**RADICAL SURGERY AND CONSENT: DO SURGEONS HAVE A LEG TO STAND ON?**

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**INTRODUCTION**

Imagine that a patient has their leg amputated to prevent the spread of gangrene to the rest of the body. A registered surgeon performs the surgery with due care and skill and obtains valid consent from the patient. Now imagine the exact same situation, but instead of the patient having gangrene, they have their leg amputated because they wish to be rid of it.

The second scenario is based on a real-life situation whereby Robert Smith, a Scottish surgeon, carried out single-leg amputations on two of his patients in 2000.[[1]](#footnote-1) Both legs were physically healthy prior to their amputation – they were removed at the patients’ requests. This triggered a public outcry,[[2]](#footnote-2) with Robert Smith subsequently banned from carrying out any more amputations of that nature by the hospital at which he was employed.[[3]](#footnote-3) While the morality of Robert Smith’s conduct was challenged, the legality was not.

What is it about Robert Smith’s conduct that elicits such a strong, negative response? What makes the prevention of the spread of gangrene morally justifiable, but a desire for body alteration on its own so morally objectionable? The reaction to the amputation of a healthy limb suggests that something more than a patient’s consent is required to morally justify body modification surgeries. But what does the law say about this? Is consent sufficient to preclude a surgeon from liability? Or is something more required? While it is generally assumed that consent is what makes surgery lawful,[[4]](#footnote-4) this is only true for the tort of battery and criminal assault.[[5]](#footnote-5) For the infliction of injuries beyond a certain degree of harm, consent is irrelevant according to the criminal law.[[6]](#footnote-6) As such, we come to a pivotal question – what role does consent play in justifying body modification surgeries that fall beyond that degree (‘radical surgeries’)?

The answer to this question is unclear, at least in the law in Western Australia (‘WA’). Consequently, this paper explores the role of consent to radical surgeries in WA. This topic requires examination for two important reasons. Firstly, while the legality of healthy limb amputation has been the subject of speculation,[[7]](#footnote-7) it ‘has not yet been tested in the courts’[[8]](#footnote-8) and thus requires clarification. This is particularly important for surgeons, who are presently on shaky grounds as to their legal position in relation to such requests. Secondly, the desire for body modification such as healthy limb amputation is becoming increasingly common.[[9]](#footnote-9) There have been many attempts to identify the nature and characteristics of the desire,[[10]](#footnote-10) but for the purposes of this paper, the condition will be termed Body Integrity Identity Disorder (‘BIID’) characterised by incongruence between the sufferer’s physical anatomy and their sense of body identity.[[11]](#footnote-11) It is estimated that there are now several thousand people worldwide who share the desire to have one or more limbs removed.[[12]](#footnote-12) With the growing incidence of this desire, more and more surgeons will likely be confronted with requests for amputation or similar body modification. In light of this, it is now more crucial than ever that surgeons have a clear understanding of their legal position.

1. The Structure of the Paper

This paper is divided into four chapters. As no analysis of medical law should begin without an exploration of the bioethical principles that underpin it, Chapter One provides a brief overview of these principles and theories that should have prominence in any law relating to radical surgery.

Chapter Two then sets out the law relating to radical surgery in WA, with particular focus on the role of consent.As the civil law is fairly straightforward on this point, most of the discussion is centred on the criminal law. In addition to healthy limb amputation, major surgery with the primary aim of changing the physical appearance of the patient (‘cosmetic surgery’) and gender reassignment surgery are used as examples of radical surgery. All three are considered forms of body modification that lack a physically therapeutic purpose,[[13]](#footnote-13) in the sense that they do not ‘remove, prevent or ameliorate’[[14]](#footnote-14) a health risk posed to the body. It is anticipated that if one legal justification for radical surgery is absent, physically therapeutic purpose, it becomes easier to determine where consent fits into the law.

Chapter Three sets out the criminal law relating to radical surgery in the United Kingdom (‘UK’). The UK provides a valuable comparison because it has a greater quantity of case law discussing the application of the criminal law to surgery than WA or any other Australian jurisdiction. Furthermore, the UK is the traditional point of reference for Australia in the area of health law, due to its significant volume of literature on the topic. As such, the comparison highlights the gaps or flaws present in the law in WA and provides alternative approaches for consideration.

Chapter Four critiques the criminal law in WA, and ultimately finds that consent is not given adequate provision in the *Criminal Code*.[[15]](#footnote-15) To correct this, the insertion of a consent provision relating to medical and surgical treatment into the *Criminal Code* is recommended*.* This proposal draws on the ethical principles discussed in Chapter One and the contrasting approaches to surgery in the UK.

**CHAPTER ONE**

**A BRIEF OVERVIEW OF THE BIOETHICAL THEORIES AND PRINCIPLES**

There are no doubt differing opinions as to the role consent should play in the legality of healthy limb amputations or other radical surgeries. There is no straightforward answer – it can be regarded as a complex ethical dilemma. Guidance on solving ethical dilemmas in the context of medical treatment can be sought from moral philosophy, which has influenced the bioethical discourse.[[16]](#footnote-16) With that in mind, this chapter aims to briefly outline the prominent bioethical theories and principles relating to medical treatment, with the expectation that a basic understanding of the bioethical discourse will enrich and inform the critical analysis of the law in WA.

1. Deontology

One theory of moral reasoning is that of deontology, which holds that the inherent rightness or wrongness of conduct depends upon whether it is in line with doing one’s duty.[[17]](#footnote-17) Expressed another way, conduct is justified if it is inconsistent with certain basic moral principles.[[18]](#footnote-18) For example, personal autonomy is an important ethical principle. Therefore, deontology would conclude that medical treatment respecting personal autonomy is right whereas medical treatment constraining personal autonomy is wrong.[[19]](#footnote-19)

1. Consequentialism

Teleology, or consequentialism, on the other hand, judges the rightfulness or wrongfulness of an action based on the consequences it produces.[[20]](#footnote-20) If there are two alternative courses of action to be taken, one should choose the one with the best overall consequences.[[21]](#footnote-21) Consequentialism appears to place little weight on the right of autonomy, as it would endorse medical treatment without the patient’s consent if the overall consequences of the treatment were beneficial.[[22]](#footnote-22) Utilitarianism is the most well-known consequentialist theory,[[23]](#footnote-23) and promotes the idea that the amount of human welfare within society should be maximised.[[24]](#footnote-24) In making ethical judgments, the appropriate choice would be the act that most increases the sum of human happiness.[[25]](#footnote-25) For example, it would justify killing one patient if their organs would save five other patients.

1. Virtue Ethics

Another theory on moral reasoning is virtue ethics, which derives from ancient Greek moral philosophy.[[26]](#footnote-26) Virtue ethics is concerned with what is needed to lead a good, flourishing life, which involves doing the right thing for the right reason.[[27]](#footnote-27) Thus, there is a focus not only on good outcomes but on the character or motivation of the individual.[[28]](#footnote-28) Virtuous motivations include honesty, compassion, kindness, justice and courage.[[29]](#footnote-29) Like consequentialism, virtue ethics rejects that personal autonomy is a supreme or overriding virtue.[[30]](#footnote-30) For example, virtue ethics would only consider a decision to have an abortion to be moral if it is driven by a virtuous motivation, such as knowledge that the unborn child will not be provided with a decent life.

1. The Principlist Approach

While applying moral philosophy enriches the reasoning process, it does not provide clear answers to doctors facing complex ethical dilemmas. Beauchamp and Childress have distilled four basic principles – autonomy, beneficence, non-maleficence and justice – that are considered to represent common morality.[[31]](#footnote-31) The principlist approach has been thought to provide a more practical approach to deciding morally challenging medical questions. In many cases, the principles point to a common course of action in a given situation. If, however, the principles provide conflicting courses of actions, it becomes necessary to determine which factor is more important in the particular circumstances.[[32]](#footnote-32)

1. *Personal Autonomy*

As McHugh J in *Marion’s Case*[[33]](#footnote-33)explains, personal autonomy concerns the right to self-determination; that an individual should be free to make his or her own healthcare decisions.[[34]](#footnote-34) Human autonomy is a fundamental idea in Kant’s philosophical writings. Kant argues that acting morally automatically implies that freedom is being exercised and that a full exercise of freedom requires acting morally.[[35]](#footnote-35) In other words, Kant considers morality and freedom, or autonomy, to be inseparable and interdependent concepts.

As this paper involves a discussion of the criminal law, it is worth noting the philosophical approaches to criminalisation. One approach closely associated with personal autonomy is liberalism.[[36]](#footnote-36) Liberalism sees an ideal society as being one in which everyone is able to make their own decisions and create themselves as they wish,[[37]](#footnote-37) with the only constraint on autonomy being when it restricts others from exercising their own autonomy.[[38]](#footnote-38)

1. *Non-Maleficence and Beneficence*

Non-maleficence, ‘above all to do no harm’, is often regarded as the first principle in bioethics,[[39]](#footnote-39) and it has its origins in the Hippocratic oath. Non-maleficence asserts an obligation to not inflict harm on others.[[40]](#footnote-40) The principle captures the notion of harm minimisation; even if an action causes harm, it is justified if it can lead to avoiding a greater harm.[[41]](#footnote-41) Beneficence, on the other hand, is concerned with the obligation to act for the benefit of others.[[42]](#footnote-42) Benefit to the patient is considered the primary goal in medicine and beneficence is its foundational value.[[43]](#footnote-43)

Both beneficence and non-maleficence are closely linked to legal paternalism, an alternative philosophical approach to criminalisation.[[44]](#footnote-44) Legal paternalism advocates that prohibiting conduct is warranted if it causes harm, or promotes the self-interest and well-being, of the actor, even if it is against their will.[[45]](#footnote-45) In other words, state interference with one’s freedom of choice is justified on the grounds that it promotes the welfare of the individuals affected by the laws.[[46]](#footnote-46) A paternalist might argue that consensual injury should not be permitted because it diminishes one’s bodily integrity. For example, the British Medical Association has said:

Mutilating surgical procedures are usually seen as a last resort in cases where a physical disease has been identified. Therefore most doctors have an intuitive aversion to the notion of deliberately removing healthy tissue in the absence of physical disease, even at the patient’s request.[[47]](#footnote-47)

This viewpoint assumes that it is in the patient’s best interests that their body remains whole. It is therefore evident that the societal norm regarding the body is ‘able-bodiedness’.[[48]](#footnote-48) Disability theory expands on this worldview. The medical model, as championed by John Harris, defines disability as the presence of a physical or cognitive difference that negatively deviates from the norm.[[49]](#footnote-49) Disability is regarded as a state of physical limitation that prevents individuals living with a disability from enjoying the pleasures or undertaking the tasks that are available to an able-bodied individual.[[50]](#footnote-50) On the other hand, the social model sees physical difference as important only if there is a discriminatory social reaction to the difference.[[51]](#footnote-51) In other words, it is the reaction to the condition, not the inherent limits it may impose, that is the condition’s signal feature. The ableist view is unable to comprehend the possibility that someone might desire anything other than able-bodiedness. That desire is thought to contradict the fundamental tenets of normative cultural logic in which disability is undesirable and wrong.[[52]](#footnote-52)

Social attitudes and perceptions towards the body and its modifications, however, are constantly evolving and changing over time. For example, at the turn of the twentieth century, physicians considered cosmetic surgery as undermining the fundamental principles of the medical profession.[[53]](#footnote-53) Nowadays, cosmetic surgery is considered commonplace.[[54]](#footnote-54) Furthermore, attitudes towards gender reassignment surgery have changed over time, to the point where legislation is now in place that expressly legalises the surgery.[[55]](#footnote-55) However, both cosmetic surgery and gender reassignment surgery arguably do not confer a disability on the patient. Rather, in the former case, the alterations to the body are generally considered positive or beauty enhancing, and in the latter case it has been said that ‘being a man or a woman is not a disability’.[[56]](#footnote-56) The case of surgery causing disability can be differentiated on the basis that it seeks to render the body less ‘normalised’. According to disability theory, society is unaccepting of that. Therefore, until perceptions of a ‘normal’ body are challenged, medical practitioners will continue to be reluctant to carry out – and society unwilling to accept – certain body modification procedures, regardless of whether the patient has consented.

