpool Law Review 19 (1997), pp. 231–239.
27. J. Herring, ‘The Criminalisation of Harassment’, *The Cambridge Law Journal* 57(1) (1998), pp. 10–13.
state, via the application of law, well beyond its appropriate confines and into the private sphere. Take, for example, the long history of legislation against homosexuality based on the preservation of the moral good and prevention of aberrant harms, or the contemporary criminalisation of ‘extreme’ bodily modifications. The justification for such prohibitions originates from the idea that harm is something which is to be avoided, be that in individual instances or regarding the protection of society as a whole. As it is the minimum responsibility of the state, via its application of law and per the harm principle, to prevent harm from befalling its citizens as a result of the actions of others, the legal system has a vested interest in restricting and punishing the actions of individuals where necessary. Consequently, the employment of an unexplored concept of harm in law leaves open the possibility for an almost unbridled level of legal paternalism, enforcing the good at the potential cost of autonomy and individual freedom.

Contrasting this, the employment of an undefined and unconsidered concept of harm in law also makes the justification for the permissibility of specific actions and procedures somewhat opaque. This is especially poignant in situations where one individual is permitted to cause harm to another, with their consent, without that harm conferring onto them any specific benefit. For example, living organ donation of non-regenerative tissue is permitted when that tissue is not essential for life. As such, if an individual decided to, they could donate one of their kidneys to another person. However, such a donation would put them at risk and constitute them undergoing wounding and *prima facie* GBH via the removal of healthy bodily tissue, without providing them with any form of benefit, beyond the knowledge that they had ‘gifted’ one of their organs to another person. As such, the procedure does not confer onto them any form of beneficence. Indeed, the legality of such altruistic living organ donations was, in the early days of donation, up for debate.

As such, without a concept of harm that is better understood, this inconsistency and obscurity as to whether specific actions and procedures are contrary to the offence of GBH with intent under section 18 of the OAPA 1861 will undoubtedly continue. Moreover, as inconsistency and obscurity are things which should generally be avoided when it comes to the law, this is an issue that needs resolving.

### Part 3: BIID and the Robert Smith amputations

BIID is a rare condition which leads an individual to feel that a particular aspect of their physical embodiment, most commonly a limb, does not correspond with their self-perceived identity. This discrepancy causes them to feel like an impaired person trapped

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28. The Buggery Act 1533; Offences Against the Persons Act 1861.
29. *R v. BM* [2018] EWCA Crim 560.
30. J. Feinberg, ‘Legal Paternalism’, *Canadian Journal of Philosophy* 1(1) (1971), pp. 105–124.
31. The Law Commission, *Consultation Paper No. 139: Consent in the Criminal Law* (London: HMSO, 1995); The Human Tissue Act 2004.
32. M. Brazier and E. Cave, *Medicine, Patients and the Law* (London: Penguin, 2011), p. 522.
33. M.B. First and C.E. Fisher, ‘Body Integrity Identity Disorder: The Persistent Desire to Acquire a Physical Disability’, *Psychopathology* 45(1) (2012), pp. 3–14.
within a non-impaired person’s body. This incongruity between their physical embodiment and self-established identity leads to significant and chronic suffering, which impacts their social, occupational and adjustment faculties. Several treatments have been employed to address this suffering by resolving this mismatch, including psychotherapy, selective serotonin reuptake inhibitors, vestibular caloric stimulation, cognitive behavioural therapy, and several relaxation and mindfulness techniques. However, the only method that has indicated a relatively consistent and continuous therapeutic effect, according to the data available, has been to acquiesce to the request for limb amputation, altering the body to match the identity. This suggested beneficial effect of healthy limb amputation has led to debate regarding whether the physical harms of amputation are outweighed by the psychological positives experienced by those with BIID. Such discussion can be interpreted as centring on a single question, whether the

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34. Whole, M. Gilbert, Sundance TV (2004).
35. C. Ryan, ‘Out On a Limb: The Ethical Management of Body Integrity Identity Disorder’, Neuroethics 2(1) (2009), pp. 21–33.
36. K. Kröger, T. Schnell and E. Kasten, ‘Effects of Psychotherapy on Patients Suffering From Body Integrity Identity Disorder (BIID)’, American Journal of Applied Psychology 3(5) (2014), pp. 110–115.
37. M.B. First, ‘Desire for Amputation of a Limb: Paraphilia, Psychosis, or a New Type of Identity Disorder’, Psychological Medicine 35(6) (2005), pp. 919–928; A.W. Braam, S. Visser, D.C. Cath and D.C. Hoogendijk, ‘Investigation of the Syndrome of Apotemnophilia and Course of a Cognitive-Behavioural Therapy’, Psychopathology 39(1) (2006), pp. 32–37.
38. V.S. Ramachandran and P. McGeoch, ‘Can Vestibular Caloric Stimulation be Used to Treat Apotemnophilia?’, Medical Hypotheses 69(2) (2007), pp. 250–252.
39. Braam, Visser, Cath and Hoogendijk, ‘Investigation of the Syndrome of Apotemnophilia and Course of a Cognitive-Behavioural Therapy’.
40. S. Noll and E. Kasten, ‘Body Integrity Identity Disorder (BIID): How Satisfied Are Successful Wannabes’, Psychology and Behavioural Sciences 3(6) (2014), pp. 222–232.
41. C. Dyer, ‘Surgeon Amputated Healthy Legs’, British Medical Journal 320(7231) (2000), pp. 332–332; First, ‘Desire for Amputation of a Limb: Paraphilia, Psychosis, or a New Type of Identity Disorder’; R.M. Blom, R.C. Hennekam and D. Denys, ‘Body Integrity Identity Disorder’, PLoS One 7(4) (2012), pp. e34702; Noll and Kasten, ‘Body Integrity Identity Disorder (BIID): How Satisfied are Successful Wannabes’.
42. R. Smith and K. Fisher, ‘Healthy Limb Amputation: Ethical and Legal Aspects’, Clinical Medicine 3(2) (2003), p. 188; T. Bayne and N. Levy, ‘Amputees by Choice: Body Integrity Identity Disorder and the Ethics of Amputation’, Journal of Applied Philosophy 22(1) (2005), pp. 75–86; The Center for Bioethics and Culture, ‘Should Doctors Amputate Healthy Limbs?’ (2018). Available at: http://www.cbc-network.org/2006/11/should-doctors-amputate-healthy-limbs/ (accessed 09 April 2018); S. Müller, ‘Amputee Envy’, Scientific American Mind 18(6) (2007), pp. 60–65; S. Müller, ‘BIID – Under Which Circumstances Would be Amputations of Healthy Limbs Ethically Justified’, in S. Oddo, ed., Body Integrity Identity Disorder: Psychological, Neurobiological, Ethical, and Legal Aspects (Lengerich: Pabst Science Publishers, 2009b), pp. 109–123; Ryan, ‘Out On a Limb: The Ethical Management of Body Integrity Identity Disorder’; R. Smith, ‘Body Integrity Identity Disorder: The Surgeon’s Perspective’, in S. Oddo, ed., Body Integrity Identity
act of elective amputation causes a net harm or net benefit to those individuals with BIID?

