

Reframing Disability Through Choice: Applying the Social Model to Body Identity Discrepancy Disorders

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Abstract

The Body Integrity Identity Disorder (BIID) raises a peculiar medical issue: the people diagnosed with this disorder feel the strong urge and necessity to amputate (the right leg, arm, etc.) the healthy body parts and they consider the parts as disconnected with the internal vision of their own bodies. Opponents of therapeutic amputation claim such amputation goes against the principle of nonmaleficence since it leaves a permanent disability to a physically healthy individual. Nevertheless, this criticism has been phrased in terms of a conventional biomedical attitude which conflates impairment and disability and disability and harm. In this article, this expectation is contradicted with the introduction of the Social Model of Disability (SMD) that separates the statement of physical impairment and the description of the construction of disability in society. The paper claims that elective amputation is not necessarily harmful since it is not inevitable that it will lead to disability simply because the debate was shifted on the basis of the SMD. Rather, when there are social and environmental accommodations that are properly carried out, persons having elective impairments need not feel excluded or disadvantaged in a sense that is normally synonymous with disability. The reconceptualization would allow a reconsideration of nonmaleficence in regard to BIID and allow the possibility of ethically permissible treatment amputations.

Keywords: Body Integrity Identity Disorder (BIID), Social Model of Disability, Elective Amputation, Bioethics, Nonmaleficence, Impairment vs. Disability, Ethical Surgery.

1.Re-evaluating Harm: Nonmaleficence in the Context of BIID

The concept of nonmaleficence, also known as first do no harm, has always served as one of the tenets of medical ethics and stood to make sure that no physicians harm or cause any suffering to their patients. Despite this straightforward seeming, the interpretive complexity can be quite great especially on those cases that question the conventional notions of harm. An example of such is the case of Body Integrity Identity Disorder (BIID), which is an unusual condition whereby people feel an aqueous and unsustainable presence in the fact that one of their limbs is not part of their body(1). This is the wish to deprive oneself of a perfectly sound limb, and sometimes may go as far back as childhood and resulted in some cases having given themselves medical amputation in order to seek a cure. Nevertheless, those kinds of requests raise a fierce ethical dilemma: is it morally acceptable to amputate a healthy limb even though in such a case nonmaleficence is not violated?

The critics of this practice object that removing a healthy part of the body as it is applied, involves adding a lifelong disability that would otherwise be unnecessary; and as such is, per se, harmful. Giving examples of critics such as W.J. Smith and Arthur Caplan, such an argument is based on the assumption that any intervention that causes physical loss, in particular, that is not accompanied by a traditional medical indication, is unethical. Such critics tend to compare the wish of amputating limbs to delusions or madness of the mind and when such wishes are given then the medical ground is lost. Indicatively; Smith said that BIID is more like a delusional thought that an otherwise healthy appendix is cancerous-in which, being cut off would not be warranted by the patient just because the latter is insisting to do so. This analogy is used to invalidate BIID through giving the impression that it is a product of false beliefs and it is not an acceptable belief under identity distress.

This analogy however falls short of scrutiny. Contrasting to a delusion, persons affected by BIID have clear awareness that their limb is regular in a biological sense. It is not the ill-information of health, but the non-perfect concordance between the physical manifestation of bodily shape and the constantly internalised body image which causes the distress. It may be more of forms of identity conflict as is experienced in some cases in gender dysphoria instead of psychosis. It is not short-sightedness in the field of anatomy, which leads to the demand of removal of the limb, but the necessity of finishing the harmonic unity of physical body and psyche.

Reframing Disability Through Choice: Applying the Social Model to Body Identity Discrepancy Disorders

In this regard, the damage done by not subjecting the surgery becomes evident. Patients tend to complain of intense mental distress, poor socialization, melancholy or even suicidal thoughts. Therefore, inaction can serve no other purpose but to increase suffering, instead of stopping it. This redefines nonmaleficence: is it better to keep a limb which generates emotional torture to the victim or to sever and make the sufferer comfortable again? This is the bind of the ethical dilemma.

