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Zurich** ^{UZH}

Institute of Biomedical Ethics

Ethical Aspects of Body Modifications

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Conceptualizing Body Modifications



What is not a body modification (for our purpose)?

- 1) **Metabolism-caused changes of body composition:** Biological bodies are in constant material flux with the environment, exchanging the physical stuff bodies are made off despite “form invariance”.

→ **Criterion of physical manifestation**

- 2) **Body changes through ageing:** All (biological) bodies underlie changes due to processes of growth and ageing (this may trigger body modifications).

→ **Criterion of time scale**

- 3) **Body changes induced by natural causes:** Variability in biological body forms can result from aberrations in embryogenesis or through infections, accidents etc.

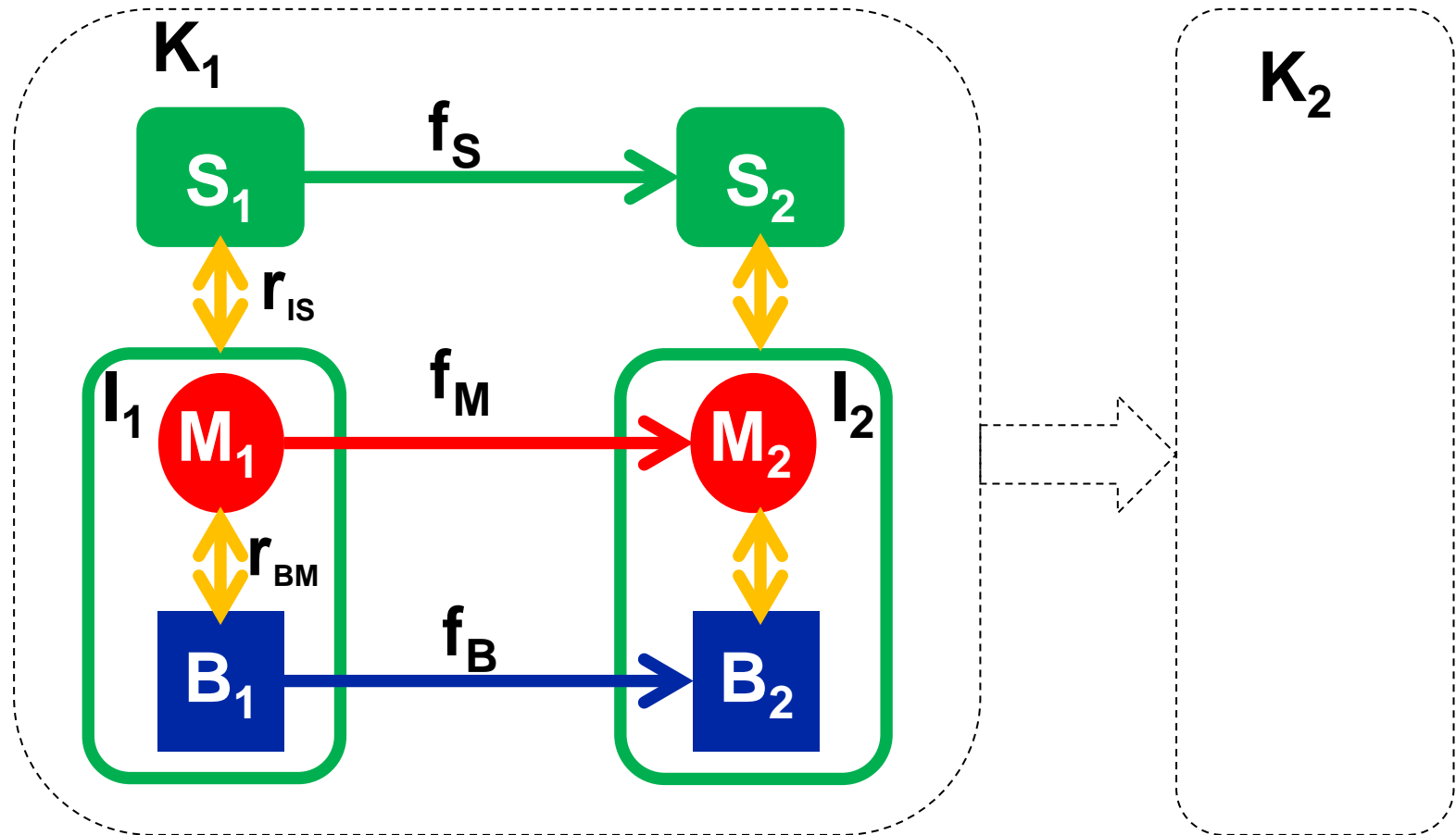
→ **Criterion of intentionality**



Ambiguities in the criteria

- 1) Physical manifestation:** There is a continuum of perceivable body modifications from very subtle changes that only experts may see to major changes in appearance – where to draw the line (e.g. shaving)? And there are ways to hide changes (e.g.: toupee).
- 2) Time scale:** Although we may be able to identify the appropriate time scale on the physical level, time scales also matter on the physical and social components of body modifications (see later).
- 3) Intentionality:** Intentionality may be indirectly involved in causing body modifications (e.g. negligence, risk-taking). And it may underlie processes (e.g. diet decisions) that could lead to body modifications.

Bio-psycho-social view of body modifications





“Modification functions” are interdependent...

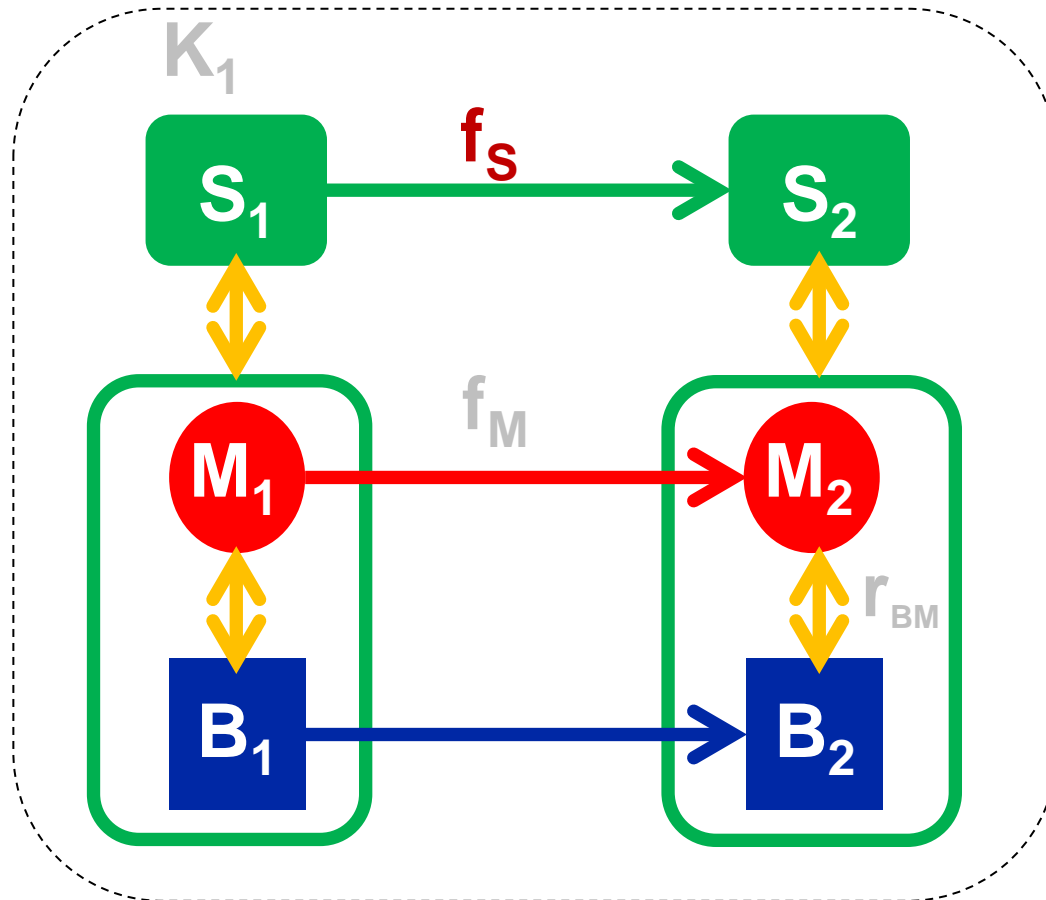
$$B_2 = f_B(B_1(M, S, r_{BM}, r_{IS}, K))$$

