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Jurisdiction in trans health

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This article utilises an alternative framework to analyse the contested boundaries between law and medicine. Bringing theoretical and empirical insights together, it expands recent socio-legal scholarship on jurisdiction. Jurisdictional analysis is conducted in an under-researched area of health law – namely, the accessibility of trans-related health care. The article draws upon the first qualitative research project to assess the impact of self-declaration of legal gender status in Denmark. This was adopted in 2014, at the same time as access to hormones and surgeries was centralised and restricted. The combined impact of these reforms disappointed the trans people interviewed, which demonstrates the importance of identifying how legal and medical norms interrelate. Jurisdiction helps illuminate how law was used to develop and protect professional competencies. Such insights will be valuable for researchers interested in the potential of self-declaration, and for scholars of health law and socio-legal studies more generally.

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> **Interviewer**: If there was one thing that you could change in the law, what would it be?
>
> **Roi** (non-binary transgender,[1] 26): I'm not sure it's in the law, but that would definitely be the way that our health care system is dealing with trans people.

Health law has long been preoccupied with how far legislatures and courts ought to intervene in the doctor-patient relationship.[2] In the theoretical literature, doctor-patient relations have been viewed through a lens where cases are judged by the extent to which they limit or expand doctors' authority and enhance or curtail patient autonomy.[3] Understanding this balance of power as a zero-sum game – where limiting the authority of the doctor increases the autonomy of the patient, or vice versa – has enabled neat summaries of the impact of a common law judgment.[4] But it offers little insight into how health is regulated in practice. While lawyers do sometimes consider health care through an adversarial lens, this view will not always accord with that of medical practitioners increasingly asked to build 'collaborative' care practices.[5] Such practices cannot be understood through a formulation of autonomy which idealises the self-government of the individual and 'a sense of separation from others in society.'[6] Attempts to theorise autonomy around an unencumbered individual, free from the prospect of governmental intervention, have been criticised for their libertarian posturing.[7] By overemphasising individuals, such formulations underplay the complex relations

[1] Interviewees self-defined their gender status.
[2] The sub-discipline of 'health law' covers similar ground to 'health care law' or 'medical law' (though boundaries are contested). Herein, the former is understood as more inclusive than the latter, as it accepts that a subject's 'health' exceeds matters which are dealt with in a medical context; J. Montgomery, Health Care Law (2002) 1-3. It is also less controversial to understand trans embodiment as a health concern rather than it would be to describe it as 'medical', for reasons discussed below.
[3] M. Brazier, 'Do no harm – do patients have responsibilities too?' (2006) 65(2) Cambridge Law Journal 397.
[4] Hence the flurry of recent scholarship on Montgomery v Lanarkshire Health Board [2015] U.K.S.C. 11, a negligence case which increases the standard of disclosure of risk expected from doctors; cf. M. Dunn, K.M.W. Fulford, J. Herring, and A. Handa, 'Between the Reasonable and the Particular: Deflating Autonomy in the Legal Regulation of Informed Consent to Medical Treatment' (2018) Health Care Analysis 1 and R. Heywood and J. Miola, 'The changing face of pre-operative medical disclosure: placing the patient at the heart of the matter' (2017) Law Quarterly Review 296.
[5] J. Herring, K.M.W. Fulford, M. Dunn, and A.I. Handa, 'Elbow room for best practice? Montgomery, patients' values, and balanced decision-making in person-centred clinical care' (2017) 25(4) Medical Law Review 582.
[6] M.A. Fineman, The Autonomy Myth: A Theory of Dependency (2004) xvi.
[7] id., p. 9.

developed between doctors, patients, patients' relatives, and other service providers within the health care system,[8] as well as the social structures within which all of these are located.[9]

Such critiques have instigated a shift from individualised formulations to more relational understandings of autonomy.[10] Emphasising relationships between individuals, their networks, and institutions (including professional regulators and agents of the welfare state) has deepened understanding of the extent to which various factors affect the ways in which decisions are made. Relational perspectives are better attuned to the complex power dynamics which shape health practice. Drawing upon recent work undertaken within socio-legal and governance studies, this article argues that further insights could be offered were relationality to be complemented with jurisdictional analysis. While a jurisdictional framework agrees that health care decisions will be made relationally, it casts greater light upon what Mariana Valverde has described as the 'qualitative features of governance' – which affect how regulation plays out in practice.[11] Jurisdictional analysis supplements relationality by addressing how governance plays out, not just where and by whom it is practiced.[12] Its potential to develop qualitative understanding of various areas of health law has been acknowledged.[13] This is particularly the case in areas where it has proven difficult to challenge the broad discretion granted to professional opinion. Jurisdictional analysis can open up what John Harrington has described as the 'black box' into which morally challenging

[8] M. Brazier and J. Montgomery, 'Whence and whither 'modern medical law'' (2019) 70(1) Northern Ireland Legal Quarterly 5, at 26.
[9] S. Sherwin, 'A Relational Approach to Autonomy in Health Care' in *The Politics of Women's Health:* Exploring Agency and Autonomy, ed. S. Sherwin (1998) 21.
[10] C. Mackenzie and N. Stoljar (eds.) Relational autonomy: feminist perspectives on autonomy, agency, and the social self (2000); J. Nedelsky, Law's Relations: A Relational Theory of Self, Autonomy, and Law (2012).
[11] M. Valverde, Chronotopes of Law: Jurisdiction, Scale and Governance (2015) 84.
[12] M. Valverde, 'Jurisdiction and Scale: Legal 'Technicalities' as Resources for Theory' (2009) 18(2) Social & Legal Studies 139, at 144.
[13] K. Veitch, The Jurisdiction of Medical Law (2007); Brazier and Montgomery, op. cit., n. 8 pp. 26-27; J. Harrington, 'Time and Space in Medical Law: Building on Valverde's Chronotopes of Law' (2015) 23 Feminist Legal Studies 361. Harrington advocates Valverde's 'chronotopical analysis' generally. This encompasses jurisdiction but also (spatial and temporal) scale; Valverde, op. cit., n. 11. As jurisdictional analysis appears particularly well-suited to illuminating the boundaries between law and medicine in the regulation of trans health, this article will focus on jurisdiction rather than scale.

yet legally indeterminate questions – including what constitutes good clinical judgement and medical practice in various contentious circumstances – have been inserted.[14] This could illuminate attempts to displace and conceal controversy, and identify forms of regulation which are being promoted and precluded in health law and other areas.

