

# The State and the Body

## Legal Regulation of Bodily Autonomy

Elizabeth Wicks



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# 1

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## Bodily Autonomy

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We have bodies, but we are also, in a specific sense, bodies; our embodiment is a necessary requirement of our social identification so that it would be ludicrous to say 'I have arrived and I have brought my body with me'. Despite the sovereignty we exercise over our bodies, we often experience embodiment as alienation, as when we have cancer or gout. Our bodies are an environment which can become anarchic, regardless of our subjective experience of our government of the body. The importance of embodiment for our sense of the self is threatened by disease but also by social stigmatization; we are forced to do facework and body-repair. Our bodies are a natural environment, while also being socially constituted; the disappearance of this environment is also my disappearance.<sup>1</sup>

### I. Introduction: Why the Body Matters

My body is my home, my transport, my clothing, my identity. It is my greatest asset and my worst enemy. It is my constant companion, my means of financial support, a source of pain, a receptacle of pleasure, and one day it will kill me. We use our bodies in so many diverse ways: to give us pleasure, to earn a living; to portray our identities to the world; and to reproduce. Our bodies are central to the landmark events of our lives: being born, growing up, making love, having children, falling ill and dying. They are also, increasingly, changeable. We are no longer stuck with the body into which we were born. From gender reassignment, to IVF treatment, to cosmetic surgery, we can change our bodies to better suit our individualised selves. Less drastic mechanisms are also available to gently mould our bodies into our idealised images through exercise, diet and cosmetics. Many uses of our body, we may take for granted, and the times when we focus on our bodies most are when they are causing us pain, distress or discomfort. Our bodies are simply more evident in sickness than in health. A simple paper cut draws disproportionate attention to a finger; arthritis reminds us of our aging joints; a loss of mobility belatedly demonstrates the ease with which we had previously moved around. We are trapped in a dis-functioning body; freed by a healthy one.

<sup>1</sup> BS Turner, *The Body and Society: Explorations in Social Theory*, 2nd edn (London, Sage, 1996) 42.

Our bodies also serve as the focal point for our most precious life choices. In this book, the choices about our bodies are categorised into five groups (although they may, and often do, overlap). First, there is a range of choices within an overarching category of reproduction. For a woman, the decision to have a child represents a unique intrusion into bodily integrity but for men too there are significant bodily choices to be made. Whether, how and when to reproduce are crucial decisions and can be complicated by the need for reproductive technologies or dilemmas about abortion. The second category of choices about the body relate to death. For many of us, there may be no choices about death or dying: it will come unexpectedly and too soon. But, increasingly, with today's technology and ageing population, there are indeed difficult choices to be made, such as how to die in a manner that we choose rather than in a way which seems to betray our lives. The legal and ethical debate about euthanasia and assisted suicide forms a backdrop to, and restraint upon, choices about how to die. For some, a choice about death may be far removed from a physical illness. Suicide—a unilateral decision to kill one's body—might be the most significant bodily choice of all. The third group of choices about the body relate to sex. Within this category, we encounter decisions about who we share sexual activity with, and how, and when. Such choices go to the heart of who we are and how we relate to, and use, our bodies, but even these most private activities will not always be immune from state interference. The fourth category of bodily choices focuses on body modification. This encompasses a wide variety of choices, from gender reassignment to the amputation of a healthy limb to female genital mutilation to breast enlargements. Are these choices ours alone to make? The final category of choices about the body focuses on the selling of the body, whether by means of prostitution, surrogacy, or the sale of organs. Most of us earn a living by utilising one part of the body or another; are other ways of profiting from the body acceptable? Concerns about exploitation and commodification of the body pose challenges to both autonomy and dignity in this context.

This myriad of choices about the body highlights the relevance of autonomous choice when considering the human body. This chapter will begin, therefore, with a discussion of the meaning of autonomy, before focusing upon the body itself. Challenges to the traditional liberal conception of autonomy, and Cartesian dualism, will be analysed and conclusions will be drawn about the type of entity that is truly autonomous in relation to the human body.

## II. Autonomy: Rights and Relations

The word 'autonomy' derives from *autos* (self) and *nomos* (rule or law), and this concept of self-rule or self-government has a long history. Famous philosophers and writers through the centuries have sought to explain and justify self-determination. For example, Kant asserted the importance of free choice in his

theory that an agent is an end in himself and should never be used as a means to an end,<sup>2</sup> while JS Mill argued that it is the hallmark of individuality that each person be allowed to make free choices (provided only that they do not cause harm to others).<sup>3</sup> It has been described by Berlin as a ‘wish to be the instrument of my own, not of other men’s acts of will ... [a] wish to be a subject, not an object; to be moved by reasons, by conscious purposes, which are my own, not by causes which affect me, as it were, from outside’.<sup>4</sup> Gerald Dworkin also effectively explains why a concept of autonomy is valuable: ‘What makes an individual the particular person he is his life-plan, his projects. In pursuing autonomy, one shapes one’s life, one constructs its meaning. The autonomous person gives meaning to his life.’<sup>5</sup> The general value of making decisions for oneself, of a freedom to live as one chooses, is intuitively appealing, but the details of what autonomy requires continue to be the subject of great debate. Questions about the role of rationality, intention, reflection and capacity fuel writers and challenge judges.<sup>6</sup> For example, does an autonomous choice need to be based upon rational desires?<sup>7</sup> Is there a meaningful distinction between autonomy and liberty?<sup>8</sup> And between autonomy and mere voluntariness?<sup>9</sup> Perhaps most significantly for our purposes, recent debate has challenged the liberal, individualistic basis of autonomy and raised the possibility of a more relational form of autonomy.<sup>10</sup> This will be considered further below. First, however, it will be helpful to clarify some terminology before seeking to understand the role of autonomy within the law, and specifically human rights law, in the context of autonomous choices about the body.