The instigating event for this discussion came in 2000 when the UK media reported that Robert Smith, a surgeon at the Falkirk and District Royal Infirmary, undertook two unilateral, above the knee limb amputations, to resolve instances of BIID, at his patient’s request and cost.\(^{43}\) The first was in September 1997 and the second in April 1999.\(^{44}\) Before both procedures, each patient underwent a psychiatric and psychological evaluation to establish their capacity to consent.\(^{45}\) Post-surgery, both patients reported complete satisfaction with the outcome of their operations and being significantly happier after the surgery than before.\(^{46}\) Despite these positive outcomes, however, the surgeries were met with a deluge of negative attention which led to the Scottish government having to clarify that there would be no governmental inquiry into the affair.\(^{47}\) Following media scrutiny, the hospital withdrew its support for any similar operations, and since then, no further UK-based, BIID-driven therapeutic, healthy limb amputations are known to have occurred.

One of the factors that likely contributed to the withdrawal of the hospital’s support for such procedures, as well as the broader clinical profession’s reluctance to make use of the therapy, is the legally grey area in which the procedure can be understood to reside. This principally concerns the offence of GBH as it is this offence under which a surgeon carrying such an operation would likely be charged.

Since *R v. Brown*,\(^{48}\) the presumption in law is that one cannot consent to any act that would cause them actual bodily harm or worse. However, as identified by Lord Mustill, to enact this rule without caveats would make vast swaths of everyday activity legally impermissible. Consequentially, exceptions were outlined under which, if an activity fell, consent could be considered valid; these included medical treatment and ‘reasonable surgical interference’.\(^{49}\) This exception means that surgeons can operate on their patients, provided they do so with the permission of someone able to provide valid

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43. *The Guardian*, ‘My Left Foot Was Not Part of Me’ (2018). Available at: https://www.theguardian.com/uk/2000/feb/06/theobserver.uknews6 (accessed 06 February 2019).
44. Dyer, ‘Surgeon Amputated Healthy Legs’.
45. Smith, ‘Body Integrity Identity Disorder: The Surgeon’s Perspective’.
46. BBC News, ‘‘No Regrets’ For Healthy Limb Amputee’ (2019). Available at: http://news.bbc.co.uk/1/hi/scotland/632856.stm (accessed 25 June 2019); Dyer, ‘Surgeon Amputated Healthy Legs’; K. Scott, *Voluntary Amputee Ran Disability Site* (London, 2000), p. 7, The Guardian Home Pages; *The Guardian*, ‘My Left Foot Was Not Part of Me’ (2018). Available at: https://www.theguardian.com/uk/2000/feb/06/theobserver.uknews6 (accessed 06 February 2019); *Complete Obsession – Body Dysmorphia*, N. Stockley (2000).
47. BBC News, ‘Surgeon Defends Amputations’ (2019). Available at: http://news.bbc.co.uk/1/hi/scotland/625680.stm (accessed 20 August 2019).
48. [1993] 1 AC 212.
49. See *Attorney General’s Reference (No. 6 of 1980)* [1980] 1 Q.B. 715; The Law Commission, *Consultation Paper No. 139: Consent in the Criminal Law*. 
consent and with a public policy justification,\textsuperscript{50} without the fear that they will then be charged with GBH. This is despite the fact that they do, \textit{prima facie}, commit an offence according to section 18 of the OAPA 1861.\textsuperscript{51}

Much of the speculation regarding the legality of BIID-driven therapeutic, healthy limb amputations has centred on whether the nature of the procedure, and of the condition itself, would invalidate the consent provided by potential patients. Critics have sought to support such a conclusion by comparing the practice with contentious surgical interventions, such as providing stomach stapling services to someone suffering from anorexia nervosa,\textsuperscript{52} or the removal of an appendix due to a patient’s delusional request that it is cancerous.\textsuperscript{53} If the consent provided by patients were demonstrated to be invalid due to such a decision having a delusional foundation, this would disqualify those surgeons who facilitate such surgeries from an exception to liability for GBH under section 18 of the OAPA 1861 as they would no longer be carrying out reasonable surgical interference with consent. Consent is established broadly where the individual’s consent is expressed in a legally recognisable manner,\textsuperscript{54} and where that individual has the freedom, capacity, and information to make a meaningful choice.\textsuperscript{55}

Additionally, even if the ability of those with BIID to consent to such surgeries was established, there is a further question regarding what ‘proper medical treatment’ means and where such a concept’s legal boundaries reside.\textsuperscript{56} The possibility of such a discussion suggests that there is the potential for the practice of elective amputation and those surgeons who carry out the procedure, to be disqualified from the medical exception from the OAPA 1861, not because of a lack of consent, but because the surgery itself is not a medical treatment but a form of body modification, albeit an extreme one.\textsuperscript{57} This conception of the operation is further complicated by the fact that while an exception from section 18 of the OAPA 1861 for tattooing and body modification does exist, facilitated by Part 8 of the Local Government (Miscellaneous Provisions) Act 1982,\textsuperscript{58} again courtesy of \textit{R v. Brown},\textsuperscript{59} the boundary of this exception is more conservative.