Beyond merely arguing in favour of a wider application of jurisdictional analysis, this article demonstrates how it could be conducted. It does so by analysing the medical and legal governance of trans embodiment. While trans issues have become more prominent within legal studies, this is mostly thanks to research conducted from human rights and anti-discrimination perspectives.[15] As concern about the (in)accessibility of trans-related health grows, it has become more prominent in other disciplines, particularly sociology.[16] But trans issues have yet to gain ground within health law.[17] Of those who have tried to capture the essence of the entanglement of legal and medical norms since the enactment of the Gender Recognition Act (GRA) 2004, Zowie Davy's description of a 'medicolegal alliance',[18] formed at a time when 'gender dysphoria' became the first psychiatric diagnosis to be written in to

[14] J. Harrington, Towards a Rhetoric of Medical Law (2017) 12. The term 'black box' refers to a process which has been rendered invisible; on account of its working effectively despite being deemed overly complex; B. Latour, Science in Action: How to Follow Scientists and Engineers Through Society (1987) 2-3.
[15] S. Whittle, Respect and Equality: transsexual and transgender rights (2002); A. Sharpe, Transgender Jurisprudence: Dysphoric Bodies of Law (2002); A. Sharpe, *Foucault's Monsters and* the Challenge of Law (2010); A. Sharpe, Sexual Intimacy and Gender Identity 'Fraud': Reframing the Legal and Ethical Debate (2018); P. Dunne, 'Ten years of gender recognition in the United Kingdom: still a "model for reform"?' [2015] Public Law 530; P. Dunne, 'Transgender Sterilisation Requirements in Europe' (2017) 25(4) Medical Law Review 554; J.T. Theilen, 'Beyond the gender binary: rethinking the right to legal gender recognition' [2018] European Human Rights Law Review 249; P. Cannoot, The pathologisation of trans* persons in the ECtHR's case law on legal gender recognition (2019) 37(1) Netherlands Quarterly of Human Rights 14; D.A. Gonzalez-Salzberg, Sexuality and Transsexuality Under the European Convention on Human Rights: A Queer Reading of Human Rights Law (2019).
[16] Z. Davy, Recognizing Transsexuals: Personal, Political and Medicolegal Embodiment (2011); R. Pearce, Understanding Trans Health: Discourse, power and possibility (2018); B. Vincent, Transgender Health: A Practitioner's Guide to Binary and Non-Binary Trans Patient Care (2018).
[17] Trans issues are not addressed in most medical law textbooks, including E. Jackson, Medical Law: Text, Cases and Materials (2016, 4th edn.), and M. Brazier and E. Cave, Medicine, Patients and the Law (2016). In J. Herring, Medical Law and Ethics (2018, 7th edn.), they are considered in relation to resource allocation.
[18] Z. Davy, 'Transsexual Agents: Negotiating Authenticity and Embodiment within the UK's Medicolegal System' in Transgender Identities: Towards a Social Analysis of Gender Diversity, eds. S. Hines and T. Sanger (2010) 119.

UK law,[19] is arguably most eminent. Yet the idea of an 'alliance' does not offer a dynamic frame to analyse the fluidity of developing regulation. For reasons discussed below, jurisdiction offers a preferable alternative. The significance of this is that despite its delayed response to the Equalities Office's consultation on 'Reform of the Gender Recognition Act 2004' (which closed in October 2018), the UK government may still follow a number of other states in implementing some form of self-declaration of legal gender status.[20] If this were to happen, it would demand consideration of how Davy's 'medicolegal alliance' was affected.

While jurisdictional analysis would prove as useful for understanding the regulation of trans health in a federal as in a unitary legal system, this article focuses primarily upon the latter. It presents findings from the first qualitative research project conducted in Denmark since it became the first European state to adopt self-declaration of legal gender status in 2014. Although self-declaration might be expected to create a personal jurisdiction to determine one's own legal gender status, this article complements previous research demonstrating that the separation of legal and medical recognition systems did not work for the immediate benefit of Danish trans people.[21] A similar outcome risks being repeated wherever the liberalisation of gender recognition processes is implemented without addressing corresponding issues, including access to health care. By contextualising this empirical work with reference to examples from more traditional concerns of health law (including abortion, capacity, and physician-assisted suicide), this article considers what jurisdictional analysis has to offer health law. Working against jurisdiction's tendency to sort and separate, it uncovers underlying tensions in the regulation of trans embodiment; analysing the 2014 reforms of the (administrative and medical) regulation of gendered

[19] S. Cowan, 'Looking Back (To)wards the Body: Medicalization and the GRA' (2009) 18(2) Social & Legal Studies 247.
[20] Self-declaration permits legal subjects to make a formal declaration of their gender status and have this recognised in civil registration systems.
[21] C. Dietz, 'Governing legal embodiment: on the limits of self-declaration' (2018) 26(2) Feminist Legal Studies 185.

embodiment in Denmark in relation to one another. By addressing how jurisdictional divisions were consolidated during these reforms, it contends that a shift in the focus of health law scholarship away from autonomy and towards jurisdiction will cast greater light upon the processes through which law orders and contains the knowledge claims, politics, and embodied effects of various institutions. In applying this alternative mode of enquiry in a novel empirical context and indicating its suitability for health law and trans studies, the article contributes to burgeoning jurisdiction literatures. Bringing together different perspectives on jurisdiction, it applies this mode of analysis at the intersection of health law and trans studies. Demonstrating the utility of jurisdictional analysis in the context of the regulation of gender and health, it presents findings which will be useful for scholars and policymakers working in this field and elsewhere.

The article is structured in three sections. The first lays out its theoretical basis; explaining what jurisdiction is, and how boundaries can be identified. It suggests that moving beyond territorial understandings of jurisdiction enables scholars to unravel the interplay of legal and medical norms in the regulation of trans bodies. Having explained how jurisdictional analysis could be employed within trans studies and health law more generally, it discusses the potential impact of such an initiative. The second section analyses the Danish reforms of 2014; identifying how jurisdictional divisions were affected by the adoption of self-declaration and contemporaneous developments in medical regulation. It suggests that the limitations of self-declaration are best understood through the lens of jurisdiction; with government unwillingness to redress boundaries between civil and medical institutions thus ensuring that recognition remained inaccessible for many trans people, despite its formal openness. In amending the Act on the Central Person Registry (CPR),[22] and yet neglecting to make

[22] 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) (DK) ('CPR law' hereafter).

provision for anything more than the right to self-declare legal gender status, the Danish Government separated professional authorities, drawing strict boundaries between them. This had a negative effect on the law's immediate impact upon trans interviewees. The result, explained in the third section, was that more challenging issues concerning health, subjectivity, and conscience were neglected, as law prioritised sorting and ordering conduct and behaviour instead. This remained the case until medical guidelines were reformed again, in 2017. But while the effect of these more recent reforms falls outside the scope of this article, the jurisdictional analysis of the initial reforms that I present has lessons for states who might implement similar gender recognition law reforms in future, and for health law in general.