$$M_2 = f_m(M_1(B, S, r_{BM}, r_{IS}, K))$$

$$S_2 = f_S(S_1(B, M, r_{BM}, r_{IS}, K))$$

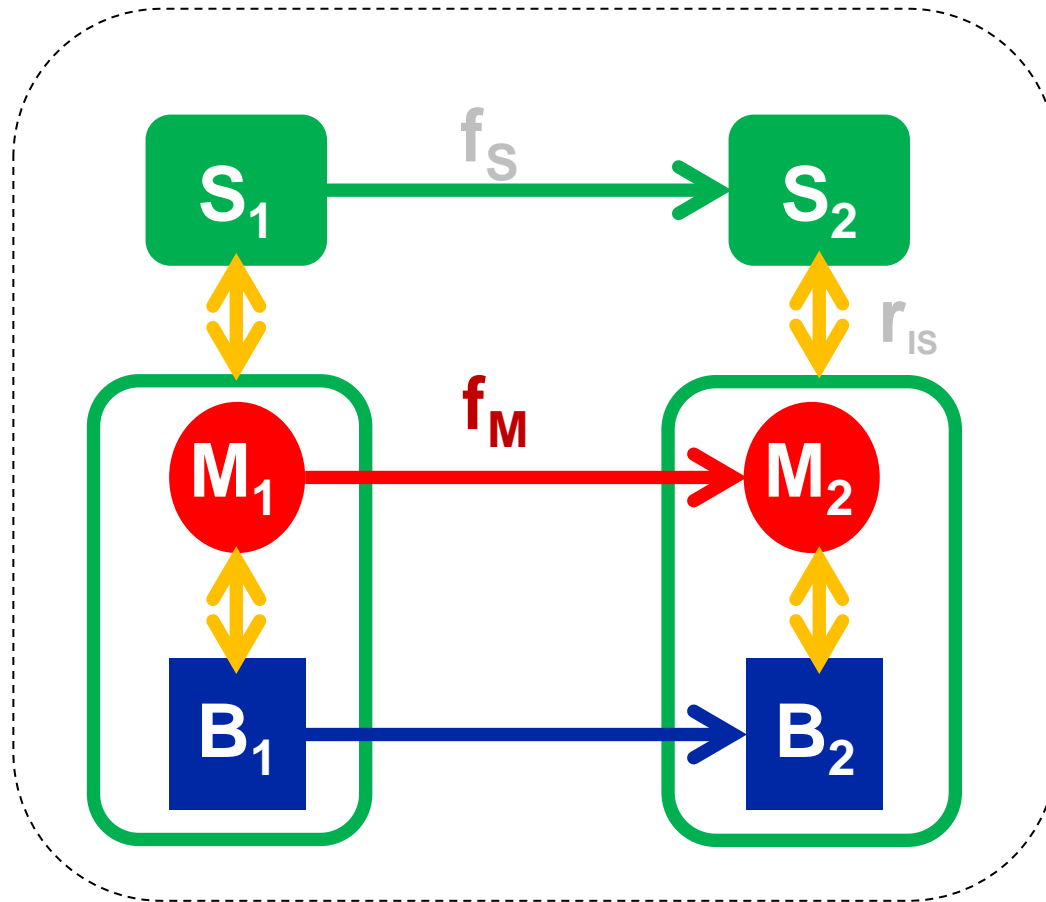
... and various sequences of transformations are possible that are related to different types of uncertainties.

