

ARTICLE

Transability in New Zealand

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How might recognition of the transabled identity be reconciled with modern understandings of medicolegal ethics, and if a case were to present in New Zealand, to what extent should we sanction disabling surgeries for the alleviation of psychological suffering?

I Introduction

Historically, consent to bodily harm in Western societies has been objectionable both as matters of values and law.¹ Over time, attitudes and understandings about health and disability have evolved, allowing certain low-level bodily harm (such as cosmetic surgery, elective amputation and gender reassignments) to be regarded as accepted and lawful.² However, the ability to consent to *grievous* bodily harm continues to be a long-standing debate. In *R v Lee*, the Court of Appeal suggested that consent to intentionally inflicted grievous bodily harm is likely to be found in “relatively rare” circumstances.³ One of these rare circumstances potentially arises in the case of transability.

Transability refers to a community of otherwise “healthy” people who identify as being disabled, and have an overwhelming lifelong desire to become disabled, often through the amputation of one or more limbs.⁴ Those with transability elect to live a life of disability rather than the life imposed on them by happenstance.⁵ As suggested by scientific data, the need to become disabled is so strongly manifested that individuals attempt to sever their limbs by laying over train tracks, using shotguns, dry ice, chainsaws and wood

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1 *R v Lee* [2006] 3 NZLR 42 (CA) at [198] and [219] regarding tattooing and piercing.

2 Robin Mackenzie “Somatechnics of Medico-legal Taxonomies: Elective Amputation and Transableism” (2008) 16 *Med L Rev* 390 at 390–391 and 398.

3 *Lee*, above n 1, at [304].

4 Michael B First “Desire for amputation of a limb: paraphilia, psychosis, or a new type of identity disorder” (2004) 34 *Psychological Medicine* 1 at 1.

5 Robin MacKenzie and Stephen Cox “Transableism, disability and paternalism in public health ethics: taxonomies, identity disorders and persistent unexplained physical symptoms” (2007) 2 *International Journal of Law in Context* 363 at 368.

chippers, or blinding themselves with acid.⁶ This is done with the aim of becoming authentically disabled rather than merely pretending.⁷

The first recorded instance of transability was in 1785. An Englishman offered 100 guineas to a French surgeon named Jean-Joseph Sue to amputate his otherwise healthy leg.⁸ Jean refused, and it was not until the Englishman held Jean at gunpoint that he reluctantly amputated the Englishman's leg.⁹ Following the operation, the Englishman thanked Jean and told him that by cutting off his leg he had removed an invisible barrier to his happiness.¹⁰

Michael First and Carl Fisher recovered anecdotal evidence from a sample of individuals afflicted with what became known as body identity integrity disorder, one of whom reported personally knowing at least 200 individuals with this condition.¹¹ While figures are obscure and numerically small, each represents a potentially fundamental challenge to our current understanding of disability, identity and medicolegal ethics.¹²

This article examines how we should conceptualise transability within broader disability discourse, the existing legal protections for compassionate surgeons, and the potential for public funding of disabling surgeries that seem to contradict public health policy. Part II of this article argues that the existing empirical evidence presents a strong case for recognising a new identity dysphoria comparable to gender dysphoria, and as such should be treated similarly under the law. Part III argues that general disability discourse should apply the neutral model, which incidentally validates transability within that discourse. Part IV then considers the key legal issues: the lawfulness of surgeries under the criminal law and public funding issues. It will be argued that the current state of the law in public funding is problematic and legislative change is necessary to address it.

II Conceptualising Transability

Those first confronted with the idea of transability immediately reject it as they often view the individual's desires as fraudulent or morally bankrupt. Therefore, recognition of transability in social and economic structures is likely to also be rejected unless there is a foundational understanding of the science around the condition.

Transability is not yet a clinically recognised psychiatric condition, largely due to the lack of research into the condition. Michael First published the first scientific investigation of transability in 2004.¹³ The study assessed 52 individuals with self-identified transability to ascertain the preliminary characteristics.¹⁴ This expanded on anecdotal evidence in an attempt to propose transability as a new and distinct identity disorder to be included in the upcoming edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM),¹⁵ which is an authoritative diagnostic guide created by the American Psychological

6 First, above n 4, at 4.

7 At 4.

8 Josephine Johnston and Carl Elliot "Healthy limb amputation: ethical and legal aspects" (2002) 2 Clin Med JRCPL 431 at 431.

9 At 431.

10 At 431.

11 Michael B First and Carl E Fisher "Body Integrity Identity Disorder: The Persistent Desire to Acquire a Physical Disability" (2012) 45 Psychopathology 3 at 5.

12 First and Fisher, above n 11.

13 First, above n 4.

14 At 1.

15 At 9.

Association on clinically recognised psychological disorders.¹⁶ First's proposed label for the condition was body identity integrity disorder (BIID)—a condition resulting from the disconnect between an individual's actual body and the psychological schema of that body.¹⁷

First and Fisher's 2012 study suggested that a diagnosis of BIID required the patient to have "persistent discomfort or intense feelings of inappropriateness concerning [their] current nondisabled body".¹⁸ Diagnosis also required persistent and intense desires to have a significant disability, beginning in early adolescence.¹⁹ However, "[t]he desire to become disabled is *not* primarily motivated by sexual arousal or ... perceived advantages of becoming disabled."²⁰ The desire is "not a manifestation of a psychotic process ... [and] is not due to a primary neurological condition such as poststroke neglect syndrome",²¹ nor is it currently accounted for by any other mental disorder such as body dysmorphic disorder,²² or factitious disorder.²³ BIID results in one or more of the following harmful consequences:²⁴

- The preoccupation with the desire to be disabled significantly interferes with the person's productivity, leisure activities or social functioning; or
- The person puts his or her health or life at significant risk by attempting to actually become disabled.

These criteria distinguish BIID from other recognised disorders whilst articulating a commonality with gender identity disorder (GID).²⁵ GID is defined as a psychological disorder where a person demonstrates clear and "persistent identification with the opposite sex", accompanied by a "persistent discomfort (dysphoria) with his or her own sex or sense of inappropriateness in the gender role of that sex".²⁶ GID demonstrates comparable behavioural patterns to BIID. The strong desires to present as or change one's gender in GID²⁷ is similar to the strong desire to become disabled in BIID. A strong dislike

16 American Psychiatric Association "About *DSM-5*" <www.psychiatry.org>.

17 First, above n 4, at 8.

18 First and Fisher, above n 11, at 12.

19 At 12.

20 At 12 (emphasis added).

21 At 12.

22 Body dysmorphic disorder belongs to the disorder class of obsessive-compulsive and related disorders. It refers to the "[p]reoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others." This obsessive "preoccupation causes clinically significant distress or impairment in social, occupational or other areas of functioning". Substance Abuse and Mental Health Services Administration Center for Behavioral Health Statistics and Quality *DSM-5 Changes: Implications for Child Serious Emotional Disturbance* (June 2016) at 54.

23 "Factitious disorder (FD) is a psychiatric disorder in which sufferers intentionally fabricate physical or psychological symptoms in order to assume the role of the patient, without any obvious gain. Patients with FD often gain hospital admission and undergo invasive procedures and surgeries exposing themselves to a considerable risk of iatrogenic harm." Ivano Caselli and others "Epidemiology and evolution of the diagnostic classification of factitious disorders in DSM-5" (2017) 10 *Psychology Research and Behaviour Management* 387 at 387 (footnote omitted).

24 First and Fisher, above n 11, at 12.

25 At 6.

26 S J Bradley and K J Zucker "Gender Identity Disorders" in Neil J Smelser and Paul B Baltes (eds) *International Encyclopedia of the Social & Behavioral Sciences* (online ed, Elsevier Science, 2001) 6011 at 6011.

27 American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders: DSM-5™* (5th ed, American Psychiatric Association, Arlington, 2013) at 452.

of one's own sexual anatomy and secondary sexual characteristics in GID²⁸ is also similar to the strong dislike of one's disabled body in BIID—both resulting in a desire to change the said characteristics. These similarities shall be considered in turn, and serve to establish transability as a legitimate dysphoria, stemming from a subjective discrepancy between actual and perceived identity.

First, the most important similarity is the clinically significant distress or impaired functioning experienced by the individual, which is termed as dysphoria.²⁹ The DSM-IV-TR, which is the fourth edition of the DSM, was revised for over 13 years and was republished in 2013 as the DSM-5. This revision omitted BIID and renamed GID as gender dysphoria (GD).³⁰ This represents an important conceptual shift, emphasising that the problem is not the identity but rather the dysphoric feelings which serve as catalysts for other detrimental health effects.³¹ In turn, treating GD does not entail rejecting the gender identity but rather, it facilitates self-acceptance to mitigate the dysphoric feelings.³² A similar conceptual framing may be appropriate for BIID.

