Towards Developing a Non-ableist and Non-cisnormative Taxonomy of Bodily Integrity Identity and Expression in Canadian Human Rights Law

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At present, Bodily Integrity Dysphoria ("BID") uncomfortably fits within the existing protected ground of "disability," under existing Canadian law. Employing a mixture of critical disability theory and legal analysis, this article comparatively analyzes the legal protections respecting gender identity and expression and applies them to BID, to move towards a taxonomy of the issues and parameters that will invariably warrant consideration when and if a claim for BID human rights protection as a disability or as a protected ground of discrimination arises federally or provincially, which is thus far an untested claim. Normatively, this paper argues that, without diminishing the gains that trans communities have achieved, the same intersectional and legal rationales justifying the human rights protection for gender identity and expression might, from a critical disability theory perspective, similarly but imperfectly or heuristically be applied to persons seeking human rights protection for BID or bodily integrity identity and expression.

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À l'heure actuelle, selon le droit canadien, la dysphorie de l'intégrité corporelle (DIC) s'inscrit incommodément dans le cadre du motif de protection contre la discrimination qu'est la « déficience ». En combinant la théorie critique du handicap et l'analyse juridique, cet article présente une analyse comparative des protections juridiques en matière d'identité et d'expression de genre, et les applique à la DIC, afin de proposer une taxonomie des questions et des paramètres sur lesquels devront immanquablement se pencher les tribunaux, au niveau provincial ou fédéral, dans l'éventualité où une affaire les conduira à déterminer si la personne ayant une DIC fait l'objet de discrimination fondée sur la déficience ou sur un autre motif de discrimination aux termes des codes des droits de la personne. Sur le plan normatif, l'article soutient que, sans minimiser les gains réalisés par les communautés trans, les raisonnements intersectionnels et juridiques qui justifient la protection des droits sur la base de l'identité et de l'expression de genre pourraient, dans l'optique de la théorie critique du handicap, s'appliquer également quoique de manière imparfaite ou heuristique, aux personnes qui cherchent à faire valoir leurs droits en raison soit de la DIC, soit de l'identité liée à l'intégrité corporelle et à l'expression de celle-ci.

I. Introduction

One of the most just and progressive developments in modern federal, provincial and territorial human rights law has been full protection for gender identity and expression.[1] Gender identity and expression became prohibited grounds of discrimination under the *Canadian Human Rights Act* ("*CHRA*") in 2017[2] and under the Ontario *Human Rights Code* ("Ontario *Code*") in 2012.[3] Persons in Ontario, for example, may now indicate their preferred gender on their birth certificates and drivers' licenses or even obtain gender-neutral driver's licenses without undergoing gender affirming surgery ("GAS") (previously referred to as sex reassignment surgery ("SRS") or as gender reassignment surgery ("GRS")).[4] Furthermore, persons seeking GAS may now undergo this procedure under the provincially funded health insurance plan in Ontario, the Ontario Health Insurance Plan ("OHIP"),[5] based on a referral from any qualified physician, not just from one obtained at the Gender Identity Clinic ("GIC") at the Centre for Mental Health and Addictions ("CAMH").[6] This is welcome news for the many people awaiting the procedure in Ontario in 2015, though over one thousand still wait for GAS.[7] In 2016, Ontario also changed the "funding

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1 See Kyle Kirkup, "The Origins of Gender Identity and Gender Expression in Anglo-American Legal Discourse" (2018) 68:1 U Toronto LJ 80 (a history of the linguistic and legal adoption of "identity" and "expression"). See also Friedemann Pfäfflin, "Remarks on the History of the Terms Identity and Gender Identity" (2011) 13:1 Intl J Transgenderism 13.

2 RSC 1985, c H-6, s 3(1); *An Act to amend the Canadian Human Rights Act and the Criminal Code*, SC 2017, c 13.

3 RSO 1990, c H 19 [*OHRC*]; "Gender Identity and Gender Expression" (last accessed 20 October 2021), online: *Ontario Human Rights Commission* <ohrc.on.ca/en/code_grounds/gender_identity> [perma.cc/LY83-RVHP].

4 See Margaret Lawson, "Transgender Glossary of Terms" (paper delivered at the 26th Annual Institute of Family Law Conference, Quebec, 21 April 2017), online: *CanLII* <canlii.org/t/srnp> [perma.cc/Y92W-WBVK]; *XY v Ontario (Government and Consumer Services)*, 2012 HRTO 726 [*XY*]. See also The Canadian Press, "Ontario to Make Driver's Licence Gender Neutral" (30 June 2016), online: *CBC News* <cbc.ca/news/canada/windsor/ontario-drivers-licence-gender-neutral-1.3659541> [perma.cc/XL39-MFS8].

5 See "Apply for OHIP and Get a Health Card" (last modified 21 October 2021), online: *Government of Ontario* <ontario.ca/page/apply-ohip-and-get-health-card> [perma.cc/75FA-SYFA].

6 See "Amendments to the Health Insurance Act and Regulation 552 – Expanding Access to Insured Sex-reassignment Surgery" (6 November 2015), online: *Government of Ontario* <ontariocanada.com/registry/view.do?postingId=19623> [perma.cc/3CE8-VZJR] (RRO 1990, Reg 552 has been amended to add sex reassignment surgery (SRS) as an insured service under the Ontario Health Insurance Plan); "Schedule of Benefits: Physician Services Under the Health Insurance Act" (2 July 2021) at AD7, online (pdf): *Government of Ontario* <health.gov.on.ca/en/pro/programs/ohip/sob/physserv/sob_master.pdf> [perma.cc/G8Z5-295W].

7 See Erica Lenti, "Why the Long Wait for Sex Reassignment Surgery Isn't About to Get Better" (10 March 2016), online: *TVOntario* <www.tvo.org/article/why-the-long-wait-for-sex-reassignment-surgery-isnt-about-to-get-better> [perma.cc/LT7H-V9D8].

criteria for transition-related surgery to align with the World Professional Association for Transgender Health ("WPATH")'s internationally-accepted standards of care for Gender Dysphoria".[8] Comparatively, the requirements and conditions under which GAS is performed and covered by health insurance plans in other provinces and territories is varied.[9]

Regarding these changes to the Ontario *Health Insurance Act*, then-Minister of Health Eric Hoskins said "[e]very Ontarian has the *right* to be who they are. Our health care system should reflect this vision, which is why we are improving access to sex-reassignment surgery".[10] Despite these expanded protections, gender dysphoria (previously referred to as "gender identity disorder") continues to be included in the *Diagnostic and Statistical Manual of Mental Disorders* ("DSM-V"), the authoritative text for medical and psychiatric practitioners in North America.[11] The listing of gender dysphoria in the DSM-V remains problematic,[12] as some do not consider gender identity to be a pathology or disorder.[13] As I will demonstrate, similar

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[8] "Transition-Related Surgery (TRS): Frequently Asked Questions for Persons Considering Surgery in Ontario and the People Supporting Them" (last modified 26 May 2017) at 1, online (pdf): *Centre for Addiction and Mental Health* <camh.ca/-/media/files/transrelatedsurgery-faq-en-pdf.pdf> [perma.cc/6VFQ-CECS].

[9] See "Policy on Preventing Discrimination because of Gender Identity and Gender Expression" (2014), s 5.2, online (pdf): *Ontario Human Rights Commission* <www3.ohrc.on.ca/sites/default/files/Policy%20on%20preventing%20discrimination%20because%20of%20gender%20identity%20and%20gender%20expression.pdf> [perma.cc/WL6E-QXDP] [OHRC, "GIAGE Policy"]; Megan Leslie, "Boys Will Be Girls: Sex Reassignment Surgery and the Ethics of State Funding" (2004) 13:9 Dalhousie J Leg Studies 239 at 241; *Center for Gender Advocacy v Attorney General of Quebec*, 2021 QCCS 191.

[10] "Improving Access to Sex Reassignment Surgery: Ontario Reducing Wait Times for Assessments and Referrals" (6 November 2015), online: *Government of Ontario* <news.ontario.ca/en/release/34796/improving-access-to-sex-reassignment-surgery-1> [perma.cc/T2DW-6L4J] [Government of Ontario, "Improving"]; "Ontario Expands Referrals for Gender Reassignment Surgery" (6 November 2015), online: *CBC News* <cbc.ca/news/canada/toronto/transgender-ontario-1.3307287> [perma.cc/VV4R-2CE6] [CBC, "Expands"] [emphasis added].

[11] See American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed (Washington, DC: American Psychiatric Publishing, 2013), s 302.85.

[12] See Alexandre Baril & Kathryn Trevenen, "Exploring Ableism and Cisnormativity in the Conceptualization of Identity and Sexuality 'Disorders'" (2014) 11:1 Annual Rev Critical Psychology 389 at 397–398 ["Exploring"]; Ido Katri, "Transgender Intrasectionality: Rethinking Anti-Discrimination Law and Litigation" (2017) 20:1 U Pennsylvania JL & Soc Change 51 at 57; Amber Ault & Stephanie Brzuzy, "Removing Gender Identity Disorder from the 'Diagnostic and Statistical Manual of Mental Disorders': A Call for Action" (2009) 54:2 Social Work 187 at 187.

[13] See Florence Ashley, "The Misuse of Gender Dysphoria: Toward Greater Conceptual Clarity in Transgender Health" (2019) 16:6 Perspectives on Psychological Science 1159 at 1159–60; Matthew P Ponsford, "The Law, Psychiatry and Pathologization of Gender-Confirming Surgery for Transgender Ontarians" (2017) 38:1 Windsor Rev Leg Soc Issues 20 at 21; Alexandre Baril et al, "Digging Beneath the Surface: When Disability Meets Gender Identity" (2020) 9:4 Can J Disability Studies 1 at 19; Baril & Trevenen, "Exploring", *supra* note 12 at 398; "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version" (2012) at 5–6, online (pdf): *The World*

problems exist in respect of what is referred to as "body integrity dysphoria".

Both advocates and critics[14] of the legal protection of body integrity dysphoria ("BID") contentiously rely upon legal rationales supporting human rights protections for gender identity and expression.[15] BID, sometimes referred to as "bodily integrity identity disorder",[16] is a rare,[17] complex and inchoately understood phenomenon. Individuals with BID desire and seek ability reassignment/confirming surgery[18] or elective amputation of an otherwise healthy limb in order to achieve a sense of existential[19] or ontological "completeness" or "wholeness" which conforms to their own body image.[20] Put more simply, individuals with BID are typically born able-bodied but seek to live in a body that is physically impaired.[21] Such a desire is seen by the medical establishment as a disorder rather than the autonomous and rational manifestation of choice.

At present, BID – not yet listed in the DSM-V but scheduled for inclusion in 2022[22] – uncomfortably fits within the existing protected ground of "disability" under the *CHRA* or the Ontario *Code*.[23] Employing a mixture of

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Professional Association for Transgender Health <wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf> [perma.cc/VW9H-8HCC]; Jodie M Dewey & Melissa M Gesbeck, "(Dys) Functional Diagnosing: Mental Health Diagnosis, Medicalization, and the Making of Transgender Patients" (2017) 41:1 Humanity & Society 37.

14 See Brenda Cossman, "Gender Identity, Gender Pronouns, and Freedom of Expression: Bill C-16 and the Traction of Specious Legal Claims" (2018) 68:1 U Toronto LJ 37 at 76–77.

15 See Elizabeth Loeb, "Cutting It Off: Bodily Integrity, Identity Disorders, and the Sovereign Stakes of Corporeal Desire in U.S. Law" (2008) 36:3/4 Women's Studies Q 44 at 48; Shirin Heidari, "Sexual Rights and Bodily Integrity as Human Rights" (2015) 23:46 Reproductive Health Matters 1.

16 See Baril & Trevenen, "Exploring", *supra* note 12 at 394.

17 See Christopher James Ryan, "Out on a Limb: The Ethical Management of Body Integrity Identity Disorder" (2009) 2:1 Neuroethics 21 at 21.

18 See Jenny L Davis, "Narrative Construction of a Ruptured Self: Stories of Transability on Transabled.org" (2012) 55:2 Sociological Perspectives 319 at 320.

19 See *ibid* at 328; Jenny Slatman & Guy Widdershoven, "Being Whole after Amputation" (2009) 9:1 American J Bioethics 48 at 48.

20 Anne A Lawrence, "Clinical and Theoretical Parallels between Desire for Limb Amputation and Gender Identity Disorder" (2006) 35:3 Archives Sexual Behavior 263 at 264.

21 See Davis, *supra* note 18 at 319.

22 See Charleen Scupin, Thomas Schnell & Erich Kasten, "How Defined is Gender Identity in People with Body Integrity Dysphoria?" (2021) 35:3 Advances in Mind-Body Medicine 4 at 8.