Arguing against a person having elective amputation because of having BIID is frequently dependent on confusing impairment and disability. Critics further fault that in the removal of healthy limb it is inevitably producing a disability thereby causing harm. However such an assumption is worth more thorough reflection. The concept of disability does not lie in a missing limb, but it is a complex product of interactions between impairment and structures in society. Such mixing of amputation (physical alteration) with disability (social functional) ignores the role of environmental and social accommodations and lack of both, which are critical in transforming impairment into a state of disability(2).

Two different forms of harm should be noted acute and chronic ones. Acute harms refer to the direct risks faced during surgery- infection, blood loss and atmospheric complication of the anesthesia. They are normally analyzed according to risk benefit in any form of surgery. Chronic harms, in turn, are long-term consequences of medical procedures, i.e., permanent disability or years of suffering. Critics point out the long-term deleterious effect of the passage of an able-bodied person to the world of disability in the instance of BIID. But when this transition causes no psychological suffering and brings about the feeling of completeness in an individual, is it a long-term harm then or a long-term good?

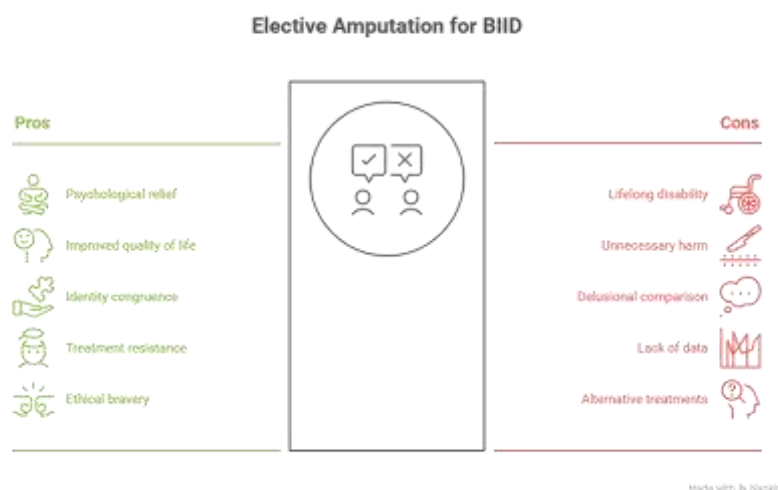


FIGURE 1 Elective Amputation for BIID

In addition, the majority of the surgeries are harmful to healthy tissue. In order to access inflamed appendix a surgeon has to cut through healthy skin and muscles. This is harmful to short-term outcomes, and we tolerate it on the ground that the net benefit averted infection or sepsis is so great. This way, nonmaleficence is already compromised because of the nature of clinical practice(3). The advice given by David Sokol to change the phrase to read as complementing instead of limiting to net harm, are specifically useful to surgeons. Doctors do not hesitate to ignore some local piecemeal harms to yield substantial overall benefit to the patient. The view lays open the possibility of BIID surgeries being assessed using comparable morals.

This raises a major point of consideration, that is benefit measurement in the scenario involving treatment that is not aimed at curing the disease but rather aligns the body of the subject with their self-perception? Although there is no strong evidence of large-scale data as it is ethical and rare to run such surgeries, there is an assertion of high level of satisfaction of those individuals who have already undergone amputations to treat BIID based on the available case studies and self-report studies. People often report feeling deeply relieved and having better quality of life after having a surgery. Nevertheless, the absence of longitudinal, peer-reviewed clinical studies impedes the possibility to compose a conclusive cost-benefit analysis. Such data gap is part of the ethical dilemma--a catch-22 in which the procedures in question must take place in order to obtain data, but the absence of data makes those procedures impossible to ethically approve.