Secondly, both BIID and GD sufferers demonstrate strong, persistent and lifelong discomfort with their current bodily configuration. Of those with BIID, 98 per cent reported having their desires commence by the age of 16.³³ Those with GD are broadly classified into early and late onset categories—late onset being defined as arising post-puberty, which suggests that almost all transgender individuals experience dysphoric feelings before reaching adulthood,³⁴ and thus can properly be regarded as lifelong desires similar to BIID.

Thirdly, BIID is distinguished from sexual disorders such as apotemnophilia and acrotomophilia,³⁵ because the primary reason for acquiring a disability is to “match their body to their identity”.³⁶ GD is distinguished from other disorders where cross-dressing is primarily motivated by erotic desires,³⁷ because those with GD choose to cross-dress as a means of relieving stress and living more authentically.³⁸ Therefore, both BIID and GD are analogous in the sense that they stem from disorder identity rather than disturbed sexual fantasies.

28 At 452.

29 For example, the definition of dysphoria in the context of gender dysphoria “refers to a psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity”. American Psychiatric Association “What is Gender Dysphoria?” <www.psychiatry.org>.

30 Zowie Davy and Michael Toze “What Is Gender Dysphoria? A Critical Systematic Narrative Review” (2018) 3 *Transgender Health* 159 at 159.

31 Kenneth J Zucker, Anne A Lawrence and Baudewijntje PC Kreukels “Gender Dysphoria in Adults” (2016) 12 *Annu Rev of Clin Psychol* 217 at 223.

32 See, for example, the support available for people experiencing gender dysphoria. American Psychiatric Association, above n 29.

33 First, above n 4, at 6.

34 Thomas D Steensma and others “Gender identity development in adolescence” (2013) 64 *Hormones and Behavior* 288.

35 Apotemnophilia is a disorder describing “the general concept of sexual arousal from the fantasy of being an amputee”, while Acrotomophilia is a disorder describing “sexual attraction to amputees”. First and Fisher, above n 11, at 4; and Mackenzie, above n 2, at 410.

36 First, above n 4, at 8.

37 Donald R Laub and Norman Fisk “A Rehabilitation Program for Gender Dysphoria Syndrome by Surgical Sex Change” (1974) 53 *Plastic and Reconstructive Surgery* 388 at 390.

38 George R Brown “Transvestism: (Transvestic Disorder)” (April 2021) MSD Manual Consumer Version <www.msmanuals.com>.

Fourthly, BIID is also distinguished from other forms of psychological disorders which manifest in a desire for amputation. The BIID label does not apply to conditions such as schizophrenia, which may induce a person to cut off a limb at the direction of a sub-conscious voice, or poststroke neglect.³⁹ BIID is also different to body dysmorphic disorder, which refers to an obsession over a perceived flaw of the individual,⁴⁰ because individuals with body dysmorphic disorder recognise the limb as being healthy and are not ashamed of its existence.⁴¹ Factitious disorder is also distinguished from BIID as BIID sufferers are not motivated by the desire for medical attention, treatment or sympathy from healthcare professionals, but rather with achieving an authentic sense of self.⁴²

Fifthly, a diagnosis of BIID requires that the person has impaired productivity, leisure, or social functioning, or that the person risks their health and life by taking steps to become disabled.⁴³ The diagnostic criteria for GD similarly demand that patients experience “clinically significant distress or impairment in social, school, or other important areas of functioning”.⁴⁴ This criterion almost word-for-word reflects the experience of those with BIID, but through a different mode of identity.

Finally, those with GD have elevated prevalence of self-aggression, depression and suicidality relative to cis-gendered peers, and this has been correlated strongly to social factors such as peer and family rejection.⁴⁵ First’s study displayed reports of depression and anxiety among those with BIID, seemingly related to the effects of incongruence between mind and body.⁴⁶ One might assume that such feelings would be exacerbated by the presence of negative social factors in light of the fact most participants had never reported their desires to their therapists.⁴⁷ Given these similarities between BIID and GD, and the similar experiences of rejection by society and internal rejection of self, there is benefit in hypothesising the prospective success of disabling procedures for transabled people. Disabling procedures for people with BIID may be successful in the same way that gender-affirming surgeries and hormonal treatments are successful for people experiencing GD.

Those wishing to transition typically begin with hormonal interventions such as puberty blockers, and testosterone or oestrogen supplements in order to alter secondary sexual characteristics in favour of their experienced gender—this phase being largely reversible.⁴⁸ A 2018 study found that there was no statistically significant decline in self-aggression in transgendered individuals after four months of hormone replacement

39 See generally Wade C Myers and Matthew Nguyen “Autocastration as a Presenting Sign of Incipient Schizophrenia” (2001) 52 *Psychiatric Services* 685; and see generally Daniel B Hier, Janice Mondlock and Louis R Caplan “Behavioral abnormalities after right hemisphere stroke” (1983) 33 *Neurology* 337.

40 Jon E Grant, Suck Won Kim and Scott J Crow “Prevalence and Clinical Features of Body Dysmorphic Disorder in Adolescent and Adult Psychiatric Inpatients” (2001) 62 *J Clin Psychiatry* 517 at 517.

41 First, above n 4, at 8.

42 First and Fisher, above n 11, at 8–9.

43 At 12.

44 American Psychiatric Association, above n 27, at 452.

45 Ramona Hampp “The effects of hormone replacement therapy on reactive aggression, self-aggression/depression and aggression inhibition in gender dysphoria — a retrospective study” (Master of Arts Thesis, University of Vienna, 2018).

46 First, above n 4, at 7–8.

47 At 7.

48 Griet De Cuypere and others “Sexual and Physical Health After Sex Reassignment Surgery” (2005) 34 *Archives of Sexual Behavior* 679 at 679.

therapy.⁴⁹ In contrast, gender-affirming surgeries have very high satisfaction rates⁵⁰ and lowered the prevalence of psychopathological and psychiatric disorders to the same levels as cis-gendered counterparts.⁵¹ Another study of 232 transgender individuals, who underwent sex reassignment surgery, reported that 41 per cent were happy with their surgery and only three per cent reported that the surgery did not change or had worsened their quality of life.⁵² The efficacy of these surgical interventions are further improved when protective factors such as social support were present.⁵³

Each of the transabled individuals in First's study who have had a disabling surgery reported satisfaction with the results and no desires for additional amputations.⁵⁴ Whilst these results are largely anecdotal and few in number, when viewed alongside the high prevalence of pretending behaviours, it appears that simulating the disabled experience for psychological relief may somewhat sufficiently satisfy the desire to actually become disabled, but not completely. This mirrors the trends within GD, for example, where cross-dressing and hormonal therapies provide psychological relief. However, many still desire permanent surgical interventions because it delivers extremely high levels of on-going satisfaction and improved quality of life at a subjective level.⁵⁵

Surgical interventions for BIID are an extreme means to an end and the efficacy of which cannot be demonstrated unless it is attempted. As explained above, the evidence available suggests that disabling surgeries would have positive patient outcomes which quell harmful co-morbidities and allow the individual to live authentically. Depending on the nature of the disability, a less invasive treatment which could be made available is the numbing of the lower limbs through anaesthetics, but this is circumstantial. Given the significant parallels between BIID and GD, there is a strong case for BIID to become a recognised dysphoria that could be adequately treated through surgical disablement.

Part III will now explore how transability may be conceptualised within a contemporary disability theoretical framework, specifically looking at the medical, social and neutral models of disability.

III Theoretical Perspectives of Disability

The term "disability", as defined by the Human Rights Act 1993 (HRA), includes any abnormality of the psychological process.⁵⁶ By falling within this statutory definition, a person becomes entitled to anti-discrimination rights protection under the HRA. BIID fits

49 Hampp, above n 45, at 8.

50 Jochen Hess and others "Satisfaction With Male-to-Female Gender Reassignment Surgery: Results of a Retrospective Analysis" (2014) 111 *Deutsches Ärzteblatt International* 795; and Tim C van de Grift and others "Surgical Satisfaction, Quality of Life, and Their Association After Gender-Affirming Surgery: A Follow-up Study" (2018) 44 *Journal of Sex & Marital Therapy* 138.

51 Charles Mate-Kole, Maurizio Freschi and Ashley Robin "A Controlled Study of Psychological and Social Change after Surgical Gender Reassignment in Selected Male Transsexuals" (1990) 157 *British Journal of Psychiatry* 261 at 263-264; and Annelou LC de Vries and others "Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment" (2014) 134 *American Academy of Pediatrics* 696 at 702.