<sup>2</sup> I Kant, *Foundations of the Metaphysics of Morals*, with critical essays edited by RP Wolff (Indianapolis, IN, Bobbs-Merrill, 1969) 52.

<sup>3</sup> JS Mill, *On Liberty* (Cambridge, Cambridge University Press, 1989, edited by S Collini) 13.

<sup>4</sup> I Berlin, *Two Concepts of Liberty* (Oxford, Clarendon Press, 1969) 123.

<sup>5</sup> G Dworkin, *The Theory and Practice of Autonomy* (Cambridge, Cambridge University Press, 1988) 31.

<sup>6</sup> Dworkin (ibid); C Mackenzie and N Stoljar (eds), *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self* (Oxford, Oxford University Press, 2000); O’Neill, *Autonomy and Trust in Bioethics* (Cambridge, Cambridge University Press, 2002); JS Taylor (ed), *Personal Autonomy: New Essays on Personal Autonomy and Its Role in Contemporary Moral Philosophy* (Cambridge, Cambridge University Press, 2005).

<sup>7</sup> J Savulescu, ‘Rational Desires of the Limitation of Life-Sustaining Treatment’ (1994) 8 *Bioethics* 191.

<sup>8</sup> J Coggon and J Miola, ‘Autonomy, Liberty and Medical Decision Making’ (2011) *CLJ* 523.

<sup>9</sup> Many conceptions of autonomy in recent years have taken on an individualistic nature whereby a person’s desires or actions are regarded as autonomous to the extent that they originate in some way from his or her motivational set (Taylor (n 6) at 1). One example is Gerald Dworkin’s hierarchical approach to autonomy. His explanation of autonomy is that of ‘second order capacity of persons to reflect critically upon their first-order preferences, desires, wishes and so forth’ (Dworkin (n 5) at 20). It is the capacity to reflect upon our instant desires which distinguishes autonomy from mere voluntariness. How realistic, however, is a requirement of self-reflection? Beauchamp argues that such a requirement expects too much: ‘Requiring reflective identification and stable volitional patterns unduly narrows the scope of actions protected by a principle of respect for autonomy’ (TL Beauchamp, ‘Autonomy and Consent’ in F Miller and A Wertheimer (eds), *The Ethics of Consent: Theory and Practice* (Oxford, Oxford University Press, 2006) 65).

<sup>10</sup> J Nedelsky, ‘Reconceiving Autonomy: Sources, Thoughts and Possibilities’ (1989) 1 *Yale Journal of Law and Feminism* 7; Mackenzie and Stoljar (n 6).

The two basic requirements of autonomy are often described as agency (the capacity for intentional action) and liberty (independence from controlling influences).<sup>11</sup> The discussion in this book will, on the whole, assume agency on the part of the individual making a choice about the body. The particular issues concerning children and adults that lack decision-making capability will not be our focus. Nonetheless, there will be occasions where the issue of decision-making capacity becomes vital, or where the voluntariness of a bodily choice is called into question. The main emphasis, and indeed the motivation, for this book, however, is the other requirement for autonomy: liberty. This is where the relationship between the state and the body takes centre stage. The state may, often by means of legal regulation, seek to restrict the choices available, and thus curtail bodily autonomy. Obvious examples might include the criminalisation of termination of pregnancy, assisted suicide and the sale of organs. In these scenarios, the individual's autonomous choices about how she wishes to use her body are subject to interference and restriction by the state. Her liberty to act autonomously is denied. This terminology is not universally accepted. For example, Coggon and Miola distinguish 'autonomy' from 'liberty', arguing that autonomy relates to free will and liberty to the freedom to act without the interference of a third party.<sup>12</sup> Using that terminology, this book is concerned with liberty: the freedom to act in accordance with one's autonomy. In this book, however, the term 'bodily autonomy' will be preferred when referring to the freedom to act upon choices made by a person with decision-making capacity which relate to the human body.

## A. Autonomy and the Law

English law has developed to protect a liberal, individualised form of autonomy. This is particularly evident within the realm of medical law. There is an absolute right to consent to, or refuse, medical treatment provided that the patient is an adult with capacity to make a decision. Furthermore, as Lord Donaldson MR famously confirmed in the 1992 case of *Re T*, that legal right of choice 'is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent'.<sup>13</sup> The law, therefore, is unambiguous that a decision does not have to be rational in order to be an autonomous choice respected by the law. It is also

<sup>11</sup> TL Beauchamp and JF Childress, *Principles of Biomedical Ethics*, 7th edn (Oxford, Oxford University Press, 2013) ch 3.

<sup>12</sup> 'Those interested in (Kantian) autonomy are concerned with the essence of a decision and how it is reached. Those interested in (Millian) liberty are concerned that a decision is made by the person whose right it is to make it, be that an individual on her own behalf or a third party deciding for her, rather (directly) than the rationality underpinning it' (Coggon and Miola (n 8) at 526).