INVESTIGATING JURISDICTIONAL ARRANGEMENTS

Most understandings of jurisdiction address territorial sovereignty, and disputes at national borders.[23] But territorial sovereignty is not the most pressing concern of contemporary scholars of jurisdiction. Mirroring the relational shift in health law, and turning attention away from disputes between states, Valverde suggests that an 'internal legal pluralism' characterises all existing regulatory systems – including national legal systems.[24] This is clearly apparent within federal systems;[25] where, for example, the maintenance of birth records is a state responsibility, and yet passports are issued by the federal government.[26] Without doing so explicitly, Dean Spade has conducted a jurisdictional analysis of the often contradictory policies regulating trans identities at federal, state, and local levels in the US.[27]

[23] Valverde, op. cit., n. 12, pp. 143-145.
[24] Valverde, op. cit., n. 11, p. 180.
[25] I am grateful to the anonymous referee for making this point.
[26] J. McGill and K. Kirkup, 'Locating the Trans Legal Subject in Canadian Law: XY v Ontario' (2013) 33(1) Windsor Review of Legal and Social Issues 96; T. Bennett, 'No Man's Land: Non-Binary Sex Identification in Australian Law and Policy' (2014) 37(3) University of New South Wales Law Journal 847, 865; A. Rappole, 'Trans People and Legal Recognition: What the U.S. Federal Government Can Learn From Foreign Nations' (2015) 30 Maryland Journal of International Law 191, 202.
[27] D. Spade, 'Documenting Gender' (2008) 59 Hastings Law Journal 731, 774.

Spade identifies the effects of this 'rule matrix' on trans people, before highlighting the bureaucratic confusion it causes the agencies tasked with implementing divergent policies.[28] Scholars have also explored the interplay between federal and provincial jurisdictions in a Canadian context.[29] Such analysis has yet to be undertaken within more unitary legal systems, like the UK and Denmark, even though governance in these nations equally involves an 'assemblage'[30] of authorities more than any abstract or autonomous 'state'.[31] By presenting findings from Denmark, the first European state to implement self-declaration of legal gender status, this article remedies this deficit. In seeking to disentangle an assemblage of authorities, Valverde's approach is distinct from other proponents of jurisdiction, including Kenneth Veitch. While both prefer to avoid normative analysis of law in favour of 'the more mundane, though by no means less important, institutional apparatus' of jurisdiction,[32] Veitch focuses primarily on the common law.[33] Internal legal pluralism aims to work more broadly; asking researchers to determine how governance is affected in any situation where one institution is granted precedence over another. This article demonstrates how internal legal pluralism can assess the impact that the norms promulgated by the Danish health care system have on trans people in Denmark.

Though Foucauldian in its foundations, jurisdictional analysis can underscore normative legal scholarship.[34] Examining the interplay between institutions does help

[28] id. p. 733.
[29] K. Starks, 'Gender Markers on Government-Issued Identification in Saskatchewan: Rights, Reform, and Jurisdiction in Shifting Legal Landscape' (2018) 81(2) Saskatchewan Law Review 213; M.P. Ponsford, The Law, Psychiatry and Pathologization of Gender-Confirming Surgery for Transgender Ontarians (2017) 38 Windsor Review of Legal and Social Issues 20.
[30] Valverde uses 'assemblage' in a 'deliberately 'untheoretical' manner', 'denoting the only partially planned combinations of capabilities and resources that do the work of governing'; op. cit., n. 11, p. 51, citing S. Sassen, Territory, Authority, Rights (2006) 5.
[31] Valverde notes: 'even in states that have by and large marginalized or even suppressed alternative or specialized jurisdictions, a variety of overlapping jurisdictions still exist'; id. p. 57.
[32] Veitch, op. cit., n. 13, p. 5.
[33] id. p. 30.
[34] Note the risk identified by Veitch, id. p. 5, that normative analysis may under-emphasise the role of 'institutional exigencies' in determining how jurisdiction is asserted.

address where responsibilities fall within governing assemblages. But it can also identify instances where responsibilities are being avoided. This raises important political questions about where such responsibilities ought ideally to be located.[35] While it may warn against conceiving of a singular monolithic state as the source of discrimination and inequalities, internal legal pluralism does not dismiss state regulation altogether. It would be misguided to assume that institutions are unregulated merely because law is incorporated into 'a continuum of apparatuses (medical, administrative, and so on)' which perform the regulatory function.[36] Valverde cites the example of the doctor permitted to prescribe what would in other circumstances be illegal substances, but whose competence to do so is delineated and restricted by, and through, state law.[37] The UK Abortion Act 1967 similarly exempts doctors performing a legal abortion from criminal sanction in accordance with sections 58 and 59 of the Offences Against the Person Act 1861.[38] Though institutions govern in different ways at different times and in different spaces, state law holds them together by determining the extent and scope of their authority. As well as governing directly, then, state law indirectly authorises the governance carried out by other institutions.[39] Whether through legislation, or court judgment, the state retains discretion to determine an institution's authority to make almost any decision.[40] Hence Valverde describes jurisdiction as 'the governance of legal governance'.[41] Importantly, given courts' reluctance to become prescriptive in respect of certain institutions, this will not usually see courts querying the substance of a regulator's

[35] J. Mant and J. Wallbank, 'The Mysterious Case of Disappearing Family Law and the Shrinking Vulnerable Subject: The Shifting Sands of Family Law's Jurisdiction' (2017) 26(5) Social & Legal Studies 629.
[36] M. Foucault, The Will to Knowledge: The History of Sexuality Volume One (1998) 144.
[37] Valverde, op. cit., n. 11, p. 57.
[38] Harrington, op. cit., n. 14, p. 170.
[39] Valverde, op. cit., n. 11, p. 83, citing M. Valverde, 'Authorizing the Production of Urban Moral Order: Appellate Courts and their Knowledge Games' (2005) 29(1) Law and Society Review 419.
[40] id. p. 83. This is exemplified by the Abortion Act 1967. While courts insist on identifying an 'authentic clinical evaluation' in every case, they have been unwilling to investigate the specific content of any medical decision; Harrington, op. cit., n. 14, p. 29.
[41] Valverde, op. cit., n. 12, p. 141.

judgment.[42] But they may question the authority of an institution to issue such a judgment in the first place.[43] This limitation is accomplished through jurisdiction.