52 Anne A Lawrence "Factors Associated With Satisfaction or Regret Following Male-to-Female Sex Reassignment Surgery" (2003) 32 *Archives of Sexual Behavior* 299 at 305.

53 van de Grift and others, above n 50, at 139.

54 First, above n 4, at 8.

55 See, for example, van de Grift and others, above n 50, at 143.

56 Section 21(1)(h).

within this statutory definition and holds a heightened degree of legitimacy. It is unique in the sense that treatment does not involve alleviating the disability label altogether, but rather shifting the classification of disability from “psychological” to actual “physical disability” under the HRA.⁵⁷

By adopting an expansive definition of what constitutes disability, the Legislature appears to draw a common thread within a highly heterogenous community for the purpose of strategic essentialism. Strategic essentialism is a generalisation about a community for the purposes of using political weight to advance the collective interest of the majority.⁵⁸ This is problematic because essentialism presumes that all persons experiencing biological or psychological impairment creates a negative experience, and anti-discrimination protections are needed to remedy against the effects of impairment. This presumption limits our ability to see impairment in a positive light, or for disabled individuals to own their identity beyond merely the context of transability. The HRA fails to reconcile with the idea that impairment may be empowering to some individuals. Effectively, the statutory definition of disability treats impairment as disabling, and therefore, creates a net-negative life experience for the afflicted individual irrespective of how they might feel.

This article will outline the medical, social and neutral models of disability, and argue that the neutral model is the least essentialised of the three. It incidentally allows for a more nuanced approach to disability based on the notion of subjective suffering.

A *The medical model*

The medical model defines disability with a heavy emphasis on medical diagnosis over the perspectives of patients,⁵⁹ and it may be regarded as the primary model of public health systems around the world as most disability frameworks still take a very clinical approach. The disabled community under this model “have nothing in common” with one another other than the fact that their biological functioning is deemed statistically abnormal relative to the reference population.⁶⁰ One becomes disabled by definition, rather than by experience.

Scientific models define “normal” as data that is “no more than two standard deviations from the mean of the population”, which necessitates that about five per cent of the population is biologically abnormal for any given trait.⁶¹ These statistical approaches are essential in shaping policy within a priority-based healthcare system such as New Zealand’s, but it is arguably not appropriate in conceptualising disability. The medical model lacks accuracy because it was created by able-bodied people to essentialise the disabled experience and make policy decisions simpler. It assumes that the same negative experience gives greater normative weight to the allocation of public funds to assisting this community.

57 Section 21(1)(h)(i).

58 Oxford Reference “Overview: Strategic Essentialism” <www.oxfordreference.com>.

59 See Simon Brisenden “Independent Living and the Medical Model of Disability” (1986) 1 Disability, Handicap & Society 173 at 173; and see Andrew J Hogan “Social and medical models of disability and mental health: evolution and renewal” (2019) 191 CMAJ E16 at E16.

60 Brisenden, above n 59, at 175.

61 Anita Silvers “On the Possibility and Desirability of Constructing A Neutral Conception of Disability” (2003) 24 Theoretical Medicine 471 at 484; and see generally Perry R Hinton *Statistics Explained* (3rd ed, Routledge, New York, 2014) at 57.

The medical model is well-intentioned, but its simplicity is the source of several incoherencies. An example of a logical extreme is hypothetically classifying red-haired population as a “disabled community” because they represent one to two per cent of the general population,⁶² despite red hair not having disabling effects. Similarly, Anita Silvers argues that the ruling in *Jordan v City of New London*—which held that a relatively higher intellectual ability disabled an applicant from being admitted into the police academy—creates a situation where someone may be disabled through over-qualification.⁶³ Lastly, the arbitrariness of the medical model is demonstrated by the 1998 re-defining of the Body Mass Index thresholds, which rendered 55 per cent of Americans as overweight overnight without them having gained any weight or altered subjective experience.⁶⁴

The second failing of the medical model is how it reinforces a restrictive and paternalistic understanding of what biological impairments can be considered as disabling or enabling. “Disability” is a question of social fact from a medical point of view—the label being subsequently imposed without consulting the subject’s experience. This system promotes an ideology where the doctor is assumed to know best while the patient is merely a passive recipient. The medical model creates a system where the afflicted individual is expected to fulfil social responsibilities through civic participation, but then does not allocate the necessary resources to fulfil this obligation. Resources are only allocated to individuals who fit within the definition of “disability” as determined by the medical community. Falling outside this medically accepted definition is seen as normal phenotypic variation, which the individual is expected to manage and overcome themselves. As a result, the medical model places social responsibilities on the individual without reciprocating the logical obligation to enable that participation through allocating resources.

Thirdly, the medical model prevents people from owning their impairment as a tolerable form of diversity. Instead, the model assumes that the disability is a burden that must be remedied by normalisation.⁶⁵ A clear example of this is the denial of deaf culture, allowing deaf people to remain deaf or have deaf children. Similar can be said for those with Down’s syndrome. This is because the medical model assumes that disability is inherently bad and creates a “net loss” to the human experience.⁶⁶ Furthermore, it argues that those with disabilities who indicate a high subjective quality of life do so because they have settled for lower expectations in respect of their quality of life.⁶⁷ This is likely because most people experience life through all five sensory modalities, and because of this, we equate that capacity as being inherently good and necessary for a full human experience.⁶⁸ Therefore, the absence of such capacity reduces the maximum quality of life we can obtain. This position is unacceptable in modern New Zealand. It is possible to acknowledge

62 Kimberly Holland “How Common Are People with Red Hair and Blue Eyes?” (24 June 2019) Healthline <www.healthline.com>.

63 *Jordan v City of New London* US App Lexis 26351 (2d Cir 2000) as cited in Silvers, above n 61, at 484.

64 Joanne P Ikeda and others “A commentary on the new obesity guidelines from NIH” (1999) 99 *Journal of the American Dietetic Association* 918; and The Associated Press “U.S. to Widen Its Definition Of Who Is Fat” *The New York Times* (online ed, New York, 4 June 1998).

65 J Clapton “Tragedy and catastrophe: contentious discourses of ethics and disability” (2003) 47 *Journal of Intellectual Disability Research* 540 at 542–543.

66 Silvers, above n 61, at 479.

67 Ron Amundson “Against Normal Function” (2000) 31 *Stud Hist Phil Biol & Biomed Sci* 33 at 47.

68 Silvers, above n 61, at 479.

another person's more privileged position without condemning your own life as being intolerably worse—whether you look at that through the lens of wealth, beauty or disability.

The medical model also asserts a hierarchy where physical health is more legitimate than mental health.⁶⁹ It has historically been premised on scientific observations. Where a biological impairment cannot be easily seen or explained, the individual is subjected to social scepticism when they subsequently appeal for medical assistance or funding to address their impairment. The legitimacy of their claim is doubted compared to those with clear physical injuries. Western medicine largely ignores social, environmental and psychological factors in favour of biological ones when assessing health. Furthermore, the medical model struggles to reconcile its approach to conditions such as depression—which are primarily founded on social, environmental and psychological factors—and subsequently fails to achieve positive health outcomes.

Within the medical model, voluntarily acquiring physical impairment will always be regarded as an intolerable net loss for human experience. This will be so regardless of the transabled person's subjective desires, and the evidence demonstrating how his or her suffering can be significantly alleviated by physical impairment.⁷⁰ Transabled people are requesting to compromise a facet of their physical health for the benefit of their mental health, providing a net therapeutic benefit that currently cannot be achieved in any other way. The medical model rejects this compromise because physical health is paramount, reinforcing the hierarchy between physical and mental health.

B *The social model*

The social model is another predominant conceptual model emerging within the field of health policy. It emphasises the conflict between biological variation with normal modes of functioning or values held by the functioning majority.⁷¹ The social model expands on the medical model by placing the emphasis not on the biological variation itself being the disabling agent, but rather the unaccommodating social context which that variation is forced to function.⁷²

The social model is concerned with both the *extent* of function, which is the degree of normal physical or intellectual performance relative to the “normal” population, and the *mode* of such function, which is the method by which performance is achieved.⁷³ For example, a person in a wheelchair is socially considered to be disabled in all environments regardless of how well they function because the mode differs from the functioning majority.⁷⁴ The disability label may be appropriate in an environment filled with stairs but seems inappropriate in the context of a marathon, for example, where the world record is faster than that of able-bodied counterparts.⁷⁵ Consequentially, a transabled person's mode of function attracts the label of disability as much as their capacity, even when their “disability” is inherently enabling.