Critics can also say that amputation should be seen as an extreme measure, as there are alternatives as well as other methods of treating it - psychotherapy or medication. However, the various reports show that traditional treatment in most cases has not improved the symptoms of BIID. In numerous reported incidences, sufferers tend to continue with their wishes to be amputated even after an intensive psychological therapy. Elective surgery may be the only way of achieving long-term well-being, when other measures are to no avail.

In conclusion, the principle of nonmaleficence in the situation of BIID cannot be conceived merely in terms of a biomedical approach calling on physical loss. It requires a wider, more textured meaning in terms of psychological well-being, deficiency of existing treatments, as well as the difference between impairment and disability. Though it is radical and irreversible, elective amputation may not always be injurious as it reduces massive suffering and reestablishes congruence of identities. By converting to this interpretation we can come to learn that that ethical requirement to avoid doing harm, in other words, the dictum of nonmaleficence, is, in certain instances, the moral bravery to lop off a leg(4).

2.From Biological Norms to Social Constructs: Rethinking Disability Through the Social Model

Disability in the classical medicine is viewed in terms of biological dysfunction. Based on this biomedical model, the disability that is present signifies that there is something wrong with the body of the person who happens to have a disability because it does not adhere to a natural or normative standard of performance. In this frame disability is an internal deficiency, a condition that exists within the individual her or himself. Sickness, deformity and disability are therefore considered as anomalies that need to be fixed or healed, and preferably bring the individual to a socially established norm of wellness. Even though this model forms the foundation of most of the modern medical practice, it is currently gainfully considered as inadequate to describe the lived experience of a person with an impairment.

Social Model of Disability (SMD), on the other hand, appeared as a complete revolution in the disability conceptualization. Instead of perceiving disability as a purely medical problem, the SMD places the accent on external social solutions and social contexts that are not able to suit human diversity. It replaces the concept of disability as a pathological deficit by conceptualizing disability as an effect of a social environment that has been constructed in such a way that it excludes systematically the people with atypical bodies or minds. In the process, it makes a strong distinction between the terms, impairment and disability: impairment is a functional or anatomical restriction, and disability is a social restriction on engagement in everyday life.

Such a reinvention is politically and ethically important. By removing the personal problem to the framework of the society, the SMD disrupts existing discourses of medical dependence, helplessness, and abnormality. To give an example, an individual in a wheelchair is not disabled by the lack of both legs but not by the world that is constructed to fit the needs of stairs, the narrow corridors, a lack of access to transportation. The fact that a blind person cannot see is not his/her disability but the fact that no one is ready to adopt Braille signs, audio navigation, or awareness about non-verbal ways of communication. In such a way, the environment, rather than only the body is the subject of attention both in critical and in the context of intervention.

Among the contributions that are critically important about the SMD, there is its relational perception of disability. It proclaims that the experience of being disabled is a phenomenon that is created as the body of a person is affected by the social world that ascribes precedence to some physical norms. This can give us an idea of envisioning a world where one has impairments that do not necessarily mean person has disabilities. Or, e.g., a person with an artificial leg might even work without disadvantage in such a society that is fully accessible to their needs- with the universal design, inclusion labor markets, assistive technologies. It would not be considered as a disability in terms of being limited or suppressed but the individual would have a deformity.

There is a fine ethical implication of this conceptual decoupling as it relates to some controversial interventions in medicine such as Body Integrity Identity Disorder (BIID). At least, disability is not necessarily presented in the elective amputation of a healthy limb, when the fact of loss of a limb is not what renders one disabled but incapability of the society to accommodate that loss. It can produce an impairment, sure, but whether the impairment turns into a disability is not in the nature of a biological reality but a consequence of social circumstances. It is through this reframing that gives a new and ethically informed approach to rethinking the moral discussions of surgical procedures in people with BIID(5).