Beyond authorising institutional competencies, jurisdiction also works as a 'sorting process';[44] organising different types and levels of authority 'into ready-made, clearly separate pigeon-holes',[45] before drawing strict boundaries between them. These boundaries may work 'spatiotemporally'; as in Valverde's example of the 'Murder on the Orient Express' conundrum, where determining the time when the murder took place establishes the precise location of the train, and therefore the police force required to investigate.[46] Alternatively, they might be differentiated in accordance with purported functionality; with competencies allocated on the basis of value judgments regarding which institution is best-suited, in terms of capacity or expertise, to the task at hand.[47] In the literature on the professions, Andrew Abbott understands such judgements as reliant upon occupational groupings which are formed following a series of 'turf battles' regarding influence and expertise.[48] It is only when such battles align that professional groupings emerge; coalescing around a common cause which has allowed, in the case of reproduction, for example, doctors to become 'doctors' and midwives to become 'midwives'.[49] Professional jurisdictions could have been allocated quite differently, and even have been in the past.[50] They are also, presently, open to dispute.[51] Yet deliberation around the practical appropriateness of a governing authority is unlikely to be

[42] Though the extent of this deference may have been overstated, since it only arose towards the end of the nineteenth century; Brazier and Montgomery, op. cit., n. 8, p. 12.
[43] Valverde, op. cit., n. 11, p. 83; K. Veitch, 'Juridification, Medicalisation, and the Impact of EU Law: Patient Mobility and the Allocation of Scarce NHS Resources' (2012) 20(3) Medical Law Review 362, at 370.
[44] Valverde, id. 83.
[45] id. p. 85.
[46] id. p. 84.
[47] id. pp. 56-57.
[48] A. Abbott, 'Things of boundaries: defining the boundaries of social inquiry' (1995) 62 Social Research 857, at 860.
[49] M. Thomson, 'Abortion Law and Professional Boundaries' (2013) 22 Social & Legal Studies 191.
[50] Thomson describes early nineteenth century health care being provided both by 'regular' (formally educated and trained) physicians and 'irregular' practitioners (herbalists, faith healers, 'quacks', midwives, and others) lacking formal education; id. p. 195.
[51] A. Abbott, The System of Professions: An Essay on the Division of Expert Labor (1988) 2.

conducted in public. Although Valverde describes the authorising function of jurisdiction as 'clearly apparent', she notes that its secondary sorting/separating function is less visible.[52] This obfuscates power relations between institutions, suppressing disputes about how authority is arranged and how governance operates.[53] Jurisdiction facilitates this de-politicising manoeuvre by pre-empting and containing potential conflicts, quelling latent disagreement at the source.[54] The result, Valverde laments, is that:

> [T]he game of jurisdiction acts to perform a kind of ethnomethodological miracle by which incommensurable processes are kept from clashing, and the consumers of legal decisions are kept from asking: how should problem X or Y be governed in the first place?[55]

By drawing attention to the processes through which law orders and contains the knowledge claims, politics, and embodied effects of various institutions, jurisdictional analysis harbours the potential to de-mystify, and even re-politicise, governing processes. This intervention could have a significant impact in numerous areas of health law and beyond.

Paying attention to the qualitative aspects of governance would enhance health law scholarship on trans issues. UK courts have tended to avoid interfering with professional decision-making in medical contexts, and trans issues are not atypical in this respect. In R v NW Lancashire Health Authority, ex p A, D and G,[56] the Court of Appeal considered the legality of a local health authority policy to fund genital reconstruction surgery only in exceptional circumstances. When asked to define what it meant by 'exceptional circumstances', the authority could only explain that 'such exceptions will be rare, unpredictable and will usually be based on circumstances that could not have been predicted

[52] Valverde, op. cit., n. 11, p. 85.
[53] Such questions concern the 'qualitative features of governance'; id. p. 84.
[54] id. p. 86; Veitch, op. cit., n. 43, p. 390.
[55] Valverde, id.
[56] [2000] 1 W.L.R. 977.

at the time when the policy was adopted'.[57] The court then affirmed that prioritising the appropriate allocation of resources fell within the authority's competence. It accepted that it was legitimate to leave 'exceptional circumstances' undefined, and that designating genital reconstruction surgery 'low priority' status could, prima facie, be considered rational.[58] Yet applying this policy in a way which meant that it was effectively impossible for trans people to access surgery did not correspond with medical judgment, and was considered irrational by the court.[59] On the facts, then, the policy was quashed. Yet in coming to this decision, the court reiterated that the European Convention on Human Rights imposes no positive obligation on a health authority to provide access to body modification technologies,[60] commending the High Court judgment that 'The Convention does not give the applicants rights to free healthcare in general or to gender reassignment surgery in particular'.[61] A later case reiterated judicial deference with regard to rationing of trans-related health care, with Hopper LJ noting: '[T]he court is not appropriately placed to make either clinical or budgetary judgments about publicly funded healthcare: its role is in general limited to keeping decision-making within the law'.[62]

The UK legislature has also deferred to professional medical opinion when regulating gender.[63] The GRA 2004 was criticised by Sharon Cowan for failing to confront 'the historical medicalization of the transgender 'condition'', but also, in making a diagnosis of gender dysphoria a pre-requisite to legal gender recognition, granting pathologisation of trans phenomena the 'stamp of statutory authority.'[64] This decision to import medical norms into

[57] id. p. 984.
[58] id. p. 991.
[59] id. p. 995.
[60] id.
[61] id. p. 996.
[62] R (C) v Berkshire West Primary Care Trust [2011] E.W.C.A. Civ. 247 [56].
[63] cf. Article 11 of the Argentinian Gender Identity Law 2012 (Ley de Identidad de Genero 26.743) (AR), which establishes a right 'to access total and partial surgical interventions and/or comprehensive hormonal treatments' on an informed consent basis.
[64] Cowan, op. cit. n. 19, p. 247.

law underscores Davy's 'medicolegal alliance'.[65] But while such analyses helped scholars understand the workings of the GRA 2004 at the time of its enactment, neither are dynamic enough to capture the ongoing interrelation of medical and legal norms in the regulation of gendered embodiment. Conceiving of 'stamps' and 'alliances' risks understating the complexity of power relations; exaggerating points of unity and obscuring dissonance. Like conceptions of unified national sovereignty, notional alliances are less attuned to the development of relations over time. This is particularly the case as institutions constantly compete for, or avoid, responsibility for governing in different instances. Research into the development of abortion law, which demonstrates how it has been shaped by complicated intra-professional rivalries more than it has by consensus,[66] usefully exemplifies this.