23 See "Policy on Ableism and Discrimination Based on Disability: Executive Summary" (27 June 2016), online: *Ontario Human Rights Commission* <www3.ohrc.on.ca/en/policy-ableism-and-discrimination-based-disability> [perma.cc/RYB4-SKCL] [OHRC, "Executive Summary"] (the Ontario Human Rights Commission's policy on ableism and discrimination based on disability does not deal with BID specifically); "A Framework for the Law as It Affects Persons with Disabilities" (September 2012) at 100, online (pdf): *Law Commission of Ontario* <www.lco-cdo.org/wp-content/uploads/2012/12/persons-disabilities-final-report> [perma.cc/V36D-YSHJ] (cited by the Ontario Human Rights Commission); OHRC, "GIAGE Policy" *supra* note 9, s 2.

critical disability theory[24] and legal analysis, this article comparatively analyzes the legal protections respecting gender identity and expression and applies them to BID.[25] The purpose of this comparison is to move towards a taxonomy of the issues and parameters that will invariably warrant consideration if a claim for BID human rights protection as a disability or as a protected ground of discrimination arises federally, provincially or territorially.[26] Normatively, this paper argues that, without diminishing the gains that trans communities have achieved,[27] the same intersectional[28] and legal rationales justifying the human rights protection for gender identity and expression might, from a critical disability theory perspective, similarly but imperfectly or heuristically be applied to persons seeking human rights protection for BID, or conceptualized differently as bodily integrity identity and expression.[29]

Terms such as "disability" and "dysphoria" are used in the narrative and discourses involved in Foucauldian exercises of power by government, the medical establishment, the legal profession and even the courts over individual subjects. As such, I too shall use them in this article, while also acknowledging their problematic nature. I do so to expose these terms for what they are: the imposition of notional and reified forms of impairment *on top of* the various ideas, values, definitions of perceived "disabilities." Furthermore, I reveal that non-ableist and non-cisnormative understandings of BID and/or bodily integrity identity and expression already exist outside of these more problematic narratives and discourses, and therefore they

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[24] See Julie Avril Minich, "Enabling Whom? Critical Disability Studies Now" (2016) 5:1 Lateral 1 at 2–3; Sami Schalk, "Critical Disability Studies as Methodology" (2017) 6:1 Lateral 1.

[25] See Antonia Ostgathe, Thomas Schell & Erich Kasten, "Body Integrity Identity Disorder and Gender Dysphoria: a Pilot Study to Investigate Similarities and Differences" (2014) 3:6 Am J Applied Psychology 138 at 138.

[26] The author's research yielded no results in which a claim of discrimination based on BID has been made in any Canadian Human Rights Tribunal or court of law. See Sean Bray, "Gender Dysphoria, Body Dysmorphia, and the Problematic of Body Modification" (2015) 29:3 J Speculative Philosophy 424 (a philosophical inquiry on the topic).

[27] See Lane R Mandlis, "Human Rights, Transsexed Bodies, and Health Care in Canada: What Counts as Legal Protection?" (2011) 26:3 Canadian JL & Society 509.

[28] See Baril et al, *supra* note 13 at 1.

[29] See generally Helen Meekosha & Russell Shuttleworth, "What's So 'Critical' about Critical Disability Studies?" (2009) 15:1 Australian J Human Rights 47 at 48–50; Richard Francis Devlin & Dianne Pothier, eds, *Critical Disability Theory: Essays in Philosophy, Politics, Policy, and Law* (Vancouver: UBC Press, 2006); Robert McRuer, "As Good as It Gets: Queer Theory and Critical Disability" (2003) 9:1 GLQ: J Lesbian & Gay Studies 79; Dan Goodley, "Dis/entangling Critical Disability Studies" (2013) 28:5 Disability & Society 631; Christine Wieseler, "Missing Phenomenological Accounts: Disability Theory, Body Integrity Identity Disorder, and Being an Amputee" (2018) 11:2 Int J Feminist Approaches to Bioethics 83; Catherine Mills, "The Case of the Missing Hand: Gender, Disability, and Bodily Norms in Selective Termination" (2015) 30:1 Hypatia: A J Feminist Philosophy 82.

ought to be legally protected.[30] I use "ableist" to mean the perspective, beliefs and practices that devalue and discriminate against people with physical, intellectual, cognitive psychiatric or other disabilities which often rest on the assumption that "disabled" people need to manifest in one specified form or another other.[31] Finally, I use "cisnormative" to mean the oppression experienced by transsexual and transgender people in a society that identities and represents cissexual/cisgender people as dominant, normal and superior as well as the oppression experienced by people who transform or seek to transform their bodies to achieve a disability.[32]

Part I discusses bodily integrity dysphoria and bodily integrity identity disorder. Part II discusses disability, bodily integrity and security of the person. Part III situates body integrity dysphoria in various narratives while Part IV discusses whether body integrity dysphoria may be properly analogized to gender dysphoria. Finally, Part V seeks to provide a human rights law taxonomy for body integrity dysphoria and/or bodily integrity identity and expression. In effect, this article reifies body integrity dysphoria as an authentic form of human identity and expression in human rights law and advocates for non-ableist and non-cisnormative policy and legal responses.

II. Bodily Integrity Dysphoria & Bodily Integrity Identity Disorder

The nomenclature of BID is complex, if not contentious.[33] For reasons of medical classification, BID is generally seen as belonging on the spectrum of the larger Body Dysmorphic Disorder (BDD).[34] BID is often reclassified as BIID, placing it in a similar position as gender dysphoria.[35] This reclassification is important because those suffering from BDD are typically

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[30] See Shelley Tremain, *Foucault and the Government of Disability* (Ann Arbor: University of Michigan Press, 2015) at 9, 11. See also Licia Carlson, "Cognitive Ableism and Disability Studies: Feminist Reflections on the History of Mental Retardation" (2001) 16:4 Hypatia: A J Feminist Philosophy 124; Alice Dreger, Hermaphrodites and the Medical Invention of Sex, (Cambridge, MA: Harvard University Press, 1998); Nirmala Erevelles, "Voices of Silence: Foucault, Disability, and the Question of Self-Determination" (2002) 21:1 Studies in Philosophy & Education 17.

[31] See Kristen Bottema-Beutel et al, "Avoiding Ableist Language: Suggestions for Autism Researchers" (2021) 3:1 Autism in Adulthood 18 at 18; OHRC, "Executive Summary", *supra* note 23; Law Commission of Ontario, *supra* note 23.

[32] See Baril and Trevenen, "Exploring", *supra* note 12 at 390–91.

[33] See Davis, *supra* note 18 at 322–24.

[34] See Rachel Barnes, "The Bizarre Request for Amputation" (2011) 10:4 Int J Lower Extremity Wounds 186 at 186.

[35] See *ibid* at 186–87; Emma Barrow & Femi Oyebode, "Body Integrity Identity Disorder: Clinical Features and Ethical Dimensions" (2019) 25:3 BJPsych Advances 187 at 188.

not considered viable candidates for surgery, experience poor outcomes, are dissatisfied with results, and in some cases have behaved violently towards the surgeon performing the surgery.[36] BID has also been referred to as "Amputee Identity Disorder", which viewed the condition as an identity disorder rather than a paraphilia or as dysmorphic,[37] and as "apotemnophilia".[38] Apotemnophilia referred to someone with a sexual fetish or paraphilia of being an amputee, but the term was inaccurate as many who experienced the condition are not aroused sexually by their desire to be an amputee.[39] Individuals with BID are also sometimes sub-culturally referred to as "wannabes".[40] Despite the seemingly derisive nickname (used by BID experiencers themselves), such individuals are typically rational, non-psychotic and non-delusional,[41] but are cast in broader cis social narratives as irrational and sexually deviant.[42] Persons aroused by the idea of sexual relationships with amputees are referred to as "devotees"[43] (also used by BID experiencers). When the term is used by others, it perpetuates notions of irrationality and sexual, moral and other deviance from heteronormative, ableist and cisnormative perspectives.[44] The term and diagnosis of "apotemnophilia" are generally no longer used to refer to BID. Given the consensus that BID is not a sexual disorder, linking it to apotemnophilia is not apposite.[45]

There are additional medical terms to refer to BID,[46] but none are conclusive or dispositive. In short, BID "concerns individuals whose perceived body image is that of an amputee and feel that they must lose a limb in order to conform to [their] perceived body image".[47] According to medical and scientific opinion, the etiology of BID as a *disorder* is complex and not easily attributable to psychological issues alone but to the complex

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36 See Barnes, *supra* note 34 at 187.

37 Theodore Bennett, "It's but a Flesh Wound: Criminal Law and the Conceptualisation of Healthy Limb Amputation" (2011) 36:3 Alternative LJ 158 at 160; Barrow & Oyebode, *supra* note 35 at 188.

38 Barnes, *supra* note 34 at 188.

39 See *ibid* at 188; Bennett, *supra* note 37 at 158.

40 Barrow & Oyebode, *supra* note 35 at 189.

41 See Bennett, *supra* note 37 at 158.

42 See Mitchell Travis, "Non-Normative Bodies, Rationality, and Legal Personhood" (2014) 22:4 Medical L Rev 526 at 527.

43 See Barnes, *supra* note 34 at 186; Barrow & Oyebode, *supra* note 35 at 188.

44 Alexandre Baril & Kathryn Trevenen, "'Extreme' Transformations: (Re)Thinking Solidarities between Social Movements through Voluntary Disability Acquisition" (2016) 3:1 Medicine Anthropology Theory 144 at 153 [Baril & Trevenen, "Extreme"]. See Loeb, *supra* note 15 at 51.

45 See Davis, *supra* note 18 at 322–24.

46 Barrow & Oyebode, *supra* note 35 at 188 (including acrotomophilia, factitious disability disorder, and xenomelia).

47 Travis, *supra* note 42 at 527.

interface between psychology, psychiatry, neurology, sexology and developmental issues.[48] There is therefore no conclusive evidence on why BID is experienced.[49] One hypothesis is that BID is most likely a neuro-psychiatric disorder reflecting abnormalities of body image and body representation because of brain dysfunction (in the right superior parietal lobule). This leads to the supposition that BID is not simply a "personal preference".[50] This hypothesis places less emphasis on the experience as a paraphilia and characterizes BID as a multifactorial and neurological disorder.[51] But this view is, strictly speaking, a medical or clinical opinion (not a legal one). Furthermore, BID is not generally classified as a form of anosognosia, though some psychologists may take egosyntonic approaches to understanding BID experience(s).[52]

Some of the key clinical features or manifestations of BID have been identified as: (a) onset in childhood or early adolescence; (b) delay in presentation to 30–50 years of age; (c) predominantly affects males; (d) increased prevalence of homosexual or bisexual orientation; (e) association with gender identity disorder or other paraphilia; (f) association with early exposure to an amputee during childhood; (g) attempts at self-amputation; (h) significant psychological distress and impairment of functioning; (i) lack of psychiatric disorders in family history; (j) lack of association with trauma or impairment to the limb; (k) lack of predominant laterality of affected limb; and (l) possible association with personality disorder.[53] Given the pervasive clinical and diagnostic uncertainties of BID, one scholar described BID as "the desire for healthy limb amputation is a phenomenon in search of a pathology".[54]

These features appear in medical or clinical diagnoses and the legal analysis presented here is not exhaustively or even primarily predicated upon them. However, they do help to illustrate some aspects of the multifactorial "disorder" posited by some medical practitioners to

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[48] See Barnes, *supra* note 34 at 187; Bennett, *supra* note 37 at 158–160.

[49] See Travis, *supra* note 42 at 531.

[50] Barrow & Oyebode, *supra* note 35 at 193.

[51] See *ibid* at 187.

[52] See Karen Jones, Judith Reed-Screen & Oliver H Turnbull, "Implicit Awareness of Deficit in Anosognosia? An Emotion-based Account of Denial of Deficit" (2002) 4:1 Neuropsychoanalysis 69; Michael B First & Carl E Fisher, "Body Integrity Identity Disorder: The Persistent Desire to Acquire a Physical Disability" (2012) 45:1 Psychopathology 3; Camilia Kong, "The Problem of Mental Capacity in Self-Harming Egosyntonic Disorder" in Andelka M Phillips, Thana C de Campos & Jonathan Herring, eds, *Philosophical Foundations of Medical Law* (Oxford: Oxford University Press, 2019) 290.

[53] See Barrow & Oyebode, *supra* note 35 at 190.

[54] Bennett, *supra* note 37 at 160.

characterize BID. Additionally, neither BID nor BIID are listed in the DSM-V, published by the American Psychiatric Association, as disorders, although BDD is listed.[55] Despite not being included in the DSM-V, as mentioned earlier, BID may be seen as being on the spectrum of BDD, even though it may be differentiated. BID is, however, listed in the *International Classification of Diseases* ("ICD"), published by the World Health Organization ("WHO").[56] Notwithstanding the lack of consensus respecting the causes of BID, viewing it as a disorder and only providing responsive non-surgical therapies to BID experiencers perhaps largely reveals socially and clinically ableist and cisnormative ideas of "disability" and "identity" within clinical and legal contexts.[57] Moreover, as Davis points out, the medicalization of BID seeks to attribute its occurrence to a single life occurrence and as something to work through as a medical issue, rather than being seen as part of the self to be embraced by individuals and medical communities.[58] Loeb argues similarly.[59] Implicated in these ideas are notions of how the law ought to respond to claims of BID.[60] That said, just because BID is not listed in the DSM-V does not necessarily mean that it will not be covered by the protections in the Ontario *Code* or remain unfunded by OHIP. While the preceding analysis briefly reveals how BID may be or has been characterized clinically, it is important to next reveal how BID may be or has been characterized legally.