Reframing Disability Through Choice: Applying the Social Model to Body Identity Discrepancy Disorders

It highlights the social, as well as the moral and social duties of the society. When an individual is made disabled due to the lack of inclusion in the built environment or social policies, then disability is not only a personal tragedy, but it is injustice too. Consequently, the solutions cannot be just within the clinical realm but should extend to other institutionalized structures, policies, and attitudes. The laws of accessibility, inclusive education, anti-discrimination and universal design cease to be a regulatory formalities and become instruments of social change. This is not a simple apprehension. The critics of the SMD have pointed out accordingly that such a model is prone to undercattering the actual physical or psychological pain that might be caused by impairments. To provide an example, a chronically ill patient in chronic pain, a patient with a degenerative disease or with very severe loss of sensation may suffer and this suffering would not be abated only by the change of social factors. Therefore, other researchers promote the model of biopsychosocial approach, which is a combination of both, the individual perspective on impairment and the social understanding of the obstacles in their ways. Nevertheless, this subtle stance cannot diminish the original thinking of the SMD: that the majority of what we term as disability, can be socially constructed and thus socially fixed.

The social model also stimulates us to make a doubt on the normative assumptions regarding what kinds of bodies and capacities are rewarded. The SMD regards the norms of the body as culturally defined and historically conditioned instead of seeing the body as a given, having objectively desirable qualities. This is particularly applicable in the era of cosmetic clinic, body alteration and transhumanist biotechnologies. The question as to what a deficiency is, is frequently determined not by biology, but by prevailing aesthetic or functional standards. Then the so-called irrational desires, like the desire to amputate one of the limbs, in BIID, can be re-read as an opposition to the hegemonic ideas of normative bodily representations.

Notably, the SMD gives us an opportunity to conceive the world where bodily variety is not pathologized. This way it creates possibilities of ethical discussions that do not begin under the premise that the deviation of the norm is a bad thing in itself (6). According to the model, the need to amputate could not be a mental illness to people with BIID but a quest to achieve a consistent and authentic identity in a good society. The question, therefore, is how to find the surgery ethical, as well as how to change the contexts that could make life after surgery either incapacitating or empowering.

The Social Model of disability triggers a more ethical consideration by shifting our conception of the issue of disability out of an individual body and into the frameworks of society. It makes us question: who has the right to rule what kind of bodies can be accepted? What is the advantage in devaluing some types of embodiment? And how are you living a good life when your body is not conventional?

So to sum up, the Social Model of Disability provides a paradigm shift, which is the move away from medicine to justice, away from defect to difference, and the move away of a patient to a citizen. It does not dispute the fact of impairments but demands that we must respond to them in the basis of inclusion, accessibility and respect. In the extreme situations such as the case of BIID, this paradigm can provide an ethical guide online dating that steers outside the dichotomy of treatment and mutilation towards more humane and pluralistic conclusion about bodily integrity.

3.Disability, Autonomy, and the Ethics of Bodily Alteration: Reconceptualizing Elective Amputation Through a Social Lens

The problem with modern bioethics remains an ongoing conflict between individual freedom and social conventions. No one can be more provocative than in the instance of elective amputations offered to sufferers of Body Integrity Identity Disorder (BIID). This disorder, which results in a strong and long-term sense of incongruency of the body, particularly regarding the existence of a superfluous limb is fuelled by an ethical dilemma. Opponents of surgical amputation of healthy limbs claim that it is against all the norms of the art of medicine, and those who support it put forward the principle of humanity, the immediate need to cope with the psychological pain. However, the discussion is mostly stuck in a two-polar opposition: should surgeons amputate a healthy limb or not? This polarity is black and white. With Social Model of Disability (SMD) as a guiding concept, we feel capable of asking a more ambiguous, telling question: is it morally acceptable to impose a bodily impairment on someone when this act does not inevitably lead to disability?

This reworded question is based on a very important conceptual distinction. Under SMD, impairments are variations in the body like missing limbs and disability is the outcome of environmental and social limitations that work against persons with different bodies. Thus, when society is designed well enough (with adaptive

technologies, legal support and cultural awareness) the presence of impairment on the person does not pose any significant disability to him or her. In this perspective, it is not only a matter of losing limbs or the physical sense of integrity but the possibility of being prejudicially unable to live well in the post-surgical setting. It does not focus on the procedure but the environment(7).