<sup>13</sup> *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649, at 652–53.

clear that English law does not only respect reasonable choices. As Lord Goff commented in the *Bland* case:

if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care might give effect to his wishes, even though they do not consider it to be in his best interests to do so.<sup>14</sup>

The only restraints upon the freedom to make decisions about medical procedures relate to capacity, voluntariness and sufficient information.<sup>15</sup> The Mental Capacity Act (MCA) 2005 contains detailed rules as to when a person has the capacity to make a decision,<sup>16</sup> as well as emphasising the need for respect for autonomy. There is a presumption of capacity,<sup>17</sup> as well as an obligation to take into account the wishes and values of a person when making decisions about them, even if that person lacks decision-making capacity.<sup>18</sup>

Indeed, respect for autonomy can be seen throughout the English legal system and is not just limited to medical law. The criminal law, for example, similarly respects autonomous decision-making of adults with capacity. The law on sexual offences has developed so that, in general terms,<sup>19</sup> non-consensual sexual acts receive condemnation by the law, while consensual acts do not.<sup>20</sup> There do remain, however, limits within different bodies of law in respect of the nature of the acts to which we can consent. The obvious example is that under the general criminal law a victim of physical harm amounting to actual or grievous bodily harm (or death) cannot consent to such harm.<sup>21</sup> There are other examples that might be given, such as treatment for mental disorder and public health controls. Nonetheless, it remains true to say that the current law places great weight upon an informed and voluntary choice made by an autonomous individual with sufficient capacity.

<sup>14</sup> *Airedale NHS Trust v Bland* [1993] AC 789 at 864 (per Lord Goff).

<sup>15</sup> *Re MB (Adult: Medical Treatment)* (1997) 38 BMLR 175 (capacity); *Re T* (n 13) (voluntariness); *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 (information).

<sup>16</sup> Mental Capacity Act (MCA) 2005, s 2(1): 'if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain'.

<sup>17</sup> MCA 2005, s 1(2).

<sup>18</sup> *Ibid* s 4(6).

<sup>19</sup> The complexities and exceptions will be considered in detail in Chapter 5.

<sup>20</sup> See A Bainham, 'Sexualities, Sexual Relations and the Law' in S Day Sclater, F Ebtehaj, E Jackson and M Richards (eds), *Regulating Autonomy: Sex, Reproduction and Family* (Oxford, Hart Publishing, 2009) 173.

<sup>21</sup> In *R v Brown* [1994] 1 AC 212, the purported consent of victims of sado-masochist sexual activities was held not to be capable of relieving the criminal liability of the perpetrators. There are necessary exceptions to this general rule, however, as explained by Lord Lane CJ in *Attorney-General's Reference (No 6 of 1980)* [1981] QB 715, where he specified a number of exceptions to the general criminal law rule that a victim cannot consent to actual bodily harm, including 'properly conducted games and sports, lawful chastisement or correction, reasonable surgical interference, dangerous exhibitions etc' (at 719.) The purported public interest justification for this is debatable. These issues will be considered in more depth in following chapters.

## B. A Right to Autonomy?

The principle of autonomy is an important foundational concept for the law of human rights, alongside principles of equality and dignity. The first generation of rights, in particular, with its focus on civil and political rights, prioritises the freedom to determine how to live one's own life. This can be seen throughout the terms of a treaty such as the European Convention on Human Rights (ECHR). There are rights to freedom of expression, association and religion, as well as rights to life, liberty and security. The ECHR requires that all human beings within its jurisdiction are free to believe in whatever they choose; to say whatever they choose; and to associate with whoever they choose, subject only to necessary and proportionate limitations such as are required by the principles of democracy. They are also able to enjoy freedom from imprisonment, mistreatment and death, and crucially a private sphere in which to make autonomous decisions about how to live. Article 8 ECHR is the embodiment of a right to be free from external interference—a right, in other words, to do as one pleases—subject only (although in practice this is hugely significant) to the proportionate interests of wider society. It protects a right to 'respect for private and family life' and both respect<sup>22</sup> and private<sup>23</sup> are terms that have been interpreted exceedingly broadly by the European Court of Human Rights (ECtHR). The difficult concept of what is private, and what is public, will be considered in the next chapter.

The ECHR is particularly significant within the United Kingdom given that it is these same Convention rights which have been brought into domestic law in the Human Rights Act (HRA) 1998, a statute as controversial as it is groundbreaking. The HRA 1998 has the effect of ensuring that a right to autonomy now has a firm legal basis on which to stand, namely Article 8 ECHR. The limitations to this right's effectiveness, however, are noteworthy. Not only is it subject to the prescribed limits within Article 8(2), but it is also binding only upon public

<sup>22</sup> See, eg, *Dickson v United Kingdom* (App no 44362/04), ECtHR, 4 December 2007 [GC], (2008) 46 EHRR 927, ECHR 2007-XIII, para 70: 'The Court recalls that, although the object of Article 8 is essentially that of protecting the individual against arbitrary interference by the public authorities, it does not merely compel the State to abstain from such interference. In addition to this primarily negative undertaking, there may be positive obligations inherent in an effective respect for private and family life. These obligations may involve the adoption of measures designed to secure respect for private and family life even in the sphere of the relations of individuals between themselves.'