\begin{itemize}
\item \textsuperscript{50} [1980] 1 Q.B. 715.
\item \textsuperscript{51} Offences Against the Persons Act 1861.
\item \textsuperscript{52} S. Müller, ‘Body Integrity Identity Disorder (BIID) – Is the Amputation of Healthy Limbs Ethically Justified?’, \textit{The American Journal of Bioethics} 9(1) (2009a), pp. 36–43.
\item \textsuperscript{53} The Center for Bioethics and Culture, ‘Should Doctors Amputate Healthy Limbs?’ (2018). Available at: http://www.cbc-network.org/2006/11/should-doctors-amputate-healthy-limbs/ (accessed 09 April 2018).
\item \textsuperscript{54} \textit{Collins v. Wilcock} [1984b] W.L.R 172.
\item \textsuperscript{55} \textit{Re C} [1994] 1 W.L.R. 290.
\item \textsuperscript{56} L. Frith, ‘What do We Mean by “Proper” Medical Treatment?’, in S. Fovargue, ed., \textit{The Legitimacy of Medical Treatment: What Role for the Medical Exception?} (Hoboken: Taylor and Francis, 2015), pp. 32–50.
\item \textsuperscript{57} Bridy, ‘Confounding Extremities: Surgery at the Medico-Ethical Limits of Self-Modification’.
\item \textsuperscript{58} Local Government (Miscellaneous Provisions) Act 1982.
\item \textsuperscript{59} [1993] 1 AC 212.
\end{itemize}
ambiguous, and inconsistent than that of the medical exemption, with the justification for why some forms of alteration are acceptable, and others not, appearing rather obscure.60

However, this article will seek to defend the operation via an alternative method. Rather than have, as a starting point, that a surgeon invariably commits a section 18 offence and then seeks exemption from prosecution by an appeal to the precedent set out in \textit{R v. Brown},61 as has been the standard approach so far, this article will challenge the assumption that GBH has occurred in the first place. It will do this by critically examining the conceptual component of harm within the offence of GBH, reflecting how ‘grievous’ and ‘bodily’ have been done in common law previously. By doing so, it will not only defend therapeutic, healthy limb amputations in cases of BIID but also seek to clarify the murky conceptualisation of harm at the centre of GBH, as well as other harm-centric legal concepts.

\textbf{Part 4: Metaphysics of harm in GBH}

As discussed, harm is an essential component of the offence of GBH. The severity and locality of harm can increase or decrease, be singular or distributed, material or psychological. This changeability of attributes can denote differences of degree within the boundary of GBH or alter the nature of a harmful act to be better considered under alternative offences like actual bodily harm. However, the conceptual component of harm is not afforded the same transformative quality. Harm is a binary component of GBH in that it is either present or not. For someone to have committed GBH, and therefore be in breach of section 18 of the OAPA 1861,62 they must have acted in a manner to cause another individual to transition to a new state of being which is said to be harmful, and it is from this new state in which that individual resides that we can say that they have been harmed. Such an account of harm, one which uses the conditions in which an individual exists to understand whether that person has been harmed, is termed a ‘state-based’ account of harm.63 It is with these formulations that this article is principally concerned.64

Three state-based accounts of harm will now be explored: the non-comparative account, the counter-temporal account, and the counterfactual account. The Smith amputations will be explored through each to answer the question of whether, by providing each of the two patients with therapeutic, healthy limb amputations, Smith harmed these individuals. The answer to this question will then be used in determining whether it is appropriate for Smith to be considered as causing GBH if he were not afforded protection

60. For a recent example of someone falling foul, the ambiguous nature of the exception from section 18 of the OAPA 1861, based on body modification and tattooing, see [2018] EWCA Crim 560.
61. [1993] 1 AC 212.
62. Offences Against the Persons Act 1861.
63. M. Hanser, ‘The Metaphysics of Harm’, \textit{Philosophy and Phenomenological Research} 77(2) (2008), pp. 421–450.
64. Other families of harm accounts exist, such as those that are event-based. However, these fall outside the scope of this article.
from this offence in lieu of the reasonable surgical interference caveat provided in \textit{R v. Brown}.\textsuperscript{65} Such a decision will then be extrapolated to the legal status of the surgical intervention in a broader sense.

\textbf{Part 4.1: The non-comparative account of harm}

The non-comparative account of harm proposes that:

\ldots an action harms someone if it causes the person to be in a bad state. Bad states are understood as states that are in themselves bad, not bad because they are worse than the state the person would otherwise have been in.\textsuperscript{66}

According to this account, the status of a state as being harmful is not derived from that state’s comparison with another possible state in which an individual would, could, or has found themselves. Instead, the harmful quality of a state is understood as an intrinsic feature of that state; one is harmed simply by being in it.\textsuperscript{67}

Despite the account’s name, not every form of comparison should be disregarded. Indeed, a proponent of the non-comparative account could hold the view that every account of harm invariably invokes a comparison with an ideal or norm, and it is this comparison that allows a state to go from being a normatively neutral alternative to a harmful state of existence. For example, for someone to say that being born with a missing leg is harmful, is to say that missing the leg is undesirable compared to not missing the leg, the latter being the state of ‘ideal’ functioning which can be interpreted as normatively desirable. This label of harm is applied to the state in which that person resides even though they could never have been in another state; the person born missing a leg could never have been otherwise. As Hanser explains:

When a proponent of the non-comparative account says that states of impaired functioning are ‘non-comparatively’ bad, he means rather that it is bad for a person to be in such a state regardless of whether a better state was ever a genuine alternative \textit{for him}.\textsuperscript{68}

\textsuperscript{65} [1993] 1 AC 212.
\textsuperscript{66} E. Harman, ‘Harming as Causing Harm’, in M.A. Roberts and D.T. Wasserman, eds., \textit{Harming Future Persons: Ethics, Genetics and the Nonidentity Problem} (Dordrecht: Springer Netherlands, 2009), p. 139.
\textsuperscript{67} It should be noted that this is one version of the non-comparative account of harm and that other slightly altered formulations exist. For example, the version presented by Shiffrin proposes that being harmed ‘primarily involves the imposition of conditions from which the person undergoing them is reasonably alienated or which are strongly at odds with the conditions she would rationally will’; S.V. Shiffrin, ‘Wrongful Life, Procreative Responsibility, and the Significance of Harm’, \textit{Legal Theory} 5(2) (1999), pp. 117–148. However, as it is with the overall structure of the account that this article is concerned, the subtleties between the various sub-accounts are not strictly relevant.
\textsuperscript{68} Hanser, ‘The Metaphysics of Harm’, p. 426, emphasis in original.
This drawing on a comparison to an ideal or normatively desirable state is of particular interest when it comes to an English law interpretation of harm as it resembles the previously mentioned accounts in case law where the nature of GBH has been explored. In *R v. Golding*, for example, when it was stated that ‘the assessment of harm done in an individual case in a contested trial would be a matter for the jury, applying contemporary social standards’, 69 this can be interpreted as an instance in which the non-comparative account of harm has been applied within the legal system. For jurors deciding whether an offence of GBH has been caused, they would be expected to apply contemporary social standards. Namely, they would judge the impact of the newly found state of the individual against what would be normatively desirable, and whether this new state has brought about an antithesis of this desired state of being.