69 Alexandre Baril “‘How dare you pretend to be disabled?’ The discounting of transabled people and their claims in disability movements and studies” (2015) 30 *Disability & Society* 689 at 697.

70 First and Fisher, above n 11, at 9.

71 Amundson, above n 67, at 48.

72 At 48.

73 See, for example, at 48–50.

74 At 50.

75 Cindy Boren “Boston Marathon 2012: Kenyan runners Wesley Korir, Sharon Cherop win” *The Washington Post* (online ed, Washington DC, 16 April 2012).

The social model can also be demonstrated through babies affected by thalidomide, who were born with malformed limbs. Instead of being taught to use a wheelchair, they wore prostheses, which forced them to stand upright and hobble painfully, dangerously and inefficiently.⁷⁶ This measure was justified by the idea that these babies would be less disabled learning to walk upright, albeit inefficiently, rather than being “wheelchair-bound”.⁷⁷ This reasoning is absurd because wheelchairs are designed to be enabling devices, fostering greater independence for the physically impaired. Resistance to these tools indicates a strong social stigma against appearing abnormal. In the minds of these clinicians, whilst the use of a wheelchair would be physically enabling, it would increase social barriers between the impaired individual and functioning majority based purely on the visibility of the impairment.

On the contrary, the social model fails to recognise some people with significant biological impairments as being disabled because they “pass” as normal. For example, Professor Roger Lewin reported that one of his students at Sheffield University had only ten per cent of the ordinary brain mass resulting from subclinical hydrocephaly, yet had an IQ of 126 and was functionally indistinguishable from his peers in both academic and social life.⁷⁸ Under a medical model, this student would be regarded as disabled despite not experiencing any subjective or objective disability. However, the social model would not regard him as disabled because he has retained both ordinary modes and degrees of function.

The social model, like the medical model, takes an external point of view when looking at disability, but it looks through the lens of society rather than the medical community. It instead asks, “how do *we*, as a society, see the abnormality impacting on *that* person?”. In contrast, the medical model merely looks for the existence of that impairment and presupposes its disabling nature. As such, the social model better conceptualises mental health issues because it looks at the *impact* an impairment has on the individual.

The medical model is also less fluid in conceptualising impairment because the cause of disadvantage is placed on the affected individual rather than society.⁷⁹ This is because the medical model sits in opposition to functional determinism, which argues that biological “normality” is an objective fact of the natural world.⁸⁰ Therefore, functional consequences arising from variation of the norm are disadvantageous to the individual, which is deemed to require mitigation through normalising treatment. Essentially, the “norm” is the *best* expression of that trait.

The clear impact of the social model is therefore to entrench existing patterns of ableist privilege and marginalise impaired individuals on the presumption that an objective normality exists. This model therefore does not conceptually fit with transability, as transabled people wish to move away from this objective physical normality rather than towards it. Furthermore, the lack of any observable cause of this desire invites social scepticism.⁸¹ The social model reinforces the notion that mental and physical well-being are distinct when academic consensus affirms their integrated relationship. Lastly, compromising mental health for the benefit of physical health has always been conceptually feasible. For example, addictive opioids, which disturb mental clarity, are

76 Amundson, above n 67, at 49.

77 At 49–50.

78 Roger Lewin “Is Your Brain Really Necessary?” (1980) 210 Science 1232 at 1232.

79 Amundson, above n 67, at 51.

80 At 51.

81 For example, people respond to transability as a financial burden, whereas the same argument would not be used for physical injury or medical treatment: Baril, above n 69, at 693.

prescribed to relieve physical pain, and we allow people to undertake hundreds of cosmetic procedures to modify their appearance for no better reason than to improve their subjective sense of self and social acceptance. Therefore, the social model's inability to conceptualise transability drives the need for a new model of disability, a need which can be satisfied by the neutral model.

C The neutral model

The neutral model effectively identifies a biological, psychological or functional variation from the norm, and then asks the individual whether they experience that variation in a disabling way, and in what contexts they feel disabled relative to others. The individual is therefore empowered to define the status and scope of their disability, whilst also providing necessary nuance to the disabled identity itself, allowing for new forms of disability to be recognised. Furthermore, because disability is something that is constructed rather than objective, it can be deconstructed through a more nuanced discourse which allows impairments to be seen as tolerable forms of diversity.⁸² The neutral model reflects the idea that biological impairments can still be health issues addressed by medicine when desired, but refutes the idea that impairment necessarily result in a negative or disabling experience in all contexts.⁸³ This allows us to affirm deaf, Down's syndrome and autistic communities as valid, and in turn do the same for transability.

The neutral model looks at the motives behind initiatives designed to accommodate difference or minimise disabling barriers, and then applies it in a way that does not depend on the label of disability.⁸⁴ For example, imagine the local post office has an ordinary queue and priority access lane for disabled people to use. Under the medical model, anyone with a recognised disability would be able to use the priority access lane and skip the queue regardless of the nature of that disability.⁸⁵ Alternatively, the neutral model would identify the purpose of that access lane as being to minimise pain and discomfort above what we would ordinarily expect an individual to tolerate when waiting in line by allowing them to get in and out quickly, thus achieving an equitable outcome. Therefore, an elderly person with no disabilities would rightly be able to utilise the priority access lane because we know it is harder for elderly people to stand for prolonged periods of time. Similarly, it is arguable that a person in a wheelchair suffers no greater degree of discomfort than an unimpaired counterpart who stands in the ordinary queue, and therefore would not be technically disabled in this context. Finally, a person with a significant anxiety disorder might experience distress queueing for an extended period of time, and therefore would be entitled to use that access lane to minimise that discomfort. In doing so, however, they invite social scepticism because that disability is not externally visible.

Lastly, because disability is subjectively determined under the neutral model, so too are therapeutic measures. For example, some deaf individuals would regard a cochlear implant as being therapeutic where they desire the ability to hear, whilst another who embraces their deaf identity may regard that procedure as an assault. For transabled people, their subjective understanding of therapy entails undergoing a procedure which physically impairs them. Such a procedure is an affront to most because we value that

82 Mackenzie and Cox, above n 5, at 370–371; and Lewin, above n 78.

83 Silvers, above n 61, at 479.

84 At 478.

85 At 478.

capability. This premise is the underlying foundation of medical autonomy and our right to refuse or accept treatment. Simply because the statistical majority would reject the treatment is not a convincing reason to deny it altogether and contradict that foundation.

The neutral model is therefore the most accommodating when it comes to transability because it acknowledges that a physical impairment does not have a disabling effect unless the individual subjectively experiences in that way. It advocates a position where transability, whilst not necessarily celebrated, is tolerated in the same way that we tolerate the lifestyle choices of others we might disagree with. This in turn allows for transability to exist as an identity whilst preserving the ability to obtain healthcare if it is desired.⁸⁶ This would mirror the current approach to transgender individuals with the identity being largely tolerated yet the ability to access publicly funded healthcare is preserved.

The issue of transability has not yet been raised in the New Zealand medical field due to the lack of reported cases of transability. However, it is generally accepted that New Zealand adopts a medical approach, and conditions only get resources dedicated to them when there is an underlying accepted medical condition to which they can be attributed. This is however not unchanging, as New Zealand is gradually evolving its health system towards a social model approach.⁸⁷ This can be demonstrated in cases such as the progression of transgender surgery and the acceptance of transgender individuals more generally.

To conclude, disability in New Zealand should be framed through the lens of the neutral model, with healthcare focused on alleviating subjective suffering rather than an objective sense of what the State considers to be in the best interests of the general public.⁸⁸ This approach reconciles the assessment of the objective need for treatment by clinicians and the subjective desire to undergo said treatment by the affected individual. This opens the door for positive recognition of transability within the public health framework whilst promoting a framework where disability is viewed as an intolerable net loss to the human experience.

IV Key Legal Issues Raised by Transability

The scope of the legal argument in this article is focused on two key issues: whether a doctor can be exempted from criminal liability for performing a disabling surgery on a patient with BIID, and if so, whether there is potential for such a procedure to be publicly funded.

A *Lawfulness of disabling surgeries*

The British Medical Association was confronted with the legality of patients demanding seemingly non-essential amputations after a doctor in Scotland performed two of these operations.⁸⁹ It concluded, rather unhelpfully, that “legal advice should be sought” before

86 At 479, Silvers argues that “priority for health care should be directed to those who suffer most from ill health, rather than be claimable on the general meaning of disablement”.

87 Louise Humpage “Models of Disability, Work and Welfare in Australia” 41 *Social Policy & Administration* 215 at 217–218.