When put like this, the SMD provides an ethical way of getting out of the dogmatic ideation that impairment is a synonym of disability, and therefore, harm. This is a very significant point since it contradicts wholesale the arguments often held that the elective amputation of a healthy limb is always guaranteed to be of such irreparable harm to the individual. Suppose one considers harm to consist of the creation of social exclusion, and suppose the person after the operation can live happily given adequate assistance, and one loses the status of categorically harmful action. In fact, one can compare it with other socially acceptable body modifications that include gender-affirming surgery, cosmetic procedures, or even voluntary sterilization, although all of them affect the body and are not studied as unequivocal harm.

Now, to make this apply to the case of BIID, we should remember that the amputation urge itself is not based on delusion, as well as not on the lack of information. People with BIID are also intelligent, self-conscious, and consistent in their aim of changing their body in a very specific manner. They do not lack awareness of what it is like to live with an amputation as a matter of fact, a good number of them have years of experience of pretending to be amputees by using wheelchairs, crutches, or prostheses, to project the appealing body image. This long relationship with the identity they have imaged illustrates a stick-to-it-iveness but also a lived experience of living with an impairment. So the idea of amputation is not something lightly chosen but the one chosen after long time of observation and sense of inner torture (8).

It could be suggested that opponents could say that allowing such amputations only promotes pathological urges and medicalizes difference. Nevertheless, this criticism does not deal with the realities facing those involved with BIID. The equally strong mismatch between identity and body in BIID, as with gender dysphoria, cannot be ameliorated in the usual ways available to psychiatry. The incongruity is usually not resolved using therapy, medication and cognitive behavioral methods. Contrarily, the results of case studies of the persons, who have already undergone amputation (both legally and incorrectly), really show high scale of satisfaction, better mental health and feeling complete after a surgical operation. That indicates that the impairment is curative, in a sense, to some people, not curative, in the medical sense, but in the existential and psychological sense.

The moral implication with regard to medical practice is far reaching. Just in case society is able to cope with the ensuing disability and/or the patient happens to feel good and relieved thus the argument that elective amputation is unethical in and of itself loses its sense. This is particularly the case in the societies where the broad range of bodily diversity is already welcomed and where some gains have been achieved in the areas of accessibility, assistive technologies, and inclusion. The ethical issue, in this case, lies in not the act of amputation but the willingness of the society to accommodate other embodiments without judgment and discrimination.

Naturally, not all ethical risks are removed with the help of this model. There is yet to contend the irreducibility of surgery, regret and informed consent limits. However, these dangers do not belong to BIID exclusively; such dangers are present in every elective surgery, whether it is rhinoplasty or gender affirmation. The irreversibility of the procedure is ethically irrelevant since it is only crucial that the patient is properly informed, competent, and independent in his/her decision. Under these circumstances, a normative vision of bodily wholeness is no longer applied by the surgeon but the surgeon is acting in accordance with the well-being of the patient in the way the patient understands it.

Indeed, the autonomy is playing a key role here. Most bioethicists uphold that autonomous beings must be left to decide major actions on their bodies despite what logic would have it say otherwise. Refusing to grant people with BIID the freedom to pursue amputation is to regard them as morally inert objects of medical paternalism. The set of positions refutes the ideas of respect and dignity that form the basis of modern bioethics. That people can make the voluntary choice to undergo surgery that is risky due to an aesthetical or identity purpose, it appears that it is random and unfair, to refuse BIID people the same freedom.

Additionally, the SMD emphasizes one vital social responsibility. In the event that impairment does not necessarily imply disability, then it is the responsibility of the society to make it so. This implies making it more accessible, eradicating institutional gatekeeping, and nurturing inclusionist apprehension that confirms various bodies, also those produced through elective surgery. In that respect, the focus of ethics shifts from the provisions of the patient and the surgeon to shared values and infrastructures of the society in which they exist.