1. *Justice*

The last of the four principles enunciated by Beauchamp and Childress is justice. Justice encompasses equality – that like cases be treated alike.[[57]](#footnote-57) It can be difficult to determine whether cases are ‘like’ or ‘unlike’. For example, should a non-smoker be given preference for a set of lungs to a smoker? Or should the only consideration be clinical need? Justice requires that the rationing of scarce resources be fair and transparent.[[58]](#footnote-58)

1. Conclusion

The role consent should play in the legality of radical surgeries such as healthy limb amputations can be analysed in terms of the duties of the surgeon, its consequences, the motives of the surgeon, which ethical principles are at stake and how the tension between principles is to be resolved. Furthermore, societal norms and perceptions also have an influence over the morality of surgery. The different approaches place differing weight on the importance of personal autonomy in the law. At present, the law in WA arguably does not place enough weight on personal autonomy, preferring a more paternalistic approach to medical and surgical treatment.[[59]](#footnote-59) Therefore, the purpose of outlining the various ethical frameworks is to determine how personal autonomy, and the other principles discussed in Chapter One, should be optimally reflected in the law.

**CHAPTER TWO**

**RADICAL SURGERY AND CONSENT IN WA**

This chapter aims to describe the law regulating radical surgery in WA, specifically through establishing the role consent plays in justifying radical surgery in the civil and criminal law. While it is acknowledged that radical surgery is also subject to self-regulation within the medical profession,[[60]](#footnote-60) that aspect of regulation is beyond the scope of this paper.

1. Consent and the Civil Law

Consent is a central feature of the civil law relating to bodily interference. Any ‘intentional or reckless, direct act of the defendant which makes or has the effect of causing contact with the body of the plaintiff’[[61]](#footnote-61) constitutes a battery, which is a category of the tort of trespass to the person. Consent to the interference ‘ordinarily has the effect of transforming what would otherwise be unlawful into accepted, and therefore acceptable, contact’.[[62]](#footnote-62) As surgical procedures involve intentional contact with a patient’s body, they constitute a battery unless the patient provides valid consent. Consent to medical treatment is considered valid if the patient has the legal capacity to consent, the consent is freely and voluntarily given, and the consent covers the act performed.[[63]](#footnote-63) All three elements need to be satisfied in order for the consent to be valid.

Regarding the element of capacity, ‘an adult is presumed to have the capacity to consent to or to refuse medical treatment unless and until that presumption is rebutted’.[[64]](#footnote-64) In order to rebut the presumption of capacity, incapacity needs to be found in respect of a particular decision made at the time the consent was sought.[[65]](#footnote-65) It is the quality of the decision-making process that is assessed, not the quality or sense of the decision itself. Irrationality therefore does not preclude capacity.[[66]](#footnote-66) In order to demonstrate sufficient decision-making capacity, one must be able to comprehend and retain information material to the treatment and weigh it up, balancing the risks and benefits of the treatment.[[67]](#footnote-67) Voluntariness refers to a decision freely made by the patient in the absence of undue pressure, coercion or manipulation.[[68]](#footnote-68) Undue influence that amounts to the overbearing of the patient’s will does not result in valid consent. The third element, that the consent covers the act performed, requires that the patient be informed in broad terms of the nature of the procedure to be performed.[[69]](#footnote-69)

Any medical treatment must therefore fall within the scope of the consent. If consent is unable to be obtained in the circumstances, only certain statutes,[[70]](#footnote-70) or necessity or emergency in the absence of statutory authorisation, will preserve the lawfulness of surgery.[[71]](#footnote-71)

1. Consent and the Criminal Law
2. *Criminal Offences Relevant to Radical Surgery*

According to the *Criminal Code*,[[72]](#footnote-72) any interference with the body of another that causes injury is prima facie criminal if the injury satisfies the legal requirements for the offences of assault occasioning bodily harm,[[73]](#footnote-73) wounding,[[74]](#footnote-74) grievous bodily harm (‘GBH’),[[75]](#footnote-75) or wounding or GBH with intent.[[76]](#footnote-76) Technically, these offences may apply to all forms of radical surgery, including those routinely practised and widely accepted.

Wounding is undefined in the *Criminal Code*, and has been defined in case law to cover cutting injuries involving penetration below the epidermis.[[77]](#footnote-77) This definition would cover the vast majority of surgical procedures.Bodily harm is defined as any bodily injury that interferes with health or comfort.[[78]](#footnote-78) The definition encompasses a black eye and a bloodied nose,[[79]](#footnote-79) which may well be a product of facial cosmetic surgery. GBH is defined as ‘any bodily injury of such a nature as to endanger, or be likely to endanger life, or to cause, or be likely to cause, permanent injury to health’.[[80]](#footnote-80) According to *R v Tranby*,[[81]](#footnote-81) permanent injury to health requires impairment to the functioning of the victim’s body, or a disease or ailment. This interpretation would exclude most cosmetic procedures from the definition. However, Macrossan CJ noted that ‘the severing of a finger or the loss of a hand at the wrist’ results in an impairment of the functions of the body,[[82]](#footnote-82) and therefore a leg amputation or gender reassignment surgery would satisfy the offence of GBH.

1. *Consent*

For some offences such as common assault in Western Australia,[[83]](#footnote-83) lack of consent is an element to be proved. If consent is present, that element cannot be satisfied and therefore the offence is not made out.[[84]](#footnote-84) But consent becomes less relevant where the bodily injury is more serious. Code case law in Australia has found that harm greater than bodily harm cannot be consented to, and consent is no defence to bodily harm if the degree of violence extends beyond that consented to.[[85]](#footnote-85) Neither wounding nor GBH have lack of consent as an element of their offence, and there is no general defence of consent provided for in the *Criminal Code*. Therefore, consent is irrelevant for physical injury graver than, and in some circumstances equal to, bodily harm in the criminal law.

1. *Where Does Radical Surgery Fit into the Criminal Law?*
   * 1. *The Medical Defence*

As discussed above, most radical surgeries would fall within the categories of bodily harm, wounding and GBH. In the latter two, consent is irrelevant in determining criminal liability. Technically, this means that consent is not a defence available to surgeons. The *Criminal Code* recognises this, and specifically provides a defence against criminal liability regarding surgical and medical treatment (‘the medical defence’).[[86]](#footnote-86)

The medical defence, s 259 of the *Criminal Code*,reads:

**Surgical and medical treatment, liability for**

1. A person is not criminally responsible for administering, in good faith and with reasonable care and skill, surgical or medical treatment (including palliative care) –
2. to another person for that other person’s benefit; or
3. to an unborn child for the preservation of the mother’s life,

if the administration of the treatment is reasonable, having regard to the patient’s state at the time and to all the circumstances of the case.

1. A person is not criminally responsible for not administering or ceasing to administer, in good faith and with reasonable care and skill, surgical or medical treatment (including palliative care) if not administering or ceasing to administer the treatment is reasonable, having regard to the patient’s state at the time and to all the circumstances of the case.

This paper specifically looks at subsection (1)(a), as it refers to the provision of surgical treatment. The medical defence has never been used to justify surgery in WA, and therefore its application in that context is uncertain. Nonetheless, it appears that it does, at face value, provide some protection to surgeons undertaking surgeries that are considered beneficial or reasonable. But it makes no mention of consent. However, the case of *Brightwater Care Group (Inc) v Rossiter*[[87]](#footnote-87)has determined that consent is a consideration in the medical defence, at least on *Rossiter*’s particular facts.

* + 1. *Rossiter*

*Rossiter* concerned a request by a mentally competent, quadriplegic patient for the cessation of life-sustaining treatment (‘the refusal’) and the provision of palliative care following the withdrawal (‘the demand’). The Brightwater care facility sought a declaration from the Court as to the lawfulness of acceding to Rossiter’s requests.

Martin CJ found that Rossiter had the requisite capacity to make decisions regarding his healthcare, including a refusal of life-sustaining treatment.[[88]](#footnote-88) As a means of justifying Rossiter’s refusal, Martin CJ applied subsection (2) of the medical defence. In doing so, Martin CJ explained that the phrase ‘all the circumstances of the case’ in the medical defence includes the informed decision of a mentally competent patient, and that ‘it is clearly ‘reasonable’ to act in accordance with the informed decision of a mentally competent patient’, having regard to the common law principle of self-determination.[[89]](#footnote-89) In light of those comments, Martin CJ concluded that subsection (2) of the medical defence would provide Brightwater Care Group with a complete defence if they discontinued the provision of nutrition and hydration to Rossiter at his request.[[90]](#footnote-90)

Martin CJ also found that the demand was justified by the medical defence, this time by subsection (1). He observed that palliative care administered with the informed consent of the patient is lawful, as long as it does not cause or hasten the death of the patient.[[91]](#footnote-91) This is significant for radical surgery, as it indicates that subsection (1) is able to accommodate demands for treatment. However, it is unclear whether the judgment is confined to palliative care, or extends to demands for treatment more broadly.

In summary, Martin CJ’s judgment relied on the amendments to the medical defence to accommodate the common law right of a competent patient to refuse treatment,[[92]](#footnote-92) as well as to accommodate a request of a competent patient. While Martin CJ’s approach is problematic – the *Criminal Code* is an exclusive statement of the criminal law, and, where the language is clear, guidance cannot be sought from the common law[[93]](#footnote-93) – consent is now relevant to determining reasonableness of medical treatment and non-treatment in the context of end-of-life care.

