A patient is asking to have a healthy leg amputated as he feels it is not part of his body. Should such requests ever be granted? And, if so, in what circumstances?

**Is it ever acceptable to amputate a healthy limb?**

**In this article...**
- A case study of a patient who had a healthy limb amputated
- The case for and against amputating healthy limbs

**Keywords:** Ethics/Amputation/Mental health/Mental capacity

- This article has been double-blind peer reviewed

For most people, the idea that anyone would wish to have a perfectly healthy leg amputated must seem bizarre. However, such people exist. This debate is based on a true case study; all names have been changed to prevent any distress to those involved.

Andrew Smith believed his left foot was not part of his body and, since the age of eight, had experienced a pathological desire to lose his left leg. This intensified over time and, as far as he was concerned, by the time he was an adult, amputation above the knee was the only option.

When Mr Smith sought professional help, he was prescribed electroconvulsive therapy (ECT) and a selective serotonin reuptake inhibitor, but neither improved the problem. After years of psychological evaluation, he was diagnosed with body dysmorphic disorder (BDD); this psychological condition, also known as dysmorphophobia, causes individuals to become preoccupied with an imagined or minor defect in their appearance to the extent that their social, occupational or other areas of functioning are impaired (Mackley, 2005).

After years of searching, Mr Smith found a sympathetic surgeon with a particular interest in amputation surgery. Mr Jenkins was willing to amputate the healthy leg, believing the diagnosis of BDD to be incorrect. He felt people seeking amputation of healthy limbs may have one of four different conditions – self-mutilation, dependency, sexual gratification, or a desire to lose a limb that has become an all-consuming part of life. Mr Jenkins believed the last condition applied to Mr Smith; importantly, he would not consider surgery for people in the other groups.

Furth and Smith (2000) firmly concluded the BDD diagnosis to be incorrect on the basis that people like Mr Smith, do not see the limb they want amputated as defective, but “want to rid themselves of a limb that does not belong to their body identity”.

After 18 months’ careful consideration, Mr Jenkins approached a private hospital where he hoped to carry out the amputation. Although the hospital’s medical advisory committee supported the surgeon, the managers did not, so he approached the medical director of an NHS trust who consented to the surgery taking place.

Mr Smith had his left leg amputated; he paid for the surgery and a five-day stay in hospital; Mr Jenkins waived his fee. The surgeon went on to carry out another “healthy limb” amputation at the same hospital, but when a third man requested such a...
Should healthy limbs be amputated? Have your say at www.nursingtimes.net/amputate

procedure the trust’s new chief executive and chairman put a ban on the surgery and ordered an internal ethical inquiry.

Many ethical issues in healthcare are caused by a conflict between the obligation of respect for autonomy, and those of beneficence (doing good) and non-maleficence (doing no harm). The term “autonomy” derives from a Greek word for “self-governing” – in other words individuals are capable of making their own decisions about matters that concern their own life (Beauchamp and Childress, 2013; Edwards, 2009). The Mental Capacity Act 2005, Section 2(1) states that people lack capacity if they are unable to make a decision owing to an “impairment of, or disturbance in the functioning of, the mind or brain”.

Brain disorder or rational decision?
In Mr Jenkins’ opinion, Mr Smith was wrongly diagnosed with BDD, although many of the psychiatrists who assessed him determined him to be paranoid and delusional. Is it justified to perform amputation surgery on a patient who arguably has a functional disorder of the brain? And can a request to have a healthy limb amputated ever be described as rational?

If Mr Smith was deemed to be autonomous with capacity, Gillon’s (1986) assertion that “the patient’s interests always come first” is certainly not true in practice and is undesirable as a moral imperative. It can be argued that the ethical obligations of beneficence and non-maleficence supersede that of autonomy. Beneficence does not mean health professionals are obliged always to do what their patients want. In the case of non-maleficence, or the duty to “do no harm”, it is not beneficial overall to do something that is beneficial in itself, if you wreak havoc in the process – a danger to which modern doctors are particularly susceptible (Gillon, 1986).