Reframing Disability Through Choice: Applying the Social Model to Body Identity Discrepancy Disorders

In short, when taken through the Social Model of Disability, the function of ethical analysis of elective amputation due to BIID takes a radical revolution. The more important question is no longer whether it is wrong to cause a disability but whether it is wrong to cause an impairment that may be non-disabling in a inclusive society. Such a reframing admits that identity, autonomy, and embodiment are no longer straightforward as they are not viewed in the classical paradigm of biomedicine(9). It does not only hold ethics of individuals or doctors but also of the social structures deciding whether impairments turn out to be disabling.

By adopting this view, we get a much more ethical and human bioethics; we get the kind that celebrates difference, that sustains autonomy, that reinvents harm as not failure to conform, but injustice of exclusion. Within this context, elective amputation is not just a medical service-it is a socializing, ethically negotiable account of self-representation.

4.Is Disability Inevitable? Rethinking Harm, Identity, and Social Response in Elective Amputation

When answering the question of whether the elective amputation of a healthy limb may be viewed as a type of ethical violation, the majority of the criticisms relied on a single argument, which remained very similar, and this is the claim that such procedures are bound to cause a disability, and will, therefore, amount to harm that can and MUST be derailed. The common idea that amputation of a functional limb creates a compromised condition of existence is embedded not only in the popular consciousness but also in the biomedical ethics. However, is this belief true per se? Does the result of the amputation always have to mean a disability? The unraveling of what makes up a disability and what amounts to a harm, together with a social constructionist look at the nature of impairment, can allow the unexpected inference that disability is not an inevitable side effect of elective amputation, particularly when considered under the magnifying lens of the Social Model of Disability (SMD).

TABLE 1 Comparative Ethical Framework: Elective Amputation in BIID

Dimension	Biomedical Model	Social Model of Disability (SMD)
Definition of Disability	Pathological deviation from normal bodily functioning	Socially constructed limitations imposed on individuals with impairments
Impairment vs. Disability	Equated; loss of function automatically equals disability	Distinct; impairment is biological, disability is sociocultural
Ethical Status of Amputation	Intrinsically harmful and ethically unjustifiable	Context-dependent; not inherently harmful if the environment is inclusive
View on BIID Requests	Reflect delusion or pathology; request should be denied	Valid form of identity expression deserving respect and potential accommodation
Role of Autonomy	Secondary to nonmaleficence; autonomy limited if outcome leads to harm	Central ethical concern; informed and competent choice should be respected
Basis of Harm	Physical loss = inevitable disability = harm	Harm arises from social inaccessibility, stigma, and non-accommodation

The most significant challenge in the ethical argument against amputation in the context of Body Integrity Identity Disorder (BIID) is the presupposition that the loss of any physical attribute inevitably leads to decline in capacity, marginalization and lack of flourishing. This argument is already a definition of disability by a biomedical paradigm: deviation of any bodily functioning in its statistical average is interpreted as pathology. In this kind of framework, an individual who lacks a limb (in whichever circumstance, motive, or preexisting adaptation) is labeled as a disabled person, and the act which caused such an adjustment becomes morally wrong.

The framework, though, fails to recognize the most important difference between impairment and disability, which has been the focus of years of disability theorists. Impairment can be described as the difference in the physiological or anatomical aspects i.e, absence of a limb. Instead disability refers to the combination of social, architectural, economic and cultural obstructions that limits a person due to the difference. By this school of thought the lack of a leg is not what disables the individual but a flight of stairs with no elevator, an inaccessible

place of work or a society unnecessary devaluation of bodily variety. Once we remove our ethical analysis to this model, then the moral calculus is altered vastly.

Consider, say, a society, which perfectly embraces differences in mobility. In this world, buildings and transportation services are all accessible, assistive technologies and positive attitudes toward inclusion make a lack of one leg mostly unnoticeable. Elective amputation here is not a cause of disability, it is just a cause of difference. It is no loss of functionality but rather an embodiment variation. Its so-called chronic debilitation of disability vanishes with the introduction of the favorable, accessible culture. Therefore, the belief that amputation is disability and consequently harm is not universal but it is a contingent.