* + 1. *Does Rossiter Extend to Radical Surgery?*

*Rossiter* makes it clear that consent is a factor to consider in the medical defence, despite its apparent absence in the provision. However, it is unclear whether *Rossiter* extends past end-of-life care, or is merely confined to its facts.[[94]](#footnote-94) Martin CJ’s interpretation of the medical defence was context-driven; he needed to find a way to accommodate the well-established common law right to self-determination. There is no equivalent right in the case of a demand for radical surgery, and a doctor is under no obligation to treat a patient.[[95]](#footnote-95)

While the scope of the application of *Rossiter* will remain uncertain until expressly resolved by case law or legislation, for the purposes of this chapter it will be assumed that *Rossiter* extends to radical surgery.

* + 1. *Practical Application of the Medical Defence to Radical Surgery*

In order to determine how significant consent is in the justification of radical surgery, it is necessary to apply the medical defence to radical surgery. For the purposes of this analysis, it is assumed that valid consent has been obtained.[[96]](#footnote-96) The first requirement is that the surgical treatment be done ‘in good faith and with reasonable care and skill’. Any surgery performed contrary to this requirement is beyond the scope of this paper, so it will be assumed that the element is satisfied. The additional requirements of benefit and reasonableness are considered in some detail below, using the examples of healthy limb amputation, cosmetic surgery and gender reassignment surgery.

1. *Benefit*

There is a requirement in the medical defence that the surgical treatment be for the patient’s benefit. Whether this requirement is satisfied depends on how benefit is defined. The medical defence has historically received most attention in the context of abortion procedures,[[97]](#footnote-97) and thus benefit has been linked to the preservation of the pregnant woman’s life. Other Commonwealth jurisdictions have interpreted benefit broadly[[98]](#footnote-98) to encompass quality of life in a broader, non-medical sense.[[99]](#footnote-99) It makes sense to interpret benefit broadly, considering that for many widely accepted procedures such as sterilisation or organ donation the patient derives no physical benefit.

1. *Healthy Limb Amputation*

In physical terms, limb amputation as a treatment for BIID sufferers is not beneficial. There are many risks and side effects of the procedure such as pain, excessive bleeding, infection and even death.[[100]](#footnote-100) The surgery is permanent and ‘disabling’, at least in the sense that it puts the patient in a position to be disadvantaged by a society not adequately set up to address their subsequent needs.[[101]](#footnote-101) However, initial evidence to date suggests that limb amputation provides a clear psychological benefit.[[102]](#footnote-102) While any generalisation should be treated with caution in the absence of further studies, it can be said that, for at least some people, the desire is not trivial and can be so intense that it ruins their lives.[[103]](#footnote-103) Another argument in favour of limb amputation is that in some cases it minimises overall harm. For some, the harm of amputation is less than the harm of living with an intense, obsessive desire that often leads to suicidal thoughts.[[104]](#footnote-104) Furthermore, many BIID sufferers will go to extreme and life-threatening lengths to remove an offending limb such as undergoing ‘back alley’ surgeries[[105]](#footnote-105) and self-amputation.[[106]](#footnote-106) The availability of professional surgeons to perform limb amputations thereby would eliminate that risk.

1. *Cosmetic Surgery*

As with healthy limb amputation, there is no physical benefit derived from cosmetic surgery, and there are many surgical risks inherent in the surgery. In many cases, cosmetic surgery is requested merely because the patient desires it rather than for any psychiatric necessity.[[107]](#footnote-107) However, it has been argued that a psychological or social benefit may be derived from the beauty-enhancing surgery, such as increased self-esteem and self-actualisation.[[108]](#footnote-108)

1. *Gender Reassignment Surgery*

Again there is no physical benefit derived from gender reassignment surgery. It is used to treat patients with Gender Dysphoria, which is characterised by a marked difference between an individual’s expressed or experienced gender and the gender others would assign him or her.[[109]](#footnote-109) Therefore, patients with Gender Dysphoria receive a strong psychological benefit from the alignment of their physical body with their ideal image of their body.[[110]](#footnote-110)

1. *Reasonableness*

While *Rossiter* has read consent into the reasonableness requirement, its scope is unclear. There may be a number of other factors that are relevant and which could lead to a finding that radical surgery is unreasonable despite consent being given. The discussion below identifies potential factors other than consent that may contribute to the assessment of reasonableness, using the same examples of healthy limb amputation, cosmetic surgery and gender reassignment surgery. It is, however, difficult to ascribe any particular meaning to reasonableness, given that it is such a contextual measure.

1. *Healthy Limb Amputation*

Healthy limb amputation may be found unreasonable if there are alternative, less drastic treatments available. However, research to date suggests that psychotherapy and drug treatment have had limited success in alleviating the symptoms of BIID.[[111]](#footnote-111) In any case, the fact that desperate BIID sufferers may take matters into their own hands with potentially life-threatening results should weigh on the assessment of reasonableness. Furthermore, other factors such as the extent of the amputation, possible effects of amputation on the patient’s lifestyle, whether alternative treatment was sought prior to seeking surgery, the costs imposed by the amputation on the health care system and on the State[[112]](#footnote-112) and the extent to which BIID impacts on the patient’s life should also be taken into account.[[113]](#footnote-113) It may be that, in certain cases, the disability and negative impact caused by the loss of a limb is a reasonable trade off given the relief from suffering it produces.[[114]](#footnote-114) However, for the most part, amputating a perfectly healthy limb would seem manifestly unreasonable notwithstanding consent.[[115]](#footnote-115)

1. *Cosmetic Surgery*

Factors relevant in determining the reasonableness of cosmetic surgery would include many identified for healthy limb amputation, such as the extent of the surgery, the effects of the surgery on the patient’s lifestyle, any costs borne by the healthcare system and the extent that the bodily ‘flaw’ requiring surgery impacts on the patient’s life. Another important consideration is the number of cosmetic procedures previously undergone. It is not unheard of for patients to become addicted to improving their appearance, often with devastating results.[[116]](#footnote-116) In these situations, cosmetic procedures would fall short of the reasonableness requirement despite consent being obtained.

1. *Gender Reassignment Surgery*

Again, similar considerations to healthy limb amputation would be taken into account in determining the reasonableness of gender reassignment surgery, such as the impact of Gender Dysphoria on the patient’s life, effects of the surgery on the patient’s lifestyle, costs to the public healthcare system and whether the surgery would minimise the risk of harm. However, it is likely that gender reassignment surgery performed on genuine Gender Dysphoria sufferers would be considered reasonable, particularly in light of the fact that their distress is severe, that surgery has proved successful in many cases and that alternative treatments have been found ineffective in 97% of cases.[[117]](#footnote-117)

In summary, it is likely that gender reassignment surgery satisfies the criteria set out in the medical defence. Regardless, it has been expressly legalised in WA.[[118]](#footnote-118) Conversely, it appears that not all cases of cosmetic surgery and healthy limb amputation would fulfil the criteria for benefit and reasonableness. However, cosmetic surgery has been a matter of little concern to the criminal law,[[119]](#footnote-119) and its legality is so firmly entrenched and broadly accepted in practice in Australia[[120]](#footnote-120) that it is unlikely that it could be successfully challenged.[[121]](#footnote-121) Significantly, a central legitimising factor of cosmetic surgery is that patients are self-selecting.[[122]](#footnote-122) ‘Consumers’ of cosmetic surgery are even encouraged to undergo procedures to attain the ideal physical image.[[123]](#footnote-123)

This is contrary to healthy limb amputation; its legality is uncertain in WA. It also faces the greatest challenge satisfying the medical defence, due to the difficulty of justifying the conferral of a disability on a patient.[[124]](#footnote-124) It seems unlikely that the Courts will consider it to be lawful, notwithstanding consent. That is, at least without sufficient evidence of therapeutic benefit or the acceptance of society,[[125]](#footnote-125) neither of which are likely to occur anytime soon.

1. Conclusion

In summary, the place of consent in alleviating liability of a surgeon performing a radical surgery is clear-cut in the civil law in WA, but is less clear in the criminal law. This is due to the irrelevance of consent in the offences that a surgeon would be potentially liable for as a result of performing radical surgeries. Martin CJ in *Rossiter* has read consent into the ‘reasonableness’ requirement of the medical defence. If this extends to radical surgery, consent does have a role in protecting surgeons from criminal liability in these situations. However, the role is insignificant. Consent is only one factor to be taken into account, and when all the considerations are weighed up it is likely that some radical procedures such as a healthy limb amputation will not be found lawful despite consent being given.

**CHAPTER THREE**

**RADICAL SURGERY AND CONSENT IN THE UK**

Chapter Three seeks to explain the role of consent relating to radical surgery in the UK’s criminal law. As canvassed in the Introduction, it is anticipated that the UK will provide a valuable comparison to WA. A jurisdictional comparison is required because of the lack of clarity in the criminal law in WA, as indicated in Chapter Two. As such, the comparison will provide clearer approaches to consent and radical surgery and thus potential avenues for law reform in WA.

1. Consent and the Civil Law

As the civil law position in WA regarding radical surgery and consent is well settled, it is unnecessary to discuss the civil law position in the UK.

1. Consent and the Criminal Law
2. *Criminal Offences Relevant to Radical Surgery*

Besides criminal assault, which is governed by the common law, offences against the person are set out in the UK’s *Offences Against the Person Act 1861* (‘OAPA’).[[126]](#footnote-126) Assault causing bodily harm, wounding and GBH remain undefined in the OAPA. ‘Wound’ has been construed by case law as involving the breaking of the whole skin and not merely the epidermis or the cuticles,[[127]](#footnote-127) and GBH has been defined as really serious bodily harm.[[128]](#footnote-128) Examples of GBH include permanent disability, permanent loss of sensory function, permanent visible non-minor disfigurement, broken bones, compound fractures, a substantial loss of blood and injuries resulting in lengthy treatment or incapacity.[[129]](#footnote-129) The OAPA requires the infliction of a wound or GBH to be malicious and unlawful.[[130]](#footnote-130) Maliciousness is understood to merely mean intentionally,[[131]](#footnote-131) and unlawfully means without lawful excuse.[[132]](#footnote-132) Assault occasioning bodily harm[[133]](#footnote-133) has been defined by case law to include any hurt or injury that is calculated to, or does, interfere with the health or comfort of the victim.[[134]](#footnote-134) The hurt or injury need not be permanent but must be more than transient or trifling.[[135]](#footnote-135) As in WA, radical surgeries meet the criteria for at least one of criminal assault, assault occasioning bodily harm, wounding or GBH in the UK. While consent is a defence to criminal assault,[[136]](#footnote-136) the answer is not so clear for the other offences.