“Cosmetic surgery”: $f_B \rightarrow f_M \rightarrow f_S$



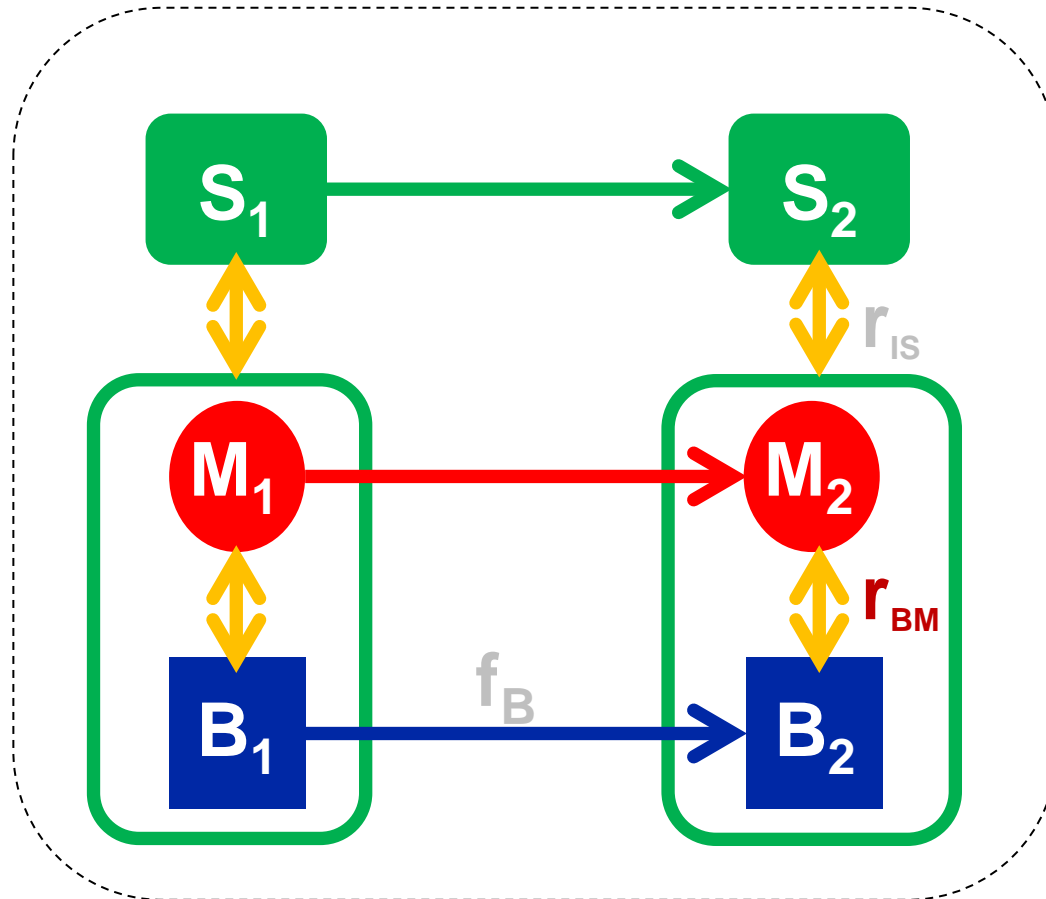


“Teenage Tattoos”: $f_B \rightarrow f_S \rightarrow f_M$



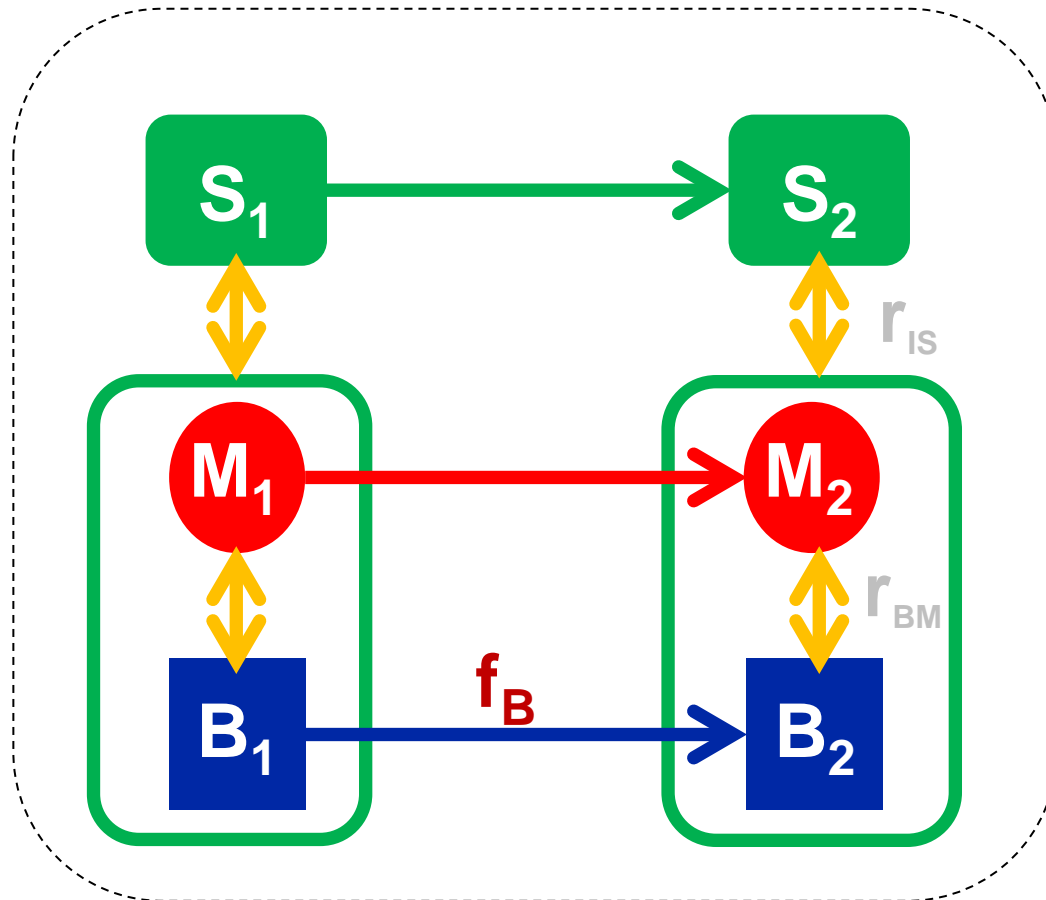


“Living liver donation for your child”: $f_S \rightarrow f_M \rightarrow f_B$



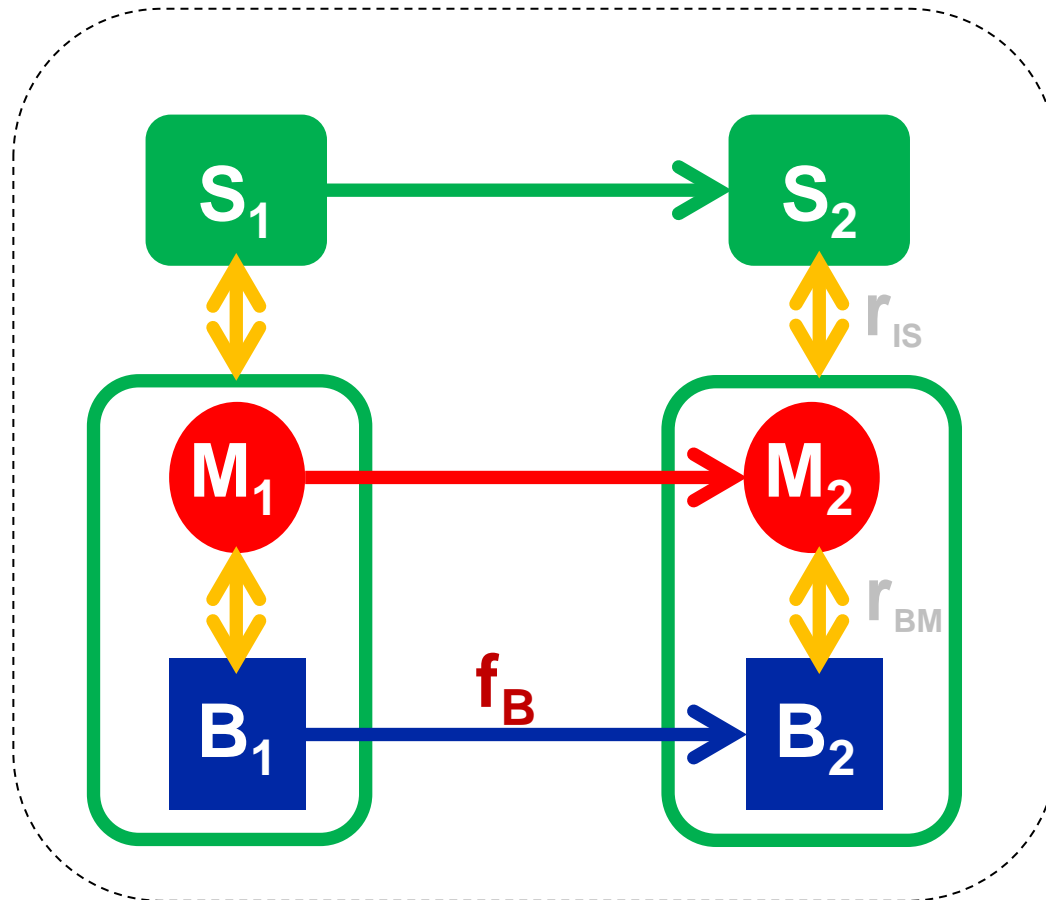


“Converting to Judaism”: $f_S \rightarrow f_B \rightarrow f_M$



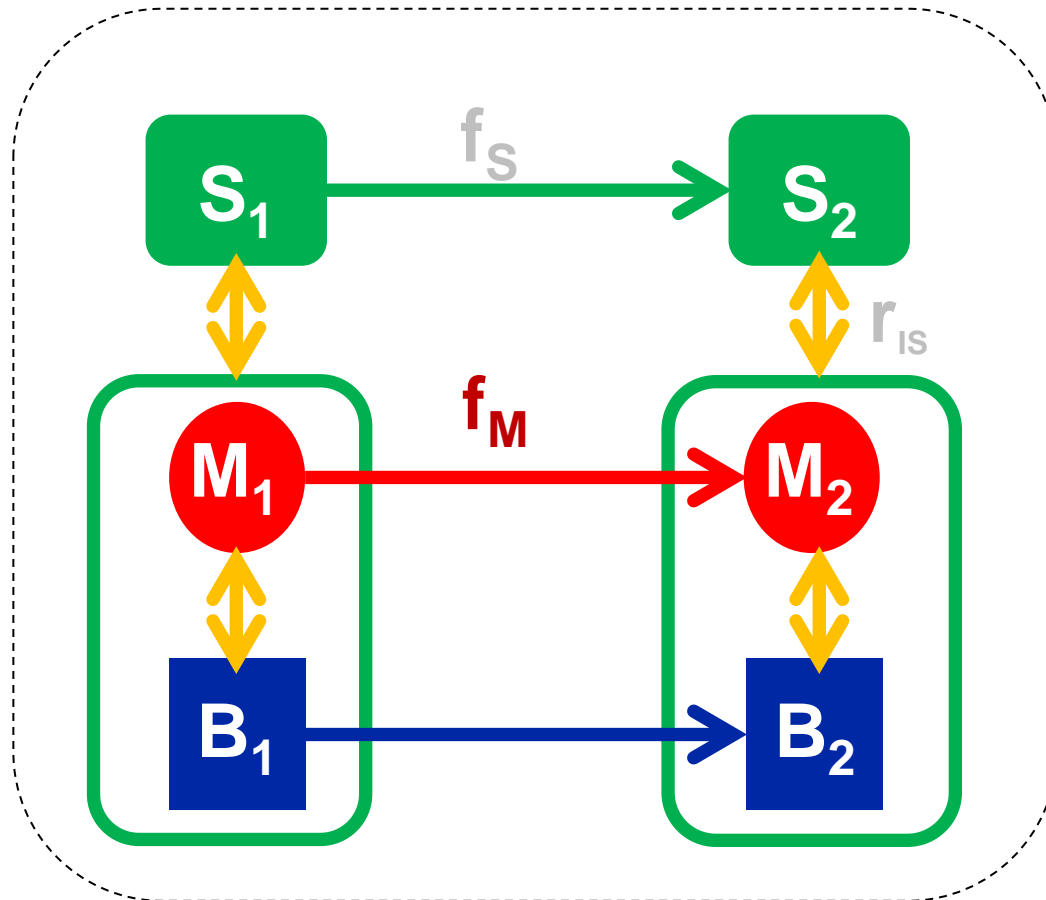


“Breast/ovary ablation in HBC”: $f_M \rightarrow f_B \rightarrow f_S$

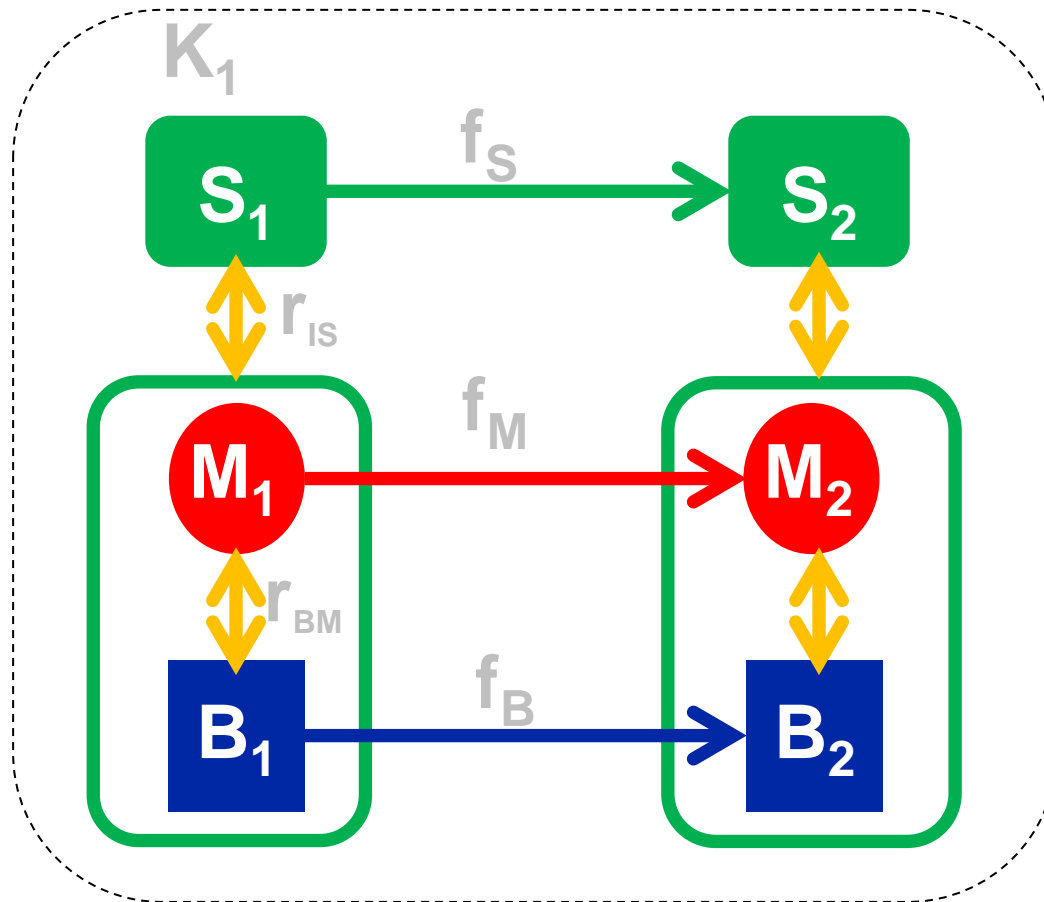




“Joining the Yakuza”: $f_M \rightarrow f_S \rightarrow f_B$



And what about xenomelia...?



Is the fact of joining the BIID community (internet) the first step to get clear that M₂ is “legitimate”?

Is the changed (simulated) M₂-state initiating the body transformation?

Is the detectable “brain state” an “anticipated” body modification?



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An empirical-normative space of (un-)certainty



The empirical dimension

This dimension relates to the uncertainties with respect to cause-effect relations:

- What is the genesis of state X?
- What is influencing X, and how?
- When we change X, what will happen to factors that are associated with X?

Social factors (broad understanding, i.e. K) modulate this dimension, namely in biasing which are acceptable framings of a problem (e.g. as a brain disease or as a psychiatric disease), where we should look for solutions, for what solution strategies we invest money (investment decision create acceptability biases), etc.