Anti-amputee activists are also prone to repose behind this definition given by biomedical fraternities without argumentative meditation upon its pre-assumptions. According to them, amputating oneself even when one has BIID is a betrayal of medical ethics because such an act condemns the person forever to a state of disability whereas he or she was initially whole(10). But this argument fails with the attempted SMD framework. When the society is indicted in constructing disability in setting aside differences in embodiments then it is not the surgery that cripples the individual on the basis of being amputated but the social disregard.

Besides, to demand that a person keep in a state of the human body which the person in question deems as strange, disturbing, and unacceptable, is to make the normative ideal of beauty or functionality to take priority over subjective happiness. In people with BIID, the person does not think his or her limb is sick or broken. Instead, they feel it as a violation of their body identity, a disturbance of the genuine self. Acquiescing to referring to their desire to be amputated as pathology because it does not respect social conventions of bodily wholeness reduces the voices of those in distress and removes their moral ability to make decisions.

What is more characteristic is the contrast with the way the various kinds of the elective procedures are treated by the society. Cosmetic restructuring procedures, sterilization, gender-affirming surgeries, and breast implants are currently acceptable even when they change healthy body functions. The morality of these interventions is not necessarily pre-defined as harmful, the pre-determinants of moral relevance are intent, autonomy and outcome. When the individual is made aware of the dangers, and gives his or her consent voluntarily, and when there is psychological relief or better satisfaction with life, such a process is justified. Then why is amputation which is related to BIID to be treated differently?

It could be said that result in BIID is simply worse as it leads to physical loss and change of mobility. This interpretation is not reflected in the facts though. There is usually general satisfaction, psychological release and completion observed among the people who have undergone amputation because of either legal or illegal ways. These are not the tales of what they wish they could have done, but what they insist is their body, one that matches their interior image. Suppose they are subjectively better off, that change is an improvement in the quality of their lives, and this is so notwithstanding the fact that the impairment is not necessarily disabling, how then can we continue to assert the harmful character of the change?

In fact, the impairment is not the only harm, which varies in occurrence among the cases, rather the reaction of the society towards the latter. What transforms the true nature of impairment into disability is discrimination, stigma, limited access and normative expectations of able-bodiedness. This is not surgical, this is societal. Provided that we eliminate the underlying causes of exclusion, we minimize the ethical issue of elective amputation. Whether or not one objects to societal reform at the same time as holding that elective amputation is wrong is therefore a circular reasoning: society causes the wrong and then points to the wrong so as to justify the denial of autonomy. Then, there is the precedent. The SMD enables us to see that it is possible to exist in a world where amputated people live as freely as other people and with all the rights the rest can enjoy. However, such world will not come into fruition automatically. It is something that needs to be built, iteratively, by means of inclusive policies, superior design, cultural openness and validation of different embodiment. Giving of autonomy to the BIID cases, in this light, is therefore not only ethically acceptable, it is also a means to advancement. As with previous disability rights, transgender recognition and neurodiversity movements, where arguments initially made against such movements focused on a priori harm, the argument made against BIID may be the same. The hot-debatable case of today might turn into a precedent tomorrow.

It is also important to note that critics who insist on the maintenance of the so called normal body usually have a presumed universality platform, which states that what is physically ideal must be morally superior. This prejudice overlooks the fact that human flourishing does not specify standard bodies. It has to be accommodated, respected, and recognized. Impaired people exist and are capable of living a good, independent, full life. In case the subject

Reframing Disability Through Choice: Applying the Social Model to Body Identity Discrepancy Disorders

is competent, fully informed, and agrees, their desire to undergo elective amputation should be considered not along with the criteria of disability but rather under the already established measures of well-being, identity congruence as well as autonomy.