1. *Consent*

The decision in *R v Brown*[[137]](#footnote-137)is the leading authority on consent to injury. It has been the subject of much discussion and criticism over the years. Significantly, there have been two Law Commission Consultation Papers[[138]](#footnote-138) written in response to *Brown* in an attempt to clarify and reform the legal principles in the area. *Brown* concerned a group of men who consensually engaged in sado-masochistic activities that involved the infliction of pain and injury on all the participants’ bodies.

1. *The Majority Judgment in Brown*

The House of Lords, by a three to two majority, determined that consent is no defence to the infliction of harm greater than or equal to bodily harm. Lord Slynn, like the majority, recognised a general rule regarding consent to injuries, but found that ‘the line should be drawn, between really serious injury on one hand and less serious injuries on the other’.[[139]](#footnote-139)

The judges, however, considered there to be special categories to which the general rule does not apply. One such category was surgery. It was recognised that ‘many of the acts done by surgeons would be very serious crimes if done by anyone else, and yet surgeons incur no liability’.[[140]](#footnote-140) This is because the accepted legality of ‘reasonable surgical interference’[[141]](#footnote-141) or ‘proper medical treatment’[[142]](#footnote-142) is justified as ‘needed in the public interest’.[[143]](#footnote-143) In other words, the social utility of the provision of surgical treatment is considered to outweigh any social harm associated with it. However, there is little guidance on the meaning and precise limits of proper and reasonable surgery. This is because, as the Law Commission (‘LC’) noted, the law relating to offences against the person has not often been applied to medical and surgical treatment in the UK in the last century.[[144]](#footnote-144)

The LC suggests various factors that may be important to the medical exemption. The factors were drawn from New Zealand and Canadian criminal provisions regarding surgical treatment.[[145]](#footnote-145) Firstly, the LC identified that a surgeon must have the necessary qualifications in order to perform the surgery.[[146]](#footnote-146) Additionally, the treatment is to be performed with reasonable care and skill, the surgery should be reasonable and the risk of harm should not be disproportionate to the expected benefit derived from the surgery. However, these three factors were considered by the LC to be irrelevant for the purposes of the medical exemption formulation due to them being more pertinent to the law of negligence and the defence of necessity.[[147]](#footnote-147) It seems odd that these factors, particularly that of reasonableness, were discarded, given that the medical exemption has been explicitly referred to as ‘reasonable’ surgical interference. Therefore, arguably, the reasonableness of the surgery should be considered.

The LC also considered that surgery needs to be beneficial to the patient, based on Denning LJ’s comments in *Bravery v Bravery*[[148]](#footnote-148) that the medical exception does not apply to surgery conducted with consent but without just cause and excuse. This idea was thought to perhaps stem from the historical defence of mayhem or maim, which consisted of injury to a part of a man’s body that rendered him less able to defend himself in a fight.[[149]](#footnote-149) Although the defence is considered to be obsolete,[[150]](#footnote-150) the LC noted that it is useful to understand the existence of the defence in an analysis of the limits of consent to surgery without apparent justification.[[151]](#footnote-151)

Furthermore, the LC also found the therapeutic purpose of the treatment to be an important consideration to the exemption. However, this factor was identified as a problem area because of the many examples of regularly performed surgeries that do not have a strict therapeutic purpose.[[152]](#footnote-152)

Importantly, consent was also found to be a factor relevant to the propriety of the surgery. This factor was drawn from the New Zealand defence of consent to surgical and medical treatment.[[153]](#footnote-153) As Lord Mustill articulated in *Bland*, ‘the reason why the consent of the patient is so important is not that it furnishes a defence in itself, but because it is usually essential to the propriety of medical treatment’.[[154]](#footnote-154) In other words, ‘the consent of the patient to the injury may usually be a necessary, but it is certainly not a sufficient, condition of that [medical] exemption’.[[155]](#footnote-155) The other factors mentioned above also need to be satisfied, according to the LC’s analysis of what is required for treatment to be considered ‘proper’.

However, this approach seems unsatisfactory. What about situations where not all factors identified by the LC are able to be satisfied and yet the treatment is considered lawful? For example, where a blood transfusion is provided to an unconscious patient,[[156]](#footnote-156) or non-therapeutic cosmetic surgery is provided to a consenting patient.[[157]](#footnote-157) It seems contrary to well-established legal principles to require all the LC’s factors to be satisfied in order for surgery to be considered ‘proper’. Rather, consent should be the sole consideration, with the other factors becoming relevant only in the absence of consent. This would bring the criminal law more in line with well-entrenched common law principles.[[158]](#footnote-158)

1. *Lord Mustill’s Approach*

Lord Mustill, in the minority, argued that questions of private morality have no place in determining the criminality of the activities:

The state should interfere with the rights of an individual to live his or her life as he or she may choose no more than is necessary to ensure a proper balance between the special interests of the individual and the general interests of the ... populace at large.[[159]](#footnote-159)

Lord Mustill found that the OAPAwas not an appropriate avenue by which to prosecute the appellants,[[160]](#footnote-160) because the consensual private acts were not offences against the existing laws of violence.[[161]](#footnote-161) The public interest did not require the conduct to be prohibited by the criminal law. In other words, consensual infliction of harm should be outside the realm of the criminal law unless the public interest requires otherwise.

1. *Where Does Radical Surgery Fit into the UK’s Criminal Law?*
2. *The Medical Exemption*

In order for radical surgery to fall within the medical exemption in the UK, the factors identified by the LC as amounting to ‘proper’ treatment need to be satisfied. Assuming the surgeon has the relevant qualifications and performs the surgery with due care and skill, the remaining factors of proportionality, reasonableness, benefit, therapeutic purpose and consent need to be satisfied. These are also relevant considerations in the medical defence in the *Criminal Code* (WA), therefore the analysis in Chapter Two is applicable to this chapter.However, unlike the *Criminal Code* (WA), where the role of consent is uncertain in the context of radical surgery, consent is an essential element in the UK’s medical exemption.

According to the analysis in Chapter Two, gender reassignment surgery to treat Gender Dysphoria would satisfy benefit, therapeutic purpose and reasonableness, and would thus fall within the UK’s medical exemption. Furthermore, gender reassignment surgery has been expressly deemed lawful in the UK.[[162]](#footnote-162) On the other hand, cosmetic surgery and healthy limb amputations are not always beneficial, reasonable or therapeutic and would therefore not always fall within the medical exemption. This is not so problematic for cosmetic surgery, which has been found lawful notwithstanding that it may have no obvious therapeutic benefit.[[163]](#footnote-163) However, for radical surgeries such as healthy limb amputation that do not fall within the medical exemption, and are not otherwise lawful, the general rule in *Brown* would render the surgery prima facie unlawful regardless of the consent of the patient.

1. *Lord Mustill’s Approach*

As an alternative to the majority’s approach*,* Lord Mustill’s reasoning can be applied to healthy limb amputation. This approach was followed in *R v Wilson*,[[164]](#footnote-164) where it was found not to be in the ‘public interest’ that the consensual branding of initials on a spouse’s buttocks be made the subject of the criminal law. Following this line of argument, it needs to be determined whether the public interest requires radical surgery such as healthy limb amputation to be criminalised, or whether criminalising the conduct would ‘serve no useful purpose at considerable public expense’.[[165]](#footnote-165)

On one hand, healthy limb amputation can be seen as being in the public interest due to its social utility. Arguably, it is merely an extension of *Wilson* whereby a person is exercising the right to control their body. There is a high social value placed on personal choice and autonomy. Surgeons and hospitals are only involved because they are the best place to get safe and tidy amputations.[[166]](#footnote-166) Furthermore, it is likely to relieve suffering, as well as reduce the risk of self-amputation or unregulated amputation in unsanitary conditions.

On the other hand, the social utility can be countervailed by the social disadvantages of healthy limb amputation, which are against the public interest. The public has an interest in the preservation of the bodily integrity of the human body,[[167]](#footnote-167) as indicated by the historical offence of maim. Healthy limb amputation is drastic, irreversible and disabling. Furthermore, it causes distress to the family of the patient, a strain on medical staff and the resources of skill and labour required, and it takes away money that could be spent improving the conditions of other patients.[[168]](#footnote-168) There are also many health risks associated with amputation, costs imposed on society and the public healthcare system, the possibility of regret by the patient and a lack of empirical knowledge in relation to the disorder and the appropriateness and success of surgery.[[169]](#footnote-169)

In summary, the public has an interest in ensuring that individuals are strong and healthy, are not a charge on society and are able to live independently. This is countered by the public interest in fostering autonomy, facilitating the treatment of illness and allowing individuals to live according to their social and personal identity. In *Re T*[[170]](#footnote-170) it was recognised that where there is ‘a conflict between two interests, that of the patient and that of the society in which he lives… it is well established that in the ultimate the right of the individual is paramount’.[[171]](#footnote-171) This comment was made in the context of a refusal of medical treatment, however, it applies to medical dilemmas generally. Consequently, Lord Mustill’s approach may justify radical surgeries such as healthy limb amputation.

However, perhaps the greatest hurdle to applying Lord Mustill’s approach to healthy limb amputation is that of public perception. Knowing that such surgeries exist invoke natural feelings of revulsion and offence from society. The request is not a common desire, nor is amputation a common aspiration. There is still little research concluding that BIID is a real disorder and that limb amputation is a legitimate treatment. This lack of understanding may impact on Judicial or Legislatorial consideration, which is invariably influenced by society and social attitudes.[[172]](#footnote-172) While unjustified personal opinions or lack of knowledge should not have any influence on the key public policy considerations identified above, it may be that only when (and if) healthy limb amputation becomes acceptable to society, would it have a chance of being made legal.

1. Conclusion

The majority judgment in *R v Brown* has found that consent is irrelevant to bodily harm or serious bodily harm in the UK. There is a medical exception to the general rule, but even if radical surgery falls within the exception, consent on its own does not make the surgery lawful. Although it is an essential prerequisite, other factors such as benefit and therapeutic purpose are also given weight. It has been illustrated that these other factors would likely render certain radical surgeries unlawful, such as healthy limb amputation, despite consent having been given. Lord Mustill’s minority judgment provides that consent is central to the lawfulness of radical surgery unless the public interest requires otherwise. This approach is more liberal than that of the majority, and thus gives radical surgery a greater chance of success as a legal form of medical intervention. Nonetheless, it still has the difficulty of overcoming the hurdle of public perception.