As such, this article tentatively suggests that the non-comparative account of harm is that account which is most commonly employed within English law as it most closely resembles the approach to harm as demonstrated in case law. When jurors are expected to apply ‘contemporary social standards’, or interpret terms, including harm, according to their ‘ordinary and natural meaning’, this seems equivalent to asking those jurors to compare the state in which an individual resides not to a carefully considered theoretically potential one but rather a socially acceptable and normatively enticing ideal.

Returning to the two Smith amputations, the question in need of answering is, did Smith, as a direct result of his actions, transition his patients into an intrinsically harmful state, and as such, harm these individuals? On the surface, the answer to this question would appear to be a straightforward yes. Smith did harm these individuals as he caused them to transition into a state of impairment via making them amputees.

However, this assumption has been challenged. 70 The conclusion that being an amputee is intrinsically harmful comes from the perception, in line with collective cultural body logic, that to have a ‘complete’ body, with all four limbs, is a normatively better state of being in which to inhabit than to lose a leg to amputation. 71 This assumption can be extrapolated into the broader claim that to live one’s life without impairment is better than livings one’s life with an impairment, given all its indicated socio-economic complications,72 as well as associated mental and physical health complexities.73 After all, the majority of individuals are not

69. [2014] EWCA Crim 889.
70. R.B. Gibson, ‘Elective Impairment Minus Elective Disability: The Social Model of Disability and Body Integrity Identity Disorder’, *Journal of Bioethical Inquiry* 17(1) (2020), pp. 145–155.
71. J.W. Jordan, ‘The Rhetorical Limits of the “Plastic Body”’, *Quarterly Journal of Speech* 90(3) (2004), pp. 327–358.
72. A. Powell, *Briefing Paper: People With Disabilities in Employment* (Parliament of the United Kingdom of Great Britain and Ireland, 2019); E. Emerson, R. Madden, J. Robertson, H. Graham, C. Hatton and G. Llewellyn, *Intellectual and Physical Disability, Social Mobility, Social Inclusion & Health*, (Lancaster: Centre for Disability Research, Lancaster University, 2009).
73. R. Turner and M. Beiser, ‘Major Depression and Depressive Symptomatology Among the Physically Disabled: Assessing the Role of Chronic Stress’, *Journal of Nervous and Mental Disease* 178(6) (1990), pp. 343–350; S.-A. Cooper, G. McLean, B. Guthrie, A.
seeking out elective amputations as such a state is, seemingly, intrinsically undesirable, and this undesirability is a feature of standard social acknowledgement. This attitude is observable in discussions regarding the use of pre-implantation genetic diagnosis to actively select for an embryo likely to possess an impairment, and whether such action causes harm to that embryo as a result of it being born, for example, deaf.\textsuperscript{74} This approach, as it relates to the discussion regarding BIID, is articulated by Sullivan who, when referring to the argument by Bruno, writes that:

\begin{quote}
[d]isability … is, then, the antithesis of able-bodiedness (as a natural development state) rather than its complement. Disability is unnatural insofar as it is the result of an accident (whether congenital or social): It is, by definition, both an aberration and an abomination and as such, is literally undesirable.\textsuperscript{75}
\end{quote}

It is easy to conclude then that to act in a manner which deliberately moves a person from a state of health and mobility to one of impairment and ‘aberration’ is to cause them significant harm. Consequentially, in the context of the OAPA 1861,\textsuperscript{76} it would seem reasonable to conclude that Smith had committed the offence of GBH with intent.

However, this form of reasoning illustrates one of the significant criticisms for which the non-comparative account is susceptible. Its reliance on a normative ideal informed by social standards; standards that can be based on less than well-thought-out considerations. Collective judgment regarding anything, including what states are harmful, can be subject to misinformation, biases, manipulation, or outright ignorance. For example, as indicated by Albrecht and Devlieger,\textsuperscript{77} individuals with severe and persistent impairments report their quality of life as being significantly higher than is assumed by external observers who perceive such a daily existence as categorically undesirable. This phenomenon, known as the ‘disability paradox’, has been subsequently reported, albeit with varying explanations and commentaries, in multiple studies.\textsuperscript{78} This paradox indicates a

\begin{flushright}
\textsuperscript{74} T.S. Petersen, ‘Just Diagnosis? Preimplantation Genetic Diagnosis and Injustices to Disabled People’, \textit{Journal of Medical Ethics} 31(4) (2005), p. 231; M.S. Fahmy, ‘On the Supposed Moral Harm of Selecting for Deafness’, \textit{Bioethics} 25(3) (2011), pp. 128–136; S. Camporesi, ‘Choosing Deafness With Preimplantation Genetic Diagnosis: An Ethical Way to Carry on a Cultural Bloodline?’, \textit{Cambridge Quarterly of Healthcare Ethics} 19(1) (2009), pp. 86–96.
\textsuperscript{75} N. Sullivan, ‘Body Integrity Identity Disorder (BIID) and the Matter of Ethics’, in J.D. Arras, E. Fenton and R. Kukla, eds., \textit{The Routledge Companion to Bioethics} (London: Taylor and Francis, 2014), p. 584.
\textsuperscript{76} Offences Against the Persons Act 1861.
\textsuperscript{77} G.L. Albrecht and P.J. Devlieger, ‘The Disability Paradox: High Quality of Life Against All Odds’, \textit{Social Science & Medicine} 48(8) (1999), pp. 977–988.
\textsuperscript{78} P.A. Ubel, G. Loewenstein, N. Schwarz and D. Smith, ‘Misimagining the Unimaginable: The Disability Paradox and Health Care Decision Making’, \textit{Health Psychology} 24(4S) (2005), pp. S57–S62; C.E. Drum, W. Horner-Johnson and G.L. Krahn, ‘Self-Rated Health and Healthy Days: Examining the “Disability Paradox”’, \textit{Disability and Health Journal} 1(2)
\end{flushright}
severe mismatch between the self-evaluated experience of being impaired and the perception of what such an existence is like by those without impairments. This mismatch highlights an issue with the evaluation that to be impaired is intrinsically harmful as many of those who are impaired do not believe themselves to have been harmed by the state in which they exist, at least not in the same intrinsic manner in which is assumed by contemporary social standards. Indeed, there is a growing movement in which impaired people see their impairment not as something that harms them but rather as a quality of their existence from which they can benefit and in which they take pride. For a non-comparative interpretation of harm, as it relates to GBH, to claim that transitioning into a state of impairment is a harm because the state of impairment is a harmful state appears to be not only reductive but also incompatible with the lived experience of impaired people. If those people with impairments do not consider themselves to have been harmed as a result of being an impaired person, then it would appear that there is an argument to be made that to transition someone into a similar state, with their consent and for therapeutic purposes, is not to harm them. What it does do is move them from one state of existence to another; a state which some may believe as being undesirable, but this is different from claiming that such a state is harmful.