88 See Health Act 1956, s 3A.

89 Veronica English and others *Medical Ethics Today: The BMA's Handbook of Ethics and Law* (3rd ed, John Wiley & Sons, Chichester, 2012) at 85.

undertaking a surgery of this nature, as such an issue has yet to come before the courts.⁹⁰ In light of this, it is important to assess a doctor's potential liability for performing a disabling surgery on a patient with BIID.

Under New Zealand law, performing a disabling surgery on a patient, even with their consent, is prima facie an assault, as the surgery involves the intentional application of force and occasions bodily harm.⁹¹ Given the nature of a disabling surgery, this exposes medical professionals to criminal charges such as common assault, injuring with intent and wounding with intent, with maximum sentences ranging from 1–14 years.⁹² Furthermore, even if the surgery was lawfully performed, it would still need to be done with reasonable skill and care to comply with the statutory duty to the patient.⁹³

In New Zealand, those performing surgical procedures are protected from criminal responsibility for a prima facie assault by ss 61 and 61A of the Crimes Act 1961. Section 61 is oriented towards more emergency-type situations, whilst the wording of s 61A appears to be oriented towards non-emergency circumstances. Section 61A was specifically enacted to affirm the legality of non-urgent operations, such as vasectomies, in light of Denning LJ's comments in *Bravery v Bravery*.⁹⁴ This case concerned a husband who had secretly undergone a vasectomy, causing great anguish to his wife who wanted more children.⁹⁵ Denning LJ seemed to suggest that this surgery, and others like it, could not be lawfully consented, deeming it act of "cruelty" on the wife without "just cause".⁹⁶ Whilst his judgment was dissenting, his comments cast doubt on the legality of a number of common medical procedures—they had essentially become criminal acts which could give rise to significant criminal sanctions.

Given the surgeries contemplated in transability, s 61A shall be the primary focus of this inquiry. Per s 61A, this defence requires three essential elements to waive the practitioner of criminal responsibility: the consent of the patient must be obtained, the surgery must be for a lawful purpose, and the procedure must be performed with reasonable care and skill. The issues of consent and lawful purpose will be the specific focus of this article, as reasonable skill and care will depend on the facts of a case.

(1) Consent of the patient

Consent is both a common law defence in its own right and a necessary element of the s 61A surgical operations defence.⁹⁷ The ability of a person to lawfully consent to bodily harm has a colourful common law history informed by both legal principles and social values, and sits at the forefront of our medical system in the post-Cartwright era.⁹⁸

90 At 87.

91 Crimes Act 1961, s 2 definition of "assault".

92 Sections 188–189, 193 and 196.

93 Section 155.

94 *Bravery v Bravery* [1954] 1 WLR 1170 (CA) at 1176–1181 per Denning LJ dissenting; and *Lee*, above n 1, at [166].

95 *Bravery*, above n 94, at 1169.

96 At 1179–1181.

97 Crimes Act 1961, ss 20(1), and 61A(1).

98 Health and Disability Commissioner Act 1994, s 20(1)(a); and Health Practitioners Competence Assurance Act 2003. The Post-Cartwright Era reflects a significant change in the ethical regulation of medical trials and delivery of medical services in New Zealand, with an enhanced focus on the informed consent of patients. See David CG Skegg "Foreword: The Cartwright Inquiry and Its Legacy" in Joanna Manning (ed) *The Cartwright papers: Essays on the Cervical Cancer Inquiry* (Bridget Williams Books, 2009) 7.

However, there are some situations where the law disregards the free and informed consent of the victim and rules the activity as being unlawful, such as the inability to consent to death.⁹⁹

Valid consent requires a degree of capacity which reflects the gravity of the decision made.¹⁰⁰ It could be contested that a person with BIID lacks the capacity to consent to an operation this significant, and therefore such a surgery can never be lawfully performed. However, given the clinical comparisons to GD and the fundamental principle of assuming the patient possesses the requisite capacity unless shown otherwise,¹⁰¹ I shall proceed on the assumption that requisite capacity can be established.

The common law's starting point for the scope of consent is *R v Brown*.¹⁰² The majority of the House of Lords held that the sadomasochistic sexual activity of the defendants was criminal despite the consent of all parties at all times.¹⁰³ Lord Templeman was unwilling to create an exception for sadomasochistic sex as he saw it as indulging cruelty and degrading its victims.¹⁰⁴ The majority broadly classified assaults into three categories based on the degree of harm the assault causes:¹⁰⁵

- (1) For assaults where *no* bodily harm arises (such as incidental touching in the course of life) or where the infliction of injury is “merely incidental” to a sporting activity, consent will always be a defence.¹⁰⁶
- (2) For assaults causing *actual*/bodily harm the consent of the victim may only be valid when the assault falls within an accepted category of conduct (such as piercings and tattooing).¹⁰⁷
- (3) Where the assault causes *grievous* bodily harm, there must be compelling social utility factors in order for consent to render the conduct lawful—the primary example being surgery.¹⁰⁸

Given the rather serious nature of a disabling surgery, the consent of the patient to the deliberate infliction of serious bodily injury will, therefore, *prima facie* not be sufficient to render the procedure lawful, unless there are compelling social utility factors.

New Zealand has steered away from the rigidity of the category-based approach to the social utility approach used in the United Kingdom, which applies a more fluid analysis depending on the behaviours and levels of intended harm in each individual context.¹⁰⁹ A person has the ability to consent to intentionally inflicted harm short of death as long as the social utility of the activity and interest in personal autonomy outweighs the public policy interests in prohibiting it.¹¹⁰ Social utility can be derived from accepted benefits to society, the need for tolerance by the majority, or upholding the expression of a fundamental human right under the New Zealand Bill of Rights Act 1990. Given that a

99 Crimes Act 1961, s 63.

100 *In re T (Adult: Refusal of Treatment)* [1993] Fam 95 (CA) at 112; and Health and Disability Commissioner (Code of Health and Disability Services Consumer's Rights) Regulations 1996, right 7(3).

101 See *VC v NC* [2015] NZHC 2014, [2015] NZFLR 892 at [13]–[14]. In the context of English law, see English and others, above n 89, at 104.

102 *Regina v Brown* [1994] 1 AC 212 (HL).

103 At 213.

104 At 236.

105 At 230 per Lord Templeman.

106 At 231 per Lord Templeman; and at 241 per Lord Jauncey.

107 At 243–245 per Lord Jauncey.

108 At 231 per Lord Templeman.

109 *Lee*, above n 1, at [300] and [305]; and *S v R* [2017] NZCA 83, (2017) 28 CRNZ 422 at [49].

110 *Lee*, above n 1, at [300].

disabling surgery is likely to constitute a very serious level of physical harm, a heightened degree of social utility will need to be established to justify its legal occurrence.¹¹¹

The strongest argument for making disabling surgeries lawful is that the circumstances presented by transabled individuals fit the circumstances contemplated in *Brown* and *Lee*, where the possibility of consent to intentional infliction of grievous bodily harm is available, albeit rare.¹¹² Demonstrating that disabling surgery has compelling social utility and interests in personal autonomy that outweigh public policy reasons in prohibiting it could validate consent to as such procedures, satisfying the first element of the s 61A defence. The desires of transabled individuals should be tolerated by the majority given how rarely they manifest, and because clinical evidence suggests that these desires are authentic resistant to other forms of treatment, making surgery (if safely administered) the most effective therapeutic option at present.¹¹³

Moreover, the physically disabling procedures that transabled individuals wish to undergo should proceed on the basis of “properly conducted medical experimentation” acknowledged in *Lee*.¹¹⁴ Society places extraordinary value on properly conducted medical experimentation, as the results of such research often have impacts well beyond their immediate circumstances. Effectively, the law of consent would be used to permit surgeries of a nature that would ordinarily constitute grievous bodily harm and could not be consented to in other contexts.

Furthermore, denying transabled claims could be construed as contrary to the freedoms of conscience and expression against those with transability, which amounts to unlawful discrimination.¹¹⁵ Unlike transabled individuals, individuals with GD—who possess an abnormality of the psychological process per the definition of “disability” under the HRA¹¹⁶—are granted access to gender-affirming procedures in both the private and public health system, and hormone replacement therapy is funded by the Pharmaceutical Management Agency (PHARMAC).¹¹⁷ These procedures have significant physiological effects on the individual, carry a risk of infertility, and the general anaesthetics necessary to undertake the procedure carry a risk of death.¹¹⁸ These voluntary surgical procedures have some disabling effects on the individual, but are permissible inflictions of grievous bodily harm where the consent of the individual waives criminal liability. Denying the claims of transabled individuals would therefore be inconsistent with the approach taken to GD. Both entail significant and elective surgical modifications of anatomy, which render the person less physically capable in order to relieve psychological distress, having a net therapeutic benefit. The weight of personal autonomy in these circumstances outweighs the desire to promote maximum physical capacity of the public, and to rule against it would produce inconsistency in principle with respect to gender-affirming procedures, sterilisations and cosmetic surgery.