**CHAPTER FOUR**

**A CRITIQUE OF THE *CRIMINAL CODE* AND RECOMMENDATIONS FOR REFORM**

Consent has a central role in justifying surgery in the civil law in WA, thus protecting the important principle of personal autonomy. On the other hand, consent’s role in WA’s criminal law appears insignificant and unsatisfactory. Consistent with its origins as a defence of medical necessity, the medical defence does not expressly mention consent; only benefit and reasonableness are relevant considerations. *Rossiter* has included consent as a factor to contemplate, however it is unclear if *Rossiter* has application past its particular facts. Even if *Rossiter* does extend to radical surgery, consent is merely one factor to consider. The weight given to the other factors means that radical surgery may be unlawful in certain circumstances despite consent being given.

The purpose of this chapter is to identify the gaps and flaws in the *Criminal Code,* and to provide suggestions for reform,drawing from the law in the UK and the ethical principles discussed in Chapter One.

1. Is the *Criminal Code* Satisfactory?
2. *The Medical Defence is Intended for Incompetent Patients*

This paper argues that the medical defence is an inappropriate vehicle by which to justify medical and surgical treatment provided to competent patients, because it is intended for *in*competent patients. In other words, it is intended to operate as a defence of medical necessity. The defence is underpinned by the concepts of best interests and proportionality, reflected by the words ‘for the benefit of’ and ‘reasonable’. These principles are predominant in the treatment of incompetent patients.[[173]](#footnote-173)

Further support for this proposition can be found by looking at the Parliamentary Debates surrounding the provision’s insertion into the *Criminal Code* in 1998. The Attorney-General at the time, the Honourable Peter Foss, commented that the medical defence ‘is not about consent…[it] is governed by circumstances’.[[174]](#footnote-174) In other words, it is intended to apply in circumstances where consent cannot be obtained. This is further evidenced by comments in the Second Reading Speech to the Act amending the medical defence in 2008,[[175]](#footnote-175) articulating that the amendments were aimed at protecting health professionals in cases where consent or refusal of consent has not been given.[[176]](#footnote-176) Therefore, it is apparent that Parliament’s intention was for the medical defence to be appled to incompetent patients. As such, it is inappropriate to use the medical defence in situations where a patient is able to consent.

1. *Critique of Martin CJ’s Judgment in Rossiter*

Assuming *Rossiter* applies to radical surgery,consent has become a relevant consideration in the medical defence. As a result, it now applies to competent patients in addition to its historical function as a defence of medical necessity. Practically, Martin CJ’s approach is understandable. While the medical defence justifies doctors’ treatment or non-treatment of incompetent patients, there is no provision in the *Criminal Code* dealing with the medical decisions of competent patients. That seems nonsensical and inconsistent. *Rossiter* serves to highlight these inadequacies in the *Criminal Code.* However, Martin CJ’s attempt at filling in the gap by accommodating competent medical decisions is unsatisfactory with problematic implications.

Blake identifies two main problems with Martin CJ’s judgment in *Rossiter.* Firstly, providing scope for consent within the reasonableness requirement merges a subjective concept with an objective concept.[[177]](#footnote-177) It is not conceptually viable for consent, which may in itself be unreasonable, to be a consideration in determining reasonableness. Additionally, by merging the concepts of reasonableness and benefit, which comprises the doctor’s duties, with consent, the right of the patient becomes incorporated into the duties of the doctor.[[178]](#footnote-178) At common law the reverse is true. Medical treatment is justified primarily by the consent of the patient and only if that right to self-determination is unavailable do the doctor’s duties become relevant.[[179]](#footnote-179) The merging of rights and duties means that competent patients and incompetent patients are treated indiscriminately and that valid consent is not sufficient to justify medical treatment in the *Criminal Code*.

Furthermore, putting aside the conceptual difficulties with Martin CJ’s judgment, the scope of consent in the medical defence is ambiguous as well as inadequate. It is at the very least unclear as to whether consent is sufficient to justify all kinds of medical treatment and surgery. More likely is the situation that some types of medical treatment and surgery, such as healthy limb amputations, will not satisfy the medical defence regardless of consent.

In summary, the medical defence in WA, even with *Rossiter’s* accommodation of consent, appears an inappropriate and inadequate means by which to justify the medical decisions of competent patients. Personal autonomy is not afforded the weight it deserves. It should form the foundation for competently made medical decisions, as it does in the common law, rather than merely being added as a gap ‘filler’ within the medical necessity defence.

1. Recommendations for Reform
2. *The Current Law in the UK*

In order to determine how the *Criminal Code* should approach consent in the context of radical surgery, guidance can be sought from the law in the UK. In the UK, there are two contrasting approaches. The majority in *Brown* considered consent to be irrelevant to bodily interference amounting to bodily harm or more serious bodily harm,[[180]](#footnote-180) with ‘reasonable surgical interference’[[181]](#footnote-181) or ‘proper medical treatment’[[182]](#footnote-182) forming an exception to the general rule. Factors relevant to the medical exemption include consent, but while it is considered a precondition to the satisfaction of the exception, it is only one of various factors that contribute to the propriety of surgery. Other considerations include reasonableness, benefit to the patient and therapeutic purpose.

On the other hand, Lord Mustill in *Brown* took a more liberal stance to consent*.* Lord Mustill considered that any consensual bodily interference should be presumed lawful unless it is in the public interest that a particular act be unlawful regardless of consent. While the majority in *Brown* did not endorse Lord Mustill’s approach, his reasoning has since been applied in *Wilson*.[[183]](#footnote-183)

1. *Which Approach Should WA Adopt?*
2. *Ethical Considerations*

In order to determine the approach WA should adopt, it is necessary to consider which approach best reflects the ethical principles and theories relevant to radical surgery. Chapter One identified deontology, utilitarianism, virtue ethics and principlism as means by which to approach the role of consent to radical surgery.

1. *Which Ethical Theory Should be Applied?*

Deontology, utilitarianism and virtue ethics are all rule-based theories. Each of them offers valuable perspective on solving medical dilemmas by applying a general rule to any given situation. However, radical surgery is a complex, ethically ambiguous area. The application of a single rule does not satisfactorily contextualise the problem, nor gives adequate consideration to all the ethical principles relevant to the situation. For example, deontology may justify radical surgery on the basis that it respects personal autonomy, but it does not explain why personal autonomy is an appropriate consideration in the specific context. Furthermore, it does not consider whether the conduct in question is beneficial or just in the circumstances. Utilitarianism endorses radical surgery if it maximises human welfare in society, but the wishes of the individual patient are afforded minimal weight.[[184]](#footnote-184) Virtue ethics validates radical surgery if it is undertaken for virtuous reasons, but like utilitarianism, personal autonomy is not a dominant consideration.[[185]](#footnote-185)

On the other hand, the principlist approach takes into account the whole range of general considerations that concern moral agents.[[186]](#footnote-186) The principles are applied in the context of the specific situation and provide guidance relevant to the particular circumstances. For these reason, principlism is the most appropriate framework by which to analyse consent to radical surgery.

1. *Application of the Principlist Approach*

The principlist approach identifies personal autonomy, beneficence, non-maleficence and justice as the basic principles that require consideration in any situation. The four principles need to be analysed in terms of healthy limb amputation, gender reassignment surgery and cosmetic surgery in order to determine the best approach to radical surgery (‘the proposed law’).

1. *Personal Autonomy*

Respecting personal autonomy requires the wishes of the patient to be taken into account. In all three examples of radical surgery, it is assumed that the patient desires the surgery and it is therefore in line with respecting personal autonomy.

1. *Non-Maleficence and Beneficence*

The duties of non-maleficence and beneficence would oblige the surgeon not to harm, but to benefit, the patient. These principles do not always endorse radical surgery. As analysed in Chapter Two, not all types of radical surgery are physically beneficial or therapeutic to the patient and only in some circumstances are they considered psychologically beneficial, in the sense that the surgery alleviates mental distress. Furthermore, all surgeries cause physical harm and only in some circumstances is overall harm minimised due to the risk of self-surgery or ‘back-alley’ procedures. Performing such surgeries may also have adverse effects on surgeons, who generally consider themselves healers who would not harm without a strong, widely accepted therapeutic justification.[[187]](#footnote-187) However, even if there was a law that expressly legalised radical surgeries such as healthy limb amputations, this would not compel surgeons to perform the surgeries – they would still have the choice to refuse.[[188]](#footnote-188) Instead, the law would serve to protect those surgeons who did elect to perform the surgeries from criminal liability.

1. *Justice*

Justice involves the allocation of scarce resources, which include the medical staff involved in the surgery, as well as the costs imposed on the public health system and society. Gender reassignment surgery on patients with Gender Dysphoria is in line with justice, because Gender Dysphoria is an official disorder and the alleviation of serious distress and suffering cannot be considered a waste of scarce resources. While BIID is thought to involve a similar level of suffering to Gender Dysphoria,[[189]](#footnote-189) the fact that it is not fully accepted as a genuine condition,[[190]](#footnote-190) or has not been adequately ‘medicalised’, might lead to the view that healthy limb amputation is futile and a waste of valuable resources and thus is inconsistent with justice.

There are also many costs associated with healthy limb amputation, such as the costs borne by the public health system as a result of the operation and rehabilitation, ongoing medical treatment and the costs of providing disability-friendly facilities.[[191]](#footnote-191) There may also be costs imposed on society through potentially reduced productivity, social welfare, income benefits, employment assistance and disability payments.[[192]](#footnote-192) While these costs are not insignificant, the rarity of BIID is such that only a small minority of people would seek an amputation and so the overall costs would be relatively minor.[[193]](#footnote-193) Furthermore, the costs associated with surgery may be offset by the reduction in consumption of other medical services, post-surgery, such as psychiatric care[[194]](#footnote-194) and those associated with fixing self-amputations or ‘back-alley’ amputations gone wrong.

Cosmetic surgery could also be viewed as unnecessary surgery and consequently inconsistent with justice, on the basis that life-saving or illness-curing surgery should be given precedence over beauty-enhancing procedures.

1. *Which Principle(s) Should be Given Pre-Eminence?*

It is apparent from the application of the four principles that not all of them justify radical surgery. In order to resolve the conflict, it is necessary to prioritise the principles. Although all four principles are regarded as being of equal value,[[195]](#footnote-195) case law has emphasised the importance and pre-eminence of personal autonomy in the medical arena.

As stated in *Marion’s Case*:[[196]](#footnote-196)

[A] person has rights of control and self-determination in respect of his or her body which other persons must respect … thus, the legal requirement of consent to bodily interference protects the autonomy … of the individual and limits the power of others to interfere with the person’s body.[[197]](#footnote-197)

Furthermore, case law has suggested that medical law has a preference for personal autonomy over the other principles. For example, it was stated in *Re T*, and endorsed in *Rossiter*, that:

The patient’s interest consists of his right to self-determination – his right to live his own life how he wishes, even if that will damage his health or lead to his premature death.[[198]](#footnote-198)

As the law clearly protects personal autonomy and the right to self-determination in the medical context, and given that consent has always been at the heart of medical and surgical intervention, personal autonomy should be given the greatest weight in the proposed law. For this reason, Lord Mustill’s more liberal approach is preferred over that of the majority.