<sup>23</sup> See, eg, *Niemietz v Germany* (App no 13710/88), ECtHR, 16 December 1992, Series A No 251-B, (1993) 16 EHRR 97, para 29: 'The Court does not consider it possible or necessary to attempt an exhaustive definition of the notion of "private life". However, it would be too restrictive to limit the notion to an "inner circle" in which the individual may live his own personal life as he chooses and to exclude therefrom entirely the outside world not encompassed within that circle. Respect for private life must also comprise to a certain degree the right to establish and develop relationships with other human beings. There appears, furthermore, to be no reason of principle why this understanding of the notion of "private life" should be taken to exclude activities of a professional or business nature since it is, after all, in the course of their working lives that the majority of people have a significant, if not the greatest, opportunity of developing relationships with the outside world.'

bodies, not including the Houses of Parliament (although including courts and tribunals).<sup>24</sup>

Beyond the ECHR, there are other European treaties that are explicit in their protection of autonomy. The Oviedo Convention (Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine) (ECHRb) is an initiative of the Council of Europe which seeks to reflect the application of the core human rights of the ECHR to the evolving field of biomedicine. Article 5 ECHRb declares that 'An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it'. The Explanatory Report explains that this rule 'makes clear patients' autonomy in their relationship with health care professionals and restrains the paternalist approaches which might ignore the wish of the patient'.<sup>25</sup> This strong emphasis upon autonomy is, of course, balanced, as in the ECHR, with other competing societal interests.<sup>26</sup> Furthermore, the Charter of Fundamental Rights of the European Union replicates the core ECHR rights, including protection for a right to respect for private life.<sup>27</sup>

A defining characteristic of the protection of autonomy within human rights treaties is that it focuses on the individual's freedom to choose how to live her own life. This may sound like a positive focus but increasingly in recent years it has been challenged on the basis that we do not live as individuals isolated from those around us.

### C. Relational Autonomy

One of the most influential proponents of relational autonomy is Jennifer Nedelsky. She begins her ground-breaking article with the stark phrase that 'Feminism requires a new conception of autonomy'.<sup>28</sup> She rejects the traditional incarnation of autonomy on the basis that it is built around a liberal individualism which fails to recognise the inherently social nature of human beings. She argues that it is not isolation that enables us to be autonomous but rather relationships. It is our 'parents, teachers, friends, loved ones ... that provide the support and guidance necessary for the development and experience of autonomy'.<sup>29</sup> It has been pointed out, however, that relational autonomy is not a unified conception of autonomy and that instead it is best regarded as an 'umbrella term, designating a range of

<sup>24</sup> HRA 1998, s 6. The courts' powers in respect of primary legislation are limited to those of an interpretative and declaratory nature (ibid ss 3, 4).

<sup>25</sup> *Explanatory Report to the Oviedo Convention*, para 34, available at <https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016800ccde5>.

<sup>26</sup> ECHRb, Art 26.

<sup>27</sup> Charter of Fundamental Rights of the European Union, Art 7.

<sup>28</sup> Nedelsky (n 10) at 7.

<sup>29</sup> Ibid 12.

related perspectives.<sup>30</sup> What these perspectives share is a particular concern with analysing ‘the role that social norms and institutions, cultural practices, and social relationships play in shaping the beliefs, desires, and attitudes of agents in oppressive social contexts.’<sup>31</sup> The danger in such an approach, however, is that it may lead to assumptions about an individual’s, especially a woman’s, capacity to make decisions for herself despite social norms and relational oppression. There is, surely, a risk of paternalism in such an approach? See, for example, the detailed explanation by Anne Donchin of why the liberal conception of autonomy is not appropriate within a healthcare context:

Often patients do not fully recognise their own beliefs and values, so reaching an autonomous decision about their care may require extended exploration of their histories and motivational structures. Then, too, patients’ self-understandings may be so confused with others’ perceptions of them (particularly in hospitals) that no decision can be disentangled from their influence. Respecting autonomy would require recognizing patients’ struggles to break free of oppressive authoritative influences and assisting them to sustain relationships essential to their self-identity and well-being.<sup>32</sup>

The sense portrayed here is that patients (especially, perhaps, female patients) do not know their own minds and must be assisted in making decisions about their own health, including, it seems, by ensuring that their existing relationships with other people are preserved over and above respecting their own wishes. It is hard to know how to describe this approach except as paternalistic, which is no doubt the polar opposite of what is intended by the writers conveying these views.

There is no doubt an excellent point lurking behind relational autonomy. Our decisions affect, and are affected by, other people, perhaps more than we would like to admit to ourselves at times. However, while relational autonomy serves a useful purpose in reminding us that our choices impact upon others, it also downplays the importance of a private, individual choice.<sup>33</sup> The individual will be left vulnerable if the law does not seek to enforce that choice irrespective of its impact on her relationships. A human rights perspective demonstrates the risk in failing to respect a choice made by a person with decision-making capacity simply because of considerations of family, relationships and community. The development of human rights law (and, it might be added, woman’s equality) is about

<sup>30</sup> C Mackenzie and N Stoljar, ‘Introduction: Autonomy Refigured’ in C Mackenzie and N Stoljar (eds), *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self* (Oxford, Oxford University Press, 2000) 4.

<sup>31</sup> *Ibid* 22.

<sup>32</sup> A Donchin, ‘Autonomy and Interdependence: Quandaries in Genetic Decision Making’ in C Mackenzie and N Stoljar (eds), *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self* (Oxford, Oxford University Press, 2000) 238.

