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Depathologising Gender: Vulnerability in Trans Health Law

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Abstract

This chapter challenges how gender has been positioned under the control of health professionals in the regulation of trans bodies. Trans people have formed complex relationships with health professionals, whose influence is often crucial in determining access to body modification treatments including hormones and surgeries. Having previously argued that this constitutes an overreach of medical jurisdiction, this chapter is more forward-looking, assessing the potential of a human right to depathologisation. After deciding that latent risks in this strategy might outweigh potential benefits, we propose an alternative agenda which understands trans bodies, and the institutions which regulate their access to health care, as vulnerable. This change of emphasis offers key insights which could benefit the activists and scholars engaged in the trans depathologisation movement.

Introduction

This chapter challenges how gender has been positioned under the control of health professionals in the regulation of trans bodies.[1] Trans people have formed complex relationships with health professionals, whose influence is often crucial in determining access to body modification treatments including hormones and surgeries. We have previously argued that this constitutes an overreach of medical jurisdiction, particularly where this

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[1] We use the term ‘trans’ here to refer to people who do not identify with the gender that they were assigned at birth and take active steps to make some form of social and/or medical transition away from that assigned gender.

intersects with legal gender recognition processes or the accessibility of health care provision (Pearce, 2018; Dietz, 2020). This chapter is more forward-looking, assessing the potential of a human right to depathologisation. After deciding that latent risks in this strategy might outweigh potential benefits, we propose an alternative agenda which understands trans bodies, and the institutions which regulate their access to health care, as vulnerable. This change of emphasis offers key insights which could benefit the activists and scholars engaged in the 'trans depathologisation movement' (Davy et al., 2018: 15).

Like other contributions to this collection, this chapter identifies a body that has been under-theorised in health law. This is one result of trans phenomena being medicalised in various ways since the start of the twentieth century. Trans issues have, over time, become more commonly discussed within legal studies, but this has mostly been due to research conducted by scholars drawing on human rights and anti-discrimination perspectives (Whittle, 2002; Dunne, 2017; Sharpe, 2010, 2018). Yet empirical research indicates that the positive impact of human rights reforms, including gender recognition legislation, may be undermined where they fail to address access to health care (Dietz, 2018). Trans health has been well-researched in sociology (Davy, 2011; Pearce, 2018; Vincent, 2020) and history (Meyerowitz, 2002; Gill-Peterson, 2018). Though trans issues have become more prominent within health law (Sørlie, 2018; Dietz, 2020), they are yet to become an established topic of study in this field.[2] Drawing upon developments in Argentina, Denmark, Uruguay, and the UK, this chapter seeks to address this deficit, developing a new research agenda for trans health law.

Once psychiatric terms enter everyday use, the boundaries between what is considered normal and pathological 'begin to blur' (Lane, 2010: 105). When such terms are imported into law – for example in requiring trans people to have been granted a psychiatric

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[2] Trans issues are not considered in most medical law textbooks, including Jackson (2016) and Brazier and Cave (2016). In Herring (2018), they are considered in relation to resource allocation.

diagnosis in order to become eligible for gender recognition – authoritative norms establish the boundaries of acceptable gendered practice. These might relate to what names people have, how they dress and behave at home and in the workplace, how their body looks, and what kind of medical interventions they have (or haven't) had to modify their bodies. Trans people, and others, are then judged in relation to these norms. Yet 'medicolegal' understandings of trans phenomena (Butler, 1993; Davy, 2010) are not static. Since the later decades of the twentieth century, the standards which maintain the boundaries of acceptable gendered embodiment have been subjected to near constant scrutiny and challenge. Courts and legislatures have responded by creating a diverse body of 'reform jurisprudence' (Sharpe, 2010: 99); with trans people now regulated in a patchwork fashion, depending upon where in the world they reside. While some states offer no form of gender recognition, others require people to undergo compulsory sterilisation in order to be granted recognition (Honkasalo, 2020). A growing number permit subjects to self-declare legal gender status, and have this recognised without further pre-conditions (Castro-Peraza et al., 2019). This chapter will not present a comparative review of different forms of legal gender recognition available within different states (see ibid). It seeks to address the policy concerns of states towards the latter end of the scale instead.

At the time of its enactment, the UK Gender Recognition Act (GRA) 2004 was considered a 'groundbreaking reform' (Cowan, 2009: 247). It dispensed, ostensibly, with a 'biological approach' (Sharpe, 2010) which understood gender to be 'fixed at birth' (*Corbett v Corbett* [1970] 2 All ER 33 [1971] P 83, 104). It was the first European law not to require sterilisation (such as through the removal of reproductive organs) as a pre-condition for recognition (Dunne, 2017). Yet the GRA 2004 still 'pathologises' trans phenomena – treating them as indicative of a mental disorder – by requiring applicants to provide supporting evidence from specialist health professionals that they have received a diagnosis of 'gender dysphoria' (GRA 2004, s. 2(1)(a)). This contrasts with legislation based upon the principle of self-declaration, which is said to constitute 'the optimal gender recognition model' (Dunne, 2015: 539). The foremost example of self-declaration, the Argentinian Gender Identity Law (*Ley de Identidad de Genero 26.743*)(LIG) 2012, responds to critiques of previous gender recognition laws by permitting trans people to make a formal declaration of their gender status and have this recognised in civil registration systems without further pre-requisites. This enacts a shift away from the pathologisation of trans bodies.