Resource issues
It could be argued that removing a healthy limb wreaks havoc on an already overstretched NHS, in which waiting lists are growing, and social services that would have to support an unnecessary disability. And where does this disability end? Elliott (2009) pointed out that while medical or surgical treatment may relieve the condition, it may only provide short-term relief, with the patient either refocusing concerns on the perceived deficit or becoming precenupied with a different aspect of their body.

The NHS is a finite resource and there is a distinction between distributions of healthcare that are just and those that are unjust. If surgery was justified, why did the NHS trust refuse to host similar operations after the second patient had surgery?

Mental capacity
This argument focuses on autonomy and capacity but fails to acknowledge that respect for autonomy concerns obligations to respect all kinds of choices, even those that go against what is considered “right”.

When patients go against medical advice, it is often thought unwise but their wishes are respected. Mr Smith’s autonomous choice to have a healthy limb removed was questioned and the issue of capacity raised. Section 2(1) of the Mental Capacity Act 2005 states a person lacks capacity if they cannot make a decision owing to an “impairment of or disturbance in the functioning of the mind or brain”, but Section 3(1) provides that, for the purposes of section 2, a person is unable to make a decision for himself if unable to:

(a) Understand the information relevant to the decision;
(b) Retain that information;
(c) Use or weigh that information as part of the process of making the decision; or
(d) Communicate his decision (whether by talking, using sign language or any other means).

Mr Smith underwent several psychological evaluations, all of which deemed him to have capacity, so it could not be said that requesting the amputation meant he lacked capacity. If a patient is well informed and has capacity, positive steps should be taken to try to facilitate making competent decisions. Indeed, Mr Jenkins said Mr Smith was “probably the best informed patient” he had ever dealt with (Elliott, 2009).

Minimising harm
In terms of beneficence and non-maleficence, not removing the healthy limb could be considered as harmful as doing so. In some cases patients undertake mutilating surgical procedures as a last resort when all other interventions and requests have failed. Mr Smith’s case is no different; he sought psychological help and lived with his affliction for many years before seeking a surgeon’s help.

Mental illness is no less severe than a physical life-altering illness. Mr Jenkins has indicated that while he was concerned that, by amputating healthy limbs, he was harming his patients, ultimately, he was more concerned that they would kill or seriously injure themselves if surgery did not take place (Elliott, 2009).

Acting in patients’ “best interests” is often seen as paternalistic – that is, doing things against their immediate wishes or without consulting them (Gillon, 1986). Since Hippocratic times, doctors have been required to do what is best for their patients, but who decides what is best? It could be that removing a healthy limb would worsen quality of life because the person will become disabled. Under the Equality Act 2010, people are disabled if they have a physical or mental impairment that has a “substantial” and “long-term” negative effect on their ability to do normal daily activities. Arguably Mr Smith did not see himself as disabled after the surgery, but more “dis-abled” with the limb intact.

The strongest argument yet in support of Mr Smith and Mr Jenkins is that of therapeutic benefit. Elliott (2009) argued in favour of healthy-limb amputation on the grounds that Mr Smith was suffering from a mental disorder that caused considerable distress. Previous psychological treatments had failed and from a holistic perspective; not amputating increases Mr Smith’s risk of self-mutilation and possible death (Elliott, 2009). Providing certain safeguards are observed (particularly in terms of ensuring the patient has capacity and informed consent is obtained), amputation is an acceptable way of treating these patients.

Conclusion
Mr Jenkins was faced with a decision fraught with ethical dilemmas. Biomedical ethics often affect nursing practice, and this article has presented some key arguments on both sides about healthy-limb amputation. However, many other perspectives could be considered; to continue this debate, visit the Nursing Times website at http://www.nursingtimes.net/amputate.

References

FURTHER READING

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