<sup>33</sup> This criticism is noted by Jonathan Herring, a proponent of relational autonomy, who recognises that ‘if traditional liberal versions of autonomy have been too ready to view individuals as isolated, relational autonomy has over-emphasised the importance of community and relationship and has ignored the importance of the private life of the self’ (J Herring, ‘Relational Autonomy and Rape’ in S Day Sclater, F Ebtehaj, E Jackson and M Richards (eds), *Regulating Autonomy: Sex, Reproduction and Family* (Oxford, Hart Publishing, 2009) 59).

restricting the impact that these wider interests can have upon individual freedom. The individual is central to human rights law, based as it is upon a principle of equality. Relational autonomy risks allowing an individual's rights to be too easily overridden in a rush to protect family or community. While no man, much less woman, is an island entire of itself, nor is he or she necessarily defined by relationships with other people.<sup>34</sup> I am a daughter, sister, partner and friend but my whole is far more than the sum of those parts. Indeed, I would argue that those relationships are choices I have made to build or maintain relations with other people that I care about, rather than a means of explaining the woman that made those choices. Relationships are what we choose to do; not who we are.

It will not be surprising, perhaps, that this book, with its overriding human rights perspective, will adopt a more traditional liberal conception of autonomy. Its individualistic nature will be viewed as a greater asset than it is a threat. However, the bodily autonomy that is championed in this book is one of the embodied self, and this is a concept that now needs to be investigated.

### III. The Body

The body is peculiarly absent from much of the law and ethics. It is the mind, and particularly a rational mind, that forms the focus of much of the debate about bodily autonomy. This section will investigate why that is the case and assess its implications.

#### A. Dividing the Mind and the Body

The seventeenth century philosopher René Descartes explained reality as consisting of only *res extensa* and *res cogitans*. The former encompasses the corporeal body, while the latter encompasses the mind. The body and the mind are thus distinct under Cartesian dualism, but the significance of this theory goes much further than that because the body is also subordinated to the mind, meaning that cognitive rationalisation dominates. As Shildrick expresses it, 'the knowing subject is disembodied, detached from corporeal raw material'.<sup>35</sup> This is why 'I think, therefore I am' is the ultimate Cartesian slogan.<sup>36</sup> The body thus comes to

<sup>34</sup> Herring explicitly notes that we have 'dignity and worth in ourselves as people, and not just in our relationships with others' (ibid 60). It is only surprising that it has to be stated.

<sup>35</sup> M Shildrick, *Leaky Bodies and Boundaries: Feminism, Postmodernism and (Bio) Ethics* (London, Routledge, 1997) 14.

<sup>36</sup> See Turner (n 1) at 10.

be perceived as a machine under the control of the superior mind.<sup>37</sup> It is desacralised. It is a machine to be controlled and, when it malfunctions, to be studied by science ‘as one would study any complex mechanism, without fear of this being an affront to human dignity and without the need of divine sanction.’<sup>38</sup>

The concept of a dominant mind over a mechanised body has been utilised by philosophers over the years to establish a focus on rationalism. For example, Kant elevates the rational moral agent to personhood.<sup>39</sup> Moral agency leads to moral status, and moral agency is really about a capacity to act autonomously. The role of the mind is far more crucial to this theory than that of the body distinct from the mind. Similarly, Locke regards a person as a psychological entity, conscious of its own thought processes, and this is essentially a non-physical entity.<sup>40</sup> In short, the mind is often viewed as the person. This facilitates an emphasis on autonomy, rationality and free choice, but it can also lead to extremes in which only a certain type of human mind qualifies for moral status. The implications of such a personhood theory will be critiqued below.

First, however, it is also important to note the gender-specific implications of the dominance of the rational mind over the emotional body under Cartesian dualism. As Shildrick notes, the ‘self-present, self-authorising subject became he who could successfully transcend his own body to take up a position of pure reason uncontaminated by the untrustworthy experience of the senses.’<sup>41</sup> The ‘he’ in this sentence is well-chosen because women are potentially disadvantaged in such a scenario. This is because women are traditionally viewed as more intimately associated with their bodies and as ‘intrinsically unable to transcend them.’<sup>42</sup> For example, hormones, PMT, pregnancy, menopause, ‘hysteria’ and anorexia are just a few ways in which a woman’s body has, over the years, been regarded as affecting her rational mind.<sup>43</sup> If a person is morally valuable because of the dominance of his rational mind over his unreliable body, the woman, at the very least, faces greater hurdles in maintaining and proving that distinction.

<sup>37</sup> The dominance of mind over body is not without challenge. Hyde argues that it is discourse rather than biology that favours the mind, noting that ‘law rarely constructs a body with independent agency, which acts without mental or moral direction or may even control the mind of the person within it. Biologically speaking, many body functions involve no mental intercession. But it is discourse, not biology, that constructs a body as a tool subject to mental direction’ (A Hyde, *Bodies of Law* (Princeton, NJ, Princeton University Press, 1997) 259).

<sup>38</sup> AV Campbell, *The Body in Bioethics* (London, Routledge, 2009) 3. Furthermore, Kay Toombs argues that by construing the body in largely mechanistic terms, ‘Western “scientific” medicine encourages individuals to give up personal control and to “hand over” their bodies to medical experts to be “fixed” and returned to them in “good working order”’ (S Kay Toombs, ‘What Does it Mean to be SomeBody? Phenomenological Reflections and Ethical Quandaries’ in M Cherry, *Persons and their Bodies: Rights, Responsibilities, Relationships* (Dordrecht, Kluwer, 1999) 88).

<sup>39</sup> Kant (n 2).

<sup>40</sup> See M Ford, ‘The Personhood Paradox and the “Right to Die”’ (2005) 13 *Medical Law Review* 80.

<sup>41</sup> Shildrick (n 35) at 26.