Following the enactment of the LIG 2012, critiques of the pathologisation of trans identities have gained momentum at national and international levels. Such critiques have recently been re-framed as arguments in favour of the 'depathologisation' of trans phenomena (Davy et al., 2018). This might reflect a desire among activists and scholars to reformulate their critical stance into a more affirmative policy proposal; akin to those seen in calls for universal design in both bioethics (Ries & Thomson, 2019) and disability law and policy (Lawson, 2008). The demand for depathologisation of trans phenomena is increasingly talked about as a right, and in some cases a human right (Cabral et al., 2016). It is at this point that we wish to enter the debate. While we acknowledge the challenges faced by the activists and scholars advocating depathologisation in this and other areas, we are also cautious about latent risks associated with the uncritical employment of human rights language. If such languages are left to reflect theoretically limited understandings of embodiment, this could end up reducing the potential scope and impact of depathologisation. In calling for a stronger dialogue between health law and trans studies, this chapter proposes some directions of travel for such collaboration. It argues that human rights interventions in this area would benefit from being guided by vulnerability theory, as developed by Fineman (including in this collection). By engaging vulnerability to analyse trans issues at the intersection of law and medicine, we offer a more realistic framing of trans bodies. Beyond its ontological intervention, which emphasises our bodily materiality, vulnerability theory demands a more considered policy offering from states; which must respond to, rather than withdraw from, the complexity of human embodiment. It also allows scholars to consider the vulnerability of institutions, including professional medical regulators and national health care systems – in a manner which has yet to be fully explored in the existing vulnerability literature.

The chapter is structured in three parts. The first discusses how gender has been pathologised, and recounts some of the ways in which pathologisation has been criticised. After reviewing the thrust and objectives of these critiques, we discuss what trans people stand to gain from a prospective depathologisation of their identities. The second part turns to depathologisation, identifying how the literature in this area has developed from the negative to the affirmative in recent years. Having identified a tendency to move towards the adoption of human rights language, we discuss some pitfalls that might be associated with this strategy, before identifying what the impact of this might be for the trans people who supposedly stand to benefit. In the third and final section of the chapter, we propose an alternative. With reference to Fineman's vulnerability theory, we evaluate the advantages of acknowledging vulnerability when seeking to depathologise trans identities. This identifies potential avenues for future research at the intersection of human rights, health law, trans studies, and vulnerability theory. The chapter contributes to human rights and health law literatures by asserting the utility of considering the vulnerability of trans patients. It also deepens the vulnerability theory literature by considering the vulnerability of institutions, in this instance addressing that of professional medical regulators and other organisations within national health care systems.

Diagnosing gender

The international context has changed significantly since the enactment of the GRA 2004 put the UK in 'pole position' in terms of gender recognition legislation, in Europe and the wider world (Sharpe, 2009: 242). Before then, the UK was one of four Council of Europe states which offered no option to amend legal gender status (*Goodwin v UK* App no 28957/95, ECtHR, 11 July 2002, para 55). At present, most European states offer some form of gender recognition, and many have abolished requirements for compulsory sterilisation as a pre-requisite to recognition (Castro-Peraza et al., 2019).[3] Though the European Court of Human Rights (ECtHR) has shied away from finding that a requirement to undergo some form of medical treatment violates the Article 8 right to a private life (Cannoot, 2019: 22), criticism of gender recognition legislation which pathologises trans identities is increasingly prevalent at national and international levels. In the UK, this targets the GRA 2004, which requires applicants for gender recognition to be in receipt of a diagnosis of 'gender dysphoria' before they can be granted a gender recognition certificate (GRA 2004, s2(1)(a)). The diagnosis of gender dysphoria is currently defined in the fifth edition American Psychiatric Association's (APA)(2013) *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*). This manual has come under sustained critique within various fields, including disability studies (Bartlett and Sandland, 2014: 1-8). It stands accused of enacting 'diagnostic bracket creep' (Lane, 2010: 105, citing Kramer 1997: 15) or 'diagnostic imperialism' (Rose, 2019: 7), whereby psychiatry expands to cover increasing areas of human behaviour since the first edition of the *DSM* was published in 1968.

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[3] The ECtHR has found that requiring sterilisation as a pre-condition for gender recognition violates Article 8 of the European Convention on Human Rights; *AP, Garçon, and Nicot v France* App nos 79885/12, 52471/13 and 52596/13 (ECtHR, 6 April 2017).

In the *DSM-5*, gender dysphoria is defined as a ‘marked incongruence between one’s experienced/expressed gender and assigned gender’ (American Psychiatric Association, 2013: 452) which is associated with ‘clinically significant distress or impairment in social, occupational, or other important areas of functioning’ (ibid: 453). It is said to last for at least six months, and is indicated by at least two of the following:

> 1. A marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics […].
> 2. A strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender […].
> 3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
> 4. A strong desire to be of the other gender (or some alternative gender different from one’s assigned gender).
> 5. A strong desire to be treated as the other gender (or some alternative gender different from one’s assigned gender).
> 6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s assigned gender). (ibid: 452)

Psychiatrists’ authority over trans people is institutionalised through medical protocols and legislation, but also individualised through the relationships that exist between patients and practitioners. As Davy and Toze (2018) have observed, gender dysphoria is interpreted and operationalised in a highly inconsistent manner within the medical and psychiatric literatures. This reflects the diversity of professional opinions and approaches, which in practice mean that quite different demands can be made of trans patients depending on the clinic they attend, and the individual attitudes held by the practitioners responsible for diagnosing them and providing referrals for treatment. In the UK, while some trans patients find that they are supported in exploring and expressing their gender regardless of how normative or non-normative it might be, others report being refused treatment or support in accessing gender recognition through the GRA 2004 if they do not conform to gender stereotypes or intend to undergo particular medical interventions such as genital surgery (Pearce, 2018). They might go on to self-medicate with hormones or undergo surgeries overseas (if they have the financial means). The risks involved in both routes indicate that the employment of the gender dysphoria diagnosis could constitute another example of pathologisation working against people's health needs (Davis, 2010), impacting upon trans people's health more generally.