III. Disability, Bodily Integrity & Security of the Person

Because of the predominating ableist and cisnormative views in Canadian society,[61] it is difficult for many to understand how or why someone would seek elective amputation, similarly to how some people cannot relate to gender dysphoria.[62] Questioning why an "able-bodied" person would want to become a "disabled" person is common. Such notions

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55 See American Psychiatric Association, *supra* note 11, s 300.7.

56 See World Health Organization, "6C21 Body Integrity Dysphoria" (May 2021), s 6C21, online: *ICD-11 for Morality and Morbidity Statistics* <www.icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/256572629> [perma.cc/4C7U-2NQS].

57 See Baril & Trevenen, "Exploring", *supra* note 12 at 393.

58 See Davis, *supra* note 18 at 331.

59 See Loeb, *supra* note 15 at 55.

60 See Tremain, *supra* note 30 at 9–10 (people classified medically have developed sociopolitical conceptions of disability).

61 See OmiSoore H Dryden & Suzanne Lenon, eds, *Disrupting Queer Inclusion: Canadian Homonationalisms and the Politics of Belonging* (Vancouver: UBC Press, 2015).

62 See Kristin Savell, "Sex and the Sacred: Sterilization and Bodily Integrity in English and Canadian Law" (2004) 49:4 McGill LJ 1093 (a discussion in respect of sterilization). See Cossman, *supra* note 14 at 58 (a similar discussion in the trans context).

of "ability" and "disability" are, however, inherently measured against the standard of the able-bodied, heterosexual, white male in western societies.[63] The diagnosis of gender dysphoria, for example, as a "disorder" is necessary to receive GAS in Ontario, but such a diagnosis medicalizes the expression of identity. It also perpetuates the stereotypes that transpersons are abnormal, deviant or other.[64] Viewing BID as a "disorder" produces similar results.[65] Gender dysphoria experiencers and those who identify and express their gender outside of the male-female binary are diverse in age, sexual orientation, ethno-racial and educational backgrounds, and relationship and parental status.[66] So too are BID experiencers, and thus the BID experience should not be viewed or understood homogenously.

Attempts to place BID into the protected ground of "disability" because it is a disorder, as gender dysphoria once was placed, is an appropriate and not ignominious *starting point* to understanding BID's awkward status in human rights law and Canadian society.[67] Given BID is imperfectly understood and viewed as a disorder by the medical community, until it or bodily integrity identity and expression becomes an enumerated prohibited ground, there is perhaps little choice but to *prima facie* place BID into the disability category of human rights protections. This is so even if it unnecessarily denies the BID experiencer some form of legal personhood[68] and perpetuates the medicalization of experiencing and expressing self-image and identity.[69] Stated differently, BID and bodily integrity identity and expression challenge ableist and cisnormative notions and expectations of what is means to be a person in society. They also challenge the normative conformity such a society demands and should, among competing perspectives, be so viewed.

However, viewing the BID experience (or bodily integrity identity and expression) as a "disability" runs the risk of perpetuating such notions and

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[63] See Baril and Trevenen, "Extreme", *supra* note 44.

[64] See OHRC, "GIAGE Policy", *supra* note 9, s 5.2.

[65] See Baril & Trevenen, "Exploring", *supra* note 12 at 404.

[66] See "'Psychology Works' Fact Sheet: Gender Dysphoria in Adolescents and Adults" (2016) at 1, online (pdf): *Canadian Psychological Association* <cpa.ca/docs/File/Publications/FactSheets/PsychologyWorksFactSheet_GenderDysphoria_Adults_Adolescents.pdf> [perma.cc/DM38-SDAA].

[67] At this moment in time, unless placed into this category, BID experiencers likely have no other primary human rights grounds upon which to rely other than perhaps secondary ones.

[68] See Travis, *supra* note 42 at 156. See also Meredith M Render, "The Law of the Body" (2013) 62:3 Emory LJ 549.

[69] See Baril & Trevenen, "Extreme", *supra* note 44. See Dewey & Gesbeck, *supra* note 13 at 39 ("Diagnosis is a language of social control, drawing the line between normal and abnormal, and giving power to medical professionals to deal with deviant individuals on behalf of society at large" at 39).

expectations and the continued demand for conformity to mainstream or conventional conceptions of body image and identity. That said, some members of the transabled[70] community support the medicalization of BID as a legal path toward ability reassignment surgery or elective amputation.[71] Others hold a contrary view. Baril, for example, writes: "[for some transabled individuals], transabled people's status as disabled is false and based on lies, deception, trickery, fraud, and betrayal. It is worth noting that trans people's identities are also often conceptualized as inauthentic and fraudulent…Indications of disability and practices such as using a wheelchair or other equipment provoke accusations of spurious disability claims. Such ruses are seen as harmful to disabled communities who must defend themselves".[72] Katri makes a similar point in the gender identity and expression context.[73]

Nonetheless, section 10 of the Ontario *Code* includes mental disorders in its definition of disability.[74] Thus, if BID is clinically classified as a mental disorder, then a BID experiencer who suffers discrimination or harassment (based strictly on BID and not bodily integrity identity and expression) might, depending on the facts, have a viable human rights claim on disability grounds.[75] Whether the BID experiencer can obtain a remedy for discrimination or harassment on the basis of disability does not, however, reach the full extent of the issues that are canvassed here. Instead, a critical question addressed is whether, to comply with Ontario human rights legislation, the provincial government has the positive obligation or duty to fund elective amputation (to accord with bodily integrity identity and expression) which ultimately renders the BID experiencer "disabled."[76] If that is the case, the correlative question emerges of whether BID, or bodily integrity identity and expression, should be recognized as an enumerated ground in Canadian human rights codes like gender identity and expression.

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[70] See Baril & Trevenen, "Extreme", *supra* note 44 at 146; Robin Mackenzie & Stephen Cox, "Transableism, Disability and Paternalism in Public Health Ethics: Taxonomies, Identity Disorders and Persistent Unexplained Physical Symptoms" (2006) 2:4 Intl JL in Context 363.

[71] See Davis, *supra* note 18 at 322.

[72] Alexandre Baril, "'How Dare You Pretend to Be Disabled?' The Discounting of Transabled People and Their Claims in Disability Movements and Studies" (2015) 30:5 Disability & Society 689 at 691 [Baril, "Dare"].

[73] See Katri, *supra* note 12 at 54.

[74] See *OHRC*, *supra* note 3, s 10(1)(d).

[75] See *Moore v British Columbia (Education)*, 2012 SCC 61 at para 33 [*Moore*] ; *R B v Keewatin-Patricia District School Board*, 2013 HRTO 1436 at para 204.

[76] See *Alberta Hospital Assn v Parcels*, (1991) 15 CHRR D/257 at para 227, 1991 CarswellAlta 1225 ("Disability is any difficulty or lack of ability to perform a normal task" at para 227).

If such a duty exists, legally classifying BID as a disability (or enumerating it a prohibited ground) becomes problematic when the very procedure BID experiencers seek to alleviate them from their "disability" will, from an ableist and cisnormative perspective, render them physically or corporeally "disabled." Once the elective amputation has been performed, the BID experiencer may under the same prohibited ground be protected by disability-related human rights law.[77] Such an outcome also raises the question of whether human rights law, which seeks to prevent and remove individualized barriers to full social participation, may be used to generate or construct them instead.[78] Understanding BID as a mental disorder, irrespective of whether it is legally classified as a disability, must therefore be mindful of the interrelated and dominant cultural, political, economic and legal narratives in which it is situated.[79] Simultaneously, BID (and bodily integrity identity and expression) cannot be viewed homogenously,[80] but should be viewed from an intersectional perspective and notions of transability understood through a common narrative of idiosyncratic individual experiences.[81] Furthermore, not all BID experiencers will identify as transabled.[82]

Once situated in these inexhaustive interrelated narratives, existing legal protections for bodily integrity and security of the person provide some guidance when determining whether the positive obligation to fund elective amputation is incumbent on the provincial or territorial government, and whether provincial human rights legislation ought to be amended to enumerate bodily integrity identity and expression as a protected ground. Doing so refines and adds conceptual variables and limitations into the taxonomy.[83] For example, concurring with Chief Justice Brian Dickson and Justice Beetz in *Morgentaler*, Justice Wilson held "the right to 'security of the person' under s 7 of the [*Canadian Charter of Rights and Freedoms* ("*Charter*")] protects both the physical and psychological integrity of the individual [claiming its protection]."[84] Justice Beetz held in the same case "'[s]ecurity of the person' must include a right of access to medical treatment for a

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[77] Might it be said that disabilities are "traded"?

[78] See Davis, *supra* note 18 at 330 (debates over the effectiveness of BIID's inclusion in the DSM).

[79] See Loeb, *supra* note 15.

[80] See Baril & Trevenen, "Exploring", *supra* note 12 at 390 (BID might include surgeries that limit vision or hearing).

[81] See Davis, *supra* note 18 at 320.

[82] See Baril & Trevenen, "Exploring", *supra* note 12 at 394.

[83] See *OHRC*, *supra* note 3, s 10(3) (while this section may encompass a subjective component to understandings of "disability," it is not expansive enough to cover BID).

[84] *R v Morgentaler*, [1988] 1 SCR 30 at 173, [1988] SCJ No 1 [*Morgentaler*].

condition representing a danger to life or health without fear of criminal sanction. If an act of Parliament forces a person whose life or health is in danger to choose between, on the one hand, the commission of a crime to obtain effective and timely medical treatment and, on the other hand, inadequate treatment or no treatment at all, the right to security of the person has been violated."[85] While seeking elective amputation or amputating oneself are not criminally prohibited actions, the *Morgentaler* holding is important to a legal understanding of BID and bodily integrity identity and expression,[86] as are the judgements from the *Rodriguez*,[87] *Carter*,[88] *Blencoe*[89] and *Bedford* cases.[90]

In *Rodriguez*, though overruled by *Carter* on other grounds, Justice Sopinka held:

> *Morgentaler* can be seen to encompass a notion of personal autonomy involving, at the very least, control over one's bodily integrity free from state interference and freedom from state-imposed psychological and emotional stress…Lamer J also expressed this view, stating…that '[s]ection 7 is also implicated when the state restricts individuals' security of the person by interfering with, or removing from them, control over their physical or mental integrity.' There is no question, then, that personal autonomy, at least with respect to *the right to make choices concerning one's own body, control over one's physical and psychological integrity, and basic human dignity are encompassed within security of the person*, at least to the extent of freedom from criminal prohibitions which interfere with these.[91]

Justice Robins, of the Ontario Court of Appeal, similarly held in *Fleming* that the "common law right to bodily integrity and personal autonomy is so entrenched in the traditions of our law as to be ranked as fundamental and deserving of the highest order of protection. This right forms an essential part of an individual's security of the person and must be included in the liberty interests protected by s 7 [of the *Charter*]".[92] The preamble to Bill C-7,

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[85] *Ibid* at 90.

[86] See Mandlis, *supra* note 27 at 514; Joyce Outshoorn, "The Struggle for Bodily Integrity in the Netherlands" in Joyce Outshoorn, ed, *European Women's Movements and Body Politics*, (London: Palgrave Macmillan, 2015) at 52–83. See also Joyce Outshoorn at al, "Women's Movements and Bodily Integrity" in Joyce Outshoorn, ed, *European Women's Movements and Body Politics*, (London: Palgrave Macmillan, 2015) at 1–21.

[87] See *Rodriguez v British Columbia (Attorney General)*, [1993] 3 SCR 519, [1993] SCJ No 94 [*Rodriguez*].

[88] See *Carter v Canada (Attorney General)*, 2015 SCC 5 [*Carter*].

[89] See *Blencoe v British Columbia (Human Rights Commission)*, 2000 SCC 44 at para 54 [*Blencoe*].

[90] See *Bedford v Canada (Attorney General)*, 2013 SCC 72 [*Bedford*].

[91] *Rodriguez*, *supra* note 87 at 10 [emphasis added].

[92] *Fleming v Reid*, [1991] 82 DLR (4th) 298 at para 41, 4 OR (3d) 74.

which amended Canada's *Criminal Code* provisions respecting medically assisted dying in 2021, recognized similar principles.[93]

These cases make clear that every person in Canada has the *negative* right to be free from state-interference with their bodily and mental integrity, and that criminalizing health services which would allow them to maintain control over such integrity violates the constitutional protections found in section 7 of the *Charter*.[94] Less clear is whether, in the absence of criminalization, withholding health services produces the same result, despite Justice Sopinka's view in *Rodriguez,* the unanimous Court's view in *Carter* and Justice Bastarache's view in *Blencoe* that persons enjoy "freedom from state-imposed psychological and emotional stress".[95] It is known, for example, that making individuals wait for GAS increases their likelihood of completing suicide.[96]

If personal autonomy with respect to the right to make choices and to control one's own physical and psychological integrity is encompassed within security of the person, then a BID experiencer *may*, from a constitutional perspective, have the *positive* right to obtain and consent to a surgery which, in their minds, allows them to be whole. This is true even if an ableist and cisnormative perspective would find that the surgery renders the BID experiencer "disabled."[97] Stated differently, by not funding elective amputations (but not prohibiting them), OHIP may be imposing upon the BID experiencer the very psychological and emotional stress that would otherwise be alleviated by the elective amputation the BID experiencer seeks.[98] A similar issue was answered in *Blencoe*: "[a]lthough an individual has the right to make fundamental personal choices free from state interference, such personal autonomy is not synonymous with unconstrained freedom. In the circumstances of this case, the state has not

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[93] See Bill C-7, *An Act to amend the Criminal Code (medical assistance in dying)*, 2nd Sess, 43rd Parl, 2021 (assented to 17 March 2021).