As such, a non-comparative account of harm seems to provide little considered guidance regarding whether Smith committed the offence of GBH, given that the account relies on a potentially ill-informed caricature of harm built upon unevaluated assumptions regarding what a desirable and healthy body should be.

**Part 4.2: The counter-temporal account of harm**

This article now turns to the counter-temporal account of harm, according to which:

\[
\text{... to suffer a harm is to move from some state of well-being to a worse state over some period of time, and that to experience a benefit is to move to a better state of well-being over}
\]

(2008), pp. 71–78; N. Watson, ‘Well, I Know This is Going to Sound Very Strange to You, but I Don’t See Myself as a Disabled Person: Identity and Disability’, *Disability & Society* 17(5) (2002), pp. 509–527.

79. The argument against the intrinsic harm of impairment can be interpreted as being fundamental to the anti-ableism movement. This movement seeks to highlight that many of the issues associated with impairment are the result not of an essential component of the state but rather of the active and passive ways in which impaired people are excluded from society alongside the benefits which come from adequate societal integration; an exclusion that is not intrinsic but extrinsic.

80. For example, see Brighton’s annual Disability Pride event (http://www.disabilitypridebrighton.com (accessed 23 July 2019) as well as Wendy Lu’s article, ‘Disabled People Don’t Need to be “Fixed” – We Need a Cure for Ableism’ (2019). Available at: https://everydayfeminism.com/2018/05/a-cure-for-ableism/ (accessed 03 June 2019).

81. This is the preferred term for this formulation of the account. Other names include the temporal comparison, the temporal comparative account, the historical account and the principle of temporal good; B. Foddy, ‘In Defence of a Temporal Account of Harm and Benefit’, *American Philosophical Quarterly* 51 (2014), pp. 155–165.
some period of time. In other words, a harm makes us worse-off than we were before the harm occurred.82

Unlike the non-comparative account, the counter-temporal account does not rely, at least explicitly, on impersonal standards or collective norms. Instead, it compares the state in which an individual existed before and after an event. This is then used to determine whether harm has occurred based on the outcome of such a comparison. If that individual is in a worse state, then they were before the event, then it is feasible to say that harm has occurred as a result of that event. Consequentially, if an individual was responsible for intentionally causing such an event, then they can be said to have caused that harm with foresight. For example, if person A hits person B with a hammer, breaking person B’s hand, it would make sense to say that person A has harmed person B as they have caused person B to be in a worse state after an action, of which person A was the direct cause, then they were before.

For a charge of GBH then, it would need to be demonstrated that one individual caused another to transition into a state in which their physical or mental well-being (the bodily aspect of GBH) had been altered significantly (the grievous aspect of GBH) in a negative manner, thereby fulfilling the three components of GBH.

Regarding the Smith amputations then, the question that would need to be considered is, did Smith, as a direct and intentional result of his actions, transition his patients into a state that is considerably worse off than the state in which they had existed prior to their elective, healthy limb amputations, and as such, harm his patients? Unlike the non-comparative account, in which there is a need to speculate on the nature of contemporary cultural body logic, with this account a more considered and research-driven approach is appropriate. Specifically, an account needs to be created of what life was like for those people with BIID before, and after, amputation. It would then be possible to say whether Smith caused counter-temporal harm and as such, is guilty of causing GBH.

To start with, this article will look at the case of Kevin Wright, the individual on whom Smith operated on in September 1997. Wright, a thirty-year-old postgraduate student, first experienced the symptoms of BIID early in childhood. As time passed, the strength of the desire increased. Before contacting Smith, Wright had sought a psychiatric solution to his condition and, over the ten years preceding his operation, had tried several different forms of psychiatric and psychopharmacological treatment, all to no avail.83 As a result of his BIID, Wright experienced severe periods of depression, which negatively affected many aspects of his life. At one point, due to the considerable distress he experienced, Wright tried to damage his leg by burning it to make an amputation necessary; this attempt failed. This distress also led Wright to contemplate suicide.84 After a psychiatric assessment evaluated Wright as being fully capable of comprehending the consequences of his request and, once Smith obtained clearance from hospital

82. Op. cit., p. 156, emphasis in original.
83. The Guardian, ‘My Left Foot Was Not Part of Me’ (2018). Available at: https://www.theguardian.com/uk/2000/feb/06/theobserver.uknews6 (accessed 06 February 2019).
84. BBC News, ‘No Regrets’ For Healthy Limb Amputee (2019). Available at: http://news.bbc.co.uk/1/hi/scotland/632856.stm (accessed 25 June 2019).
management, the surgeon carried out an above-the-knee amputation on Wright, under general anaesthetic. Wright has said that the operation has changed his life for the better, stating that ‘[b]y taking that leg away, that surgeon has made me complete’, and ‘[o]f course I am not a different person now, but I might as well be. I have happiness and contentment and life is much more settled, so much easier’. Since the operation, Wright has not experienced any further symptoms of BIID, nor has he felt the need for continuing psychiatric treatment, and, while he does occasionally experience a phantom limb, he has not experienced any occasions of phantom pain.