While the concept of gender dysphoria may have been new to the law in 2004, it has informed medical discourse in relation to transsexualism since the early 1970s (Hines, 2010). This reflects a long and complicated historical relationship between the law, trans people, and health professionals. Norms have been developed through an on-going interaction between the two latter groups, before being imported into law by legislation such as the GRA 2004 (Pearce, 2018; Riggs et al., 2019). Doctors have both helped and hindered trans people in their search for access to body modification technologies – usually in the form of hormones and surgeries – and assisted reproduction. Sexologists such as Harry Benjamin gained fame through treating, and publishing research about, trans patients. Psychiatrists continue to play an important gatekeeping role, not only in determining trans people's access to body modification technologies, but also in facilitating or blocking access to legal gender recognition in states including the UK (Pearce, 2018). By judging trans embodiment with reference to a range of subjective standards, psychiatrists maintain norms which legitimate some trans people while at the same time excluding others. This places them in an authoritative position at the intersection of medical and legal regulation of gender.

Sociological and socio-legal literature on the GRA 2004 has long been critical of the exclusionary effects of pathologising trans identities in the health care system and in statutory legislation (Cowan, 2009; Davy, 2010; Hines, 2010). Such critiques have recently begun to gain wider traction. As the UK Government Equalities Office (2018: 15) stated in its consultation document on reforming the GRA 2004: 'The Government's view is clear: being trans is not a mental illness. It is a simple fact of everyday life and human diversity.' While such a statement constitutes an interesting development, its impact will be negligible unless it is backed up by reforms to the GRA 2004 that would enable this statement to become reflective of legal and medical practice. To date, these have not been forthcoming. Similar critiques could be made of states such as Denmark, where a law purporting to prohibit the treatment of trans phenomena as constitutive of a mental illness was passed in May 2016 (B7 Bill to debate removing transsexualism from the diagnosis code (*Forslag til folketingsbeslutning om fjernelse af transseksualisme fra sygdomsliste*)). Having adopted self-declaration two years earlier (L 182 Law amending the Act on the Central Person Registry (11 June 2014) (*L 182 Lov om ændring af lov om Det Centrale Personregister*)), one might assume that trans people in Denmark would be able to access health care and gender recognition without a psychiatric diagnosis. Yet on a formal level, 'transsexualism', as defined in the tenth edition of the World Health Organization's (WHO)(1992) *International Statistical Classification of Diseases and Related Health Problems* (*ICD-10*), is retained in the Danish national diagnosis code (albeit in its own distinct section). And in practice, trans people are still granted or denied access to body modification technologies by psychiatrists using diagnostic manuals including those of the WHO and the APA (Dietz, 2018).

Following the lead of the sociological literature and international advocacy groups such as Global Action for Trans* Equality (GATE), critiques of pathologisation have become more embedded in the international human rights literature (Theilen, 2014; Cannoot, 2019; Gonzalez-Salzberg, 2019). Pathologisation is now considered not only as an exclusionary method for distinguishing between 'true' trans people and others, but also as a stigmatising process even for those who are granted a diagnosis of 'gender dysphoria' – in light of the assessments which they are expected to undergo, and the information that they are required to disclose, within the clinical setting (Dietz, 2018: 190). Concerns may be raised as to how far the argument that trans people are not mentally ill does justice for those trans people who do have mental illnesses, disabilities, or neurological differences (as in the context of asexuality, discussed by Kim, 2010). But critiques of pathologisation have been raised in the disability context (Bartlett and Sandland, 2014: 1-8; Rose, 2019), including from proponents of the social model of disability (Lawson & Priestley, 2017). Alliances between trans activists and disability activists have also been mooted in the trans studies literature (Krieg, 2013). In any case, abolishing pathologisation does appear to hold significant appeal among trans activists and scholars alike. Critiques of pathologisation have, in conversation with international activism, developed into calls for the 'depathologisation' of trans phenomena. We turn to the trans depathologisation movement in the next section; examining how it is being formulated, how its demands are being implemented, and what potential limitations it might encounter in practice.

Depathologisation and its limitations

As critiques of gender recognition law shift from concerns about the absence of recognition, to physical pre-requisites (such as sterilisation), and now on to psychiatric requirements, the human rights law and health sociology literatures have begun to converge around the strategic importance of depathologising trans phenomena. As we have noted, we understand this as a shift in strategy from the oppositional to the propositional. No longer does the literature merely criticise the pathologisation of trans identities, it also proposes mechanisms to ensure that states and medical authorities actively cease to do so. Even greater convergence between the legal and sociological literature is evidenced in recent attempts to re-formulate the demand to depathologise as a right, or even a human right (Theilen, 2014; Cabral et al., 2016; Davy et al., 2018; Castro-Peraza et al., 2019).