[94] See *Canadian Charter of Rights and Freedoms*, s 7, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

[95] *Blencoe*, *supra* note 89 at paras 55–57. See *Carter*, *supra* note 88 at para 64; Mandlis, *supra* note 27 at 515.

[96] See Iman Sheikh, "Why Surgery Wait Times Put Transgender People at Risk of Suicide" (29 April 2015), online: *TVO* <www.tvo.org/article/why-surgery-wait-times-put-transgender-people-at-risk-of-suicide> [perma.cc/6AAQ-9LFZ]. See also "Lesbian, Gay, Bisexual, Trans & Queer Identified People and Mental Health", online: *Canadian Mental Health Association Ontario* <ontario.cmha.ca/documents/lesbian-gay-bisexual-trans-queer-identified-people-and-mental-health/> [perma.cc/MW5C-QENN].

[97] See Aimee Louise Bryant, "Consent, Autonomy, and the Benefits of Healthy Limb Amputation: Examining the Legality of Surgically Managing Body Integrity Identity Disorder in New Zealand" (2011) 8:3 J Bioethical Inquiry 281.

[98] See Travis, *supra* note 42; Loeb, *supra* note 15 at 45. See also *Blencoe*, *supra* note 89 at para 56.

prevented the respondent from making any 'fundamental personal choices'".[99] In the absence of any such prevention from making fundamental personal choices to electively amputate, an assertion of a *positive* right to elective amputation is therefore likely to fail under *Charter* jurisprudence.[100] However, failure of such an argument is not guaranteed given the Supreme Court of Canada's ("SCC") holding in *Gosselin* that: the administration of justice does not refer exclusively to processes operating in the criminal law; section 7 jurisprudence recognizes that the administration of justice can be implicated in a variety of circumstances; and the SCC has not yet determined that an adjudicative context is necessary in order for section 7 to be implicated.[101]

Therefore, it seems that most, if not all, restrictions (not just criminal ones) that would prevent the BID experiencer from elective amputation might be seen to interfere with such autonomy and control or "fundamental personal choices" in the same fashion that terminating a pregnancy did in *Morgentaler*, provided such restrictions did not deprive the experiencer of the security of the person.[102] While there currently is no such legal restriction to elective amputation or self-amputation, physicians are reluctant to perform elective amputations for BID experiencers for a variety of medical, ethical and legal considerations. This often leads patients to self-amputate under unsanitary, unsafe and generally gruesome conditions.[103] Aside from ethical and medical concerns, from the physician's or surgeon's point of view, the surgery which the BID experiencer seeks involves essentially committing an assault/battery upon their patient, an offence under the *Criminal Code*. Performing elective amputations may also constitute a tort.[104] Even though the BID experiencer willingly and informedly consents to the procedure, consent is only a limited and subjective defence to an assault under Canadian criminal law.[105] If such elective amputations verily constitute an assault or battery under criminal law (and remain unaccepted

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[99] *Blencoe*, *supra* note 89 at para 54

[100] It is important to be mindful that this paper is mostly concerned with human rights concerns, rather than strictly *Charter* ones.

[101] See *Gosselin v Quebec (Attorney General)*, 2002 SCC 84 at para 78.

[102] See *Bedford*, *supra* note 90 at para 105.

[103] See Travis, *supra* note 42 at 529–530; Bennett, *supra* note 37 at 161.

[104] See e.g. *Carbone v Whidden*, 2013 ABQB 434 at paras 19, 40 (the defendant doctor should have referred a patient for psychiatric assessment, and not operated, had he thought the patient experienced body dysmorphic disorder).

[105] See *R v Jobidon*, [1991] 2 SCR 714, [1991] SCJ No 65 (for when consent will be vitiated). See also Dennis J Baker, "Should Unnecessary Harmful Nontherapeutic Cosmetic Surgery Be Criminalized" (2014) 17:4 Buffalo Crim L Rev 587.

as a valid form of treatment by the medical community and violate medical ethics), whether physicians or surgeons performing the elective amputation would be harming BID experiencers and therefore interfering with their bodily or psychological integrity becomes a serious legal consideration, as does whether the province or territory has the duty to fund elective amputations.[106] Furthermore, whether funding elective amputations for BID experiencers would sanction state interference with a person's bodily integrity, on the basis that it permits the rendering of an otherwise "abled" person into "disabled" one, also becomes a practical concern.[107] At its core, BID is an experience, identification and expression of bodily autonomy and integrity and, hence, security of the person should – in a world marked by normative ideals of gender and ability – at least be legally viewed as such.[108] As Travis states, "the denial of choice to autonomous individuals in relation to voluntary amputation throws…light on the relationship between legal personhood and pervasive paradigmatic notions of the body".[109]

IV. Body Integrity Dysphoria Situated in Various Narratives

Disability and security of the person concerns – admittedly problematic in relation to other concerns dealt with in this article – provide the conceptual legal *starting point* at which to begin development of the taxonomy presented here. They also subsequently serve as the appropriate *departure point* from which to consider and contextualize some of the wider issues extant in the various interrelated narratives in which BID is situated.

A. Medical & Ethical Considerations

Any amputation procedure or major surgery, in addition to removing a limb, is accompanied by a number of risks and side-effects, including those associated with anesthesia, pain, excessive bleeding, infection and even

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[106] See Loeb, *supra* note 15 at 46; Tracey Elliott, "Body Dysmorphic Disorder, Radical Surgery and The Limits of Consent" (2009) 17:2 Medical L Rev 149 at 162.

[107] See *Morgentaler*, *supra* note 84 at para 22.

[108] See Jonathan Herring & Jesse Wall, "The Nature and Significance of the Right to Bodily Integrity" (2017) 76:3 Cambridge LJ 566 at 575–576. See also Ponsford, *supra* note 13 at 23; Gowri Ramachandran, "Against the Right to Bodily Integrity: of Cyborgs and Human Rights" (2009) 87:1 Denver UL Rev 1.

[109] Travis, *supra* note 42 at 528.

death.[110] Elective amputation is inherently biologically dangerous.[111] From a medical and ethical perspective, several questions arise in respect of elective amputation, and perhaps none as frequently as whether elective amputations may be dismissed as symptomatic of a mental disorder, or as a meaningful, autonomous claim about a deeply held desire by a free, informed, autonomous and consenting subject.[112] Given what may be seen as a "bizarre desire" to amputate an otherwise healthy limb, the capacity of the BID experiencer to consent to such a procedure is widely viewed with suspicion by the medical community and others.[113] Because BID is imperfectly understood and, because from an ableist and cisnormative view, elective amputation inflicts harm in the form of a "manifest disability," most physicians and surgeons are reluctant to perform these surgeries.[114] However, such a position disproportionately places emphasis on the corporeal results of the elective amputation in contrast to the psychological or psychiatric harm that results from *not* performing the elective amputation.[115] Where a BID experiencer cannot find a qualified physician or surgeon willing to perform the elective amputation, some will inflict self-harm in a way to make the surgical removal of a limb(s) a medical necessity, thereby achieving indirectly the results which they cannot obtain directly.[116] The BID experiencer ultimately achieves the desired conformity to their body image and identity, both corporeal and psychological, and gains relief from the distress associated with not yet having undergone *elective* amputation. Bayne and Levy offer similarly persuasive therapeutic justifications for elective amputation.[117] Barrow and Oyebode are supportive of this view, writing:

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[110] See Bennett, *supra* note 37 at 161; Daniel Patrone, "Disfigured Anatomies and Imperfect Analogies: Body Integrity Identity Disorder and the Supposed Right to Self-Demanded Amputation of Healthy Body Parts" (2009) 35:9 J Medical Ethics 541 at 542.

[111] See generally John Kirkup, *A History of Limb Amputation* (London, UK: Springer-Verlag London Limited, 2007) (a detailed discussion on the dangers of amputation).

[112] See Bennett, *supra* note 37 at 158; Peter Brian Barry, "The Ethics of Voluntary Amputation" (2012) 26:1 Public Affairs Q 1 at 5. See also Josephine Johnston & Carl Elliott, "Healthy Limb Amputation: Ethical and Legal Aspects" (2002) 2:5 Clinical Medicine 431.

[113] Bennett, *supra* note 37 at 160. See Robin Mackenzie, "Somatechnics of Medico-Legal Taxonomies: Elective Amputation and Transableism" (2008) 16:3 Medical Law Rev 390.

[114] Barrow & Oyebode, *supra* note 35 at 191.

[115] See Richard B Gibson, "No Harm, No Foul? Body Integrity Identity Disorder and the Metaphysics of Grievous Bodily Harm" (2020) 20:1 Medical L Intl 73; Barrow & Oyebode, *supra* note 35 at 193.

[116] See Barnes, *supra* note 34 at 187–188. See also Bertrand D Berger et al, "Nonpsychotic, Nonparaphilic Self-amputation and the Internet" (2005) 46:5 Comprehensive Psychiatry 380 at 382–383.

[117] See Tim Bayne & Neil Levy, "Amputees by Choice: Body Integrity Identity Disorder and the Ethics of Amputation" (2005) 22:1 J Applied Philosophy 75 at 82–84.

> [T]he point Bayne and Levy seem to be making is that BIID is a condition that causes harm, namely mental suffering, and that doctors have a duty to relieve harm and suffering and are under an obligation to act with beneficence in mind…patients with BIID suffer from psychological distress and often seek to secure amputations either through self-harm or from unorthodox and suspect agents.[118]

Additionally, the question of whether BID manifested as bodily integrity identity and expression ought to be eligible for OHIP funding is further problematized given the medical community itself is divided as to whether elective amputation is a clinically valid form of therapy to treat BID, considering "less invasive" alternatives.[119] As stated earlier, physicians or surgeons able to perform elective amputations harbour concerns that performing such a procedure inflicts permanent harm or serious bodily injury, and further that the person consenting to such a procedure may not be able to truly provide free, informed and autonomous consent.[120] With the verity of the consent in question, physicians or surgeons worry about criminal and tort liability because such consent may ultimately be vitiated if given by a person deemed to be medically "disordered."[121] Thus, instead of performing elective amputations, these medical practitioners currently aim to treat persons who experience BID with non-invasive and non-surgical therapies, such as counseling, pharmaceuticals and/or psychotherapy. However, persons seeking or undergoing elective amputation feel that psychoanalysis, counselling and psychotropic medication are completely ineffective in helping with their experience of BID, and that medical professionals lack a veritable understandings and conceptions of the BID experience.[122]

For similar reasons, some surgeons refuse to perform the surgery because of moral qualms and fears of violating medical ethics.[123] In the lore of the Hippocratic Oath, it is said that one of the abiding principles physicians swear to is to "first do no harm" to patients.[124] Some physicians and surgeons question the ethics of permanently removing an otherwise healthy limb, which may from their perspective contravene this Hippocratic principle and others which guide the practice of medicine,[125] even though

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[118] Barrow & Oyebode, *supra* note 35 at 192.
[119] See Sabine Muller, "Body Integrity Identity Disorder (BIID)—Is the Amputation of Healthy Limbs Ethically Justified?" (2009) 9:1 The American J Bioethics 36 at 42.
[120] See Patrone, *supra* note 110 at 542–544.
[121] See e.g. *Criminal Code*, RSC, 1985, c C-46, s 265. See also Mackenzie, *supra* note 113.
[122] See Travis, *supra* note 42 at 531.
[123] See Bennett, *supra* note 37 at 158.
[124] Davis, *supra* note 18 at 335.
[125] See Mackenzie & Cox, *supra* note 70.

perhaps the same concerns do not exist with respect to GAS (which may involve the removal of organs). Others, however, view these non-surgical therapies as responsive to the BID experiencer's psychological or mental distress and thus as a valid and ethical form of treatment for BID *as a pathology* or *mental disorder*. The medical profession and academy, nevertheless, remain divided over the appropriate medical treatments for BID. One scholar aptly summarizes these medical and ethical concerns: "[t]he pivotal argument seems to be that a surgeon who performs elective amputations of healthy limbs may be at risk of a medical malpractice suit because the procedure is not yet considered by a responsible body of medical opinion to be an appropriate and effective treatment of a medical condition".[126] Another commentator suggests that elective amputation is not the end of treatment, but rather its beginning.[127]

B. Legal Considerations

As noted several times earlier, some surgeons refuse to perform elective amputations for fear of criminal and tort liability.[128] Under the *Criminal Code,* interference with a person's body or bodily integrity is *prima face* criminal.[129] Although insured against malpractice, surgeons performing elective amputations worry that they may be inflicting *permanent* harm or serious bodily injury upon the person seeking the amputation. Surgeons also worry that the person consenting to such a procedure may not be able to truly provide free, informed, and autonomous consent because they purportedly suffer from a pathology or disorder.[130] The conceptualization of the desire for elective amputation as a pathology or mental disorder, however, works to legally disenfranchise the BID experiencer by undermining their ability to give consent by positioning the consent as an irrational symptom of a disordered mind.[131] Patrone writes, "even if we regard the BID patient's response to [their] experience as irrational, this cannot, on the pain of inconsistency, justify a refusal to comply with [their] demands. Irrationality

[126] Barrow & Oyebode, *supra* note 35 at 192.
[127] See J Kirkup, *supra* note 111, at v.
[128] See Barnes, *supra* note 34 at 187.
[129] See e.g. *Criminal Code*, RSC, 1985, c C-46, s 265. See also Bennett, *supra* note 37 at 158.
[130] See Amy White, "Body Integrity Identity Disorder Beyond Amputation: Consent and Liberty" (2014) 26:3 HEC Forum 225 (an argument in support of informed consent with respect to elective amputation); James Stacey Taylor, "Introduction: The Limits of Consent and Conscience in Medicine" (2014) 26:3 HEC Forum 181 (a discussion on the limits of consent).
[131] See Bennett, *supra* note 37 at 160.

is not itself necessarily a reason to deny that a patient is capable of autonomous decision-making as it is understood in the medical context".[132]

Conceptualizing the BID experience as a pathology or disorder directly then implicates the BID experiencer's security of the person under the *Charter* section 7 jurisprudence discussed earlier. Justice Major, for the majority of the SCC in *Starson,* held that capacity to consent involves two criteria: (1) a person must be able to understand the information that is relevant to making a treatment decision, which requires the cognitive ability to process, retain and understand the relevant information; and (2) a person must be able to appreciate the reasonably foreseeable consequences of the decision or lack of one, which requires a person to be able to apply the relevant information to their circumstances, and to be able to weigh the foreseeable risks and benefits of a decision or lack thereof.[133] Generally, BID experiencers would likely be able to demonstrate both criteria in a request for elective amputation.