1. *Should Personal Autonomy be Constrained by the Other Principles?*
2. *Non-Maleficence and Beneficence*

Justifying criminal intervention in terms of harm and benefit is in line with paternalism. Paternalism advocates that conduct should be prevented if it is against the self-interest and wellbeing of the subject of the law, regardless of the person’s wishes.[[199]](#footnote-199) This paper argues that the paternalistic promotion of welfare should not constrain the liberal preference for respecting personal autonomy. While it is conceivable that an individual may be mistaken as to their own best interests and consequently act to the detriment of their wellbeing,[[200]](#footnote-200) paternalism’s commitment to promoting best interests has some troubling repercussions.

Firstly, at what point does this commitment stop? Many people make lifestyle choices that are not consistent with their best interests, such as smoking, drinking alcohol or eating fatty foods. However, it is not the place of the criminal law to turn every member of society into, as the LC terms it, ‘superfit clean living spartans whether we like it or not’.[[201]](#footnote-201) The Legislature should not use its unique position of power to mould society the way it sees fit. The fact that a practice is not mainstream or conventional should not justify its criminalisation, provided the participants are willing.

Another problem with paternalism is that it would likely advocate that radical surgeries such as healthy limb amputation should not be permitted because of the disability it confers. This view is in line with disability theory, and represents an ableist view of the body.[[202]](#footnote-202) That is, that no rational person would desire any deviation from the ideal body template and a desire for disability is incomprehensible, objectionable and plainly wrong.[[203]](#footnote-203) However, the ableist view presupposes a normative conception of bodily integrity.[[204]](#footnote-204) It does not take into account the possibility that there are different perceptions of a ‘normal’ body. For example, Smith’s two patients reported feeling more normal, whole and better able to function in society after their amputations.[[205]](#footnote-205) While their bodies may have been impaired, they do not see themselves as having a disability. Furthermore, for many people with disabilities, the disability forms part of their identity and cannot merely be separated from their person.[[206]](#footnote-206) For example, for people living with deafness, their inability to hear or verbally communicate is merely a fact, and may not diminish their quality of life or ability to function in society.[[207]](#footnote-207) Instead, it has been claimed that living with deafness has advantages that more than compensate for the auditory limits it provides, such as being part of a community built around a shared language and experience.[[208]](#footnote-208)

There can also be physical advantages to having a disability. For example, Oscar Pistorius, a double amputee, wanted to participate in the 2008 Olympic games using high-tech prosthetic limbs. His eligibility to participate was challenged by the International Association of Athletics Federations on the basis that his racing blades would provide an unfair advantage over those with natural legs.[[209]](#footnote-209) While the challenge was unsuccessful, this serves to illustrate that a disability should not always be considered a barrier; it may sometimes even provide an advantage over able-bodied individuals.

Furthermore, disability can be considered merely a matter of degree and timing rather than a deviation.[[210]](#footnote-210) The process of growing old brings with it the potential for disability such as relative loss of sight, hearing and mobility. Therefore, it is not something a person ‘has’ or ‘does not have’. A person may experience differing degrees of disability throughout the course of their life.

For the above reasons, beneficence and non-maleficence should not be prominent in the proposed law. Only in cases where the right to autonomy does not exist due to incompetence should the duties of beneficence and non-maleficence apply. This situation has already been provided for in the medical defence*.* The proposed law aims to bridge the gap in the *Criminal Code* by providing a justification for medical and surgical treatment regarding competent patients. Thus, the proposed law should favour liberalism over paternalism: the right to personal autonomy should be the dominant ethical principle reflected in the proposed law.

1. *Justice*

Justice, as opposed to beneficence and non-maleficence, should be given due consideration in the proposed law. This is because Lord Mustill’s approach requires that public policy considerations be taken into account. However, justice should not be considered in the initial inquiry of determining lawfulness. According to Lord Mustill, public policy is only relevant in determining whether conduct can be deemed unlawful and therefore justice should only be considered at that stage.

1. *Critique of the ‘Quantitative Approach’*

In addition to the fact that personal autonomy should have pre-eminence in the law, Lord Mustill’s approach in *Brown* is favoured because the majority’s approach has a number of flaws. The majority took a ‘quantitative approach’ to bodily interference; that there is a limit to the degree of injury one can lawfully consent to, outside of specific exceptions to which the general rule does not apply. The majority found that the line should be drawn at bodily harm. Lord Slynn in the minority also embraced a quantitative approach, but drew the line at serious bodily harm. While a general rule applicable to a variety of different situations arguably avoids confusion and uncertainty in its application, this paper contends that the quantitative approach is conceptually and practically undesirable for the reasons outlined below.

1. *Severity of Harm Conclusive of Wrongfulness?*

The quantitative approach assumes that a uniform standard, the severity of the injury, is applicable to a wide range of different situations. However, severity is not necessarily the most persuasive indicator of the wrongfulness of an act.[[211]](#footnote-211) The nature of an injury will differ depending on the situation. Thus, all the circumstances of the case should be taken into account in determining whether the act is wrongful. The quantitative approach only takes such considerations into account at a later stage in the inquiry; to determine whether the conduct forms an exception to the general rule. Arguably, it is counterproductive to only consider the circumstances after the act has already been presumed unlawful. It is more logical to consider all relevant factors in initially determining whether the conduct is lawful, as in Lord Mustill’s approach. This eliminates the need for a two-step inquiry, as all circumstances are considered in the first step.

1. *Reversal of Onus*

By automatically presuming an act to be unlawful if it amounts to bodily harm or greater, the general rule prejudices the outcome before it has begun.[[212]](#footnote-212) The onus of proof is placed on the defence and guilt is presumed until the defence can prove innocence by showing that his or her conduct fell within one of the special categories of exemption. This is contrary to the traditional criminal law presumption, which places the onus on the prosecution and presumes innocence until guilt is proven. By reversing the onus of proof, the defence is placed in an unfair and disadvantaged position from the outset. Lord Mustill’s methodology is more in line with the criminal law presumption, as it places the onus of proof on the person advocating for criminalisation. This places surgeons in a fairer position to defend their conduct.

1. *Practical Consequences of the Quantitative Approach*

The quantitative approach is overly elaborate,[[213]](#footnote-213) which has troubling implications. Prescribing a general rule with exceptions requires that much time and effort be spent by the Legislature considering and providing for all conceivable exceptions. This exercise is not cost or time efficient and runs the risk that any number of situations may be missed in the process. If a particular exception is omitted from the list by oversight, or if a particular type of conduct is unable to fit into an existing exception, that conduct will be considered a criminal offence by default. This may unfairly prejudice minority groups or participants of relatively unheard of, unconventional practices that have not yet been brought to the attention of the Legislature. Lord Mustill’s approach avoids such implications. As Russel LJ observed in *R v Wilson*:[[214]](#footnote-214)

The law should develop upon a case by case basis rather than upon general propositions to which, in the changing times in which we live, exceptions may arise from time to time not expressly covered by authority.[[215]](#footnote-215)

Lord Mustill’s approach allows for consideration of novel situations as and when they catch the attention of the Legislature. Until such time, no individual or group is unfairly prejudiced.

1. The Proposed Law

Consent to radical surgery is a matter of public policy ‘for the legislature to decide’.[[216]](#footnote-216) As foreshadowed above, it is proposed that Lord Mustill’s approach in *Brown* be adopted in the *Criminal Code,* specifically in the context of medical and surgical treatment. In other words, a provision should be inserted that justifies medical and surgical treatment on the basis of consent. For consistency, the wording should follow that used in the medical defence. It should read as follows:

**Consent to Surgical and Medical Treatment**

A person is not criminally responsible for administering, in good faith and with reasonable care and skill, surgical or medical treatment (including palliative care) to another person with that person’s consent, if the administration of the treatment is lawful.

Using this approach, all surgical and medical treatment will be considered lawful unless expressly deemed unlawful through legislation. This provision would consequently justify all radical surgeries, as long as valid consent has been obtained.

The addition of a consent provision will move the regulation of radical surgery away from the criminal law. Health professionals would likely know their patients better than any member of the Legislature and should thus be the ones entrusted with the decision-making. The consent provision will allow health professionals to have full discretion as to the appropriate treatment for their patients without fear of criminal sanctions.

The addition of the term ‘lawful’ is to avoid any unintentional implications of inserting the provision such as legalising euthanasia or other activities that are already accepted as being unlawful in WA. If the Legislature wants to render a particular treatment or surgery unlawful for reasons of public policy, it would need to enact legislation expressly outlawing the conduct, much like how female genital mutilation has been expressly outlawed.[[217]](#footnote-217) This is because ‘circumstances must alter cases’[[218]](#footnote-218) – all circumstances must be taken into account before concluding that an injury constitutes a criminal offence, not just the degree of harm. Each individual fact situation needs to be considered, and relevant arguments for and against criminalisation must be evaluated on their merits.

While beyond the scope of this paper, it is also suggested that the proposed law include a subsection that deals with the non-administration of treatment. This would bridge the gap in the *Criminal Code* regarding refusals of life-sustaining treatment.[[219]](#footnote-219)

**CONCLUSION**

Surgeons performing radical surgeries at a patient’s request are at risk of criminal sanctions in WA. If the surgery is not beneficial or is unreasonable, surgeons may be found criminally liable notwithstanding that consent has been obtained. This is because there is a gap in the *Criminal Code* regarding surgical and medical treatment for competent patients. Martin CJ in *Rossiter* has recognised this gap. However, by reading consent into the medical defence, it has not been satisfactorily bridged. As such, the *Criminal Code* requires reform.

In ascertaining the appropriate avenue for reform, direction can be obtained from the criminal law in the UK. The UK provides two contrasting approaches to consent to medical and surgical treatment in *R v Brown*; one more liberal and the other more paternalistic. As personal autonomy requires supremacy in the proposed law, Lord Mustill’s liberal approach is preferred to that of the majority. Furthermore, the majority’s quantitative approach has flaws solvable by Lord Mustill’s approach. As such, Lord Mustill’s approach should be committed to legislation in WA, in the form of a consent provision inserted into the *Criminal Code.*

This would mean that all types of radical surgery would be prima facie legal in the presence of consent. While the implications of this would not be so significant for gender reassignment surgery and cosmetic surgery, which are already legal in WA, such reform would have great significance for controversial surgeries such as healthy limb amputation. Apart from Robert Smith, most Western surgeons refuse to perform such procedures.[[220]](#footnote-220) If it became clear that healthy limb amputations would not attract criminal sanctions, the increasing number of BIID sufferers would have a greater chance of finding a willing surgeon to comply with their request. This would bring them closer to achieving freedom from their intense suffering and distress.