The language of human rights has become an established lens through which to consider trans issues. Human rights perspectives have been mobilised to challenge the ways in which gender is regulated in various nation states, as inadequate legislative provisions have created, or at least contributed to, problems for those who do not identify with the sex/gender that they were assigned at birth. The first wave of these critiques lamented the absence of gender recognition laws across the world, the effect of which was to prevent trans people from amending their legal gender from that which they were assigned at birth. As the establishment of gender recognition processes became more common, a second wave of human rights interventions trained their lens upon the pre-conditions involved in those laws. In both instances, the basic language of human rights was well-suited to being mobilised to challenge these laws and establish new legislation in their place – identifying, as they did, an individual trans person or group of trans people whose life, body, and autonomy was being (more or less) forcibly interfered with or ignored to meet the authoritative demands of an illiberal nation state. Yet questions can be asked as to how effective human rights concepts can be when it comes to countering more subtle medical norms than compulsory sterilisation.

Whether as ‘reference points’, or ‘as part of an argumentation strategy’, the increasing significance of human rights principles within the depathologisation movement – including ‘human dignity’, ‘bodily integrity’, and ‘self-determination’ – has been noted (Davy et al., 2018: 27). Theilen (2014: 332) adds ‘human freedom’ and ‘personal autonomy’ to the list of values which ‘cannot be reconciled with trans pathologisation’. Each of these concepts are, without exception, borrowed from the human rights literature. Drawing upon a classical liberal understanding of the body as a source of rights and freedoms, they convey the idea that this body should not be interfered with by the state, or other actors, without the consent of the individual (Locke, 1980: 9). Such a strategy has its advantages. Human rights have proven to be a useful vehicle for making political claims intelligible to a wide audience (Munro, 2007:

75, citing Smart, 1989: 143). The strategy also responds to activist work that has been going on for some years. Principle 18 of the Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity, originally agreed in 2006, states that ‘a person's sexual orientation and gender identity are not, in and of themselves, medical conditions and are not to be treated, cured or suppressed’. Yet arguments in favour of a human right to depathologisation are still formulated in negative terms to some extent. They tell states what they need to stop doing, without clearly expressing what they ought actively to do instead. To ameliorate this, Theilen conceptualises the human right to depathologisation as part of a wider right to gender identity:

> the right to depathologisation […] is likewise a part of the right to gender identity, properly understood. The right to depathologisation of transgenderism may be both less accepted and less tangible than what is commonly understood to be part of the right to gender identity, that is, the right to have one’s gender legally recognised; but the two issues are interrelated. (Theilen, 2014: 342)

Theilen (2014) helps flesh out the content of this right by envisaging three prospective levels of obligations for state parties. The first level of obligations falls on states themselves; to ensure that gender recognition is available without pathologising pre-requisites (such as a requirement for psychiatric diagnosis). The second level of obligations fall upon sub-state institutions such as the medical profession, and civil society more widely; to treat trans people – and in the case of the medics, provide health care – without pathologising their identities. The third level of obligations applies to transnational bodies, such as the WHO; and would require diagnostic reform in order to allow states to acknowledge trans phenomena without understanding them as automatically constitutive of a mental illness.

The first and second level of obligations are addressed by Argentina’s LIG 2012, which was implemented following a successful campaign by transsexual and *travesti* activists working through organisations such as the Federación Argentina LGBT and the National

Front for the Gender Identity Law (Rucovsky, 2019). A key feature of the LIG 2012 is that legal recognition depends solely upon the request of the individual concerned (self-declaration), and not on any medical procedure or psychiatric diagnosis. The law also ‘guarantees obligatory access to the medical system’ (Rucovsky, 2019: 230). This second key feature is implemented through Article 11 of the LIG 2012, which requires that all persons older than 18 years ‘be able to access total and partial surgical interventions and/or comprehensive hormonal treatments to adjust their bodies, including their genitalia, to their self-perceived gender identity’ (GATE, 2012: 3). The right to free access to these medical interventions (including for migrants) through both public and private health providers is ensured through their explicit inclusion in Argentina’s Compulsory Medical Plan (Arístegui et al., 2017). Moreover, as with legal recognition, this access to medical interventions is no longer reliant on psychiatric diagnosis: ‘The only requirement will be […] informed consent by the individual concerned’ (GATE, 2012: 3). Research indicates that this has resulted in increased access to specialist medical interventions for trans people; but this can be inconsistent in practice, depending on the attitude of local authorities and insurance providers and the availability of medical resources and relevant vocational training (Arístegui et al., 2017; Hollar, 2018). Consequently, Rucovsky (2019: 233) observes that the recognition afforded by the LIG 2012 ‘marks a minimum departure point – not an arrival – with respect to the state of the law, which is to say, it does not pronounce itself on the effective mechanisms to resist inequality’.

Following the passage of the LIG 2012, several other states have met Thielen’s first level of obligations, either partially or in full, by enacting laws which recognise gender on the basis of self-declaration (usually expected to take place through a statutory declaration or some other request to legal authorities). These include Belgium, Colombia, Denmark, Ireland, Malta, Norway, Pakistan, Portugal and Uruguay, plus several regions or states in Australia, Canada, Mexico, Spain and the USA. Yet, in general, these laws do not explicitly require that trans people have access to appropriate health care. One exception is Uruguay's Comprehensive Law for Trans Persons 2018 (*Ley Integral Para Personas Trans*). Like the LIG 2012, this law ensures access to specialist medical interventions through public and private health care providers, on the basis of informed consent and a shared decision-making process. It also goes further, creating quotas for employment and access to education, and establishes reparations for trans people persecuted under Uruguay's 1973-1985 military dictatorship.