Furthermore, while it may seem "bizarre" to the ableist and cisnormative observer to find any benefit in elective amputation, the benefits the BID experiencer finds are easily measured in comparatively more frequent and socially normative alterations and amputations of healthy human tissue.[134] Bennett suggests that male foreskin amputation is argued to provide hygienic benefits, liposuction is argued to provide aesthetic and social benefits to the patient (looking and feeling "better"), and that genital modification or amputation is argued to provide identity-based psychological benefits to transpersons in being able to achieve conformity with their self-experienced and self-ideated selves.[135] The idea that subtracting tissue can add something to someone's life is perhaps not as incomprehensible when these other forms of elective amputation are compared to the BID experiencer's desire for similar elective amputations.[136] Furthermore, contextualizing and contrasting BID elective amputation to these practices enables the benefits of the amputation to be validated, or to not be characterized as abnormal or deviant. The contrast may (eventually) help to conceptualize elective amputation as lawful and therefore socially acceptable.[137] In most jurisdictions, however, there is a lack of case law or statutory law dealing with BID, which may be attributed to the discursive

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[132] Patrone, *supra* note 110 at 543–544.
[133] See *Starson v Swayze*, 2003 SCC 32 at para 78.
[134] Bennett, *supra* note 37 at 160–161; see also Berger et al, *supra* note 116 at 380.
[135] Bennett, *supra* note 37 at 161.
[136] *Ibid*.
[137] *Ibid*.

instability surrounding the meaning, desire for and the practice of elective amputation.[138]

C. Cultural & Economic Considerations

The view that elective amputation will always and necessarily—in other words, normatively—result in "disablement" can be tested in two ways.[139] First, while the reasons for denying coverage for elective amputations under OHIP (or another provincial or territorial health insurance plan) may seem obvious to the ableist or cisnormative observer, when viewed with more scrutiny by critical disability theory or the generally critical observer such a position becomes untenable. Cosmetic procedures such as breast augmentation, liposuction, rhinoplasty, removal of superfluous limbs or digits in children, for example, most of which are largely not funded by provincial or territorial health insurance, nevertheless illustrate that there is a wide degree of social and cultural tolerance for body modification in Canadian and other societies.[140] Each of these cosmetic procedures generally attempts to obtain or achieve a normative model of embodiment for the person undergoing the body modification, and none of them are seen as disabling, aberrant, abnormal or deviant.[141] As Bennett writes, "[w]hether or not a procedure that removes healthy tissue is constructed as 'disabling' and 'harmful,' then, seems to be merely a contingent judgment at least partly based on underlying assumptions about what constitutes a 'normal' body and a 'normal' request for body alteration".[142] Baril, a leading trans and disability scholar in Canada, makes similar points in several pieces of scholarship.[143] Patrone is, however, critical of such analogies, writing:

> [A]s we have already seen, the analogy with cosmetic surgery obscures the point that self-demanded amputation is not cosmetic: it necessarily entails permanent disability. If a demand for cosmetic surgery were both irrational and posed an equal threat of serious harm, it is unlikely, or at least equally unclear, that agreeing to the demand for cosmetic surgery would be ethical. Therefore, this analogy cannot do the work required of it. It can only establish that we need not regard all irrational requests as non-autonomous requests; it does not establish that we must also regard irrational and seriously harmful demands for treatment as deserving respect. The

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[138] *Ibid* at 158.
[139] *Ibid* at 159.
[140] *Ibid*; Loeb, *supra* note 15 at 47, 52.
[141] See Bennett, *supra* note 37 at 159.
[142] *Ibid*.
[143] See Baril & Trevenen, "Exploring", *supra* note 12; Baril & Trevenen, "Extreme", *supra* note 44. See also Baril, "Dare", *supra* note 72.

> dissimilarities in likely harms between cosmetic surgery and [BID] self-demands for amputation renders such analogies untenable.[144]

Irrespective of Patrone's point, persons who seek and obtain cosmetic procedures that enable them to conform to their normative self-identity and body image are frequently in the economically advantageous position to purchase these costly surgeries. This thereby places them in the further advantaged position to achieve such conformity without threat to their security of the person and without being subjected to the gaze[145] and scrutiny of the public and government health officials. Furthermore, ableist and cisnormative observers do not view these individuals as "disordered" in the way that gender dysphoria and BID experiencers are viewed for having sought out and privately paid for these cosmetic surgeries. Stated differently, while the normativity which informs or underpins the conceptualization of elective amputation is self-evident in the medicalization or pathologization of the BID experience, there is no equivalent demand from society to pathologize a desire for body alteration that corresponds more closely to socio-cultural ideals, or that falls within the range of acceptable ableist and cisnormative somatic presentations.[146] GAS surgery is funded by OHIP but the question remains whether elective amputations may be properly analogized to GAS.

Second, elective amputation may not necessarily be "disabling" for the BID experiencer who undergoes the procedure, but it may place them in the social position of being "disabled" because of societal norms that make "accommodation" of their "disabled" status as BID experiencers inadequate. As Bennett writes, "[t]he conception that the amputation of a limb is always and necessarily disabling in every case can be seen to be less an accurate reflection of the physical capabilities of amputees and more the projection of an assumption based on one's internalized and normative desire to be 'able'-bodied".[147] Such a view is deeply entrenched and internalized in the law.[148]

This entrenchment and internalization is further exemplified in the social and legal discussion of how limited public resources should be distributed

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[144] Patrone, *supra* note 110 at 544.

[145] See Caroline Evans & Lorraine Gamman, "The Gaze Revisited, or Reviewing Queer Viewing" in Paul Burston & Colin Richardson, eds, *A Queer Romance: Lesbians, Gay Men and Popular Culture* (London, UK: Routledge, 1995) at 14–17.

[146] See Bennett, *supra* note 37 at 160.

[147] *Ibid* at 159.

[148] *Ibid*.

in society.[149] Funding the elective amputation of an able-bodied person's otherwise healthy limb, such that they become corporeally "disabled", creates the question of whether they then become normatively "disabled" and perhaps financially dependent upon the province or territory.[150] Questions about the distribution of medical, hospital and human resources to perform elective amputations are also raised,[151] leading to the description of elective amputations by some as "resource theft."[152] Patrone writes "the difference between a refusal of treatment and a demand for it is, in fact, significant because respecting the latter, in some contexts, might divert medical resources away from other patients who might have legitimate needs for them".[153] Barrow and Oyebode write "[t]he concern that Patrone expresses is best described as distributive justice, a term that refers to the fair, equitable and appropriate distribution of resources in society determined by justified norms that structure the terms of social cooperation".[154] Yet, it is precisely "norms", justified or otherwise, which are being interrogated here.

D. Benefits of Elective Amputation

These interrelated narratives leave perhaps the most important question of all unanswered: whether elective amputation can be said to be for the "benefit" of the BID experiencer. One medical view holds that turning an otherwise "able-bodied" person into a "disabled" one cannot be beneficial to the BID experiencer given the inherent biological and medical dangers discussed earlier.[155] That said, from a psychological perspective, the BID experiencer's desire for elective amputation is often unwavering and frequently marked by longevity, resilience and perhaps even freedom.[156] Further, the limited evidence available shows that those BID experiencers who have succeeded in removing their unwanted limbs through elective amputation are pleased with the result. One individual who underwent elective amputation remarked that five years after the surgery they "felt the

[149] See Loeb, *supra* note 15 at 54.
[150] See e.g. *1402-01547 (Re)*, 2015 ONSBT 477 (CanLII); *1804-02552 (Re)*, 2019 ONSBT 2756 (CanLII); *1907-05422 (Re)*, 2020 ONSBT 828 (CanLII); *810-06788 (Re)*, 2019 ONSBT 2047 (CanLII) (gender dysphoria has been recognized by the Ontario Social Benefits Tribunal as a disability for ODSP purposes).
[151] See Barrow & Oyebode, *supra* note 35 at 193.
[152] Baril, "Dare", *supra* note 732 at 693.
[153] Patrone, *supra* note 110 at 543.
[154] Barrow & Oyebode, *supra* note 35 at 193.
[155] Bennett, *supra* note 37 at 161.
[156] *Ibid*.

best [they] ever felt".[157] Noll and Kasten concluded in their 2014 study that "the often assumed negative consequences of an amputation or further surgery do not occur. Thus, a realization of the wish of a person affected by BIID could be a possible form of therapy for patients, when other therapies have shown no effects".[158] Such a development raises questions of whether BID may be properly analogized to gender dysphoria and whether elective amputations should be funded under OHIP in a similar manner as GAS.

V. Analogizing Gender Dysphoria to Body Integrity Dysphoria

Strong parallels between BID and other identity disorders such as gender dysphoria are frequently identified.[159] Analogizing BID to gender dysphoria is contentious and even controversial.[160] Despite this controversy, their comparison carries value because manifestations of gender identity and expression as well as bodily integrity identity and expression thwart patriarchal society's heteronormative, ableist and cisnormative project. Furthermore, making this comparison permits the development of a taxonomy of the legal issues that may arise in a human rights claim predicated on BID. Thus, the comparison is not being made for its own sake or to abrogate the achievements trans-persons and trans-communities have made in our society. Instead this comparison illustrates the complicated legal issues that BID presents to Canadian and Ontarian human rights law[161] to reify body integrity dysphoria as an authentic form of human identity and expression in human rights law and to advocate for non-ableist and non-cisnormative policy and legal responses.

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[157] *Ibid*. See Müller, *supra* note 119.

[158] Sarah Noll & Erich Kasten, "Body Integrity Identity Disorder (BIID): How Satisfied Are Successful Wannabes" (2014) 3:6 Psychology & Behavioral Sciences 222 at 222, 231. See also Elliott, *supra* note 106 at 162–164.

[159] See Barrow & Oyebode, *supra* note 35 at 187.

[160] See Baril & Trevenen, "Exploring", *supra* note 12 at 390–391. See generally Lawrence, *supra* note 20 at 263.

[161] See Baril & Trevenen, "Exploring", *supra* note 12 at 391–392 (the hierarchy between "identity troubles" in a sex-negative, ableist, and cisnormative society).

A. Contextualizing the Analogy

The comparative inquiry and the analogy drawn here based on the similarity of self-expression and self-identity, phenomena not easy to describe or quantify.[162] The Chief Justice of Canada, Richard Wagner, remarked that "identity is not about labels. It is a shorthand for how people see themselves, how others see them, and how those two things interact in peoples' lives…it flows from the *experience* of their personal and group characteristics. Experience is what separates identity from a mere catalogue of attributes".[163] This article aims to taxonomize for law the BID experience as expressive, as identity and as something *more* than a mere catalogue of attributes. It creates this taxonomy by comparatively viewing and inquiring as to whether the legal rationales that support legal protection for gender identity and expression similarly lend themselves to support for bodily integrity identity and expression.

One clinical scholar rightfully posited that transsexualism, as the "extreme form of gender dysphoria", is not based on sexual orientation, not a somatic-type delusional disorder, not a body dysmorphic disorder, not a dissociative identity disorder, and not a body identity integrity disorder.[164] Undergoing GAS therefore is instead about achieving conformity with the way a person feels about themselves, identifies, and wants and needs to live in the world. Garcia-Falgueras, however, suggests that gender dysphoria is unlike BID because the BID experiencer seeks to have *limbs* amputated, not genitals or breasts,[165] intimating that the outcome of elective surgeries in these distinctive situations is radically different. From a clinical perspective, it would therefore seem that drawing an analogy between gender dysphoria and BID may indeed be inapposite. Others might say there is no such distinction to be drawn or that such a distinction is without a difference.[166] But, law might view the matter differently based on the process of analogy, a key feature of the foundational common law principle of *stare decisis*.[167]

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[162] See Alicia Garcia-Falgueras, "Gender Dysphoria and Body Integrity Identity Disorder: Similarities and Differences" (2014) 5:2 Psychology 160 at 160.