111 Crimes Act 1961, s 188; and *S v R*, above n 109, at [44].

112 *Lee*, above n 1, at [296] and [304]; and *Brown*, above n 102, at [231] per Lord Templeman. See also *Brown*, above n 102, at [259] per Lord Mustill who, in his dissent, concluded that “all or almost all the instances of the consensual infliction of violence are special”.

113 First and Fisher, above n 11, at 10–11.

114 *Lee*, above n 1, at [299].

115 New Zealand Bill of Rights Act 1990, ss 13–14 and 19; and Human Rights Act 1993, s 21(1)(h)(v).

116 Human Rights Act, s 21(1)(h)(v).

117 Ministry of Health “Health care for transgender New Zealanders” (5 December 2019) <www.health.govt.nz>.

118 M S Arbous and others “Mortality associated with anaesthesia: a qualitative analysis to identify risk factors” (2001) 56 *Anaesthesia* 1141.

There is a strong case for upholding the validity of consent to a significant degree of bodily harm at the request of the transabled individual, highlighted by the interests of personal autonomy, the rarity of the condition, and its features analogous to lawful surgical procedures involving grievous bodily harm.

(2) Surgery must be for a lawful purpose

For s 61A of the Crimes Act to apply, it must be established that the consensual surgery is being conducted for a lawful purpose. There has been no New Zealand case law to define exactly what a “lawful purpose” is for the purpose of the Act. In other jurisdictions, a “lawful purpose” has been held to mean doing something required by law and not doing things prohibited by law.¹¹⁹ For this article, it can be inferred that lawful purpose entails being in accordance with clinical guidelines and medical best practice, alongside the express element of consent.

A potential argument could entail applying Lord Mustill’s dissent in *Brown*, which made the point that there is a “critical level” at which consent would not ordinarily be sufficient to waive criminal liability for high degrees of bodily injury, unless there are “special situations” necessitating a certain degree of bodily invasion (such as surgical intervention).¹²⁰ Lord Mustill goes on to say that consented surgical procedures that are “well on the upper side of the critical level” may be regarded as “legitimate if performed in accordance with good medical practice”.¹²¹ While the dissent was focused on the issue of consent, requiring such surgeries to be performed “in accordance with good medical practice” branches into the realm of “lawful purpose” in the context of medical intervention. It can, therefore, be argued that the circumstances of transabled individuals fall within the class of “special situations”, where consent to significant surgical treatment will be valid so long as it is performed in accordance with good medical practice.

“Good medical practice” currently demands that a medical professional’s actions are supported by a “body of professional opinion” that is “responsible, reasonable or respectable”, and such opinion is capable of withstanding logical analysis by the Court regardless of how well established it is.¹²² However, the lack of empirical evidence surrounding transability means that there is minimal foundation upon which a sufficient “body of opinion” can be found and subsequently withstand criticism. The weight of medical opinion is not strongly in support of transability; thus, appealing to other factors that could suggest a lawful purpose will be necessary.

The first of these factors could be the Court of Appeal’s statement in *Lee*, where it was suggested that the s 61A defence could be extended to properly conducted medical experimentation.¹²³ This seems to be supplementary to the idea of “sound medical practice” stated in *Bolitho*, which allows the defence to apply even when the scientific evidence supporting the procedure remains speculative, but the potential therapeutic impact of the procedure compels the need for the surgery.¹²⁴

Secondly, the historical justification for laws criminalising maiming, wounding or disfiguring were to prevent men avoiding compulsory military service.¹²⁵ Whilst military

119 See, for example, the Australian case *Taikato v Queen* (1996) 186 CLR 454 (HCA) at 460.

120 *Brown*, above n 102, at 258.

121 At 258–259.

122 *Bolitho v City and Hackney Health Authority* [1998] AC 232 (HL) at 241–243.

123 *Lee*, above n 1, at [299].

124 *Bolitho*, above n 122, at 241.

125 *Lee*, above n 1, [297].

service is no longer compulsory, the expectation that New Zealanders perform certain civic duties and not intentionally become a charge on society are still relevant considerations in public policy.¹²⁶ Whilst these concerns are relevant, they presuppose that physical impairment necessarily detracts from a person's societal contributions. The purpose of these procedures is to alleviate a psychological constraint on the individual—therefore, the physical impairment is an enabling experience. The surgery is for a lawful purpose because it is intended to better fulfil the policy objective of maximising participation in society.

(3) High Court approval

If such a procedure were being planned, the lawfulness of that procedure could (and probably should) be approved by the High Court prior to taking place. This would align with the “special features” outlined *In re F (Mental Patient: Sterilisation)*, which is a case concerning a sterilisation patient who lacked the mental capacity to consent to the operation, so the doctors sought prior court approval.¹²⁷ The following six “special features” outlines the necessary nature of a surgical procedure, prior to approval by the High Court, to ensure legality:¹²⁸

- (1) The operation would likely be irreversible;
- (2) The effect of the surgery would irreversibly deprive the patient of what is widely regarded as a right of the patient (such as the right to bear children);
- (3) “[T]he deprivation of that right gives rise to moral and emotional considerations to which many people attach great importance”;
- (4) If the decision was made without involvement of the courts, there would be an increased risk of the issue being decided wrongly;
- (5) If the court was not involved, there would be increased risk of the surgery “being carried out for improper reasons or with improper motives”; and
- (6) The involvement of the court should protect health care professionals from adverse criticisms or legal claims.

The present claims regarding transability clearly satisfy all six special features. The operation would be irreversible and deprive transabled people of a socially valued capability ordinarily protected by the law. The procedure has significant moral and emotional considerations that would pressure clinicians into potentially deciding the issue incorrectly, or risking the surgery being performed for an improper purpose. Court approval would alleviate the responsibility of the clinicians from what is ultimately a legal question.

In *Re F*, however, a High Court approval was necessary where a vulnerable patient required medical intervention and they could not give consent: the Court's concern here is the protection of an incompetent patient. On the other hand, individuals with BIID are arguably competent; individuals with GD, who are also deemed competent, do not require such court approval for their medical treatments. I argue however, given the novelty of transability within public understanding, that it invokes the need to balance the protection of vulnerable patients from harm prior to a significant medical event against the freedom of competent individuals to make their own decisions. As such, I argue that there must be High Court approval prior to the procedure for BIID—at least for now.

126 At [301].

127 *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 (PC) at 1 and 56.

128 At 56.

It is highly contested as to whether a person suffering from BIID is competent enough to decide and undergo procedure. Unlike BIID, GD is a clinically accepted condition, and patients with GD are widely accepted to have capacity to consent to treatment. Where an inquiry as to the competence of a patient is in the balance, the court should err on the side of oversight both for the benefit of the patient and the professionals involved in administering invasive medical treatment. This protects the patient from harmful experimentation—a core objective of our medical system in the post-Cartwright era—and medical professionals from criminal liability. Therefore, whilst I argue that a patient with BIID could be considered as competent, there is still at present a strong public interest in establishing that competence, in fact, exists before undergoing a significant medical procedure. It is possible, however, that this need for court approval may eventually dissipate as BIID becomes clinically accepted and more scientific evidence is able to demonstrate capacity of patients and the efficacy of treatment. Over time, public stakeholders can be better informed about the legitimacy of the undoubtedly controversial conduct that would take place in an intentionally disabling surgery.

To conclude, medical professionals are likely to satisfy the s 61A defence, thus protecting them from criminal responsibility, assuming that the procedure is conducted with reasonable care and skill and the requisite capacity is established. The consent of the patient will permit a high degree of voluntary physical harm in these circumstances, which will give New Zealand a more fluid scope through which to analyse the social utility of the action taken. This will hopefully align transableism surgery to similar surgeries like gender reassignment surgery, which are already lawful. Secondly, the procedure would be for a lawful purpose as properly conducted medical experimentation in light of available clinical evidence and would promote public values of participation by alleviating psychological suffering. This claim would be more fruitful if BIID were recognised as an official disorder in the next revision of the DSM-5, and other less invasive treatment options were explored and deemed ineffective.

However, prior approval of the High Court is desirable as it would offer certainty to doctors and alleviate them from undertaking a significant legal decision, which the Court is more equipped to undertake.

B Public funding for disabling surgeries

Assuming that disabling surgeries can be lawfully performed in New Zealand, the next question that arises is the possibility for these procedures to be funded within the public health system, or whether patients will have to privately fund these procedures.