Instead of searching for sovereignty, Valverde proposes concentrating on the workings of jurisdiction; a practical legal technology which is used to distinguish 'more than territories and authorities, more than the where and the who of governance'.[67] Jurisdiction includes 'the 'what' of governance – and, most importantly, because of its relative invisibility, the 'how' of governance.'[68] A hierarchy plays out as a four-step 'chain reaction':

> 1. where: territories;
> 2. who: authorities (whether sovereign, delegated, or private);
> 3. what: the objects of governance (e.g. potholes are municipal, aboriginal reserves are federal);
> 4. how – which in turn has two dimensions:
> (a) governing capacities, and
> (b) rationalities of governance.[69]

The divergent regulation of abortion in the UK exemplifies how the first two steps in this 'chain reaction' can determine how the remainder play out in practice. Though it may soon be

[65] Davy, op. cit. n. 18 p. 119.
[66] S. McGuinness and M. Thomson, 'Medicine and Abortion Law: Complicating the Reforming Profession' (2015) 23(2) Medical Law Review 177.
[67] Valverde, op. cit., n. 12, p. 144.
[68] id.
[69] id.

brought into line with the rest of the UK,[70] abortion remains prohibited in Northern Ireland.[71] It has thus become common for Irish women to travel to England for abortion care.[72] Most medical abortions require the patient to ingest two pills: mifepristone and misoprostol.[73] When an Irish subject takes these pills at an English clinic, they are governed as a patient of the English National Health Service (NHS). This falls under the jurisdiction of English professional regulatory bodies and UK health law, being deemed a medical concern. If something goes wrong, or the patient wishes to complain, they are granted the right to appeal to these professional regulatory bodies, and courts of law, for recompense. Yet if they were to ingest the same pills in Northern Ireland, this would fall under the jurisdiction of the Northern Irish criminal law – which could lead to criminal prosecution and conviction.[74] The decision of where the pills are ingested determines not only who the subject is governed by, but also as what they are governed as (patient or suspect), and how they are governed (in accordance with medical or criminal law).

Another example can be found in the rules governing legal capacity in a medical context.[75] The common law standard known as Gillick[76] competence permits patients under the age of 16 to consent to medical treatment independently of their parents, provided they are intelligent enough to understand fully what is being proposed by the doctor. As in the abortion example, the location of the subject – in this context, where the underage patient is

[70] Northern Ireland (Executive Formation) HC Bill (2017-19) 190, cl 9.
[71] The Abortion Act 1967 never applied in Northern Ireland; s 7(3). All abortions save for those necessary to preserve the mother's life are currently prohibited by s 25 of the Criminal Justice Act (Northern Ireland) 1945 and ss 58-59 of the Offences Against the Person Act 1861.
[72] At least 724 women travelled to England from Northern Ireland for abortion care in 2016; Department of Health and Social Care, 'Report on Abortion Statistics in England and Wales for 2016', 13 June 2017, <https://gov.uk/government/statistics/report-on-abortion-statistics-in-england-and-wales-for-2016>.
[73] S. Sheldon, 'British Abortion Law: Speaking from the Past to Govern the Future' (2016) 79(2) Modern Law Review 283 fn. 9.
[74] Abortions have been prosecuted in Northern Ireland on three occasions since 2016; J.M. Rooney, 'Standing and the Northern Ireland Human Rights Commission' (2019) 82(3) Modern Law Review 525, 527-528.
[75] Harrington, op. cit. n. 13, p. 364.
[76] Gillick v West Norfolk and Wisbech Area Health Authority and another [1985] 3 All E.R. 402.

located on the temporal scale of 'growth and maturity'[77] – decides who the relevant authorities are (parent or doctor). This, in turn, determines what the patient is (child or adult) and how they will be treated (as competent or incompetent, capable of consenting to treatment or not). The decision of whether they can consent to treatment could have important consequences for the patient's health, depending upon the type of treatment which they might undergo. Again, once jurisdiction has been allocated to an authority, the questions of 'what' the object of governance is and 'how' it ought to be conducted are decided quietly – as though these do not to merit much discussion.[78] Such decisions can easily be obfuscated and depoliticised, making the qualitative dimensions of regulation more difficult to ascertain and challenge.

Shaunnagh Dorsett and Shaun McVeigh echo Valverde's emphasis on the pluralistic workings of jurisdiction.[79] They agree that objects of governance are at least partially shaped by governing authorities, noting that the 'jurisdictional quality of persons' begins with a question of authorities more than it does a question of legality or morality.[80] Considering under 'which' jurisdiction such questions are asked will give scholars not only a source of authority but 'a sense of rival authorities'.[81] This suggests that viewing the regulation of trans embodiment in the GRA 2004 or the Danish reforms of 2014 'as an act of sovereign will or reason' will 'impose more uniformity than is present in legal practice'; deflecting attention 'from the material and institutional ordering of law'.[82] Rather than equating law with sovereign demand, regulation is better understood as a contest 'of speakers and listeners – joined, however inadequately, through jurisdiction.'[83] The actors involved in regulating gender in Denmark would include legal officials, such as judges – particularly if a specific provision of

[77] id. at 421 (Lord Scarman).
[78] M. Valverde, 'Studying the governance of crime and security: Space, time and jurisdiction' (2014) 14(4) Criminology & Criminal Justice 379, at 388.
[79] S. Dorsett and S. McVeigh, Jurisdiction (2012) 14.
[80] id. p. 82.
[81] id. p. 82.
[82] id. p. 95.
[83] id. p. 134.

the 2014 reforms were to be challenged in court. If we are to grasp how medical law 'actually works' in this area,[84] it is necessary to look beyond these archetypally legal 'speakers and listeners', and to include the legislators, doctors, civil servants, professional regulators, and trans people themselves, who are all involved in implementing and resisting the policies which regulate gendered embodiment in Denmark.

By creating a personal jurisdiction which allows people to self-declare their gender, removing medical gatekeepers from the recognition process, it might be assumed that the reforms affected the ordering of Danish legal and medical institutions. Yet the CPR law is ineffective beyond civil registration, as will be established in the following section. This suggests that self-declaration can be enacted in a way which does not affect other institutional spheres of governance, like the health care system, which constitute important locations for the regulation of gendered embodiment.