[163] The Honourable Mr. Justice Richard Wagner, "How Do Judges Think About Identity? The Impact of 35 Years of Charter Adjudication" (2018) 49:1 Ottawa L Rev 43 at 49.

[164] Garcia-Falgueras, *supra* note 162 at 161–162.

[165] See *ibid* at 162.

[166] See Bray, *supra* note 26 at 429 (comparing "gender identity disorder" and "body dysmorphic disorder" and their medical perception).

[167] See Stephen R Perry, "Judicial Obligation, Precedent and the Common Law" (1987) 7:2 Oxford J Leg Studies 215.

For example, a small and limited study found several similarities between gender dysphoria and BID, most notably with respect to the etiology of the desire: BID sufferers as well as transpersons could not give a rational explanation for their desire for surgery, nor could any substantial explanations of cause and effect be found; however, it was revealed that BID experiencers and people diagnosed with gender dysphoria primarily attributed the etiology to biological-genetic reasons.[168] The authors of this study concluded that

> [T]he evaluation of the findings showed similarities of the feeling that the own biologically healthy or assigned body does not correspond to the subjective mental body image. Both groups confirmed this to a great extent. This incongruence between the own body and the feeling how the body should be was the most important reason to justify the desire for a surgical approximation. This desired surgery in both samples was associated with the hope to establish a congruence between (a) the subjective body image and (b) the visible, physical body.[169]

Given that there is similarity in the hope to establish a congruence between the subjective body image and the visible, physical body in both dysphorias, this article accepts the comparison between gender dysphoria and BID to this extent only, using it as the basis of this article's comparative inquiry. BID experiencers themselves believe that they truly *should have* a physical impairment, not that they *necessarily have* a physical impairment.[170] Furthermore, understanding the legal nomenclature of gender dysphoria is an indispensable precursor to conceptualizing potential legal arguments relative to funding bodily integrity identity and expression under provincial and territorial health insurance and even recognizing bodily integrity identity and expression as a prohibited ground of discrimination under extant or expanded human rights law.[171]

B. The Nomenclature of Gender Dysphoria

Substantial scholarship has been published which interrogates the nomenclature of gender dysphoria, questioning whether the term itself and what it denotes is accurate.[172] Both gender dysphoria and BID are clinical diagnoses, differing significantly from manifestations of gender identity and

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[168] See Ostgathe, Schell & Kasten, *supra* note 25 at 139.

[169] *Ibid* at 141.

[170] See Davis, *supra* note 18 at 323.

[171] See e.g. Zach Strassburger, "Disability Law and the Disability Rights Movement for Transpeople" (2012) 24:2 Yale JL & Feminism 337 at 372, 375.

[172] See e.g. Ashley, *supra* note 13 at 1159–1160 (gender dysphoria should only be diagnosed when it is necessary). See also Ault & Brzuzy, *supra* note 12 at 188.

expression. Gender *identity* is, nevertheless, understood as a person's internal and individual experience of gender and encompasses that person's sense of being a woman, a man, both, neither or anywhere along a spectrum. A person's identity may or may not be the same as or different from their birth-assigned sex.[173] Furthermore, a person may identify outside normative gender categories of female/male and/or may see their gender identity as fluid, moving between different genders at various points in their life.[174] Similarly, *lived* gender identity refers to the gender a person identifies with internally ("gender identity" along the gender spectrum) and expresses publicly ("gender expression") in their daily life.[175]

Gender *expression* is how a person publicly expresses or presents their gender and can include their behaviour, outward appearance such as dress, hair, make-up, body language and voice as well as their chosen name and pronouns, all attributes by which others may perceive a person's gender.[176] In totality, every person, irrespective of their gender identity, expresses gender and does so in any number of ways.[177] People who are trans may, but will not necessarily, seek surgical intervention, GAS, or other health services to align their body with their gender identity.[178]

Trans or transgender is an umbrella term referring to people with diverse gender identities and expressions that differ from stereotypical gender norms. People who fit within this category include but are not limited to: people who identify as transgender; trans women (male-to-female); trans men (female-to-male); transsexual; cross-dressers; or gender non-conforming, gender variant or gender queer.[179] As a term, "trans," therefore, includes people whose gender *identity* is different from the gender associated with their birth-assigned sex and who may or may not seek health services to align their bodies with their internally experienced gender identity.[180] The Ontario Human Rights Commission ("OHRC") has said that "for transgendered people, insisting on their treatment in accordance with

[173] See OHRC, "GIAGE Policy", *supra* note 9, s 3 (defining "gender identity"). See also Lawson, *supra* note 4 (defining "gender identity").
[174] See OHRC, "GIAGE Policy", *supra* note 9, Appendix B.
[175] *See ibid*, s 3.
[176] See *ibid* (defining "gender expression").
[177] See *ibid*.
[178] See *ibid.* See also The World Professional Association for Transgender Health, *supra* note 13 at 9–10 (describing therapeutic options for "gender dysphoria").
[179] See OHRC, "GIAGE Policy", *supra* note 9, at 3.
[180] See *ibid,* s 1.

their birth gender for all purposes is discriminatory because it fails to take into account their lived gender identity".[181]

Gender *non-conformity* (also "gender variant") encompasses individuals who do not follow gender stereotypes based on their sex assigned at birth and who may or may not identify as trans.[182] WPATH has described gender non-conformity as "the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex" and adds that "only some gender-nonconforming people experience gender dysphoria at some point in their lives".[183]

Gender identity and expression as protected grounds in human rights legislation "make it clear that trans people and other gender non-conforming individuals are entitled to legal protections in the same way that people are protected from discrimination and harassment based on race, age, disability and all other prohibited grounds".[184] International human rights principles also provide that every person has the right to define their own gender identity as one of the most basic aspects of self-determination, dignity and freedom.[185] "For legal and social purposes", the OHRC policy states, "a person whose gender identity is different from their birth-assigned sex should be treated according to their lived gender identity".[186]

The question arises of whether BID experiencers should, under human rights law and jurisprudence, expect to be similarly treated according to the level of internal and lived identity and that they wish to express publicly in their daily life even if that identity does not conform to ableist and cisnormative views of physical "ability." If both domestic and international law protect an individual's "right to define their own gender identity",[187] why not in respect of bodily integrity as well? In other words, should transabled persons or transabled forms of identity and expression (transableism) be enumerated prohibited grounds of discrimination under provincial, territorial and federal human rights law? Furthermore, should elective amputations therefore be funded by provincial or territorial health insurance? Bray states "we need new criteria for understanding our justifications for supporting those who seek to modify their bodies, criteria that should not be fully reducible to questions of gender identity…Given

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[181] *Ibid*, s 6. See *Vanderputten v Seydaco Packaging Corp*, 2012 HRTO 1977 at paras 66–67.
[182] OHRC "GIAGE Policy", *supra* note 9, at 3 (defining "gender non-conforming").
[183] The World Professional Association for Transgender Health, *supra* note 13 at 5.
[184] OHRC, "GIAGE Policy", *supra* note 9, s 1.
[185] See *ibid*, ss 1, 5.3.
[186] *Ibid*, s 6.3.
[187] *Ibid*, ss 1, 5.3.

that [gender dysphoria] and [BID] have so much in common, it is worth asking how gender dysphoria came to be privileged as a condition worthy of medically insured treatment with major procedures of body modification, while [BID] is still considered to be a disorder that can manifest itself either as a severe neurosis or as a mild psychosis".[188]

As noted, gender identity and expression are enumerated prohibited grounds of discrimination in both federal, provincial and territorial human rights legislation and no longer awkwardly made to fit within disability grounds and disability-related jurisprudence. This means that transpersons need no longer exclusively contend with the classification of gender identity or gender dysphoria as a "disability" at law, an important distinction in the comparative analysis of gender dysphoria and BID. This does not mean that transpersons in Ontario are not still viewed as "disordered" or do not still suffer discrimination,[189] when they do.[190] Gender dysphoria[191] continues to be seen as a mental disorder and is still listed in the DSM.[192] Despite in some ways denying autonomy to transpersons, this medical diagnosis is in fact what enables a transperson to obtain GAS, without which they might not be availed the GAS provided to them under some provincial health legislation.[193]

WPATH writes in the *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People*:

> Some people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder. Such a diagnosis is not a license for stigmatization or for the deprivation of civil and human rights. Existing classification systems such as the…DSM…and the…ICD…define hundreds of mental disorders that vary in onset, duration, pathogenesis, functional disability, and treatability. All of these systems attempt to classify clusters of symptoms and conditions, not the individuals themselves. A disorder is a description of something with which a person might struggle, not a description of the person or the person's identity. Thus, transsexual, transgender, and gender-nonconforming individuals are not inherently disordered. Rather, the distress of

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[188] Bray, *supra* note 26 at 425–426, 429.

[189] See Ponsford, *supra* note 13 at 30.

[190] See Ayden I Scheim & Greta R Bauer, "Sex and Gender Diversity among Transgender Persons in Ontario, Canada: Results from a Respondent-Driven Sampling Survey" (2015) 52:1 J Sex Research 1 at 1–2; Greta R Bauer et al, "Reported Emergency Department Avoidance, Use, and Experiences of Transgender Persons in Ontario, Canada: Results from a Respondent-Driven Sampling Survey" (2014) 63:6 Annals Emergency Medicine 713.

[191] The World Professional Association for Transgender Health, *supra* note 13 at 5.

[192] See "What Is Gender Dysphoria?" (last accessed 17 January 2022), online: *American Psychiatric Association* <psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria> [perma.cc/LJZ7-QWBK].

[193] See Ponsford, *supra* note 13 at 30–31, 33.

> gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available. The existence of a diagnosis for such dysphoria often facilitates access to health care and can guide further research into effective treatments.[194]

If gender dysphoria is clinically considered a disorder, not a description of the person or their identity, and is not evidence of that person being inherently disordered, then the question arises whether BID must be the same. In other words, can the same rationales that protect gender dysphoria as manifested in gender *identity* and *expression* in human rights law be used to protect BID as manifested in bodily integrity *identity* and *expression*? Specifically, if lived gender *identity* refers to the gender a person identifies with internally and expresses publicly in their daily life,[195] can the same not be said for BID? Can lived bodily identity refer to the physical body a transabled person identifies with internally and expresses publicly as a physically/cisnormatively "disabled" transabled person in their daily life? *Expression*, after all, is how a person publicly expresses or presents their gender and can include their behaviour, outward appearance, body language and other attributes by which others may perceive them. Therefore, would the same not hold true in respect of a person's body or physical ability and image who expresses themselves as cisnormatively "disabled"?[196] Answers to such questions are not easily derived, and as such this article attempts to develop a taxonomy of human rights for BID experiencers.

VI. A Human Rights Law Taxonomy for Body Identity Dysphoria

A possible human rights law taxonomy that answers the above questions are most effectively approached in three stages. The first stage considers whether a person who i*dentifies* as "disabled" from an ableist cisnormative perspective ought to be afforded protection under the disability category in human rights legislation. The second stage considers whether provincial or territorial governments ought to fund BID elective amputations under provincial or territorial health insurance plans. The third stage considers whether federal and provincial or territorial governments ought to

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[194] The World Professional Association for Transgender Health, *supra* note 13 at 5–6.
[195] See OHRC, "GIAGE Policy", *supra* note 9, s 3.
[196] See Baril & Trevenen, "Exploring", *supra* note 12 at 392.

recognize BID as an enumerated prohibited ground in human rights legislation.

A. Disability Protection for Body Integrity Dysphoria

As noted earlier, no consensus exists in the medical and clinical community as to the causes of BID. However, the community has generally agreed that BID presents a complex interrelated etiology. As also noted, BID is not yet listed in the DSM but is listed in the ICD. Whether BID should be listed in the DSM is not an imperative concern of this article. However, should BID come to be listed in the DSM by viewing BID as a mental disorder at law, this article is concerned with whether the BID experiencer may come to be protected under disability-related human rights law and jurisprudence. Such protections could be a heuristic way for human rights systems to *begin* responding to BID until more distinct laws and policies can be developed to respond to BID and bodily integrity identity and expression.[197] In fashioning any such laws or policies, BID should not simply be viewed as only either a medical or social condition, being more appropriately understood in a manner that is attentive to the structurally oppressive considerations in the narratives discussed earlier.[198] That said, Romeo illustrates why a disability paradigm was problematic in the gender dysphoria context, demonstrating why it may prove to be so in the BID context. Romeo states that a disability paradigm "sets up the medical establishment as a gatekeeping institution that regulates gender [or bodily] nonconformity and predicates legal rights on access to health care".[199]

Under the Ontario *Code*, to be successful in a discrimination complaint, a claimant must show: (1) they have a characteristic protected from discrimination, (2) they have experienced an adverse impact within a social area protected by the Code and (3) the protected characteristic was a factor in the adverse impact experienced.[200] Whether a BID experiencer, a transabled person or person manifesting BIIE succeeds in a discrimination complaint (on the basis of disability) will depend on the facts of each case. However, if BID is admitted or acknowledged to be a disability (for medical

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[197] See Davis, *supra* note 18 at 334. See also Lyn Jongbloed, "Disability Policy in Canada: an Overview" (2003) 13:4 J Disability Policy Studies 203 at 208.