The normative dimension

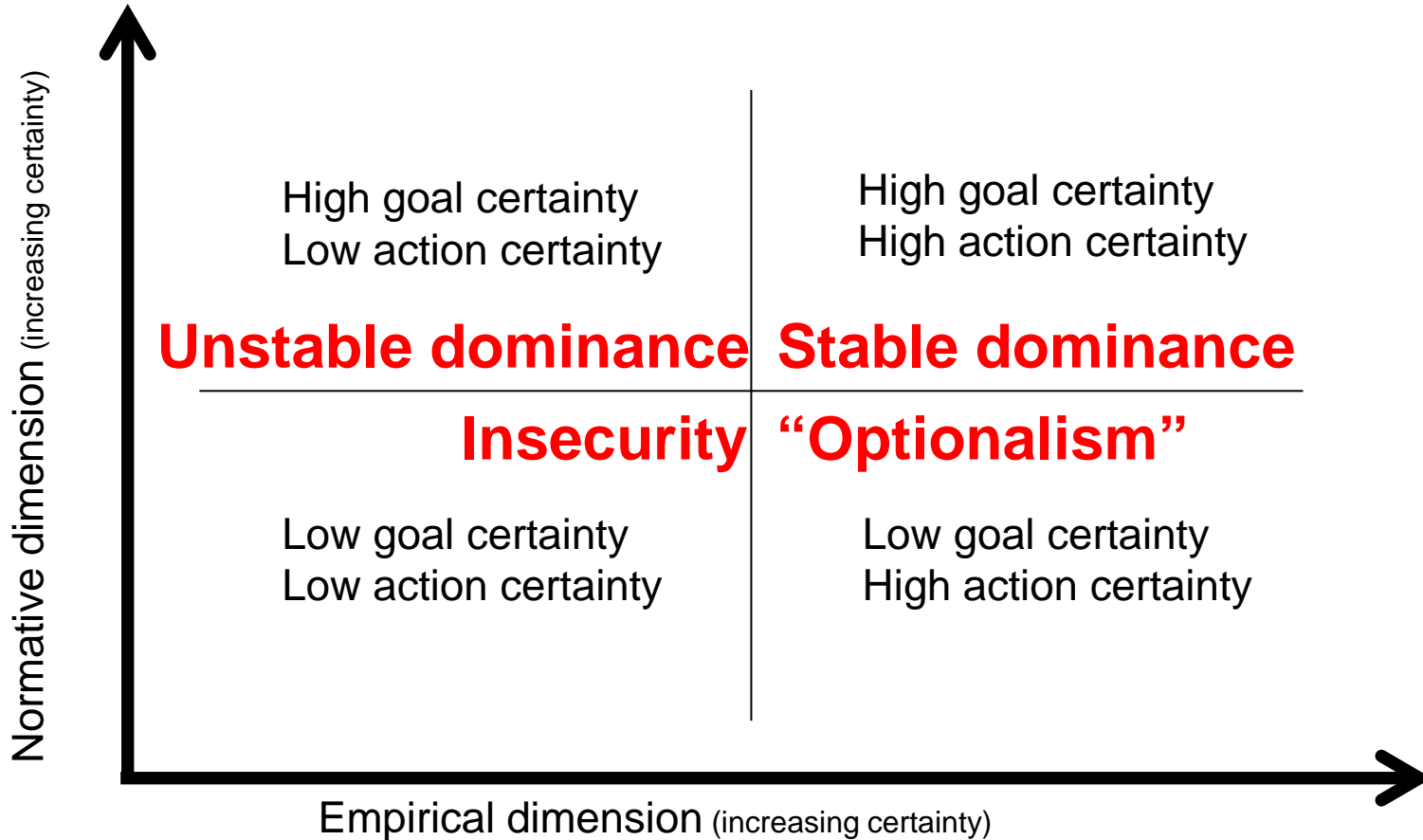
This dimension relates to the uncertainties with respect to justifications:

- Which values play a role in justifications for a body modification M?
- How are they prioritized?
- Is a subject wanting M legitimated to rely on those values?
- What does the value really mean in this particular context of M?

Social factors (broad understanding, i.e. K) modulate this dimension, namely in biasing the weight and interpretation of values (e.g.: status of autonomy in Western societies).