Developments at the third level of obligations – concerning international diagnostic categories – have also been forthcoming since the publication of Theilen's (2014) article. In June 2018, when the WHO updated its classification of diseases, 'transsexualism' was replaced with a new diagnosis of 'gender incongruence' in the *ICD-11*. This move followed extensive campaigning by trans human rights organisations, including GATE, that favour depathologisation. The location of the diagnosis shifted from Chapter V of the *ICD-10*, concerning 'mental and behavioural disorders and 'disorders of adult personality and behaviour', to Chapter 17 of the *ICD-11*, which includes 'Conditions related to sexual health'. This shift in terminology has been welcomed by campaigners and researchers who support depathologisation (Moser, 2017; Davy et al., 2018: 27). But it is too early for us to speculate as to exactly what effect the introduction of this new diagnosis will have in practice. Whether it will result in a genuine improvement in access to health care for trans people is something which must be assessed within future research. In the interim, questions can be asked as to how far the challenges raised by the depathologisation movement are likely to be resolved with reference to human rights language.

One approach would be to replicate legislation in Argentina and Uruguay. Another would be to explicitly understand requirements for sustained psychiatric diagnosis in order to be granted access to body modification technologies such as hormones and surgeries as a form of ‘medical abuse’, which human rights demand protection from (Davy et al., 2018: 15). However, even if more states are willing to remedy this by stepping into what has come to be regulated as a purely medical jurisdiction (Dietz, 2020), human rights concepts such as personal autonomy and bodily integrity offer few pointers as to what active steps need to be put in place in order to ensure the consistent and universal provision of accessible health care. Moreover, while a significant body of human rights scholars and activists would point to international successes in gaining recognition of economic and social rights alongside civil and political rights in numerous areas, there have been few examples of this in the trans health context to date.[4]

Even more holistic gender recognition laws have been critiqued by the communities which supposedly stand to benefit, along with the wider language of human rights on which they are based. Rucovsky (2019: 232), citing *travesti* activist Marlene Wayar, observes that the LIG 2012’s ‘process of dispute and negotiation was hatched in the name of a markedly liberal trans model of citizenship […] developed in the terms of individual, possessive and personal rights’. It requires trans people to become recognisable within a state framework built around the presumption of binary gender and mandatory surveillance. By focusing upon the individual, the law elides collective efforts to achieve trans liberation, both within and beyond trans communities – including through the concerted efforts of the coalition that successfully campaigned for the LIG 2012 itself. As Rucovsky (2015: 24) notes, the LIG 2012

> recognizes and guarantees access to certain rights, but it does not refer to the global networks that support life and make it proper to be lived – whether they involve education, employment, housing, nutrition, integral health, protection against police abuse, etc.

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[4] Even the Yogykarta Principles constitute an example of non-binding, ‘soft’, law, as the UK Government Equalities Office (2016: 8-9) was keen to stress.

Similar arguments have been made by transfeminist activists based in the UK, including van der Drift (2019: 15), who critiques the turn to 'informed consent' in trans discourse, arguing that 'individualised consent will sign away those that need a changed institution and communal support […]. Consent requires possibilities, timelines and support in ways that fit a person into a collective'. Similarly, Raha (2019: 17) insists that

> The lack of resources for trans healthcare is linked to the neoliberal disinvestment in healthcare as a whole. They do not want us to live well. They do not believe in our futures: they only believe that we should join their future (assimilation). We know that this is a ruse, and that it won't end well (ecological collapse and new forms of climate colonialism) […] Don't let them make this about 'Rights'. Don't make your slogans supporting us just about Rights.

In considering the potential limits of human rights language in the context of trans-related health care, we accept that rights claims are best judged in terms of their effect rather than their conceptual clarity or political coherence (Herman, 1993). We also acknowledge that their political potential is not limited to existing formulations, which would underestimate the power of 'human rights to come' (McNeilly, 2018: 4). As a 'malleable politico-legal language with widespread purchase' (ibid), human rights may continue to prove useful, strategically and rhetorically, for the depathologisation movement. We would be very happy if this proved to be the case. Certainly, the practical benefits of legislation such as the LIG 2012 should not be understated (Arístegui et al., 2017; Radi, 2019; Rucovsky, 2019). But even advocates of human rights have acknowledged that these are often inappropriately conceived as being property-based, autonomous, and protective, rather than contingent, interconnected and dependent (Munro, 2007: 75, citing Glendon, 1991: 14). This might offer one explanation as to why, to date, human rights research has not been embedded well within health law (Brazier & Montgomery, 2019: 24). If it is to be successful in articulating the importance of access to trans-related health care, facilitating the re-drawing of boundaries between health care systems, professional regulators, medical practitioners, and their trans patients, then the depathologisation movement will have to overcome various limitations in human rights language – including the libertarian posturing of individualised conceptions of autonomy – and focus instead upon contingency, interconnection, and dependency, among other factors. In what remains of this chapter, we suggest that vulnerability theory constitutes a useful ethical space which is more than capable of guiding this endeavour.