[198] See Alexandre Baril, "Transness as Debility: Rethinking Intersections between Trans and Disabled Embodiments" (2015) 111:1 Feminist Rev 59 at 64–66.

[199] Franklin H Romeo, "Beyond a Medical Model: Advocating for a New Conception of Gender Identity in the Law" (2005) 36:3 Columbia Human Rights L Rev 713 at 730.

[200] See *Moore*, *supra* note 75 at para 33.

purposes) then the first stage of the test is generally met. Evidence in respect of the second and third prongs would thus need only be further marshalled in support of any such claim.

When BID is viewed and classified as a "mental disorder", the question as to whether a "mentally disordered" person can provide rational, free and autonomous consent in respect of elective amputation remains unanswered in the BID context. This issue of consent remains despite the fact that generally the consent given to GAS by the gender dysphoria experiencer is not viewed with the same level of suspicion, skepticism or doubt. Such a result may be in part because GAS does not render a person permanently "disabled" in the manner that elective amputation might, a critical difference between GAS and elective amputations. However, research associated with a recently established Canadian organization that assists "detransitioning, desisting, and re-identifying Canadians"[201] suggests that only approximately one per cent of persons who undergo GAS seek to destransition.[202] Nevertheless, the possibility remains that, as the gender dysphoria diagnosis catalyzes the funding and availability of GAS and related health services, BID's classification as a disorder may also catalyze the funding and availability of health services for elective amputations. As such, viewing BID as a disability may be the heuristic, albeit imperfect, starting point for human rights law to contemplate legal responses to BID claims.[203]

On that point, the *Universal Declaration on Human Rights* provides that "[e]veryone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or *other status*."[204] Whether BID qualifies as an "other status" remains a critical question in this taxonomy. However, the *Convention on the Rights of Persons with Disabilities* ("*CRPD*"), which Canada has signed and

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[201] "Detrans Canada: About Us" (last accessed 30 January 2022), online: *Detrans Canada* <detranscanada> [perma.cc/RJ8S-DZNM].

[202] See Tom Blackwell, "'I Feel Angry': Why Some People Regret and Reverse Their Transgender Decisions" (14 December 2020), online: *National Post* <nationalpost.com/news/canada/i-feel-angry-why-some-people-regret-and-reverse-their-transgender-decisions> [perma.cc/N72D-WVKP]; Sara Danker et al, "Abstract: A Survey Study of Surgeons' Experience with Regret and/or Reversal of Gender-Confirmation Surgeries" (2018) 6:8 Plastic & Reconstructive Surgery 189.

[203] See Jeannette Cox, "Disability Law and Gender Identity Discrimination" (2019) 81:2 U Pittsburgh L Rev 315 at 321–22.

[204] *Universal Declaration on Human Rights*, GA Res 217A (III), UNGAOR, 3rd Sess, Supp No 13, UN Doc A/810 (1948), art 2 [emphasis added].

ratified,[205] provides limited guidance towards answering this critical question. In article 25, the *CRPD* provides that:

> State Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability [and] […] shall take all appropriate measures to ensure access for persons with disabilities to health services…In particular, State Parties shall: (a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons…(b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities…(d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care; (e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner; [and,] (f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.[206]

These provisions made in article 25 would seemingly support the BID experiencer's entitlement to appropriate measures and health services for their "disability", much as such measures and health services would be provided to other persons with other cisnormative "disabilities." Article 25(a) might even lend support to the claim that elective amputations are analogous to and thus ought to be similarly viewed and funded as GAS. Article 25(b), in contrast, proves to be of obscure guidance in the BID context.[207] Such obscurity arises because elective amputations are generally not seen by the medical community to be appropriate interventions nor as services designed to minimize and prevent further disabilities. Moreover, providing psychological treatment and therapies to treat BID but not providing or funding elective amputations may also not be seen as "minimizing" but as exacerbating the BID "disability."

The classification of BID and the desire for elective amputation as a "mental disorder" therefore ultimately ends up in a vicious cycle. In this cycle, the transabled person or BID experiencer firstly seeks elective amputation to conform to their own body self-image, seen in and of itself as a "disability." The elective amputation which they seek then results in the

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[205] *Convention on the Rights of Persons with Disabilities*, 30 March 2007, 3 UNTS 2515 (entered into force 3 May 2008, accession by Canada 11 March 2010) [*CRPD*].

[206] *Ibid*.

[207] *Ibid*.

person, from ableist and cisnormative perspectives, becoming physically "disabled", a labelling and classification which the BID experiencer perhaps sought to avoid in the first place.[208] If the elective amputation is not performed or funded, the BID experiencer remains "disabled" and left feeling incomplete or incongruous with their own identity. Nevertheless, viewing BID as a mental disorder and therefore protectable as a "disability" perhaps remains a merely heuristic starting point for further discussions of BID in Canadian law. Romeo emphasizes the problems of such an approach in the gender dysphoria context:

> The result of courts' reliance on the medical model of gender is that those instances of gender nonconformity recognized by the medical establishment are portrayed as real and legitimate – and therefore worthy of at least some legal protections – while other transgressive experiences of gender are viewed as unreal, fraudulent, or illegitimate. Thus, the normative standards to which the medical establishment holds gender nonconforming people in order to access gender-related medical care become mirrored in the recognition of legal rights. The many gender nonconforming people whose experiences do not conform to these norms therefore do not gain the access to legal rights that the medical model of gender affords.[209]

It is not certain that every BID experiencer or transabled person would seek elective amputation. Thus, while the analysis in the BID context does not provide a perfect solution, it does at least demonstrate that new criteria are needed to understand the legal justifications for supporting those who seek to modify their bodies.[210]

B. Funding Body Integrity Dysphoria Elective Amputations

In 2000, a physician in Scotland provided elective amputation to a number of his patients and was ultimately prohibited from performing such surgeries.[211] No similar incidents have yet occurred in Canada. However, given that GAS is now funded in Canada, some BID experiencers might claim that elective amputations should also be funded. At present, elective amputations are not funded under provincial or territorial health insurance, programs such as OHIP retaining the discretion not to fund such surgeries.[212]

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[208] See Katri, *supra* note 12 at 57 (in the transgender context).
[209] Romeo, *supra* note 199 at 733.
[210] See Bray, *supra* note 26 at 425.
[211] See Davis, *supra* note 18 at 334. See also Barry, *supra* note 112 at 1–3.
[212] See *Irwin Toy Ltd v Quebec (Attorney General)*, [1989] 1 SCR 927 at 993, 58 DLR (4th) 577; Mandlis, *supra* note 27 at 520.

Subsection 18(2) of the Ontario *Health Insurance Act* provides that OHIP "may refuse to pay a claim for payment for an insured service provided by a practitioner…if [OHIP] is of the opinion, after consulting with a practitioner who is qualified to provide the same service, that all or part of the service was not therapeutically necessary[; and f]or a service provided by a health facility, if [OHIP] is of the opinion, after consulting with a physician or practitioner, that all or part of the service was not medically or therapeutically necessary."[213] Subsection 18(2) makes clear that funding elective amputations remains at the discretion of the provincial government, should such a claim emerge. But, as raised earlier in the discussion on bodily integrity, is the withholding of funding for elective amputations a form of "state-imposed psychological and emotional stress"? According to a 2004 decision of the SCC, the answer appears to be "no."

In *Auton (Guardian ad litem of) v British Columbia (Attorney General),* the SCC held that not all medical services and only essential services are presumptively funded by provincial health insurance plans and, further, that provinces retain the discretion to decide which services to fund and which not to fund. The SCC held that "[t]he legislative scheme does not promise that any Canadian will receive funding for all medically required treatment. All that is conferred is core funding for services provided by medical practitioners, with funding for non-core services left to the province's discretion. Thus, the benefit here claimed – funding for all medically required services – was not provided for by the law".[214] *Auton* thus affirms that provincial governments are entitled to allocate health services funding as they see fit. This entitlement means that, given the various ambiguities surrounding BID, the province is well within the ambit of the law to decline funding for elective amputations. Such discretion persists even if the BID experiencer is of the position that such surgery constitutes an essential service. This assertion is not, however, dispositive of the question as to whether Ontario *should* fund elective amputations.

While the analogy between GAS and elective amputations may appear *prima facie* apposite, the outcomes from the procedures are at least somewhat different from one another and may therefore be inappropriate for comparison. GAS does not result in reified physical disability (as seen from an ableist cisnormative perspective) while elective amputation ostensibly does. Additionally, the person who undergoes GAS does not necessarily

[213] *Health Insurance Act*, RSO 1990, c H-6, s 18(2).
[214] *Auton (Guardian ad litem of) v British Columbia (Attorney General)*, 2004 SCC 78 at para 35 [*Auton*].

become "disabled" or dependent on social assistance the way the BID experiencer might after an elective amputation.[215] That said, if Canada and its provinces and territories seek to create an inclusive society, does denying elective amputations to BID experiencers not reinforce patriarchal, heteronormative, ableist and cisnormative notions of experience, identity, and human existence? The answer appears to be "yes."

Elective amputations might, however, be funded by OHIP on the basis of economies of scale. For example, OHIP covered 203 GAS in the 2016-17 fiscal year, up from 158 and 154 in the two previous years.[216] The American Society of Plastic Surgeons reported 3,200 GAS surgeries in 2016, the first time that an annual number has been provided.[217] Given the rarity of the BID experience, relative to GAS at least, the proverbial floodgates will not open if elective amputations were funded.

Furthermore, the current Ontario regime respecting GAS may offer some practical guidance as to how elective amputations might be funded. In accordance with the standards established by WPATH, Ontario funds two types of GAS: genital and chest. To qualify for funding under either category, a GAS applicant must: (a) be assessed and recommended for surgery by either one or two healthcare providers (e.g. a qualified doctor, nurse practitioner, registered nurse, psychologist or registered social worker); (b) have a referral for surgery completed and submitted to the Ministry of Health and Long-Term Care by a physician or nurse practitioner; and, (c) have the surgery approved by the Ministry of Health and Long-Term Care before the surgery takes place.[218]

To be approved for genital surgery, a GAS applicant must provide: two assessments recommending surgery (one must be from a doctor or nurse practitioner and the other from a qualified doctor, nurse practitioner,

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[215] See S E James et al, "The Report of the 2015 U.S. Transgender Survey" (2016) at 56, online (pdf): *Washington, DC: National Center for Transgender Equality* <transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf> [perma.cc/X7T5-JE54] (many transgendered persons still experience violence and poverty).

[216] See Kelly Grant, "Toronto Hospital to Become Second in Canada Offering Genital-reconstruction Surgery" (22 June 2017), online: *Globe and Mail* <theglobeandmail.com/news/national/toronto-hospital-to-become-second-in-canada-offering-genital-reconstruction-surgery/article35441753/> [perma.cc/S69V-NTAB].

[217] See "First Ever Data on Number of Gender Confirmation Surgeries" (last accessed 22 January 2022), online: *American Society of Plastic Surgeons* <asps.multimedia-newsroom.com/index.php/2017/05/22/first-ever-data-on-number-of-gender-confirmation-surgeries/> [perma.cc/32ZI-C9Q2].

[218] See "Gender Confirming Surgery" (9 March 2016), online: *Government of Ontario* <ontario.ca/page/gender-confirming-surgery> [perma.cc/Z48M-MWBY] [Government of Ontario, "GAS"].

registered nurse, psychologist or registered social worker), and both assessments must confirm that the GAS applicant: (a) has a diagnosis of persistent gender dysphoria; (b) has completed 12 continuous months of hormone therapy (unless hormones are not recommended); and (c) have lived 12 continuous months in the gender role they identify with.[219] The Ontario government states that, if the applicant obtains GAS surgery before obtaining Ministry approval, the cost of the surgery will not be covered.[220]

To be approved for chest surgery, a GAS applicant must provide: one assessment recommending surgery from a qualified doctor or nurse practitioner, confirming that the GAS applicant has (a) a diagnosis of persistent gender dysphoria and (b) has completed 12 months of continuous hormone therapy with no breast enlargement (unless hormones are not recommended) if the GAS applicant is breast augmentation.[221]

Perhaps similar requirements could be placed on the BID experiencer before elective amputations would be funded under provincial or territorial health insurance. First, BID experiencers or transabled persons seeking elective amputation would need to present two assessments recommending surgery, one from a doctor or nurse practitioner and the other from a qualified doctor, nurse practitioner, registered nurse, psychologist or registered social worker. These assessments would need to confirm that the elective amputation applicant: (a) has a diagnosis of persistent BID; (b) has completed 12 continuous months of counselling or therapy; and (c) has lived 12 continuous months at the level of physical ability they identify with or in conformity with their own body image. An obvious problem with such a regime in the BID context might be obtaining the referrals for elective amputation.

Another more significant problem would be finding physicians or surgeons willing to perform the procedure.[222] By funding elective amputations, however, the BID experience might come to be normalized or regularized in the medical community. In the absence of any proactive steps being taken by a province, a slim possibility remains that denying funding

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[219] See *ibid*.