SEPARATING JURISDICTIONAL COMPETENCIES

I uncovered the utility of jurisdictional analysis while conducting research into the Danish reforms of 2014. First, through doctrinal analysis of legislative materials; including the report of the inter-ministerial working group ('the working group') on legal sex/gender change,[85] parliamentary debates,[86] and explanatory comments drawn up to accompany the CPR law.[87] Second, through empirical interviews conducted with 33 respondents – fourteen trans people, one intersex person, eleven activists and campaigners, and seven other stakeholders

[84] Veitch, op. cit. n. 13, p. 30.
[85] Ministry of Justice (DK), Rapport fra arbejdsgruppen om juridisk kønsskifte (27 February 2014) <http://justitsministeriet.dk/sites/default/files/media/Pressemeddelelser/pdf/2014/Rapport%20om%20juridisk%20k%C3%B8nsskifte.pdf>.
[86] Folketingstidende 20 May 2014, 91. møde, kl. 17:45.
[87] Bill for amending the Act on the Central Person Registry (30 April 2014) (Forslag til Lov om ændring af lov om Det Centrale Personregister) (DK).

(including one politician, four civil servants, and two medical practitioners) – during a fieldwork visit to Denmark in 2015. This followed the enactment of the CPR law in June 2014, which changed how legal 'sex/gender' [88] could be amended in the CPR. Previously, legal sex/gender could only be altered where this involved correcting an 'error'.[89] In practice, this required applicants to demonstrate that they had undergone surgical removal of their uterus (hysterectomy) and ovaries (bilateral oophorectomy), or penis (penectomy) and testicles (orchiectomy).[90] Since 2014, any Danish resident over the age of eighteen is permitted to change their legal gender status. To do so, they must make an online declaration stating that they experience 'belonging to the other sex/gender', then confirm this application following a six-month reflection period.[91] They need not have undergone medical treatment. Nor must they be in receipt of any psychiatric diagnosis.

The CPR law was enacted before compulsory sterilisation had been held to constitute a violation of Article 8 of the European Convention on Human Rights,[92] and when psychiatric diagnoses of 'gender dysphoria' or 'transsexualism' still constituted pre-requisites to legal gender recognition in all European states that did not require sterilisation.[93] It also constituted the first enactment of self-declaration outside of Argentina.[94] Hence the CPR law was celebrated by scholars,[95] and campaigners,[96] for creating a personal jurisdiction for the

[88] I translate the Danish term 'køn' as 'sex/gender' whenever the conceptual distinction is unclear.
[89] Order regarding the Act on the Central Person Registry (9 January 2013) (Bekendtgørelse af lov om Det Centrale Personregister) (DK), s 3 para 5.
[90] Genital reconstruction surgery was never a pre-requisite; N.V. Munkholm, 'Legal Status of Transsexual and Transgender Persons in Denmark' in The Legal Status of Transsexual and Transgender Persons, ed. J.M. Scherpe (2015) 153.
[91] L 182, op. cit., n 22, s 1; Order regarding the Act on the Central Person Registry, op. cit., n 89, s 3 para 6.
[92] YY v Turkey App no 14793/08 (ECtHR, 10 March 2015).
[93] Including the UK, by s 2(1) of the GRA 2004.
[94] Gender Identity Law 2012, op. cit. n. 63.
[95] P. Dunne, 'Rethinking legal gender recognition: recent reforms in Argentina, Denmark and the Netherlands' (2015) 1 International Family Law 41.
[96] 'Denmark goes Argentina! Denmark passes best legal gender recognition law in Europe' TGEU, 11 June 2014, <http://tgeu.org/denmark-goes-argentina>; 'Denmark the first European country to allow legal change of gender without diagnosis' ILGA Europe, 1 June 2014, <https://ilga-europe.org/resources/news/latest-news/denmark-first-european-country-allow-legal-change-gender-without>.

purposes of declaring gender. When asked to assess its impact on their everyday lives, the law was welcomed by interviewees, including Kirsten:

> **Kirsten** (Female, 57): [T]he demand for you to get surgery or hormone therapy is no longer there, so if you don't need that, you can just do as I have done and ask for a new social security number with the right number at the end […]. And now I have this, so I am a female in a legal sense.

That similar sentiments were echoed by almost all interviewees indicates that there is a desire for self-declaration among trans communities. Yet the qualifier that the legislation works best "if you don't need" "surgery or hormone therapy" is worthy of note. For, while the CPR law is formally inclusive,[97] its scope is limited by the fact that its provisions are purely administrative. It grants a right to amend legal gender status, and nothing more. It emerged during interviews that the limited scope of the CPR law contributed to a regulatory scenario whereby self-declaration was not experienced as practically accessible for all trans interviewees despite its formal inclusivity. For those who wished to undergo body modification before amending legal status, the absence of a right to access health care was lamented. In a context where medical professionals wield significant power 'to determine what is considered sick or healthy, normal or pathological, sane or insane',[98] trans people were granted no additional regulatory support within the clinical setting.

The fact that the CPR law did not include any provisions concerning access to health care was compounded only months after its enactment when, in December 2014, new medical guidelines effectively centralised authorisation for access to all body modification technologies understood to be constitutive of 'sex/gender modification treatments' at the Sexological Clinic (Sexologisk Klinik) of the National Hospital (Rigshospitalet) in

[97] Non-residents, and residents under the age of eighteen, are both excluded. The CPR law also grants legal gender recognition only within the male/female gender binary.
[98] S. Stryker, Transgender History (2008) 36, cited in J.T. Theilen, 'Depathologisation of Transgenderism and International Human Rights Law' (2014) 14 Human Rights Law Review 327, at 338.

Copenhagen.[99] This certified a de facto monopoly for trans-related health care provision at this clinic, which was originally established, in 2012, after a surgeon working in a private-sector hospital was subjected to disciplinary proceedings for performing a double mastectomy on a fifteen-year-old trans person named Caspian Drumm.[100] Before 2012, a regulatory loophole permitted access to treatments other than castration through a small number of medical practitioners willing to prescribe hormones and perform minor surgeries on an informed consent basis.[101] After this loophole closed, all new patients and existing patients under the age of eighteen were required to present themselves for sustained psychiatric assessment at the Sexological Clinic. This situation persisted until the Danish Health Authority approved treatments at a new Sexological Centre (Sexologisk Center) at the Aalborg University Hospital in September 2017 – five years after the monopoly at the Sexological Clinic had been established, and three years after self-declaration had been adopted.[102] While it remains to be seen how well this new system will work alongside the legislation permitting self-declaration of legal gender status, it is instructive to investigate the causes of this three year time-lag in order to ensure that self-declaration can be as effective as possible in other states that implement it.