Acknowledging vulnerability

Vulnerability has become an important concept for philosophical investigation of human bodies. In part, this is due to the scholarship of Butler (2006; 2016). Yet it is Fineman's work on vulnerability which has become most influential within feminist legal studies, and legal scholarship more generally. Unlike classical rights language (e.g. Locke, 1980), vulnerability theory challenges any attempt to emphasise any individualised and atemporal approach to freedom or autonomy. Rather than centring an abstract and 'fully competent, capable individual adult' (Fineman, 2017: 148), vulnerability theory asks researchers to shift their attention to the relational structures in which all humans are embedded. To avoid valorising independence and self-sufficiency, the vulnerable subject is understood to be both 'embodied' and 'embedded' (Fineman, 2017: 143). This reflects the fact that humans are both physically and socially vulnerable. Physically, our skin is porous and subject to injury and lesion. We are also social beings embedded within social institutions and relationships, including those relations developed between health professionals and their trans patients.

Vulnerability theory develops Fineman's previous work on dependency (Fineman, 2004). For, while people slip in and out of dependency over time, vulnerability is both constant and universal. Vulnerability should not be used to refer to individuals or groups – or 'vulnerable populations' – as somehow 'more or less' vulnerable than others (Fineman, 2017:

142). Humans are all vulnerable, in that ‘we are universally and individually constantly susceptible to change in our well being’ (Fineman, 2017: 142). If we accept that human vulnerability to injury is both constant and universal, then there is no completely safe and secure ‘position of invulnerability’:

> The term ‘vulnerable’, used to connote the continuous susceptibility to change in both our bodily and social well-being that all human beings experience, makes it clear that there is no position of invulnerability – no conclusive way to prevent or avoid change. (Fineman, 2017: 142)

The insight ‘that no individual can avoid vulnerability entirely’ (Fineman, 2008: 67) forces scholars to look beyond individual circumstances and onto societal institutions instead. As Fineman (2008: 67) admits, ‘society cannot eradicate our vulnerability either.’ Yet it can lessen our vulnerability through various institutions and structures:

> Undeniably universal, human vulnerability is also particular: it is experienced uniquely by each of us and this experience is greatly influenced by the quality and quantity of resources we possess or can command. Significantly, the realization that no individual can avoid vulnerability entirely spurs us to look to societal institutions for assistance. Of course, society cannot eradicate our vulnerability either. However, society can and does mediate, compensate, and lessen our vulnerability through programs, institutions, and structures. (Fineman, 2008: 10)

Scholars are therefore encouraged to focus upon social and institutional contexts, without neglecting that the body is prone to injury and harm. Vulnerability theory acknowledges the importance of access to resources that will enable people ‘to endure or prosper from change, even harm, throughout institutions and relationships across the life-course’ (Fineman, 2017: 149). From its point of conception, then, Fineman has moved her theory beyond its ontological concern with the material basis of the body, and onto the social policy that the result of this inquiry demands. She argues for an ‘active’ and ‘responsive’ state, which ought to be considered in ‘non-authoritarian terms’ (Fineman, 2008: 19), adding:

> Orientating the state to be responsive to the Vulnerable Subject would require dedication to a different set of values than those that informed the state built on an image of the Liberal Subject. Vulnerability's values would be more egalitarian and collective in nature, preferring connection and interdependence rather than autonomy and independence in both political and personal visions. (Fineman, 2013: 26)

How might this be applied in trans health law? In a context where trans people have been scrutinised by health professionals wielding significant power 'to determine what is considered sick or healthy, normal or pathological, sane or insane' (Stryker, 2008: 36), it is unsurprising that the instinct of the depathologisation movement would be to claim rights to freedom and autonomy. It is possible then that calls for a shift towards vulnerability would be viewed with suspicion by activists and scholars, as in debates around disability (Clough, 2017), sex work (Munro & Scoular, 2012), and sexual assault (Munro, 2017). Yet implicit acknowledgements of vulnerability have always been present in trans studies. Trans people and trans scholars have worked through their vulnerability via reflective biographies which address both difficult and affirmative aspects of life during transition (Raun, 2016; Jacques, 2016), autoethnographic accounts of sexual embodiment and gendering processes (Stryker, 1994; Stewart, 2017; cardenás, 2016), and structural disempowerment in health care settings (Latham, 2017; shuster, 2018). Explicit conceptual engagement with vulnerability is also becoming more common in the trans studies literature (Horak 2018; Straube & Tainio, 2019).

Even so, with trans people often patronised as a 'vulnerable population', and often one that is assumed to be 'more vulnerable' than other groups, it could seem counter-intuitive to foreground vulnerability. Understanding trans people as 'a particularly vulnerable group' is a theme of contemporary ECtHR jurisprudence (Cannoot, 2019: 33-34).[5] And while attempts have been made to square such approaches with vulnerability theory (Peroni & Timmer, 2013), individual responses to a particular group's apparent vulnerability are not likely to give

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[5] We are grateful to the anonymous reviewer for raising this point.

rise to the universal policy responses favoured by Fineman. Labelling trans people as particularly vulnerable has also been used to justify what has become known as 'trans exceptionalism' (Heyes & Latham, 2018: 174). This marks trans people out from their non-trans ('cis')[6] peers, justifying additional hurdles being placed in front of them – in order to access medical treatment, for example – as a direct consequence of being identified as trans. But if vulnerability is understood as constant and universal, and not merely as a descriptor of 'weak' and 'powerless' groups and 'populations' (Clough, 2017: 469; Fineman, 2008: 8), then trans people's health care needs could be understood as specific but still commensurate with the diverse health needs of cis populations.[7]