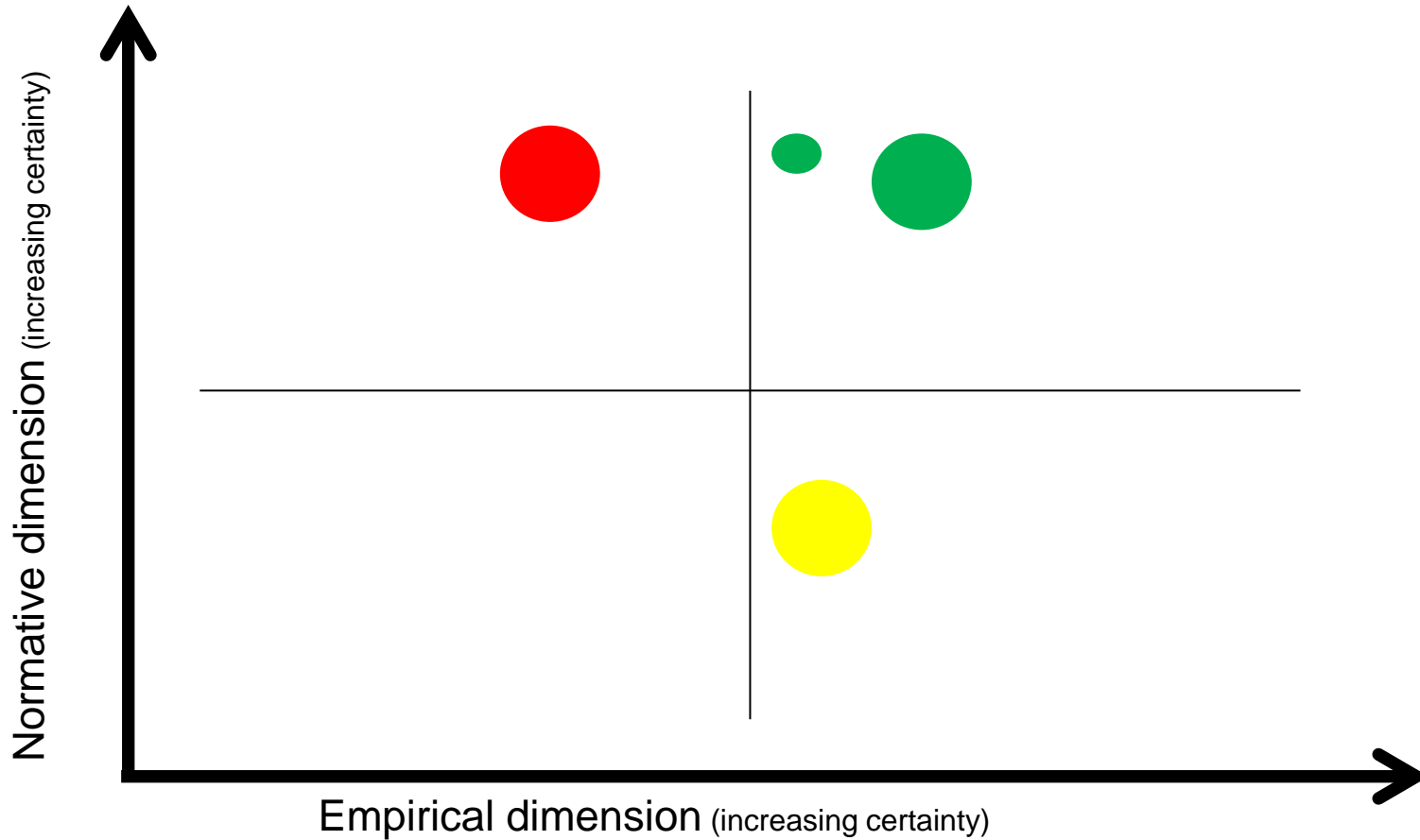


Setting up the empirical-normative space



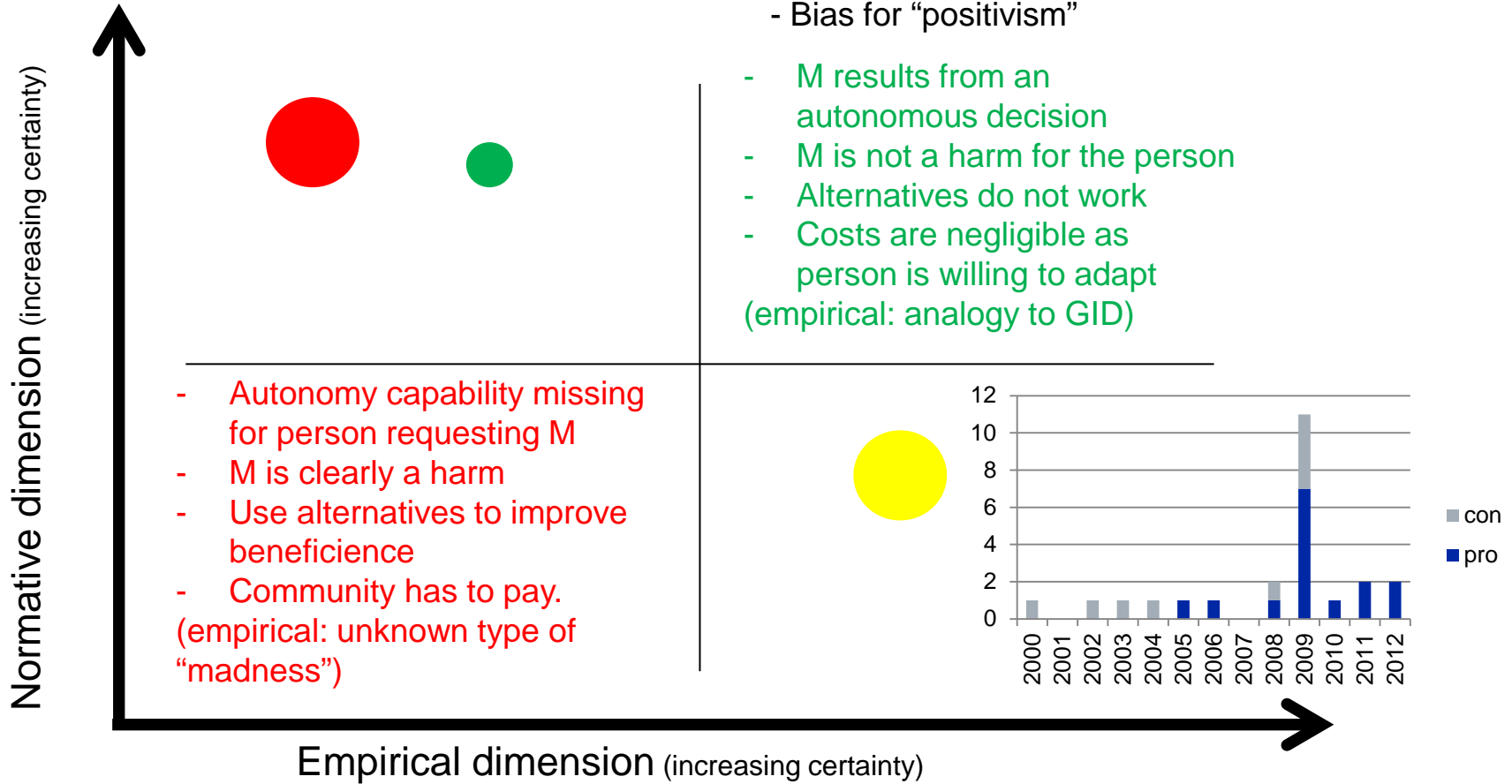


Social modulation – the example circumcision (UK)





Localizing xenomelia



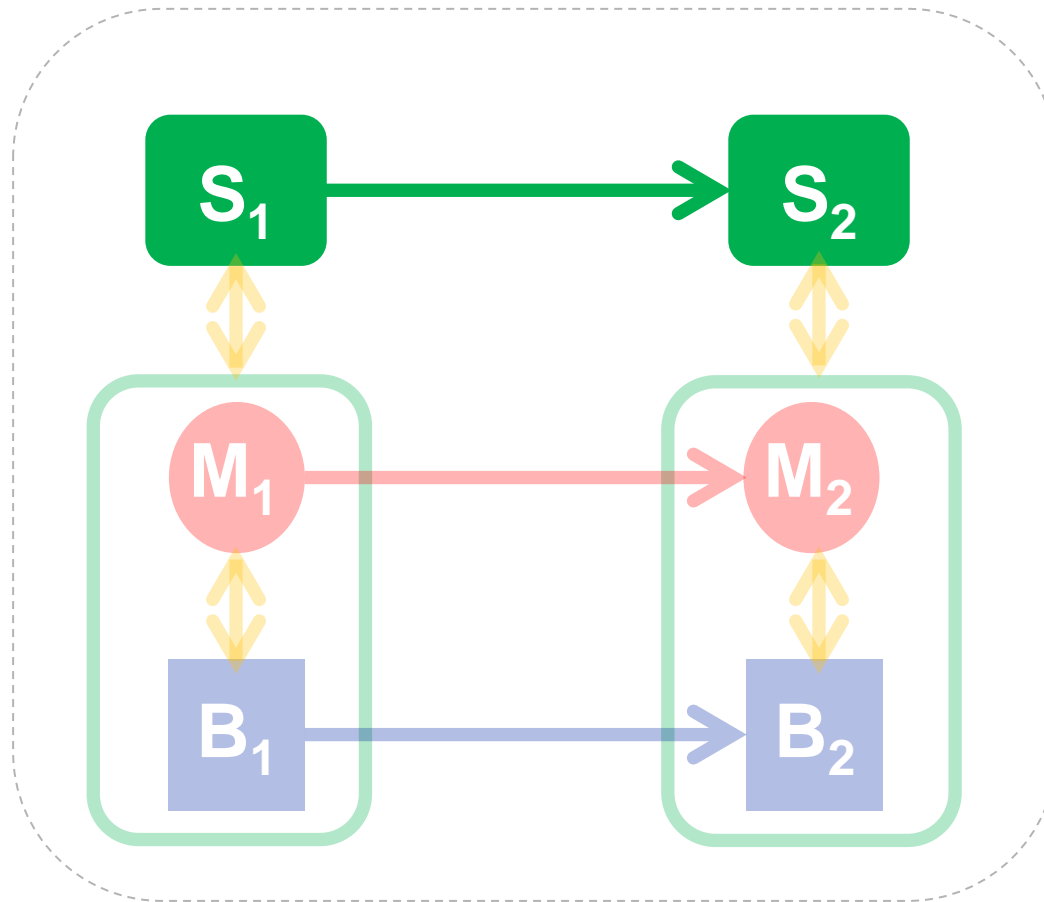


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Practical Challenges of a Surgical Therapy