This account is similar to that of Hans Schaub, the recipient of the second healthy limb amputation carried out by Smith. Much like Wright, Schaub, a fifty-seven-year-old businessman, began experiencing the symptoms of BIID in childhood. Initially, the desire for an amputation had been linked to sexual arousal, however, as time passed and the strength of the desire intensified, this sexual component dissipated to the point of non-existence. By the time Schaub reached his mid-fifties, his compulsion to become an amputee had become overwhelming. Schaub planned to injure himself by lying under a train. However, due to the concern of additional injury and death, this plan was abandoned. He experienced repeated periods of depression, for which he took medication, which he linked to his amputation desire remaining unfulfilled.

After Schaub was assessed as being fully competent and aware of the consequences of amputation, Smith performed a unilateral, above the knee amputation in April 1999. That same evening, Schaub was moving around on crutches and required no post-operative analgesia. He was discharged five days after undergoing the operation and has reported no further symptoms of BIID. In fact, much like Wright, Schaub stated, during a meeting between himself and Smith in 2000, that the quality of his life has improved because of the removal of the limb, saying that ‘[i]t improved my life quite a bit ‘cos that’s the way I wanted to be, that’s the way it is so I’m quite happy about that’. Smith then follows this up by saying:

If he wasn’t satisfied with it would he admit it, but if you look at Hans’ life now he’s extroverted, he’s, he [sic] was going to retire from business. He’s now carrying on his business because he finds it’s a new challenge now that he’s an amputee. I, I [sic] certainly don’t think Hans is suffering from having had the operation. I’m pretty definite in my mind that Hans has been enormously benefited by it.

Comparing these accounts, it is possible to draw out some similarities between the pre- and post-operative experiences of Wright and Schaub. Before amputation, both individuals suffered as a result of having BIID. This suffering led to both experiencing bouts of depression which they linked to the presence of the unwanted limb. Both had felt

85. Op. cit.
86. Op. cit.
87. Smith, ‘Body Integrity Identity Disorder: The Surgeon’s Perspective’, p. 47.
88. Op. cit.
89. Stockley, Complete Obsession – Body Dysmorphia, 2000.
90. Op. cit.
the need to ‘pretend’ to be impaired, either at home or in public. Each had sought out various, less drastic forms of treatment to eliminate the desire with nominal to non-existent success. Both individuals had considered ways in which they could force an amputation to occur; Wright by damaging the leg and then seeking a surgically facilitated amputation, Schaub by amputating the entire limb himself and then seeking medical assistance. During preoperative assessments, both were found to be fully competent to consent to the surgery by the relevant legal and policy standards and were aware of the consequences of such a procedure. After their amputations, each recovered quickly, required minimal to no analgesia, and were discharged from the hospital within less than a week. Both have independently stated that the amputations have had a positive impact on their lives, resolving the distress they felt as a result of their BIID and enabling them to engage with the people and world around them more fully. Finally, both have characterised the amputation, not in terms of a loss of bio-matter or functionality but rather, as a process of becoming and securing fulfilment.

These singular accounts correspond with the academic literature that has examined the pre- and post-amputation experiences of those with BIID. In the studies of First, Noll and Kasten, Blom et al., Johnson et al., in addition to several case reports, and anecdotal accounts, those with BIID experience significant and chronic distress associated with the presence of the affected limb. Additionally, these same studies

91. The average period from the day of operation to the day of hospital discharge, for a non-elective amputation, is 10 to 14 days; markedly higher than the period for Wright and Schaub.
92. First, ‘Desire for Amputation of a Limb: Paraphilia, Psychosis, or a New Type of Identity Disorder’.
93. Noll and Kasten, ‘Body Integrity Identity Disorder (BIID): How Satisfied are Successful Wannabes’.
94. Blom, Hennekam and Denys, ‘Body Integrity Identity Disorder’.
95. A.J. Johnson, S. Liew and L. Aziz-Zadeh, ‘Demographics, Learning and Imitation, and Body Schema in Body Integrity Identity Disorder’, Indiana University Undergraduate Journal of Cognitive Science 6 (2011), pp. 8–11.
96. B.D. Berger, J.A. Lehrmann, G. Larson, L. Alverno and C.I. Tsao, ‘Nonpsychotic, Nonparaphilic Self-Amputation and the Internet’, Comprehensive Psychiatry 46(5) (2005), pp. 380–383; R.M. Blom, N.C. Vulink, S.J. van Der Wal, T. Nakamae, Z. Tan, E. Derks and D. Denys, ‘Body Integrity Identity Disorder Crosses Culture: Case Reports in the Japanese and Chinese Literature’, Neuropsychiatric Disease and Treatment 12 (2016), pp. 1419–1423; A.W. Braam and N. de Boer-Kreeft, ‘Case Report – The Ultimate Relief; Resolution of the Apotemnophilia Syndrome’, in S. Oddo, ed., Body Integrity Identity Disorder: Psychological, Neurobiological, Ethical, and Legal Aspects (Lengerich: Pabst Science Publishers, 2009), pp. 70–76.
97. K. Mercerlaura, L. Connor and L. Connor, ‘Nick Knows There Is Nothing Wrong With His Leg – but He Still Wants it Amputated’ (2018). Available at: https://www.mirror.co.uk/news/uk-news/nick-knows-nothing-wrong-leg-10124073 (accessed 24 January 2018); I. Tuttle, ‘People Who Cut Off Their Own Limbs (and Their Enablers)’ (2018). Available at: https://www.nationa lreview.com/2015/06/bruce-jenner-sex-change-self-mutilation/ (accessed 19 December 2018); C. Yates, ‘Talking to a Guy Who Found Peace Through
reported that those individuals who had been successful in securing a healthy limb amputation also secured a considerable and consistent increase in the congruity between their identities and physical embodiments. This realignment led to markedly improved mental states, with one study participant questioning whether they should even be in a BIID study, stating ‘since my amputation I do not have BIID feelings anymore’. Indeed, for those with BIID, healthy limb amputation appears to be a potentially viable treatment option, at least in the most extreme cases, even though such an intervention runs counter to contemporary body logic.