<sup>42</sup> *Ibid.*

<sup>43</sup> *Ibid.*

## B. Problems of Personhood Theory

A popular theory within bioethics in recent years, the personhood theory, might well sound unbelievable on first encounter. It proposes that not all human beings are ‘persons’ with rights. Its leading proponents such as Peter Singer<sup>44</sup> present plausible arguments for why such a theory overcomes intellectual problems with a ‘speciesist’ approach in which all human beings have equal moral value solely on the basis of being a member of the human species. Mary Anne Warren explains the view that personhood is ‘a psychological concept, not a biological one. It is a being’s mental and behavioural capacities that make it a person, not the shape of its body, the microstructure of its chromosomes, or any other strictly physiological characteristic.’<sup>45</sup> Although the exact requirements of personhood tend to vary between writers, they do all focus on a disembodied mind. Consciousness is widely regarded as a minimum characteristic, and other proposed criteria include capacity for reason (Singer), capacity to value one’s own existence (John Harris)<sup>46</sup> and moral agency (Kant). Regrettably, such requirements inevitably exclude many human beings from the prized category of person and thus from moral status.<sup>47</sup> To be clear, this is not just a recognition that some individuals lack the capacity to make decisions for themselves (which is something that the law recognises)<sup>48</sup>; rather, the personhood theorists would deny moral status to anyone lacking their requisite (mental) capacities. Singer and Harris are comfortable with excluding infants and persistent vegetative state (PVS) patients from personhood, and thus from moral status, but it is impossible to reconcile such an approach with the concept of human rights. That these rights are due to all of humanity (and not only ‘persons’ in a narrowly defined manner) is at the heart of the human rights movement. A PVS patient, although unable to make contemporaneous decisions about his or her continued treatment, retains a myriad of rights, including a right to life, to respect for private life and to freedom from degrading treatment.<sup>49</sup> Personhood theory’s focus only on a person with some degree of capacity takes the Cartesian model to its extreme manifestation. It recognises only the human mind and

<sup>44</sup> P Singer, *Rethinking Life and Death: The Collapse of Our Traditional Ethics* (Oxford, Oxford University Press, 1995) 206. In Singer’s view, personhood need not be confined to the species *homo sapiens* and he is a strong proponent of animal rights.

<sup>45</sup> MA Warren, *Moral Status: Obligations to Persons and Other Living Things* (Oxford, Clarendon Press, 1997) 93–94.

<sup>46</sup> J Harris, *The Value of Life: An Introduction to Medical Ethics* (London, Routledge, 1985).

<sup>47</sup> Warren proposes a multi-criterial approach to moral status which would explain ‘why it is appropriate to accord full moral status to infants and other sentient human beings who are not moral agents, while denying it to most non-human animals—including many whose mental capacities are more impressive than those of a human infant’: (n 45) at 181.

<sup>48</sup> As, for example, in the Mental Capacity Act 2005.

<sup>49</sup> See E Wicks, ‘When is Life Not in Our Own Best Interests? The Best Interests Test as an Unsatisfactory Exception to the Right to Life in the Context of PVS Cases’ (2013) 13 *Medical Law International* 75.

not the human body as being morally valuable and rests upon a concept of the disembodied self. Some personhood theorists, such as Harris, are unapologetic about this:

On many accounts of personhood, including that of myself, Singer and others, persons need not be organic life forms at all. It would be possible for very sophisticated computers which are not alive in any sense to be persons, and the wrong of ending their existence would be the same as the wrong of ending the life of an organic person but not because they were alive. Persons are the set of capacities that make for personhood, however embodied or individuated and the value of the existence of persons has to be understood in terms of the nature of those capacities.<sup>50</sup>

Harris continues by emphasising that the value of life separable from personhood is zero. In other words, life has no value for any human being who does not qualify for personhood.<sup>51</sup> Thus, once personhood is lost (for example, due to a loss of capacity as in PVS) or before personhood has developed (as with the foetus), human life has no value. The body here counts for nothing.

Mary Ford has noted that some more recent writers on personhood theory have recognised that purely psychological theories of personhood encounter problems of circularity (because by relying on memories to establish personhood, there is a presupposition that a person created them).<sup>52</sup> There may increasingly be some recognition, therefore, that such problems can only be solved by conceiving of persons as embodied entities. Ford identifies what she calls 'supporting approaches' to personhood which accept that embodiment is a necessary support to personhood, but is not constitutive of it.<sup>53</sup> This would indeed be a beneficial development but it is in stark contrast to the core personhood theory, which is built upon a disembodied mind and entirely overlooks the value of the human body in a rush to remove rights from some human 'non-persons'. Whatever the future evolution of bio-ethical debate on this topic, the absolute exclusion of any category of human beings from the protection of fundamental human rights cannot be tolerated within legal doctrine. The human mind and body may indeed be distinct in nature but they are in frequent interaction with each other. A theory of moral status that entirely excludes the human body in order to elevate human minds with certain characteristics is incapable of recognising the equality and rights shared by all human beings. It is the 'non-persons' under personhood theory who often require the greatest protection from the state and society. As Byk has noted, an important advantage of the concept of universal human rights when we seek to develop an understanding of the legal and moral status of the human body is that 'all human bodies are different, yet, at the same time, all human persons enjoy

<sup>50</sup> J Harris, 'The Right to Die Lives! There is No Personhood Paradox' (2005) 13 *Medical Law Review* 386 at 389.

<sup>51</sup> *Ibid.*

<sup>52</sup> Ford (n 40) at 93.