It is emphasised within trans studies that surgery should not be misconstrued as 'the hallmark of trans experience'.[103] Yet it remains necessary to acknowledge that the desire for

[99] Guideline no 10353 on the treatment of transgender patients (19 December 2014) (Vejledning nr 10353 om udredning og behandling af transkønnede) (DK).
[100] T. Raun, 'The "Caspian Case" and Its Aftermath: Transgender People's use of Facebook to Engage Discriminatory Mainstream News Coverage in Denmark' in New Dimensions of Diversity in Nordic Culture and Society, eds. J. Björklund and U. Lindqvist (2016) 79.
[101] Medical practitioners outside the Sexological Clinic were not formally prohibited from performing body modifications other than surgical castration, as medical guidelines previously concerned only this specific treatment; Guideline no 10077 on surgical castration for the purposes of sex/gender modification (27 November 2006) (Vejledning nr 10077 om kastration med henblik på kønsskifte) (DK).
[102] This new institution was established in accordance with Guideline no 9921 on health care related to gender identity (22 September 2017) (Vejledning nr 9921 om sundhedsfaglig hjælp ved kønsidentitetsforhold) (DK), which has since been updated by Guideline no 9658 on health care related to gender identity (16 August 2018) (Vejledning nr 9921 om sundhedsfaglig hjælp ved kønsidentitetsforhold) (DK).
[103] D. Spade, Normal Life (2011) 14.

body modification plays an important part in many trans people's lives.[104] While not all of the fifteen interviewees who were asked about how they had been personally affected by the CPR law expressed a persistent desire for hormones or surgery, they all reported at least considering undergoing one form of body modification or another. But around half were unable or unwilling to undergo the officially-sanctioned process of psychiatric evaluation at the Sexological Clinic; either because they feared having, or had previously had, a negative experience when doing so. Since treatment by informed consent was prohibited, legal recognition proved inaccessible to those wary of amending their legal status without medical approval. The centralisation of access to body modification technologies at the Sexological Clinic meant that while barriers to legal gender recognition were reduced, the initial effect of the 2014 reforms was that Danish law would continue to exclude those unable or unwilling to amend their status without material support.[105] The policy implication is that self-declaration can be undermined by a failure to implement equally inclusive reforms of health care provision. Considering the interplay of legal and medical regulations is imperative for those seeking to assess the impact of law reforms on experiences of gendered embodiment. The internal legal pluralism identified by jurisdictional analysis offers one explanation; demonstrating how administrative civil regulations and medical guidelines are experienced in relation to one another. Scholars may celebrate the liberalisation of administrative laws such as the CPR law, but it is just as important to ensure that such reforms work in concert with other modes of regulation.

Beyond its primary function – authorising governing competencies – jurisdiction also sorts and orders different governing mechanisms, drawing boundaries between them.[106] In Denmark, institutional spheres were carefully delineated, with institutions such as the

[104] E. Plemons and C. Straayer, 'Introduction: Reframing the Surgical' (2018) 5(2) Transgender Studies Quarterly 164, 166.
[105] For more on the stated intentions and impact of the CPR law, see Dietz, op. cit., n. 21.
[106] Valverde, op. cit., n. 11, p. 85.

Sexological Clinic granted exclusive authority over various aspects of trans embodiment putatively positioned outside the civil administrative sphere. The decision to avoid mentioning health when designing the CPR law was motivated by a reluctance to encroach upon the competence of the medical professionals tasked with determining how body modification technologies ought to be accessed. When interviewed about the government's role in drafting the medical guidelines, Flemming Møller Mortensen, health care spokesperson for the Social Democrats (who led the Danish coalition government in 2014), stressed the limits of governmental influence:

> **Flemming Møller Mortensen**: We have to put some arm's-length principles into this. It's not the Ministry [of Health] at all doing this [drafting the medical guidelines] – it's made by some organisations under the Minister.

The institution which Mortensen alludes to here, which authored the medical guidelines of 2014, was the Danish Health and Medicines Authority (DHMA).[107] The specialist expertise of this professional regulator was also emphasised in an interview with John Erik Pedersen, a representative of the Ministry of Health:

> **John Erik Pedersen**: The Health and Medicines Authority is an agency under the Department of Health, in a hierarchical sort of way. But they have the expertise – doctors and so on and so forth – which we do not have in the Department. So, their assessments, and judgements, on medical issues we do not have the expertise here to overrule. So, we do not do that.

The drafting of the 2014 guidelines is presented as a technical issue, demanding a specific form of professional (medical) expertise. When asked about why this might have been the case, Linda Thor Pederson, transgender spokesperson at LGBT Denmark, was blunt:

[107] After evidence came to light indicating a failure to maintain professional treatment standards, the DHMA was stripped of its supervisory duties and medicines licensing tasks. These duties are now devolved to the Danish Patient Safety Authority and the Danish Medicines Agency. The new Danish Health Authority's 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>.

> **Linda Thor Pederson**: [T]he civil servants are keeping the politicians out of their domain. That's the main problem. They believe that only medically-educated people can have opinions about health care. […] [T]he only the politician in the Ministry is the Minister. The rest are civil servants, and they don't care about the Minister – he's only temporary.

Pedersen's testimony suggests that, in addition to wielding authority over generalist colleagues at the Ministry of Health, medics working in a civil capacity for the DHMA are protecting their professional jurisdiction from the interference of elected politicians. The implication is that doctrinal legal authority had been inverted, and regulators with professional expertise granted authority over those without it.[108] While this might sound alarming at first, it is important to remember that deference is not uncommon within health law. Nor is it an inexplicable idiosyncrasy in the otherwise non-hierarchical model of health provision. As Harrington notes, the UK NHS was founded upon the twin pillars of radically egalitarian access to treatment free at the point of use for any patient and a starkly hierarchical deference to professional medical opinion.[109] Bent Sigurd Hansen acknowledges that the Danish health care system (and wider welfare state) was developed in a similar manner.[110] But, even if they are unexceptional, the 2014 reforms can still be understood as a form of 'boundary-work'; that is, an attempt to protect professional autonomy 'against outside powers who are attempting to encroach on or exploit scientists' epistemic authority'.[111]

Meanwhile, the fact that medicine is not a homogenous profession is obscured, and divergences in medical opinion ignored. Parallels can be drawn with Sheelagh McGuinness and Michael Thomson's analysis of the intra-professional rivalries which shaped abortion law

[108] cf. doctrinal hierarchy in Danish law, where Acts of Parliament (lov) have authority over administrative orders (bekendtgørelser) and guidelines (cirkulærer or vejledning); Munkholm, op. cit., n. 90, 149.
[109] Harrington, op. cit., n. 14, ch. 7.
[110] B.S. Hansen, 'Something Rotten in the State of Denmark: Eugenics and the Ascent of the Welfare State' in Eugenics and the Welfare State: Sterilization Policy in Denmark, Sweden, Norway and Finland, eds. G. Broberg and N. Roll-Hansen (1996).
[111] McGuinness and Thomson, op. cit. n. 66, p. 190, citing T.F. Gieryn, 'Boundary-work and the Demarcation of Science from Non-science: Strains and Interests in the Professional Interests of Scientists' (1983) 48 American Sociological Review 781.