Drawing a conclusion, it should be pointed out that the claim that elective amputation in the case of BIID inevitably leads to disability is not an objective fact but a socio-ethical assessment. In terms of the SMD, when one considers that disability is the loss of a limb, it becomes obvious that disability never brings any harm because losing a limb only brings harm when the society does not adapt, whether it is the disfigurement or lack of reasons to be a valid subject. The ethical arguments concerning BIID are thus in need of a reorientation: fear of getting harmed must no longer be the key argument, but a welcome towards inclusion, defending norms must no longer be a concern, but respecting autonomy has to be made a priority, and not giving someone a treatment should no longer be the main line of argument, but building a world where being different is not causing disadvantage.

5. Conclusion and Future work

The general assumption over decades that human beings with or without disability will always be disabled when an otherwise healthy limb is amputated electively has been core to bioethical arguments against the surgical interventions in Body Integrity Identity Disorder (BIID). But, as put forward by this paper, this assumption is based very much on a biomedical model that amalgamates impairment with disability as well as bodily deviation and pathological dysfunction. With the help of the Social Model of Disability (SMD) we are provoked to view disability as not the imminent outcome of a modified body, but the consequence of a social world that is disparate to house diversity of embodiment.

In this light, the critique of elective amputation is transformed into the ethical analysis of context rather than an unremitting critique. In case the environment is inclusive enough, in case the patient is autonomous and informed, and so that post-surgical life results in flourishing and increased identity congruence, then the act cannot be categorically rejected as of the intrinsically harmful nature. Elective amputation of BIID patients can actually restore them: it will provide the concept of belonging to a body, diminish the psychological strain and allow the patients to become more active in their lives.

The one thing that this discussion has revealed is that it is imperative that the linkage of difference and deficit be destroyed. In most cases, the actual damage is not damaging of a limb but the social and structural institutions that make such an event tragic. In practicing body diversity as a healthy and worthy variation of human diversity we also confront the normalizing abilities and bring the life enhancement of ethical medicine to the interpretation of identity and agency.

Finally, to stay attuned to the changing sense of embodiment, identity and autonomy, bioethics needs eventually to go beyond anchored retrospective definitions of harm based on an expired medical orthodoxy. It cannot, however, but adhere to a different and more socially conscious concept of disability, a notion that not only renders patients right, but adds to various livelihood options, and really to craft a world where being different does not automatically imply being disadvantaged.

Future Work

Though the theoretical foundation introduced here can be regarded as a proper ethical factor in revisiting the issue of elective amputation in the case of BIID, multiple avenues of empirical and interdisciplinary research should be addressed blatantly.

Outcomes Research

Most of the evidence that is provided today regarding post-amputation satisfaction in the BIID cases is highly anecdotal or the small case studies. Future studies must entail massive longitudinal studies involving psychological, social and functional outcomes of people who have already undergone the amputation process due to elective operations. This will enable to present more solid evidence to evaluate the real therapeutic benefit of the procedure and confirm or question the existing anecdotal consensus.

Consent and Competency Procedures

Since the affected individuals with BIID are always questioned regarding their autonomy and mental competence, future studies ought to aim at establishing sound ethical and psychological models to determine consent capacity in this particular case. This would include the uniformity of psychiatric examinations, definite prescriptions of diagnosis limits and perhaps an interdisciplinary review group so that there can be informed judgments.

Policy and Law Contemplations

At the moment, numerous health centers and the law do not allow healthy limb amputation. The international comparative research, involving nations with different medical-legal systems, would be able to identify the models of the regulated, yet ethical approving pathways, where patient rights would be balanced with professional responsibility. This groundbreaking study is the first systematic study of augmented reality technology as a therapeutic tool to treat Body Integrity Identity Disorder to provide preliminary data based on the viability, safety, and probable success of virtual amputation experiences to treat one of the most complex and questionable disorders in psychiatry. The consistent evidence of physiological tracking and the subjective symptom ratings indicates that well-constructed augmented reality applications may lead to quantifiable and clinically significant alterations in

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Conflicts of interest

The authors have no conflicts of interest to declare

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