If the Legislature wishes to outlaw a particular type of radical surgery, it would need to do so expressly, having regard to public policy considerations such as whether the surgery is consistent with the notion of justice. However, such considerations should not be coloured by preconceived ideas of a ‘normal’ body. Everyone has different views on how they wish their body to look. For some members of society, this might exclude certain body parts. As long as it is not inconsistent with justice, the Legislature should not be able to prohibit steps taken by members of society to attain their ideal body image. After all, ‘every human being of adult years and sound mind has a right to determine what shall be done with his own body’.[[221]](#footnote-221)

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12. Bennett, above n 7, 15. [↑](#footnote-ref-12)
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50. Ibid 372. [↑](#footnote-ref-50)
51. Ibid 370. [↑](#footnote-ref-51)
52. Bogdanoski, above n 33, 509. [↑](#footnote-ref-52)
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75. *Criminal Code* s 297. [↑](#footnote-ref-75)
76. *Criminal Code* s 294. [↑](#footnote-ref-76)
77. *Devine v R* [1982] Tas R 155, 157–8 (Green CJ). [↑](#footnote-ref-77)
78. *Criminal Code* s 1(1). [↑](#footnote-ref-78)
79. *Lergesner v Carroll* [1991] Qd R 206. [↑](#footnote-ref-79)
80. *Criminal Code* s 1(1). [↑](#footnote-ref-80)
81. [1992] Qd R 432. [↑](#footnote-ref-81)
82. Ibid 438. [↑](#footnote-ref-82)
83. *Criminal Code* s 313. See s 222 for definition of assault. [↑](#footnote-ref-83)
84. Although note s 223 states that the presence of consent will not prevent an assault from taking place. [↑](#footnote-ref-84)
85. *Lergesner v Carroll* [1991] Qd R 206. [↑](#footnote-ref-85)
86. *Criminal Code* s 259. [↑](#footnote-ref-86)
87. (2009) 40 WAR 84. [↑](#footnote-ref-87)
88. Ibid [13]-[14]. [↑](#footnote-ref-88)
89. Ibid [44]. [↑](#footnote-ref-89)
90. Ibid [48]. [↑](#footnote-ref-90)
91. Ibid [53]. [↑](#footnote-ref-91)
92. Meredith Blake, 'Doctors liability for homocide under the WA Criminal Code: defining the role of defences' (2011) 35 *University of Western Australia Law Review* 287, 309. [↑](#footnote-ref-92)
93. See e.g. the Queensland cases of *R v Martyr* [1962] Qd R 398 and *Shane Barlow* (1997) 93 A Crim R 113, 136 (Kirby J) – they are also relevant to WA. [↑](#footnote-ref-93)
94. The extension of *Rossiter* to radical surgical procedures has been considered in Blake, above n 33, and applied in Theodore Bennett, ‘It’s but a flesh wound: criminal law and the conceptualisation of healthy limb amputation’ (2011) 36(3) *Alternative Law Journal* 15. [↑](#footnote-ref-94)
95. *Re J* [1991] Fam 15. See also Western Australia, *Parliamentary Debates,* Legislative Council, 6 December 2006, 9244-9245 (Hon Sue Ellery, Parliamentary Secretary) where it was expressly stated that the *Acts Amendment (Consent to Medical Treatment) Act 2008* (WA) does not change the common law position regarding a demand for treatment. [↑](#footnote-ref-95)
96. However, it has been questioned whether BIID sufferers are able to give valid consent: see e.g. D Patrone, 'Disfigured anatomies and imperfect analogies: Body Integrity Identity Disorder and the supposed right to self-demanded amputation of healthy body part' (2009) 35 *Journal of Medical Ethics* 541. [↑](#footnote-ref-96)
97. Blake, above n 33, 306. [↑](#footnote-ref-97)
98. See for example *Crimes Act 1961* (NZ) s 61 and *Criminal Code,* RSC 1985, c C-46 s 45. [↑](#footnote-ref-98)
99. Aimee L Bryant, 'Consent, autonomy, and the benefits of healthy limb amputation: examining the legality of surgically managing Bodily Integrity Identity Disorder in New Zealand' (2011) 8 *Bioethical Inquiry* 281, 284. [↑](#footnote-ref-99)
100. Bennett, above n 35, 161. [↑](#footnote-ref-100)
101. Ibid. [↑](#footnote-ref-101)
102. In First’s recent study of BIID sufferers, 6 of the subjects had limb amputations in accordance with their wishes, and all of them made it clear that they were satisfied with the outcome. First reported comments such as ‘I am absolutely ecstatic’, ‘the only regret is that I did not have it earlier’, ‘I have felt the best I’ve ever felt’ and ‘it finally put me at peace’: MB First, Desire for amputation of a limb: paraphilia, psychosis or a new type of identity disorder’ (2005) 35 *Psychological Medicine* 919. Furthermore, both of Robert Smith’s patients were reported as having been very happy with their operations, one noting ‘I have happiness and contentment and life is so much more settled, so much easier. I have not regretted the operation one bit’: Josephine Johnston and Carl Elliott, ‘Healthy limb amputation: ethical and legal aspects’ (2002) 2(5) *Clinical Medicine* 431, 431. [↑](#footnote-ref-102)
103. Johnston and Elliott, above n 43, 432. [↑](#footnote-ref-103)
104. Ibid. [↑](#footnote-ref-104)
105. For example, in the Californian case of *People v Brown* 91 Cal App 4th 246 (2001)*,* a 79-year-old patient sought a ‘back alley’ leg amputation from a Californian surgeon whose medical licence had been revoked. The patient died a few days after the operation from gas gangrene as a result of improper wound care and dirty surgical conditions. [↑](#footnote-ref-105)
106. Instances have been reported of self-removal of limbs using chainsaws, shotguns, woodchoppers, dry ice and other dangerous methods: Tracey Elliott, 'Body Dismorphic Disorder, radical surgery and the limits of consent' (2009) 17 Medical Law Review 149, 163. [↑](#footnote-ref-106)
107. G Williams, *Textbook of Criminal Law* (London: Stevens & Sons, 2nd ed, 1983) 589-591. [↑](#footnote-ref-107)
108. Aileen Kennedy, ‘Regulating bodily integrity: cosmetic surgery and voluntary limb amputation’ (2012) 20 *Journal of Law and Medicine* 350, 356. [↑](#footnote-ref-108)
109. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Publishing, 5th ed, 2013). [↑](#footnote-ref-109)
110. Bryant, above n 40, 285. [↑](#footnote-ref-110)
111. First, above n 43; Bennett, above n 35, 161. [↑](#footnote-ref-111)
112. Costs may include social welfare benefits for lost income, cost of wheelchairs, employment assistance, medical costs, assistance in the home, childcare and disability pensions. [↑](#footnote-ref-112)
113. Bryant, above n 40, 285. [↑](#footnote-ref-113)
114. Johnston and Elliott, above n 43, 432. [↑](#footnote-ref-114)
115. Elliott, above n 47, 175. [↑](#footnote-ref-115)
116. For example, the socialite Jocelyn Wildenstein had so many cosmetic procedures on her face that she unintentionally transformed herself into a ‘catwoman’. The surgery involved more than seven facelifts, drastic eye reconstruction surgery and collagen injections in her lips, cheeks and chin, costing around $4 million: Sarah Bull, 'Toning down her feline side: catwoman Jocelyn Wildenstein goes for a more subdued look on date night', *Daily Mail* (Online), 12 December 2012 <http://www.dailymail.co.uk/tvshowbiz/article-2246837/Catwoman-Jocelyn-Wildenstein-goes-subdued-look-date-night.html>. [↑](#footnote-ref-116)
117. Bryant, above n 40, 285. [↑](#footnote-ref-117)
118. The legality of gender reassignment surgery has been put beyond doubt following a series of cases in which patients who have undergone gender reassignment surgeries have challenged a refusal by the Gender Reassignment Board to issue a recognition certificate under s 15 of the *Gender Reassignment Act 2000* (WA). See *AH v State of Western Australia* (2011) 281 ALR 694; *AB v State of Western Australia* (2011) 244 CLR 390. No medical practitioner has been found criminally liable for performing gender reassignment surgery in a proper case, and such treatment is partially funded by Medicare. [↑](#footnote-ref-118)
119. Sally Sheldon and Stephen Wilkinson, 'Female genital mutilation and cosmetic surgery: regulating non-therapeutic body modification' (1998) 12(4) *Bioethics* 263, 270. [↑](#footnote-ref-119)
120. Kennedy, above n 49, 353. [↑](#footnote-ref-120)
121. Sheldon and Wilkinson, above n 60, 269. [↑](#footnote-ref-121)
122. Kennedy, above n 49, 356. [↑](#footnote-ref-122)
123. Elliott, above n 47, 182. [↑](#footnote-ref-123)
124. Emily Jackson, Medical Law: Text, Cases and Commentary (Oxford University Press, 2nd ed, 2010) 219. [↑](#footnote-ref-124)
125. Johnston and Elliott, above n 43, 433. [↑](#footnote-ref-125)
126. *Offences Against the Person Act 1861* (UK) (24 & 25 Vict. c. 100). [↑](#footnote-ref-126)
127. *JJC (A minor) v Eisenhower* [1983] 3 All ER 230. [↑](#footnote-ref-127)
128. *DPP v Smith* [1961] AC 290. [↑](#footnote-ref-128)
129. Richard Card, *Card, Cross & Jones: Criminal Law* (Paperback, 2012) 198. [↑](#footnote-ref-129)
130. See s 18 of the OAPA for the offence of wounding or inflicting GBH with intent to inflict GBH and s 20 for the offence of wounding or inflicting GBH. [↑](#footnote-ref-130)
131. *R v Mowatt* [1968] 1 QB 421. [↑](#footnote-ref-131)
132. Card, above n 4, 184. [↑](#footnote-ref-132)
133. See s 47 of the OAPA for indictment of an assault occasioning bodily harm. [↑](#footnote-ref-133)
134. *R v Donovan* [1934] 2 KB 498, 509 (Swift J). [↑](#footnote-ref-134)
135. Ibid. [↑](#footnote-ref-135)