New Zealand's legal framework has been carefully constructed to ensure that while the quality of healthcare is guaranteed—should one be provided—there are no absolute rights to access healthcare due to resource constraints that make such guarantees unadvisable.¹²⁹ Despite this, the issue has been litigated on several occasions. In her article, Joanna Manning cited an example case which argued that the denial of dialysis amounted to unlawful age-based discrimination.¹³⁰ The Human Rights Commission found that there was no right to have the treatment; however, the social backlash resulted in the

129 Joanna Manning "Litigating a Right to Health Care in New Zealand" in Colleen M Flood and Aeyal Gross (eds) *The Right to Health at the Public/Private Divide: A Global Comparative Study* (Cambridge University Press, New York, 2014) 19 at 28.

130 *South Auckland Health* as cited in Manning, above n 129, at 36.

doctors administering it anyway.¹³¹ Similarly, in *Shortland v Northland Health*, the decision to not administer dialysis was supported by five physicians, but the Court reiterated that no right to access treatment existed.¹³² In *Walsh v Pharmaceutical Management Agency*, the decision to not fund a 12 month course of Herceptin was judicially reviewed.¹³³ While the Court made PHARMAC reconsider its decision based on a technicality, it implicitly operated on the fact that in a system of limited resources, access rights to healthcare in New Zealand do not exist; however, to compensate, we have a robust system that operates on meaningful consultation so that the best decisions are made with those resources.¹³⁴

The public health system necessarily requires a population health focus, which in turn demands an approach where the allocation of health resources maximises value for money.¹³⁵ Whilst this approach achieves many positive outcomes, it can leave genuine health needs behind. Therefore, like all New Zealanders, transabled people do not have a right to government funded elective surgeries.

The decision of funded and non-funded procedures is made by district health boards with some government influence.¹³⁶ Significant health issues are dealt with by specialists who determine a patient's need for an elective procedure and allocate a priority score.¹³⁷ The treatment is then provided based on priority rather than time once a particular threshold has been satisfied.¹³⁸

The nature of transabled claims means they are not likely to be prioritised, nor are they likely to meet a requisite priority threshold if one were to exist. This is much in the same way that gender reassignment surgeries are not prioritised within New Zealand's public health system given other resourcing priorities. It is this reality that drives the private healthcare system.

Despite this, there are extremely limited circumstances where gender reassignment surgeries are publicly funded under the Ministry of Health's High Cost Treatment Pool.¹³⁹ This scheme is designed to fund one-off procedures that are not generally available within New Zealand's public health system, and high cost is specifically the barrier to obtaining that treatment privately or overseas.¹⁴⁰ In 2018, the Ministry of Health estimated that the funded procedures typically range in cost from \$50,000 to over \$500,000 (including post-surgery complications).¹⁴¹ The allocation of \$2.99 million from the High Cost Treatment Pool to the Gender Affirming (Genital) Surgery Service in Budget 2019 enables up to 14 genital reconstruction surgeries to be performed a year within the public system, the

131 Manning, above n 129, at 36.

132 *Shortland v Northland Health Ltd* [1998] 1 NZLR 433 (CA).

133 *Walsh v Pharmaceutical Management Agency* [2010] NZAR 101 (HC).

134 At [206]–[208].

135 Ministry of Health "Value and high performance" (15 April 2016) <www.health.govt.nz>.

136 Ministry of Health "District health boards" (12 February 2020) <www.health.govt.nz>.

137 Ministry of Health "Planned Care services" (21 October 2019) <www.health.govt.nz>; and Ministry of Health "Questions and answers – Planned Care services" (21 October 2019) <www.health.govt.nz>.

138 Ministry of Health "Questions and answers – Planned Care services", above n 137.

139 Ministry of Health "Health care for transgender New Zealanders", above n 117.

140 Ministry of Health "High-cost treatment pool" (29 May 2020) Ministry of Health <www.health.govt.nz>.

141 Thomas Coughlan "Gender affirmation surgery cap lifted" (23 October 2018) Newsroom <www.newsroom.co.nz>.

majority of which are likely to be male-to-female transitions based on the proportion of surgical referrals and relatively lower mean cost of those surgeries.¹⁴²

The Ministry of Health provided that only “New Zealand citizens or permanent residents may be considered for treatment funded under the High Cost Treatment Pool”, and applications are assessed against the seven eligibility criteria:¹⁴³

1. The treatment must not be available from any public hospital in New Zealand (or under any existing contractual arrangement).
2. The treatment must have proven efficacy through appropriate clinical trials, and preferably has also been established as effective when applied in regular practice.
3. The treatment is well-established and is not an experimental form of treatment.
4. Failure to receive the treatment would result in serious irreversible deterioration in the patient’s condition or an inability to recover lost function, or significant impairment to normal development of a child; or
5. Failure to receive the treatment could deny an adult with a lifelong disability access to treatment, which would lead to a marked improvement in their quality of life.
6. The chosen treatment is cost-effective, which means that:
 - the expected long-term savings to the health care system outweigh the initial costs of the treatment, [and]
 - the dollar costs per unit of benefit are acceptable when evaluated against other Ministry of Health priorities.
7. Treatment would lead to reasonable prospects of survival and to an improved quality of life after treatment.

Transabled individuals are prevented from accessing the High Cost Treatment Pool for several reasons. First, qualified surgeons for amputations are readily available within the public health system. In 2014, the total number of amputees in New Zealand amounted to 4,311—roughly one in 1,000 New Zealanders.¹⁴⁴ In contrast, gender reassignment surgeries under the High Cost Treatment Pool are specifically for genital reconstructions, for which there is only one qualified physician in New Zealand.¹⁴⁵

Secondly, amputations are relatively lower cost: a non-emergency amputation in 1994 would cost the New Zealand economy \$23,038 per amputation, which is roughly \$38,000 in today’s dollars accounting purely for inflation.¹⁴⁶ Whilst the cost is certainly higher in today’s dollars, it would still likely sit at the lower end of high-cost procedures that the fund aims to address.¹⁴⁷ On the other hand, the cost of male-to-female transitions as of

142 “Updates from the Gender affirming (genital) surgery service: February 2021 update” (3 March 2021) Ministry of Health <www.health.govt.nz>.

143 Ministry of Health “High-cost treatment pool”, above n 140.

144 New Zealand Artificial Limb Service *Report of the New Zealand Artificial Limb Service: Peke Waihangā, Aotearoa* (30 June 2014) at 22.

145 Gender Minorities Aotearoa: Irawhiti Takatāpui, Transgender, and Intersex NZ “Referral for Genital Reconstruction Surgeries in NZ” <<https://genderminorities.com>>. As of 2018, Dr Rita Yang is the only surgeon qualified to perform genital reconstruction surgeries. She operates in Wellington and Auckland.

146 Helen M Scott and Guy W Scott “Critical Leg Ischaemia in New Zealand: Economic Cost of Amputation versus Intravenous Iloprost” (1994) 6 *Pharmacoeconomics* 149 at 149. To convert the 1994 cost to the most current value accounting for inflation, see Reserve Bank of New Zealand “Inflation calculator” <www.rbnz.govt.nz>.

147 While there is no clear definition on what treatments or procedures are considered “high-cost”, a 2010 report estimated them to be as low as \$20,000-\$100,000 to as high as \$500,000: Paul

October 2018 averaged at \$53,382, while female-to-male transition costs averaged at \$218,892.¹⁴⁸ Lower cost feminising and masculinising procedures, which are procedures that are performed to make the persons physical aesthetic more feminine or masculine, are not eligible under the High Cost Treatment Pool.¹⁴⁹ The procedures might be viewed by some as more cosmetic in nature. In contrast, sexual organ reconstruction is specifically about the genitalia, and is less aesthetic in nature.

It could be argued that amputations to treat a psychological condition are fundamentally different in nature from ordinary amputations, and therefore are not generally available within the public system. However, this argument is undermined by the fact that inaccessibility to this kind of treatment is not due to lack of skill or high cost in the public sector. Instead, the lack of access is more likely to be attributed to an unwillingness by the medical profession to engage in physically disabling procedures on personal, professional, or utilitarian based grounds.

A funding application would also fail due to the lack of proven efficacy through clinical trials and the practice not being well established. The need for evidence, specifically through clinical trials, imposes an incredibly high threshold for any proposed treatment plan. This type of evidence is simply lacking for transability. Furthermore, such research is unlikely to ever exist, given the stigma that would inevitably surround any attempt to conduct such research, reputational damage to those involved, and the difficulty in gaining ethics approval for such a trial.

However, the claims of transabled people do satisfy criteria four and six, as the evidence previously cited demonstrates improved quality of life for individuals post-operatively, and similar success is reported in comparable procedures such as gender reassignment.