It is worth recalling that it is pathologisation, rather than health care as such, which has come under the scrutiny of the depathologisation movement (Theilen, 2014: 335). Challenging a diagnosis does not mean neglecting the health care needs around which it was formulated (Davis, 2010: 130). As Heyes & Latham (2018: 186) note, ensuring 'just and equitable treatment' does not require all trans patients to undergo 'identical regimes of interventions'. Vulnerability theory is well-equipped to mediate between seemingly conflicting issues of universality and particularity in this context. Vulnerability 'does not seek equality, but equity' in decision-making and social policy (Fineman, 2017: 143). Rather than flattening out differences between subjects, vulnerability acknowledges the plasticity of the body by incorporating 'a life-course perspective' (Fineman, 2017: 143). How to regulate the relationship between health professionals and their trans patients in a way that reflects this will be challenging. Historically, the adoption of a life-course perspective in trans health care has too often been used to justify sustained psychiatric investigation into a trans person's

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[6] 'Cis' is an adjective used to refer to people who do not identify as trans.

[7] The vast majority of trans-related body modification technologies were not originally developed for use on trans patients (Riggs et al., 2019). For example, phalloplasty was developed in the aftermath of the First World War to treat the victims of landmines; Schultheiss et al., 2005). The first total penis and scrotum transplant was recently performed on a veteran soldier who had suffered injury from an improvised explosive device while serving in Afghanistan (Nitkin, 2018).

suitability for body modification, or indeed withholding access to hormones and surgeries altogether. This is something that the depathologisation movement is more than aware of. But this chequered history does not mean that a life-course perspective could not be used equitably in future; helping determine, supportively, what course of treatment would be best suited to the circumstances of an individual trans patient.

Theilen (2014: 336) suggests that while working towards a ‘more genuine acceptance’ of trans phenomena is ‘bound to be difficult’, it will be ‘near impossible’ while trans people continue to be pathologised. Parallels can be drawn with disability studies research into the social model of disability, which attempts to understand disabilities as arising from social structures and inequalities rather than individual pathologies (Lawson & Priestly, 2017). Again, a vulnerability perspective which is cognisant of relationality and attuned to structures which mediate between people and institutions appears better suited to this task than one which unrealistically and unhelpfully centres on individual autonomy. As in the disability context, vulnerability theory could raise ‘questions for how we can make law and policy responsive to particular individuals and how interventions or shifts in broader structures or institutions would impact on users of services’ (Clough, 2017: 479). The same could be said of the parallel drawn between trans activism and the reproductive rights movement (Theilen, 2014); which also seeks to ‘secure access to competent, legal, respectfully provided medical services for a nonpathological need’ (Stryker, 2008: 98).

Vulnerability theory demands ‘a robust sense of state responsibility for social institutions and relationships’ (Fineman, 2017: 143). This should not be misinterpreted as implying that trans people are not the experts on their own identities. This is imperative in a context where family relationships have been exclusionary, and state regulation of trans people has been unresponsive at best, and authoritarian at worst (Stryker, 2008; Monro & Van Der Ros, 2018). While envisaging an active role for the state could be deemed paternalistic, state responsibility for trans health is an important element emphasised from a vulnerability perspective. Scholars and activists within the depathologisation movement will be all too aware that the role of the state remains imperative in increasing trans people's access to formal health care. Empirical research conducted in Argentina has identified a postcode lottery of unequal treatment depending upon the trans person's proximity to metropolitan clinics and pharmacies, plus a skills shortage in Argentinian hospitals when it comes to performing surgeries (Arístegui et al., 2017: 451-452). Moreover, the example of European countries such as Denmark has shown that if equity is to be achieved for trans people in their access to health care, it is not enough for the state to become more 'withdrawn' (Fineman, 2008: 6); depathologising gender recognition in a way which permits access to health services only for those trans people who can either access pathologising public clinics or afford to travel overseas or turn to the black market for treatment. Instead, demanding accessible health care requires that questions be asked about how body modification technologies can be safely and equitably distributed. This, in turn, raises more challenging questions about how medical resources ought to be established and allocated.

As attention shifts from the micro to the macro – and the management of health resources – we would like to draw attention to a more recent development in the vulnerability theory literature. This turns attention slightly away from human vulnerability, and onto the vulnerability of institutions (Reiss, 2010; Marvel, 2015; Fineman, 2015; Fineman et al. 2017; Dehaghani & Newman, 2017; Travis, 2019). While humans are vulnerable as a result of being physically embodied and socially embedded, Fineman has noted that institutions too can be understood as vulnerable:

> Of course, societal institutions themselves are not foolproof shelters, even in the short term. Metaphorically, they too can be conceptualized as vulnerable: They may fail in the wake of market fluctuations, changing international policies, institutional and political compromises, or human prejudices. Even the most established institutions

> viewed over time are potentially unstable and susceptible to challenges from both internal and external forces. (Fineman, 2008: 12)