According to available evidence then, there is a compelling argument to be made that Smith did not harm the two individuals on whom he operated as both can be considered to have been conferred a net benefit as a consequence of the surgeries they underwent. Understood holistically, neither were in a worse state after the operation than before but, in fact, better. The relief from suffering which the operations provided was a more significant benefit than the subsequent impairment and disability resulting from the absentee limb. The singular accounts of the benefits of healthy limb amputation, as relayed by Wright and Schaub themselves, are tentatively supported by the broader academic literature into the effectiveness of healthy limb amputation in cases of BIID. Consequentially, there is a strong case to argue that Smith did not commit the offence of GBH with intent according to a counter-temporal account of harm.

**Part 4.3: The counterfactual account of harm**

The final state-based account that this article will examine is the counterfactual account of harm, according to which:

\[ \ldots \text{harm is caused by comparing what actually happened in a given situation with the} \]
\[ \text{‘counterfacts,’ i.e. what would have occurred had the putatively harmful conduct not taken} \]
\[ \text{place. If a person’s interests are worse off than they otherwise would have been then a} \]
\[ \text{person will be harmed.} \]

Much like the counter-temporal account of harm, the counterfactual account draws upon the consequences of an action to facilitate a comparative analysis, and subsequent evaluative judgment, regarding whether such action causes an individual to move into a harmed state and thus be harmed. Unlike the counter-temporal account, however, this account does not use the state in which an individual existed before an act or event as a baseline. Instead, it utilises a theoretical alternative state in which that individual would reasonably have been in had the event or act in question not occurred. As such, while the counter-temporal account employs a retrospective viewpoint, the counterfactual account takes a prospective one. Returning to the example employed earlier, for illustration, if

Self-Amputation’ (2018). Available at: https://www.vice.com/en_uk/article/jmaeqk/talking-to-a-guy-who-found-happiness-through-self-amputation (accessed 07 March 2018).

98. Blom, Hennekam and Denys, ‘Body Integrity Identity Disorder’.

99. C. Purshouse, ‘A Defence of the Counterfactual Account of Harm’, *Bioethics* 30(4) (2016), pp. 251–259, p. 251.
person A hits person B with a hammer, breaking person B’s hand, it will make sense to claim that person A has harmed person B as they have caused person B to be in a worse state after an action, of which person A was the direct cause, then they would have otherwise been, at the same point in time, had they not hit them in the hand. That is, had person A not hit person B with the hammer, person B would have remained unharmed.

For a charge of GBH to be entertained, when harm is understood according to a counterfactual interpretation, it would need to be demonstrated that one individual caused another to transition into a state in which their physical or mental well-being had been altered significantly, in a negative manner, from the state in which that person would have otherwise existed, and, as such, has caused harm to that individual. Regarding the Smith amputations, the question that would need to be answered is whether Smith, as a direct and intentional result of his actions, transitioned his patients into a state that is considerably worse off than the state in which those individuals would have been had Smith not performed such healthy limb amputations and as such, grievously harmed his patients?

The details utilised in the counter-temporal account of harm relating to the post-amputation experience of both Wright and Schaub, as well as the data present in the academic literature, can be used in this account as well. Doing so will provide the ‘actual’ state against which the possible alternative state of non-amputation will be compared.

As already outlined, those individuals who undergo a healthy limb amputation, including both Wright and Schaub, experience a decrease in the incongruity between their physical selves and their self-perceived identities. This decrease leads, in turn, to an increase in their quality of life, and this increase vastly outweighs any difficulties in navigating the world as an impaired individual. For example, a respondent to Noll and Kasten’s study, when answering a question relating to the advantages resulting from achieving their desired amputation, replied that:

Since living permanently in a wheel-chair (July 2010) I’m free of depressions and can enjoy my life. Even in the wheel-chair I’m able to work in my occupation. Before this, BIID pressed me into a double-life. Now this compulsion is gone. The more atrophy I’m getting in my legs, the easier it becomes for me.

According to the available literature, neither of Smith’s patients considered suicide or self-harm after the operation, nor did they regret undergoing the procedures. Again, this is replicated in the broader empirical research into the phenomenology of BIID, with none of the respondents to Firsts’, Noll and Kasten’s, Blom et al.’s, nor Johnson

100. Noll and Kasten, ‘Body Integrity Identity Disorder (BIID): How Satisfied are Successful Wannabes’.
101. Op. cit., p. 226.
102. First, ‘Desire for Amputation of a Limb: Paraphilia, Psychosis, or a New Type of Identity Disorder’.
103. Noll and Kasten, ‘Body Integrity Identity Disorder (BIID): How Satisfied are Successful Wannabes’.
104. Blom, Hennekam and Denys, ‘Body Integrity Identity Disorder’.
et al.’s studies regretting their acquired impairments. The regret most often expressed by respondents to these studies concerns the time and quality of life wasted before the amputation, with several claiming that the only change they would make regarding their elective amputation is having it earlier. The evidence is clear that those who undergo a healthy limb amputation, to resolve an instance of BIID, typically enjoy a positive outcome as a result of the surgery, at least as indicated by the currently available data.

To facilitate a counterfactual comparison, what is required is a non-actual alternative state in which an individual who has undergone a healthy limb amputation could/would reside if said amputation had not occurred. However, such a task, as currently imagined, is vast to the point of impossibility. This is because the possible states in which an individual could reside if a particular act did not take place are practically innumerable; the number of states that one could reside in outnumbering the single state in which one does reside. What is required is a narrowing down of the possible states in which an individual could reside into a smaller group of possible states in which it is reasonably foreseeable, and likely, that the same individual would have come to reside in, at that same comparative moment in time, had the amputation not occurred. For such comparison to be made, this article needs to outline, and to a limited degree speculate, the likely state in which Wright and Schaub would have existed had they not received their elective amputations.