[220] See *ibid*. See e.g. *CM v Ontario (Health Insurance Plan)*, 2015 CanLII 2414 (ON HSARB); *BJP v Ontario (Health Insurance Plan)*, 2015 CanLII 61761 (ON HSARB).

[221] See Government of Ontario, "GAS", *supra* note 218.

[222] See House of Commons, Standing Committee on LGTBQ2S Health in Canada, *Trans Surgery Briefing Note* by Kate Greenaway & Emery Potter, 42-1, No 28 at 2 (June 2019), online (pdf): <ourcommons.ca/Content/Committee/421/HESA/Brief/BR10451781/br-external/WomensCollegeHospital-e.pdf> [perma.cc/46J3-FC4F] (locating Canadian GAS surgeons or practitioners is also difficult).

for elective amputation is discriminatory and that perhaps the only way a dispositive answer to this question will be given is via adjudication. Whether BID should be an enumerated ground under the Ontario *Code* is similarly tenuous.

C. Enumerating Body Integrity Dysphoria as a Protected Ground

Given that BID is a rare, complex and inchoately understood phenomenon, it might, from an ableist and cisnormative perspective, be seen as premature to provide protection for it as an enumerated ground in human rights codes. However, factors exist that suggest there may be no harm in recognizing bodily integrity identity and expression as distinctly enumerated grounds. Such factors include the small number of people who experience BID, the relatively small number of elective amputations that would be performed and the general desire to create and foster an inclusive society in which every member can realize and achieve their potential without barriers.

WPATH states that gender dysphoria is "discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)".[223] As we have seen, BID shares similar characteristics: there is discomfort or distress caused by a discrepancy between the BID experiencer's bodily identity and the body they were born with. The similarities are ontologically not that far off.

If then, the BID experiencer – generally speaking, a transabled person – experiences a discrepancy between their identity and their ability assigned at birth, should they not be free to undergo an elective amputation funded by the province or territory? The answer to this question perhaps ultimately depends on how one differentiates or chooses to differentiate gender dysphoria and BID. But the common law, with its canon of *stare decisis*, would seem to lend much support to viewing BID similarly to gender dysphoria and further to protecting at law a person's bodily integrity identity and expression in similar fashion as well.

In *XY v Ontario*, the Ontario Human Rights Tribunal ("Tribunal") held that Ontarians are free to choose which gender, if any, to identify with on Ontario birth certificates *prior* to undergoing GAS and that to hold otherwise

[223] The World Professional Association for Transgender Health, *supra* note 13 at 5.

would be discriminatory. The Tribunal held regarding the *Vital Statistics Act ("VSA")* that:

> [T]he legislative scheme conveys the message to the community at large that a transgendered person's gender identity is not "legitimate" in and of itself. Section 36 of the [*VSA*] in particular perpetuates disadvantage and prejudice against transgendered persons because it gives force to the prejudicial notion that transgendered people are not entitled to have their gender recognized unless they surgically alter their bodies. The message conveyed is that a transgendered person's gender identity only becomes valid and deserving of recognition if she surgically alters her body through "transsexual surgery". This reinforces the prejudicial view in society that, unless and until a transgendered person has "transsexual surgery", we as a society are entitled to disregard their felt and expressed gender identity and treat them as if they are "really" the sex assigned at birth. After all, if the law says that a transgendered woman is not "female" until she has had and proved that she has had "transsexual surgery", how can we expect more from citizens at large? In this way, the legislative requirement for "transsexual surgery" in s 36 of the [*VSA*].[224]

By analogy to the Tribunal's reasoning, a person should be free in Ontario to identify as a cisnormatively "disabled" person if that is how to they chose to identify *prior* to undergoing an elective or self-induced amputation. In other words, to say that transabled people are *not* entitled to have their bodily image recognized unless they surgically alter their bodies or that their bodily identity only becomes valid and deserving of recognition if they surgically alter their body through surgery would seem as similarly arbitrary and even discriminatory as it does in the transgender context.[225] Furthermore, to not view a person in the way *they wish* to be viewed would similarly seem to "reinforce the prejudicial view in society that, unless and until a transabled person has [surgery], we as a society are entitled to disregard their felt and expressed bodily integrity identity and treat them as if they are 'really' the person with the body they were born with."[226] To say that these principles apply in the gender dysphoria context and not in the BID context would again appear to be arbitrary and possibly indefensible. As Bray states, "[t]he growing acceptance by the medical community of the need for some transsexuals to modify is testament to the empowerment possible in the sphere of bodily integrity. Yet transsexuals are just one group among many who can suffer the experience of wrong embodiment".[227]

In 2020, Chief Justice Richard Wagner stated with respect to the *Charter* that "[w]hen the Court eventually faces a question touching on transgender

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[224] *XY*, *supra* note 4 at para 172.
[225] See *ibid*.
[226] *Ibid*.
[227] Bray, *supra* note 26 at 435.

identity…[the]…propositions…that identity is not fixed, but changing, and that identity is not innate, but contextual [will provide essential frames of reference]".[228] Chief Justice Wagner also added that "[i]n addition to being shaped by context, identity is an inescapable part of how we see the world. It shapes our perspective. Identity is who we are and where we are coming from. It is fundamental to how we make sense of the world. This is as true of those who are subject to laws as it is of those who make and adjudicate them."[229] Identity is thus fundamental to the Canadian legal system.

If so, then it seems that it would not be inappropriate to view BID and bodily integrity identity expression as its own enumerated ground under human rights codes, given that the BID experience portends multiple opportunities for discrimination. Finally, analogous grounds in *Charter*-related equality jurisprudence describe personal characteristics that are either immutable (characteristics that people cannot change) or constructively immutable (characteristics that are changeable only at unacceptable cost to personal identity).[230] *Charter* section 15 analyses might identify BID experiencers as an analogous group for analytic purposes, but such questions are beyond the scope of this article.[231]

VII. Conclusion

In 2016, Eric Hoskins (former Ontario Minister of Health) stated that "[e]very Ontarian has the *right* to be who they are".[232] If true then, from an ontological legal perspective, the BID experience ought to be viewed as a humanly authentic form and expression of identity that expresses one's legal *right* to be who they are. However, pathologizing BID as a mental disorder, much like gender dysphoria has been pathologized, medicalizes the experience of bodily integrity, identity and expression. This phenomena ultimately denies the BID experiencer that expression, identity and some form of legal personhood.[233] Nevertheless, viewing the BID experience as a "mental disorder" and therefore a "disability" may provide the heuristic

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[228] Wagner, *supra* note 163 at 49.

[229] *Ibid* at 52 [citations omitted].

[230] See "Section 15 – Equality Rights" (last modified 1 September 2021), online: *Department of Justice* <justice.gc.ca/eng/csj-sjc/rfc-dlc/ccrf-ccdl/check/art15> [perma.cc/2VQR-4KR8].

[231] See Wagner, *supra* note 164. See also Jonathan Penney, "A Constitution for the Disabled or a Disabled Constitution - Toward a New Approach to Disability for the Purposes of Section 15(1)" (2002) 1:1 JL & Equality 83.

[232] Government of Ontario, "Improving", *supra* note 10. See CBC, "Expands", *supra* note 10.

[233] See Maria Elisa Castro-Peraza et al, "Gender Identity: The Human Right of Depathologization" (2019) 16:6 Intl J Environmental Research & Public Health 978.

starting point for the reification of the BID experience into just and progressive tangible policy and human rights responses.[234] Elective amputations might then even come to be seen in social and medical discourses as justifiable in the context of an "identity disorder" or "disability."[235] Such an assertion, however, is not meant to denigrate practical and legal understandings of disability nor to assert that disabled individuals are justified in viewing the BID experience as somehow "inauthentic."[236] As Baril writes:

> Anti-ableist activists' sense of entitlement to define disability, combined with their cisnormativity as cisdisabled individuals, provides justification for refusing trans-abled people's right to self-definition. From a cisnormative perspective, transabled people are always at fault. If they do not transition, they are excluded from the category of 'disabled person' and, if they do transition, are considered frauds.[237]

It is important to note that there is no equivalent to the WPATH for BID which might provide advocacy, policy and legal guidance on the interrelated issues respecting elective amputations and the BID experience for BID experiencers. Many BID experiencers must advocate for themselves in isolation with the fear of being stigmatized in a society that still largely demands conformity to white, male, heteronormative, ableist and cisnormative ideals.[238]

Additionally, one study has placed the GAS market size at $319 million USD in 2019, indicating its increased normalization or regularization in the medical field and society.[239] Thus, from an ontological and legal perspective, efforts to make Canadian society more inclusive and to promote full and active social participation and social justice should be welcomed. Such efforts are especially valuable when they thwart the continued assimilationist project of mainstream Ontarian and Canadian society. Humans experience positive emotions when our identities are affirmed.[240] As Davis writes, "selves and identities are interactive performances, played

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[234] See Davis, *supra* note 18 at 335.
[235] Baril & Trevenen, "Exploring", *supra* note 12 at 390.
[236] Baril, "Dare", *supra* note 72 at 695–696.
[237] *Ibid* at 698.
[238] See Davis, *supra* note 18 at 320–21.
[239] See Sumant Ugalmugle & Rupali Swain, "Sex Reassignment Surgery Market Size by Gender Transition (Male to Female {Facial, Breast, Genitals}, Female to Male {Facial, Chest, Genitals}), Industry Analysis Report, Regional Outlook, Application Potential, Price Trends, Competitive Market Share & Forecast, 2020 – 2026" (March 2020), online: *Global Market Insights* <gminsights.com/industry-analysis/sex-reassignment-surgery-market> [perma.cc/A3P4-HNF5].
[240] See Davis, *supra* note 18 at 327.

out in complex ways".[241] BID is a unique experience and should be treated as such.

That said, the comparison between gender dysphoria and BID may seem *prima facie* apposite. However, there may be too many contingent questions which need to be answered in respect of the BID experience in some form or fashion before a dispositive answer can be given as to whether the analogy or comparison is indeed properly made. Even if it is the case that the analogy is appropriate, a number of legal issues persist in how human rights law codes, policies and responses by tribunals involving BID claims might be fashioned.[242] In some ways, another vicious cycle exists. Until policy responses are fashioned by the OHRC, courts or other entities, questions posed by the BID experience will remain unanswered. That said, OHRC policies are not panaceas and the ones fashioned in respect of gender identity and expression were not without controversy.[243] Nevertheless, by leaving such questions unanswered, the additional question of how to legally navigate the BID experience will be left somewhat of a mystery. Given this reality, some may find it premature to suggest that bodily integrity identity and expression should be an enumerated ground under human rights legislation and, further, that elective amputations should be publicly funded. If that is the case, then such sexist, classist, ageist, racist and heteronormative biases need to be examined and denounced.[244]

Consent given by the BID experiencer to elective amputation remains the biggest legal obstacle to overcome in the taxonomy of issues presented here. The second biggest obstacle to be overcome appears to be the medical community's unwillingness to perform elective amputations as a bona fide therapeutic treatment for the BID experience. Finally, there might be an unwillingness in the BID community to have the BID experience analogized to gender dysphoria and/or gender identity and expression or to become allied with transgender communities (and vice versa).[245] Such aversion may persist even though some of the rationales which have normalized GAS might support elective amputations, bodily integrity identity and expression, and BID.

This article has, for these reasons, attempted to reveal the issues implicated by the BID experience and, by an illustrative comparison to

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[241] *Ibid* at 327.
[242] See Jongbloed, *supra* note 197 at 207.
[243] See Cossman, *supra* note 14 at 50.
[244] See Baril & Trevenen, "Extreme", *supra* note 44 at 158.
[245] See Baril & Trevenen, "Exploring", *supra* note 12 at 406.

gender dysphoria, to provide a simple taxonomy of the issues that may arise should such a claim arise in provincial, territorial or federal human rights law, before or after any such policy responses are fashioned. This article has, using a mixture of critical disability theory and legal analysis, reified bodily integrity identity and expression as a legitimate form of human expression and identity in human rights law and advocated for non-ableist and non-cisnormative policy and legal responses. No suggestion has been made that the lives, experiencesor legal rights hard fought for and won by transpersons is any way diminished by analogizing BID to gender dysphoria, gender identity or gender expression. In fact, the opposite is the case. Given the amazing achievements transpersons have made, and their effect on mainstream societiess, we can hope that more will be made to make Ontarian and Canadian society more inclusive and positioned to engage in "increased dialogue and the creation of alliances between trans and disability studies and movements."[246] Gains can also be made outside of the human rights law sphere,[247] and we should once again welcome all efforts to ensure that Canadian society delivers on its promises of a just, fair, and equitable society.[248]

[246] Alexandre Baril, "Needing to Acquire a Physical Impairment/Disability: (Re)Thinking the Connections between Trans and Disability Studies through Transability", translated by Catriona LeBlanc (2015) 30:1 Hypatia 30 at 31.

[247] See Samuel Singer, "Trans Rights Are Not Just Human Rights: Legal Strategies for Trans Justice" (2020) 35:2 Can JL & Society 293 at 301.

[248] See Baril & Trevenen, "Exploring", *supra* note 12 at 408.