<sup>53</sup> *Ibid* 93.

equal rights.<sup>54</sup> A definition of persons based upon a disembodied self is simply not compatible with current human rights law, nor with the underlying concept of universal human rights.

### C. Embodied Self

Embodiment theory focuses upon the whole person as a union of body and mind.<sup>55</sup> It recognises the interaction and relationship between our mental selves and our bodies, and gives value to the body, in contrast to the body-as-a-machine viewpoint of Cartesian doctrine. A special moral value for the human body also contrasts with a commodification approach. Campbell argues that ‘the risk of this slide to the disrespect of persons is present as soon as we begin to disaggregate the organic unity on which human life depends.’<sup>56</sup> As Bryan Turner explains, much radical thought has challenged the Cartesian opposition of the mind and body, regarding it as ‘an aspect of social power, which subordinates desire to reason for purposes of authoritarian control.’<sup>57</sup> Foucault has been particularly influential in arguing that the body is the focus of power in modern societies. He regards the medicalisation of bodies as a means of control of persons.<sup>58</sup> Indeed, arguably Foucault reverses the Cartesian privileging of the mind with an emphasis on the body alone. Turner explains that Foucault does this ‘by denying any centrality to subjectivity (the thinking, Cartesian subject) and by treating the body as the focus of modern discourse.’<sup>59</sup>

Feminist theory too has sought to emphasise the importance of the body. As noted above, many feminist writers argue that the traditional Cartesian model has gendered implications. Women are more closely identified with their bodies and often portrayed as less able to transcend them than men.<sup>60</sup> Women also have bodies that change more frequently than men’s, and the medicalisation of the body (which is a feature of the Cartesian model’s instrumental approach to the body) has meant that those changes are often viewed as medical problems. Shildrick gives examples of commonplace changes to the female body, such as puberty, menstruation, reproduction, lactation and menopause, as changes that are classified as medical problems.<sup>61</sup> The fact that these are healthy developments that are

<sup>54</sup> C Byk, ‘The Impact of Biomedical Developments on the Legal Theory of the Mind-Body Relationship’ in M Cherry, *Persons and their Bodies: Rights, Responsibilities, Relationships* (Dordrecht, Kluwer, 1999) 271.

<sup>55</sup> Campbell (n 38) at 4.

<sup>56</sup> Ibid 123. Furthermore, it can be argued that our bodies are not all distinct. We are connected to our environment in a myriad of ways. Herring and Chau have argued that our bodies are not ‘ours’ because they are ‘interdependent, interconnected and intermingling with other bodies’ (J Herring and P-L Chau, ‘My Body, Your Body, Our Bodies’ (2007) 15 *Medical Law Review* 34 at 45).

<sup>57</sup> Turner (n 1) at 53.

<sup>58</sup> Turner (ibid) discusses this at 63.

<sup>59</sup> Ibid 74.

<sup>60</sup> Shildrick (n 35) at 26.

<sup>61</sup> Ibid 169.

nonetheless brought under medical control suggests ‘a deep cultural unease with the embodiment of women.’<sup>62</sup> The close scrutiny given to women’s weight and appearance (so much more than to that of men) further supports the argument that women are more closely linked to their bodies, while, as we have seen, it is the rational mind that is traditionally regarded as the focal point of personhood.

Kay Toombs notes that there are both positive and negative consequences of embodiment. The personal dimension refers to our strong sense of bodily identity while the interpersonal element relates to the tendency to overlook the distinction between body and person when making judgments about others, especially in relation to disability, age and gender.<sup>63</sup> The personal dimension is all too often overlooked by the law in relation to bodily autonomy. Fletcher, Fox and McCandless, while criticising healthcare law’s neglect of bodies and embodiment, argue for greater recognition of the subjective value in the body. This might even extend beyond individuals who possess autonomy and include even those unable to make an autonomous decision on their own but who are self-aware and may have a subjective value in their body.<sup>64</sup> Without an emphasis on our own subjective, personalised views on our bodies, the problem of a ‘normal’ human body arises. Embodiment theory counters notions of a single universal body subject to uniform regulation, thus enabling a recognition that even a body which does not meet the ‘normalised’ criteria may be valued by the person concerned. As Fletcher, Fox and McCandless recognise, ‘Ideals of normal bodies work to diminish the subjective value which disabled people and reproducers, would-be amputees and those seeking cosmetic surgery attribute to their own bodies.’<sup>65</sup> In other words, no one understands our personalised relationship with our bodies as we do ourselves, nor can they appreciate the peculiar value that we may place upon aspects of our bodily identity which deviate from the norm.

Pregnancy is often cited as a unique example of embodiment. Stychin explains the feminist objection to a foetal rights approach to pregnancy because the ‘woman’s body is increasingly taken out of the reproduction equation’ to become ‘an object of control rather than an autonomous self.’<sup>66</sup> A dichotomy between pregnant woman and foetus runs the risk of disregarding the unique experience of embodiment felt by the woman. Her body’s boundaries have changed, and

<sup>62</sup> Ibid 170.

<sup>63</sup> Kay Toombs (n 38) at 89–92.

<sup>64</sup> R Fletcher, M Fox and J McCandless, ‘Legal Embodiment: Analysing the Body of Healthcare Law’ (2008) 16 *Medical Law Review* 321 at 335–36.