Though important research has been conducted into how bodies are affected by the norms promulgated by health and social welfare institutions (Garland & Travis, 2018; Ries & Thomson, 2019), it is also necessary to consider how those institutions resist or change their regulations in response to political pressure generated, at least in part, by the bodies that they regulate. In a trans health law context, this can be exemplified in various ways. In Argentina, the vulnerability felt by the psychiatric profession is demonstrated by their negative reaction to the enactment of the LIG 2012. As Hollar (2018: 464) observes, ‘many doctors [in Argentina] have not been complying with the law—for example, requiring psychiatric evaluation before providing hormones’. In the UK, the vulnerability of the medical profession is exemplified by disciplinary investigations into practitioners including Helen Webberley, a private-sector physician who gained a reputation for providing more flexible treatment than the NHS gender clinics (Pearce, 2018: 167-168). In Denmark, after evidence came to light of a series of failures to maintain professional treatment standards, the professional regulatory body responsible for authoring the medical guidelines which pathologised trans phenomena in Denmark was stripped of its supervisory duties and medicines licensing tasks.[8] Although this re-organisation of professional regulators could not be said to have resulted directly from trans activism,[9] it still serves to highlight how the institutions which might intimidate ordinary patients are themselves subject to existential political and economic pressures.

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[8] The duties of the now defunct Danish Health and Medicines Authority (DHMA) have been devolved to the Danish Patient Safety Authority and the Danish Medicines Agency. The new Danish Health Authority website only alludes to these scandals, noting ‘The purpose of the organisational change is to devote more attention to medicines licensing and to improve patient safety’; ‘The history of the Danish Health Authority’ Danish Health Authority, <https://www.sst.dk/en/about-us/the-history-of-the-danish-health-authority>.

[9] Two other scandals attracted more controversy in Danish media: one involving two psychiatrists, who appeared to be implicated in the deaths of several patients in spite of the DHMA being aware that they had both been subject to numerous complaints; and another concerning the unauthorised use of the drug Misoprostol to induce births in hospitals, resulting in a number of tragic deaths.

Insufficient attention has been paid to how these pressures factor into institutional judgements and decisions. To date, this form of vulnerability has not been explored as comprehensively as it might have been in the vulnerability literature. Unfortunately, we also do not have enough space to do justice to the concept of institutional vulnerability here. However, future research might productively explore the relationship between vulnerable humans and vulnerable institutions, particularly in the context of trans health and within health law more broadly. Such insights could give rise to a host of interesting questions for the depathologisation movement; including how best to work with professional medical regulators and health care institutions to allocate resources and develop treatment guidelines which are mutually acceptable to all actors and communities involved.

Conclusion

This chapter mounts a challenge to the way that the gendered body has been understood by health professionals. With a focus upon trans issues, which have arisen at the intersection of law and medicine, it has analysed recent developments in the literature on pathologisation. It acknowledged insights developed within the health sociology and human rights law literatures, before identifying a recent point of convergence around the importance of asserting a human right to depathologisation. Significant gains have been made in the regulation of trans people, not least in the area of legal gender recognition. At a time when self-declaration of legal gender status gains admiration from activists and scholars alike, it is also draws attention from policymakers and legislators. In granting legal subjects the right to amend their legal gender status without pre-conditions, self-declaration might appear to be compatible with human rights concepts such as personal autonomy. However, its limitations – including not necessarily granting access to health care – have been criticised, particularly in instances where self-declaration does not stop states withdrawing from taking responsibility for the more complex issues which affect their subjects' embodiment.

As the trans depathologisation movement grows in stature and influence, more questions will be asked of its political strategy. Though it is perfectly possible that the increasing mobilisation of human rights language could lead to further political gains, this is by no means guaranteed. After discussing some potential drawbacks which may arise in the current human rights-oriented strategy in the first half of this chapter, we proposed an alternative in the second. With the aid of Fineman, we identified several areas in which the trans depathologisation movement could benefit from integrating vulnerability theory into its political strategy. Without shying away from potential limitations in engaging vulnerability, and without dismissing the potential of human rights language to further the demands of the trans depathologisation movement completely, we have made the case in this chapter for placing a greater emphasis on trans vulnerability. This applies to the trans depathologisation movement, as well as within trans health law and health law more widely. Beyond acknowledging the vulnerability of trans patients, this also offered us the opportunity to consider the vulnerability of institutions including professional medical regulators. Institutional vulnerabilities have been shown to have exerted an important influence on the regulation of trans bodies in UK, Danish, and Argentinian contexts, and offers pause for thought for regulators, activists, and scholars in the future.

Vulnerability theory warns against indicating that trans people are somehow 'more vulnerable' (Peroni & Timmer 2013: 1060-1061) than (cis) others. Instead, the universal and constant vulnerability of all humans, and potentially also institutions, ought to be more widely acknowledged, and ameliorated through supportive policymaking. If it is applied in an engaged and universal register, vulnerability theory should be able to counter 'trans exceptionalism' and pathologisation, while offering an indication as to how trans issues could be better managed by states and institutions. Vulnerability theory's commitment to material and pragmatic concerns, alongside theoretical matters, is vital. As Radi (2019: 57) argues, with respect to criticisms of the LIG 2012 by non-Argentinian, non-trans, scholars such as Butler, 'the law was designed to ensure recognition of trans* people's gender identity, not to embody the emancipatory fantasies of cis theorists'. By reconsidering the role of the state, and not merely asking the state to withdraw from the management of trans health, vulnerability theory facilitates a move beyond straightforward calls for freedom and autonomy. It instead asks questions about how resources could be allocated to ensure that health care is accessible for all trans and cis bodies. Depending upon how these questions are answered, this could better reflect the needs and demands of trans people as they seek to access legal recognition and health care in practice.

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