Becoming dependent

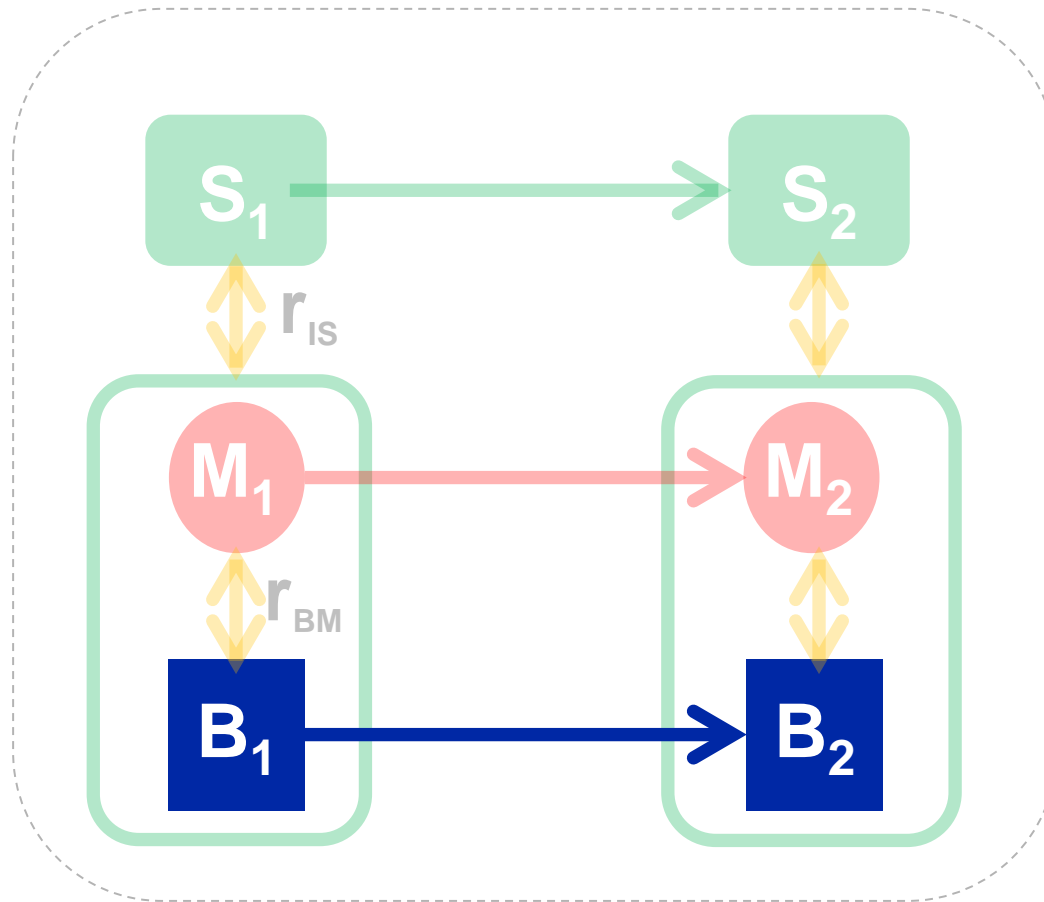


Although the general costs of the intervention may be negligible due to low case numbers, cost sharing will have to be discussed.

Becoming dependent will also affect the close relations of the person requesting M, i.e. they have to be included into the decision making.

The degree of preparation for future disability may be a criterion for eligibility.

Lack of satisfaction

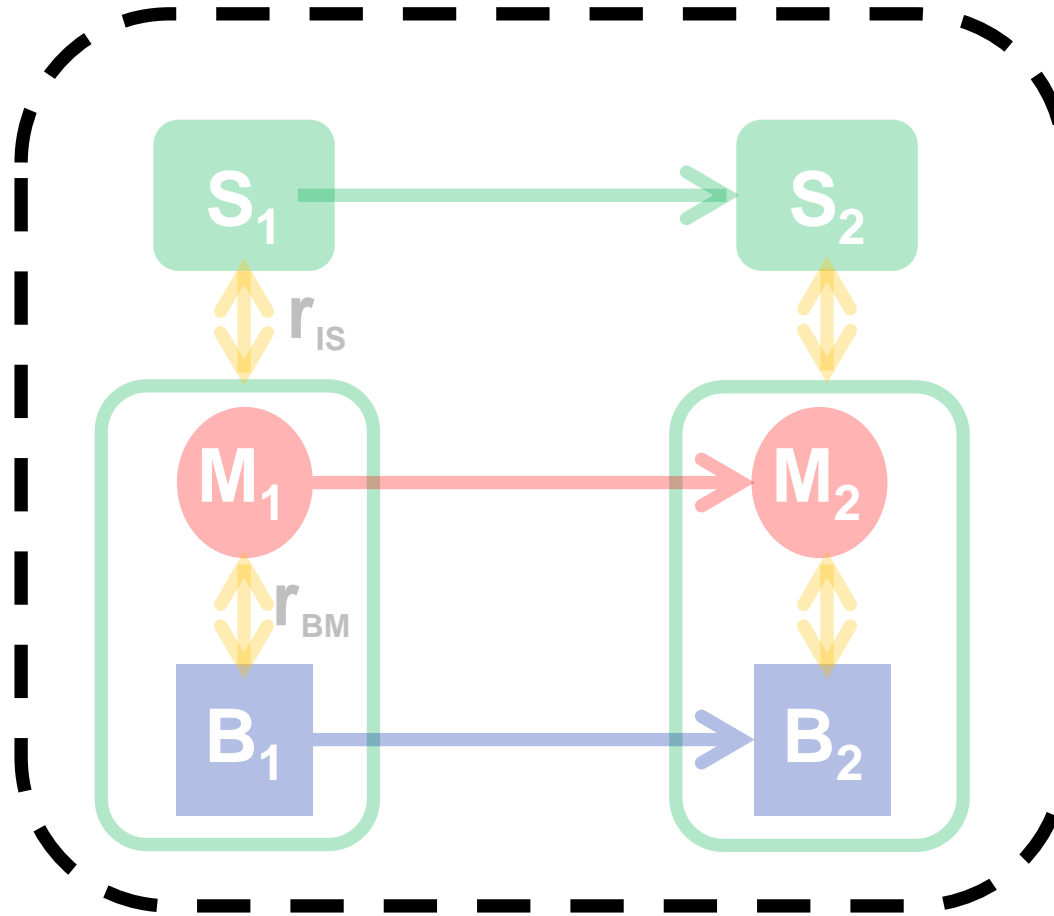


The amount of surgical amputation may be subject of “negotiation” (e.g. staged surgery).