Firstly, as the question this article is considering relates to Smith’s amputation of Wright’s and Schaub’s limbs, it would be prudent to assume that had he not performed these surgeries, both patients would still have their affected limbs. It is feasible that they could have secured a limb removal via alternative means, such as performing a self-inflicted amputation or securing surgery with another clinician. However, to include these theoretical potentialities in the evaluation of Smith’s actual actions would appear to ascribe too much causal determinism to Smiths actions, or lack thereof. As such, this article will assume that each would still have both of their legs. The second assumption this article will make is that the instances of BIID, from which Wright and Schaub suffered, did not spontaneously resolve themselves. In other words, both individuals would have continued to have, and suffer from, BIID. This seems a sensible assumption to make given both the longevity of the condition in both Wright and Schaub’s lives, as well as its resistance to the other forms of treatment that they had tried. Finally, this article will assume that no universally accepted form of treatment for BIID has been discovered from the point of the Smith amputations onwards. This is in keeping with the current lack of sufficient or agreed upon treatment options for those with BIID.

105. Johnson, Liew and Aziz-Zadeh, ‘Demographics, Learning and Imitation, and Body Schema in Body Integrity Identity Disorder’.

106. This is not to say that further research into the condition is not needed. BIID is an extremely under-researched phenomenon and more research not only into its cause, but also the lived experiences of those with the condition both before and after amputation, can only be a positive thing.

107. A. White, ‘Body Integrity Identity Disorder Beyond Amputation: Consent and Liberty’, Health Care Ethics Committee Forum 26(3) (2014), pp. 225–236.
The form that this theoretical alternative state takes then is as follows; Wright and Schaub continue to suffer from the presence of their limbs as a result of having BIID, and there continue to be no viable treatment options open to them to resolve this. However, with the presence of both limbs, each does not experience any disability as it relates to mobility and can navigate their built environment without any significant degree of impairment. Nor do they experience any of the prejudices or exclusion so often experienced by impaired people.108

By comparing these two accounts, it would seem that there is an argument to be made that Smith did not harm his patients, according to a counterfactual account, as the overall quality of life which his patients experience after their amputation appears to be significantly preferable to that of the theoretical alternative laid out in this article. For Wright and Schaub, to still be ‘whole’ would have meant a continuation of the suffering that they experienced throughout their lives as a direct result of the incongruity between their bodily image and embodiment. The amputations carried out by Smith, while constituting a momentous intervention in the lives of his patients, diverted their futures away from a continued state of distress, dissatisfaction, depression, and despair. This is not to say that Smith’s actions did not have any negative consequences. Living one’s life with an impairment, such as the absence of a lower limb, invariably entails a more complicated relationship with one’s environment: be that physical, social, economic and political, among numerous other facets.109 This increase in complexity can be understood, in turn, as a form of existential harm itself. However, the benefits of BIID-driven amputations, as currently indicated, appear to outweigh these costs.

For those who undergo an elective amputation, the costs of having a limb removed are a price worth paying as such a surgery allows for a more significant benefit in the mental well-being of those with the disorder. Consequentially, according to the counterfactual account of harm laid out in this article, Smith did not commit the offence of GBH with intent.

Part 5: Conclusion

English criminal law is principally concerned with the prevention of harm and the punishment of those who unduly cause it.110 However, the nature of harm, in-and-of-itself, has remained unexamined. This is not problematic in cases where its presence or nature is easily assumed. Nevertheless, in borderline cases, where what exactly constitutes harm is critically important, this conceptual ontology can be vital in delineating between the causing, or not, of serious offences which have harm as a central component, such as GBH.

This article sought to examine one such instance where the presence or absence of harm is crucial in understanding the legality of an action, that being the use of

108. C. Smith and S. Dixon, *Independent. Confident. Connected.* (London: Scope, 2018).
109. Centers for Disease Control and Prevention, ‘Common Barriers to Participation Experienced by People With Disabilities’ (2019). Available at: https://www.cdc.gov/ncbddd/disabilityandhealth/disability-barriers.html#ref (accessed 12 July 2019).
110. Tadros, *Wrongs and Crimes.*
therapeutic, healthy limb amputation in cases of BIID. Three state-based accounts of harm were utilised to illustrate the lack of jurisprudential nuance as it relates to the concept of harm and to understand harm’s nature better. Each of these formulations was applied to the two cases of elective amputation carried out by Robert Smith to understand better whether he had committed GBH with intent according to section 18 of the OAPA 1861. The purpose of this article was not to advocate for one account over another but rather to demonstrate that by applying a critical and considered eye to Smith’s actions, it becomes possible to understand healthy limb amputation not as the creation of bodily aberrations but instead as a viable and potentially legal treatment for a condition that causes a lifetime of suffering.

The employment of a metaphysically informed concept of harm in English law, beyond instances of BIID, would undoubtedly have disruptive consequences. Such an approach would radically alter how interventions and alterations to the body are categorised, not only in a legal capacity but also beyond it. Instances, where the causing of harm is in dispute, would need to be evaluated in a much more considered manner than a simple paternalistic approach which determines that harm is obvious and its presence is validated not by the supposed harmed party but by an external measure. For example, the sentencing of Brenden McCarthy for three counts of GBH as a result of the body modification procedures he carried out at his three client’s request would need re-evaluating.111 This is because it can be argued that these procedures have not, in-and-of themselves, harmed those individuals; they are not worse off now than they were before or would otherwise have been, they are merely different. They are only worse off in comparison with the legally assumed bodily ideal; an ideal that is itself woefully uncritiqued.

The employment of a more reflexive concept of harm could also render the medical exception provided by R v. Brown112 redundant, as one would no longer need to appeal to this exception but rather argue that harm itself has not been caused. Put differently, one would not need to argue that they should be excused from causing bodily harm when it is done with consent for an acceptable reason, such as surgery, if they could instead argue that they did not cause any form of harm in the first place. This would go some way to combating the paternalism inherent in the R v. Brown113 ruling and undo some of its legacies that, while not wholly negative, have resulted in a highly critical approach to activities that do not qualify for what can be described as ‘appropriate conduct’. This more nuanced approach to the lawfulness of harm within the law has an advantage over the current patchwork ‘category-based’ system in that such categories are cursory and paternalistic.114

Questions regarding how such an approach would work in tandem with the charging of GBH via wounding would need addressing in subsequent works. However, much like

111. [2018] EWCA Crim 560.
112. [1993] 1 AC 212.
113. Op. cit.
114. M. Giles, ‘R v Brown: Consensual Harm and the Public Interest’, The Modern Law Review 57 (1994), pp. 101–111.
the legal concept of wounding and the other conceptual components of GBH that have been explored in case law so far, this article holds that a clearer understanding of what is meant by the term harm is required.

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