<sup>65</sup> Ibid 336. Travis makes a similar point in relation to Bodily Integrity Identity Disorder, noting that attempts to have the disorder entered into the DSM (American Psychiatric Association’s influential *Diagnostic and Statistical Manual of Mental Disorders*) propagates the idea ‘that to deviate from the normative conception of the body—indeed, simply to engage with it—is irrational, or worse signification of a mental health disorder’ (M Travis, ‘Non-Normative Bodies, Rationality and Legal Personhood’ (2014) 22 *Medical Law Review* 526 at 545).

<sup>66</sup> CF Stychin, ‘Body Talk: Rethinking Autonomy, Commodification and the Embodied Legal Self’ in S Sheldon and M Thomson, *Feminist Perspectives on Health Care Law* (London, Cavendish, 1998) 225.

alongside this is a physical and emotional attachment to a new entity. While there are sound arguments for some recognition of limited rights for a foetus towards the end of pregnancy,<sup>67</sup> these should never discount the relevance of the woman's body and her bodily experience of pregnancy. Mackenzie explains what an embodiment approach could offer:

It is a question of being able to shape for oneself an integrated bodily perspective, a perspective by means of which a woman can respond to the bodily processes which she experiences in a way with which she identifies, and which is consistent with the decision she makes concerning her future moral relationship with the foetus.<sup>68</sup>

While there are complications within the pregnancy scenario (which will be considered further in the reproduction chapter), the general point about the need to make decisions within a particular embodied experience is an important one. An autonomous decision concerning pregnancy must be made by a pregnant woman who is experiencing the changing boundaries and new interconnectedness of pregnancy. Or in other words, it is the embodied self that is capable of making truly autonomous decisions rather than a disembodied mind. Stychin gives a useful example of a surrogate who changes her mind about giving up her child after birth. However genuine her decision before she was pregnant, it was not a decision made within the embodied experience of pregnancy and thus legal recognition of such a change of mind would be 'an acknowledgment that an informed (and rational) decision ultimately can only arise out of the particular embodied experience; in this case, the necessarily both connected and individuated experience of pregnancy and childbirth'.<sup>69</sup> By contrast an insistence that the surrogate is bound by an earlier decision, however informed and reasoned it was at the time, would seek 'to transcend the actual experience of the body'.<sup>70</sup> The same point might be made about choices in relation to assisted dying. Can a decision made before the body experiences the process of dying, or the pain and suffering, truly be an autonomous decision, when the embodied experience may add so much more value and context to the decision-making process?

By putting the body back into the equation, it is the *embodied* self who is autonomous rather than the *disembodied* mind. This does not represent a privileging of the body over the mind because an autonomous decision about the body will still require a mind capable of making informed decisions. Nor does this entirely ignore the distinction between mind and body. Rather it gives long overdue recognition to the interaction between the two. Throughout this book, we will

<sup>67</sup> E Wicks, *The Right to Life and Conflicting Interests* (Oxford, Oxford University Press, 2010) ch 1 (arguing that 'life' begins at viability); E Wicks, 'The Meaning of Life: Dignity and the Right to Life in International Human Rights Treaties' (2012) 12 *Human Rights Law Review* 199 (arguing that human dignity requires some limited protection for all human life regardless of legal status). See also Chapter 3.

<sup>68</sup> C Mackenzie, 'Abortion and Embodiment' (1992) 70 *Australian Journal of Philosophy* 136 at 151.

<sup>69</sup> Stychin (n 66) at 230.

<sup>70</sup> *Ibid.*

encounter many complex, controversial and emotive decisions about the human body. The autonomy of the individual will be paramount but it will be argued that it is a genuine *bodily* autonomy that is important. In other words, in order to be autonomous, a decision must be made within a particular embodied experience. This should serve to heighten the strength of autonomy, rather than undermine it: the mind will make better decisions when it is encouraged to learn from bodily experience, and the state should be particularly wary about encroaching upon exercises of autonomy by embodied selves.

## IV. Conclusion

The relationship between the state and the body hinges around bodily autonomy and the extent to which the state is able and willing to respect that. This introductory chapter has identified some current debates surrounding both the ethical principle of autonomy and respect for the human body. It has argued that a liberal conception of autonomy which retains a focus upon individualism is the most appropriate way of protecting an individual's rights and freedom and that the legal implementation of autonomy should not be watered down with undue deference to a relational model. This is not to deny the importance of relationships and communities to individual decision-making, but a person is more than just the sum of their relationships. Ultimately, it is for the individual to choose the extent to which they will be influenced by others, as well as the extent to which maintaining existing relations is a goal of the decision-making process. To assist this, the state must have in place extensive equality protections and proactive protection for the vulnerable, but it must also trust in the choice made by an individual with decision-making capacity.

While a relational autonomy approach has been rejected in this chapter, a more sympathetic view has been taken of the embodiment theory. It has been argued that in order to be autonomous a decision concerning the body must be made within a particular embodied experience. In contrast to Cartesian dualism, it has been argued that it is the embodied self that is autonomous rather than a disembodied mind. This approach, it is suggested, will truly facilitate bodily autonomy by ensuring that the focus is not just on autonomous decision-making of the mind, nor solely upon objective respect for the human body but, crucially, on a combination of the two which embeds decision-making about the body into the specific context of an embodied experience. When coupled with the strong focus on the self as opposed to a relational model, this emphasis upon the embodied self ensures a pertinent starting point for considerations about when the state can, and should, intervene to regulate the exercise of bodily autonomy. The next chapter will begin this investigation by addressing the difficult question of what is private in relation to the human body in the context of a public-private divide.