“Stop-points” will have to be defined for the case of wishes for cumulative amputations

One may have to include a “non regress” clause for the case that an amputation is regretted.

Awareness for cultural effects

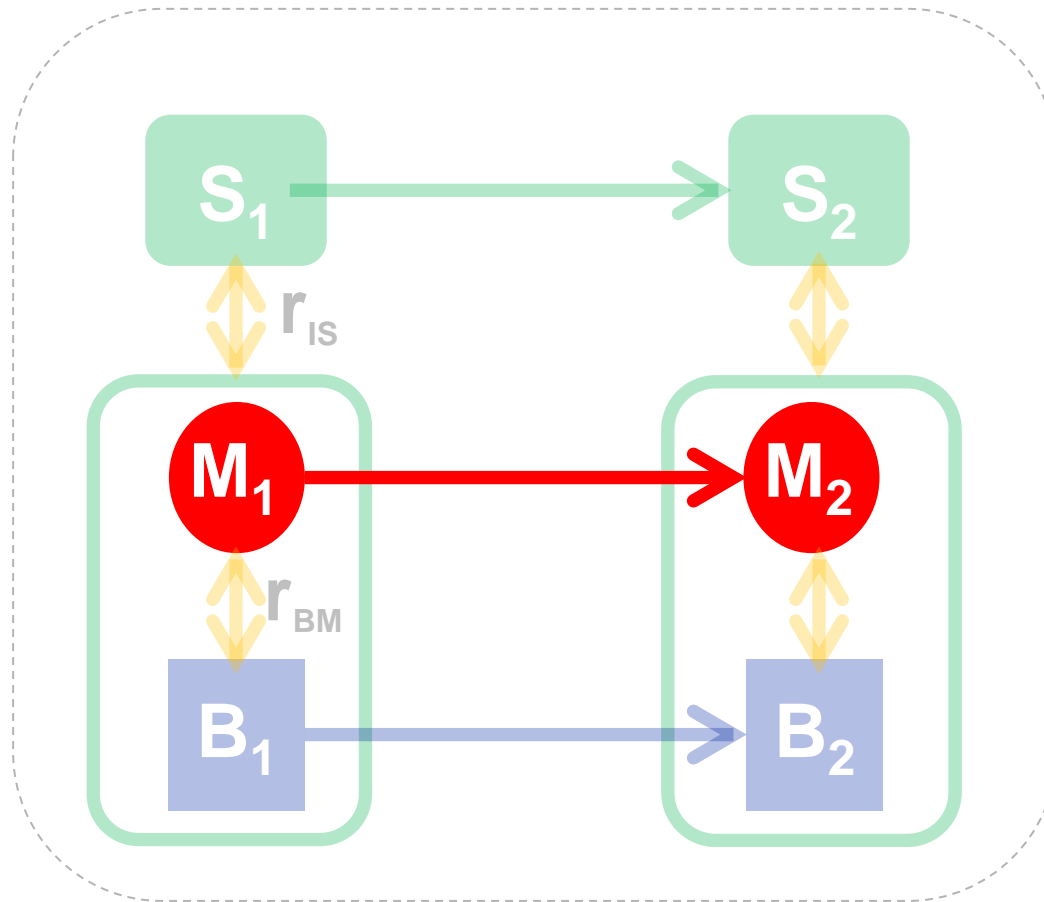


Vulnerability of psychotic persons searching for “new identities” have to be taken into account.

One may think of a “code of communication” with respect of “advertising” being a “BIID person”.

And what about cultures that will (due to lower weight of autonomy) never accept surgical interventions (surgery as human right vs. symptom of decadence)?

Remind ambivalences with respect to autonomy

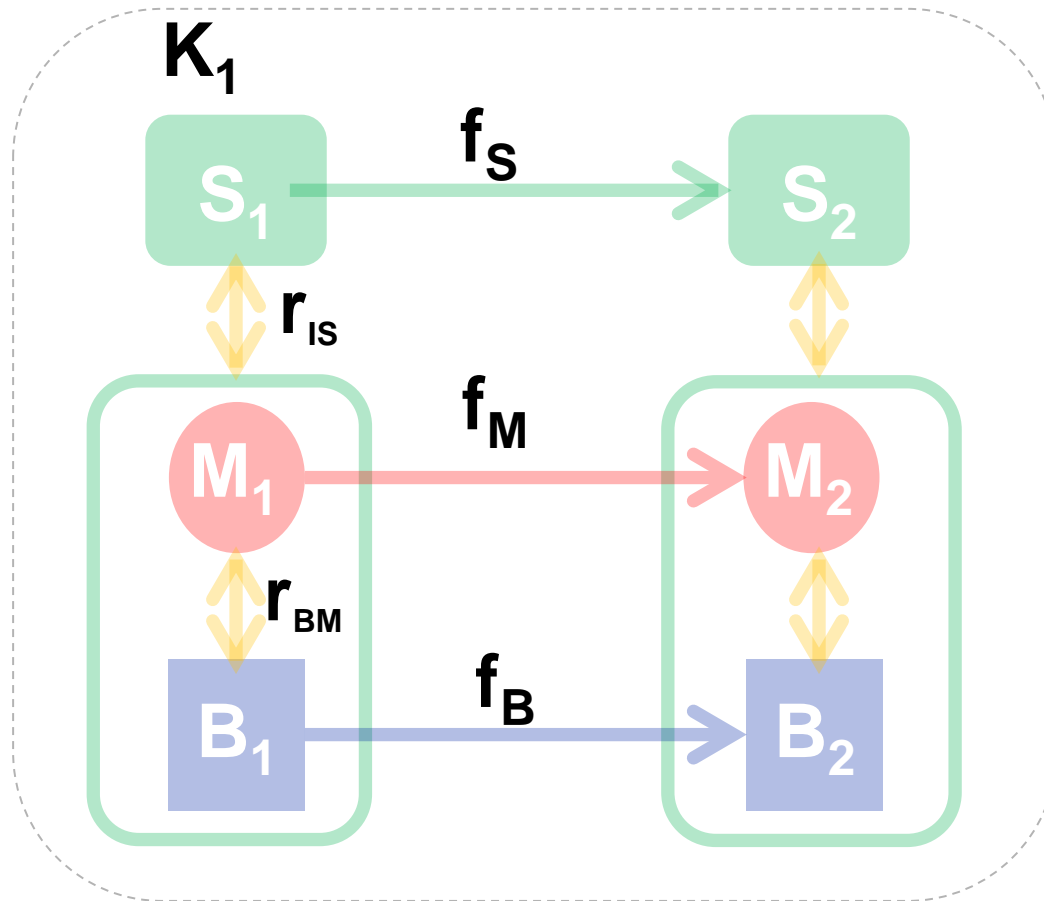


A “neural understanding” possibly leading to new therapies aggravates the problem of autonomy.

A bio-psycho-social model of xenomelia may involve responsibilities for involved persons (e.g., parents).

This also concerns the researchers: they should be aware of the complex feedback effects among the involved levels.

Research on xenomelia



The still low degree of empirical knowledge may require a duty for xenomelia patients: to participate in research.

However, this “back door” (for ethicists) may have unwanted side effects: hindering innovations in medicine by “ethical over-regulation”.

And we will have (again) a conflict with respect to autonomy.



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Thank you!