136. Criminal assault involves the intentional or reckless application of unlawful force to the body of another person: Card, above n 4, 176. [↑](#footnote-ref-136)
137. [1994] 1 AC 212. [↑](#footnote-ref-137)
138. Law Commission, *Consent and Offences Against the Person,* Consultation Paper No 134 (1993); Law Commission, *Consent in the Criminal Law,* Consultation Paper No 139 (1995). [↑](#footnote-ref-138)
139. *R v Brown* [1994] 1 AC 212, 280. [↑](#footnote-ref-139)
140. Ibid 266 (Lord Mustill). [↑](#footnote-ref-140)
141. *Attorney-General's Reference (No. 6 of 1980)* [1981] QB 715, 719 (Lord Lane CJ). [↑](#footnote-ref-141)
142. *Airedale National Health Services Trust v Bland* [1993] AC 789, 892 (Lord Mustill). [↑](#footnote-ref-142)
143. *Attorney-General's Reference (No. 6 of 1980)* [1981] QB 715, 719 (Lord Lane CJ). [↑](#footnote-ref-143)
144. Law Commission, *Consent in the Criminal Law,* Consultation Paper No 139 (1995) 102. [↑](#footnote-ref-144)
145. *Crimes Act 1961* (NZ) ss 61 and 61A; *Criminal Code,* RSC 1985, c C-46 ss 45 and 216. [↑](#footnote-ref-145)
146. Law Commission, *Consent in the Criminal Law,* Consultation Paper No 139 (1995) 106. [↑](#footnote-ref-146)
147. Ibid 107. Reasonable care and skill is the general test for medical negligence, and notions of reasonableness and proportionality are apparent in the defence of necessity. [↑](#footnote-ref-147)
148. [1954] 1 WLR 1169. [↑](#footnote-ref-148)
149. *R v Brown* [1994] 1 AC 212, 262 (Lord Mustill). [↑](#footnote-ref-149)
150. Ibid. [↑](#footnote-ref-150)
151. Law Commission, *Consent in the Criminal Law,* Consultation Paper No 139 (1995) 108. [↑](#footnote-ref-151)
152. Ibid. [↑](#footnote-ref-152)
153. *Crimes Act 1961* (NZ) s 61A. [↑](#footnote-ref-153)
154. *Airedale National Health Services Trust v Bland* [1993] AC 789, 891. [↑](#footnote-ref-154)
155. Law Commission, *Consent and Offences Against the Person,* Consultation Paper No 134 (1993) [2.4]. [↑](#footnote-ref-155)
156. This situation would be covered by the defence of emergency: Ben White, Fiona McDonald and Lindy Willmott, Health Law in Australia (Thomson Reuters, 2010) 108. [↑](#footnote-ref-156)
157. *Lacy v Laird* 139 NE 2d 25 (Ohio, 1956). Furthermore, it has been justified on the basis that the English law unconsciously recognises that criminal law has no place in regulating such procedures: see Law Commission, *Consent in the Criminal Law,* Consultation Paper No 139 (1995) 111. [↑](#footnote-ref-157)
158. See e.g. *Re T* [1992] 4 All ER 649. [↑](#footnote-ref-158)
159. *R v Brown* [1994] 1 AC 212, 273. [↑](#footnote-ref-159)
160. Ibid 258. [↑](#footnote-ref-160)
161. Ibid 275. [↑](#footnote-ref-161)
162. *Corbett v Corbett* [1971] P 83 (Ormrod J). Furthermore, the *Gender Recognition Act 2004* (UK),which enables gender dysphoria sufferers to obtain a certificate recognising their newly acquired gender, makes mention of and thus legitimises gender reassignment surgery: see s 3(3). [↑](#footnote-ref-162)
163. See above n 32. [↑](#footnote-ref-163)
164. [1997] QB 47. [↑](#footnote-ref-164)
165. Ibid 51 (Russel LJ). [↑](#footnote-ref-165)
166. Josephine Johnston and Carl Elliott, 'Healthy limb amputation: ethical and legal aspects' (2002) 2(5) Clinical Medicine 431, 433. [↑](#footnote-ref-166)
167. Annemarie Bridy, 'Confounding extremities: surgery at the medico-ethical limits of self-modification' (2004) 32 The Journal of Law, Medicine and Ethics 149, 150. [↑](#footnote-ref-167)
168. *Airedale National Health Services Trust v Bland* [1993] AC 789, 896 (Lord Mustill). [↑](#footnote-ref-168)
169. Aimee L Bryant, 'Consent, autonomy, and the benefits of healthy limb amputation: examining the legality of surgically managing Bodily Integrity Identity Disorder in New Zealand' (2011) 8 Bioethical Inquiry 281, 282. [↑](#footnote-ref-169)
170. *Re T* [1992] 4 All ER 649. [↑](#footnote-ref-170)
171. Ibid [26]. [↑](#footnote-ref-171)
172. Bryant, above n 44, 282. [↑](#footnote-ref-172)
173. Meredith Blake, 'Doctors liability for homocide under the WA Criminal Code: defining the role of defences' (2011) 35 *University of Western Australia Law Review* 287, 291. [↑](#footnote-ref-173)
174. Western Australia, *Parliamentary Debates,* Legislative Council, 1 April 1998, 1192/1 (Hon Peter Foss, Attorney-General). [↑](#footnote-ref-174)
175. *Acts Amendment (Consent to Medical Treatment) Act 2008* (WA). This Act inserted subsection 2 of s 259, and also made significant changes to the *Guardianship and Administration Act 1990* (WA)*.* [↑](#footnote-ref-175)
176. Western Australia, *Parliamentary Debates,* Legislative Council, 6 December 2006, 9244-9245 (Hon Sue Ellery, Parliamentary Secretary). [↑](#footnote-ref-176)
177. Blake, above n 1, 312. [↑](#footnote-ref-177)
178. Ibid 313. [↑](#footnote-ref-178)
179. *Marion's Case* (1992) 175 CLR 218, 259. [↑](#footnote-ref-179)
180. *R v Brown* [1994] 1 AC 212. [↑](#footnote-ref-180)
181. *Attorney-General's Reference (No. 6 of 1980)* [1981] QB 715, 719 (Lord Lane CJ). [↑](#footnote-ref-181)
182. *Airedale National Health Services Trust v Bland* [1993] AC 789, 889 (Lord Mustill). [↑](#footnote-ref-182)
183. *R v Wilson* [1997] QB 47. [↑](#footnote-ref-183)
184. Jonathan Herring, *Medical Law and Ethics* (Oxford University Press, 2nd ed, 2008) 15. [↑](#footnote-ref-184)
185. Emily Jackson, *Medical Law: Text, Cases and Commentary* (Oxford University Press, 2nd ed, 2010) 13. [↑](#footnote-ref-185)
186. Ben White, Fiona McDonald and Lindy Willmott, *Health Law in Australia* (Thomson Reuters, 2010) 45. [↑](#footnote-ref-186)
187. Robert C Smith, 'Less is More: Body Integrity Identity Disorder' in Stephen W Smith and Ronan Deazley (eds), *The Legal, Medical and Cultural Regulation of the Body: Transformation and Transgression* (Ashgate, 2009) 147, 153. [↑](#footnote-ref-187)
188. There is no right to demand treatment, see *Re J* [1991] Fam 15. [↑](#footnote-ref-188)
189. MB First, ‘Desire for amputation of a limb: paraphilia, psychosis or a new type of identity disorder’ (2005) 35 *Psychological Medicine* 919. [↑](#footnote-ref-189)
190. Josephine Johnston and Carl Elliott, 'Healthy limb amputation: ethical and legal aspects' (2002) 2(5) *Clinical Medicine* 431, 431. [↑](#footnote-ref-190)
191. Aimee L Bryant, 'Consent, autonomy, and the benefits of healthy limb amputation: examining the legality of surgically managing Bodily Integrity Identity Disorder in New Zealand' (2011) 8 *Bioethical Inquiry* 281, 282. [↑](#footnote-ref-191)
192. Sabine Muller, ‘Body Integrity Identity Disorder (BIID) – is the amputation of healthy limbs ethically justified?’ (2009) 9(1) *The American Journal of Bioethics* 36, 41. [↑](#footnote-ref-192)
193. Bryant, above n 19, 288. [↑](#footnote-ref-193)
194. Smith, above n 15, 153. [↑](#footnote-ref-194)
195. Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (Oxford University Press, 6th ed, 2009) 99. [↑](#footnote-ref-195)
196. (1992) 175 CLR 218. [↑](#footnote-ref-196)
197. Ibid 309. [↑](#footnote-ref-197)
198. *Re T* [1992] 4 All ER 649, [26]. [↑](#footnote-ref-198)
199. Law Commission, *Consent in the Criminal Law,* Consultation Paper No 139 (1995) 263. [↑](#footnote-ref-199)
200. Ibid 264. [↑](#footnote-ref-200)
201. Ibid. [↑](#footnote-ref-201)
202. Tony Bogdanoski, ‘Every *body* is different: regulating the use (and non-use) of cosmetic surgery, body modification and reproductive genetic testing’ (2009) 18(2) *Griffith Law Review* 503, 517. [↑](#footnote-ref-202)
203. Ibid 509. [↑](#footnote-ref-203)
204. Tom Koch, ‘Disability and difference: balancing social and physical constructions’ (2001) 27(6) *Journal of Medical Ethics* 370, 370. [↑](#footnote-ref-204)
205. Tracey Elliott, ‘Body Dismorphic Disorder, radical surgery and the limits of consent’ (2009) 17 *Medical Law Review* 149, 172. [↑](#footnote-ref-205)
206. Bogdanoski, above n 30, 517. [↑](#footnote-ref-206)
207. Koch, above n 32, 372. [↑](#footnote-ref-207)
208. Ibid 373. [↑](#footnote-ref-208)
209. *Oscar Pistorius: Athlete, Activists, Fastest Man on No Legs* (9 September 2008) Beijing 2008 Paralympic Games <http://en.paralympic.beijing2008.cn/news/special/features/n214592913.shtml>. [↑](#footnote-ref-209)
210. Koch, above n 32, 371. [↑](#footnote-ref-210)
211. Law Commission, *Consent in the Criminal Law,* Consultation Paper No 139 (1995) 274. [↑](#footnote-ref-211)
212. Ibid. [↑](#footnote-ref-212)
213. Ibid 248. [↑](#footnote-ref-213)
214. [1997] QB 47. [↑](#footnote-ref-214)
215. Ibid 50 (Russel LJ). [↑](#footnote-ref-215)
216. *R v Brown* [1994] 1 AC 212, 282 (Lord Slynn). [↑](#footnote-ref-216)
217. See *Criminal Code* s 306. [↑](#footnote-ref-217)
218. *R v Brown* [1994] 1 AC 212, 270 (Lord Mustill). [↑](#footnote-ref-218)
219. See Blake, above n 1, for the desirability of a consent provision that justifies refusals of life-sustaining treatment. [↑](#footnote-ref-219)
220. Theodore Bennett, ‘It’s but a flesh wound: criminal law and the conceptualisation of healthy limb amputation’ (2011) 36(3) *Alternative Law Journal* 158, 158. [↑](#footnote-ref-220)
221. *Schloendorff v The Society of the New York Hospital* 211 NY 125 (1914), 129-130 (Cardozo J). [↑](#footnote-ref-221)