Therefore, it is relatively clear that the High Cost Treatment Pool is not an available source of funding in this case. This conclusion would ordinarily be innocuous, however another more sinister source of funding exists within New Zealand's Accident Compensation Corporation (ACC) scheme. ACC funds treatment and rehabilitation costs resulting from unintentional personal injuries.¹⁵⁰ However, s 119 of the Accident Compensation Act 2001 provides a small caveat for personal injuries which are intentionally inflicted, but restricting the entitlements to just direct treatment costs and ancillary costs.¹⁵¹ This provision is seen to strike a balance between incentivising the public to act in the best interests of their health, and recognising that many prevalent illnesses such as depression manifest themselves in self-harming behaviour.

The meaning of "intentionally" under s 119 of the Accident Compensation Act has been litigated and concerns the intentional infliction of harm. This meant that in *Accident Compensation Corporation v Stevens*, a prison inmate who had his gangrenous hand amputated following IV drug use remained entitled to full sch 1 benefits, because the intention of the injection was to receive gratification from the drug rather than to inflict injury.¹⁵² In contrast, in *DMTH v Accident Compensation Corporation*, a 15-year-old boy was denied the full scope of benefits for brain injuries he sustained in an attempted

McCormack, Joy Quigley and Paul Hansen *Report to Minister of Health, Hon Tony Ryall: Review of Access to High-Cost, Highly-Specialised Medicines in New Zealand* (March 2010) at 33.

148 Coughlan, above n 141.

149 Ministry of Health "Health care for transgender New Zealanders", above n 117.

150 Accident Compensation Act 2001, s 3.

151 Sections 119(1)(a), 119(2) and 119(3).

152 *Accident Compensation Corporation v Stevens* [1993] NZAR 322 (HC).

suicide.¹⁵³ The Court rejected the argument that the necessary intention was to obtain compensation, or that the boy was intending death rather than injury when he shot himself, instead ruling that it is the act of inflicting injury itself that must be intended, regardless of the purpose of that injury.¹⁵⁴ This authority also negates an argument that the full sch 1 benefits are still available because the self-inflicted physical injury was intended for psychological relief.¹⁵⁵

This policy has a unique impact on transabled individuals. In the absence of public funding schemes or effective referrals for elective surgeries, the patient has a significant financial incentive to self-inflict an injury that results in an amputation and subsequently claim the immediate treatment costs through ACC.¹⁵⁶ This financial incentive complements and reinforces the natural manifestations of BIID to self-harm demonstrated in the diagnostic criteria, and therefore, creates a genuine risk of serious harm.

This unforeseen financial incentive to self-harm rather than seek clinical guidance and funding is detrimental to all parties involved, and is therefore contrary to the Ministry of Health's statutory function to improve, promote and protect public health within resource constraints.¹⁵⁷ The individual suffers greater harm by self-inflicting an injury in a non-clinical setting which increases the risk of medical complications and death. The public is detrimentally affected—witnesses, emergency staff, friends and family are unnecessarily exposed to self-inflicted trauma and may even be placed in harm's way themselves.

The policy creates the least efficient use of resources as the same surgery now has to take place in an emergency context, detracting the resources of time and money from other deserving procedures and interfering with surgical priorities. Such costs can be easily avoided when a relatively low-cost amputation is performed in a controlled clinical context, which also aligns with the Ministry of Health's objectives.

An administratively simple solution to this position would be to increase the flexibility of the criteria for the High Cost Treatment Pool. One way to do so might be to remove the absolute requirements of proven efficacy through clinical trials and medical practice. Another way might be to expand the existing range of treatments that are "not available" in the public system, so that expensive and routine procedures being used for alternative or non-routine purposes—such as a standard amputation as treatment for individuals with BIID—could be funded by the High Cost Treatment Pool. These linguistic alterations would strike a fair and equitable balance, allowing a transabled person to at least have their application heard whilst retaining the discretionary nature of the funding pool. To do so would be to allow the individual to have their surgery publicly funded and done in a clinical setting, which will lower the net cost both economically and socially, despite the controversial nature of the procedure itself. However, the perseverance of s 119 of the Accident Compensation Act would effectively operate as an unintended access right, guaranteeing funding in the event that the Ministry of Health or private funding is unavailable. I do not advocate for any changes to s 119, as to restrict its scope in response to a rare and unusual situation could detrimentally impact the rights of depressed and suicidal New Zealanders who represent a greater demand for healthcare, and rely greatly on the provision as it stands.

153 *DMTH v Accident Compensation Corporation* [2004] NZAR 385 (HC).

154 At [27].

155 At [19] and [22].

156 Accident Compensation Act, s 20(1).

157 Health Act, s 3A; and New Zealand Public Health and Disability Act 2000, ss 3(1)(a)(i) and 3(2).

V Conclusion

The transabled community represent a theoretical challenge to our current understanding of and approach to disability. The existing clinical evidence demonstrates a compelling case for the recognition of a new identity dysphoria comparable to GD. This new identity dysphoria, however, stems from a psychological disturbance in the individual's sense of ability. The diagnostic shift in the recent revision of the DSM-5 shifted the focus of GD away from the *identity* being the problem, but rather the dysphoric feelings which stem from rejection of that identity. A similar approach should be taken to BIID, where the identity is embraced and the dysphoria is remedied.

Transability is best looked at under the neutral model, which defines disability based on a combination of objective abnormality and subjective experience of the impairment. Under this model, a biological impairment is only disabling if the affected individual sees themselves as being disabled by it, giving them options to either accept and embrace their difference, or partake in public health measures to normalise the affected function. This can be contrasted with the medical and social models, which impose a label of disability based on the mere existence of the impairment regardless of its impact on the person's subjective experience. Only the neutral model can conceptualise this and validate the compromise of physical capacity to alleviate psychological suffering for a net therapeutic effect. This article argues that compromising physical capacity does not necessarily create an intolerable net loss to life quality, especially when it is being done to alleviate psychological suffering.

This article argues that disabling surgeries can be performed, and the doctors involved will not be liable for any form of criminal assault, as the surgical operations defence under s 61A of the Crimes Act is likely to apply. Furthermore, the consent of the patient will be valid despite the high degree of harm, given New Zealand's more flexible approach to social utility. The surgery would be for a lawful purpose given the intentions behind the procedure, the fact it would be a properly conducted medical experimentation, and the historical rationale for the crime of maiming—preventing injury to self that would inhibit one's contributions to the community at large—is actually achieved by performing the surgery. However, prior approval for the procedure by the High Court would be desirable given the special features articulated in *Re F*.

Lastly, there are no legally enforceable access rights to healthcare in New Zealand, and the rights that exist reflect the provision of quality care. The public health system in New Zealand is needs-based, and funding is subject to strong value for money considerations which diminishes the priority for disabling surgeries. The High Cost Treatment Pool currently does not provide an avenue for public funding as disabling surgeries are relatively lower cost, involve procedures that are generally available within the public system, and exhibit a lack of scientific evidence supporting the efficacy of such surgeries. However, New Zealand's ACC scheme provides a pseudo-access right by guaranteeing the immediate treatment costs be publicly funded for intentionally self-inflicted injuries. The disentitlements are irrelevant because the transabled person does not wish to be rehabilitated. This position, whilst well-intentioned, promotes harm to all parties and increased treatment costs which do not comply with the Ministry of Health policy objectives. A potential solution would be relaxing the strictness of the High Cost Treatment Pool requirements to allow a person's case to be heard and considered whilst retaining the discretionary nature of the fund. The desired effect would be to hear unique claims for medical assistance where other factors such as cost-effectiveness are compelling, although doing so would alter the intended purpose of the High Cost Treatment fund.

The way we approach the ethical and social challenges of transability, whilst far-fetched, represents a more systemic perspective. It brings into focus how we look at and define disability, how we implement policies to affirm identity and maximise participation in society, and offers a criticism for the primacy of physical well-being within our medical system that extends beyond the mere implications in this case.

The crux of this article is to encourage readers to look at disability with a more critical eye, and analyse the future of healthcare and disability policy through a more nuanced lens which empowers people to define their own status as a disabled person, and the scope of their disability. This is a piece written about autonomy. Successful and transformative disability policy recognises and encourages that autonomy for the community is essential for health policy going forward. At present, transability represents a hypothetical extreme to autonomy and the way we characterise disability under the neutral model. Until more cases present are well documented by physicians and academics, further policy debate feels somewhat arbitrary in the abstract, and the way we respond will inevitably turn on the social context in which these cases manifest. However, it is my hope that this article encourages readers to go into any discussion with an open mind and a stronger sense of how empowering that status of “disability” can be for those who choose it.