reform in 1960s Britain, as different professional specialisms sought to gain occupational terrain.[112] Before 2012, the Sexological Clinic offered one route to body modification via psychiatric diagnosis; while private-sector gynaecologists, endocrinologists, psychologists, and even surgeons offered another based on informed consent. During the 2014 reforms, the claims of the latter groups are silenced within official accounts, as they were prohibited from taking on any new trans patients. The medical guidelines of 2014 could therefore be considered an excellent vehicle for 'boundary-work'; resisting not only 'encroachment by the legislature on clinical discretion and decision-making'[113] but also the demands of patients to be treated on the basis of informed consent and the claims of the medics willing to grant this to them. By trumpeting specialist expertise, the Danish government effectively condones the expansion of a medical jurisdiction as a by-product of a wider attempt to respect professional self-regulation. Yet even if the drafting of medical guidelines is understood in this manner, jurisdictional analysis still identifies such regulations as dependent upon state authorisation. Even 'independent' institutions such as the DHMA regulate in accordance with a competence which could be limited by state law.[114] From this perspective, the decision of the Danish government not to intervene in the drafting of the medical guidelines equates to a tacit certification of the expansion of the DHMA's professional jurisdiction. This legitimises the top-down decision-making processes of the DHMA as an institution, rendering the government complicit in any drawbacks associated with the results of this practice of governance.

[112] id. p. 191.
[113] id. p. 190.
[114] Valverde, op. cit., n. 11, p. 83.

It has been established, then, that jurisdiction ensured that self-declaration could be limited to a minor amendment of administrative law. It enabled civil and medical reforms to be enacted at the same point in time but as distinct governing projects, which did not align either in terms of principle or application. This lack of alignment is no more apparent than when considering the 'rationalities of governance' under which the two jurisdictions proceed.[115] While the CPR law is formally open to any adult seeking to declare an experience of belonging to 'the other sex/gender',[116] medical guidelines were more restrictive. When asked to clarify this, Annamaria Giraldi, Senior Registrar at the Sexological Clinic, explained:

> **Annamaria Giraldi**: We don't have the informed consent model totally in Denmark, because we have the guidelines that say that there are some strict things that need to be taken care of, and there are some things that need to be fulfilled, before you can have the permission. […] the health care system also needs to find the people for whom it [body modification] is not a good idea.

Administrative and medical practices are marked by what Harrington calls 'diverse temporalities'; in that they produce, and are produced by, different conceptions of time.[117] This is reflected in their distinct objectives. Civil regulation concerns itself with the present and is formally inclusive.[118] Medical regulations imagine a prospective future – of those "for whom it is not a good idea" – and are openly restrictive. The concern that people might 'regret' body modification is motivated by a paternalistic, risk-averse, rationale which eschews the inclusive basis of self-declaration.[119] The requirement to undergo sustained psychiatric

[115] Valverde, op. cit., n. 12, p. 144.
[116] L 182, op. cit. n. 22.
[117] J. Harrington, 'Time as a dimension of medical law' (2012) 20 Medical Law Review 491.
[118] Changing CPR number on multiple occasions is permitted, unlike the GRA 2004 – which demands gender 'permanence'; E. Grabham, 'Governing Permanence: Trans Subjects, Time, and the Gender Recognition Act' (2010) 19(1) Social & Legal Studies 107.
[119] Notions of 'regret' permeate debates about access to body modification, despite high rates of satisfaction among trans people (estimated to be as high as 96% by the Royal College of Psychiatrists; Good practice guidelines for the assessment and treatment of adults with gender dysphoria (CR181, 2013) 19-20). Even

assessment impacts upon trans people's experiences of time – including how long it takes to access hormones and surgeries (if at all). Such 'temporal mechanisms' also have diffuse somatic effects, shaping trans people's experiences of embodiment, as Emily Grabham has noted.[120] Still, the government was able to authorise both rationales with the aid of jurisdiction, which holds them together as part of the same governing assemblage. Conflicting knowledges are sorted and separated by allocating distinct jurisdictions to different institutional authorities. This consolidatory function of jurisdiction is not atypical. As Valverde explains, governing projects are always differentiated by the way in which they 'select' certain aspects of governance while de-selecting or ignoring others.[121] Yet its effects are worth considering. Although drawing strict distinctions between administrative and medical regulations did not make sense from the perspective of those governed by them, the same could not be said of the policymakers who diligently followed their limited mandate. Civil registration may have been understood as administrative and thus ripe for amendment by civil servants at the CPR Office, but regulations governing access to body modification technologies were construed as a medical issue best left to professional regulators. When interviewed about how the Department for Gender Equality would deal with a written complaint about access to health care, their representative, Trine Ingemansen, responded:

> **Trine Ingemansen**: If you wrote to us regarding that question, then we would send the letter on to the Ministry of Health.
>
> **Interviewer**: So that's a health issue and not at all a social issue?
>
> **Trine Ingemansen**: Yes.

among the minority who are dissatisfied, the most significant factor for regret results from poor outcomes after genital reconstruction; A.A. Lawrence, 'Factors associated with satisfaction or regret following male-to-female sex reassignment surgery' (2003) 32 Archives of Sexual Behavior 299.

[120] Grabham, op. cit., n. 118, p. 113.

[121] Valverde notes: 'there is no such thing as a law in general, since every legal process comes already classified as belonging to a specific project (criminal law, family law, etc.)'; Valverde, op. cit., n. 11, pp. 60-61.

That the Department for Gender Equality willingly defers to the Ministry of Health highlights the exclusivity of this medical jurisdiction. When read alongside the comments made by John Erik Pedersen in the previous section – that the Ministry of Health also defers to professional expertise – it seems unlikely that any government ministry would make a substantive intervention for fear of encroaching upon the professional jurisdiction of the DHMA. The inability of the CPR law to increase the accessibility of health care can therefore be explained as a direct effect of the jurisdictional settlements arrived at by the 2014 reforms.

Not only are different types and levels of authority sorted and separated, but the sorting process has been so normalised that an 'open-ended non-legalistic discussion about which type of governance is or is not appropriate in a given situation' is foreclosed.[122] Once reforms were limited to cover only administrative issues, qualitative debate about the practicalities of governance were avoided. The question of whether body modification should be as accessible as amending legal gender status – or whether restricting access might reduce the impact of self-declaration – did not arise during the reform process. Instead, such questions were assumed to follow 'automatically' from the question of 'who' governs, as if 'by magic'.[123] Jurisdictional analysis thus renders the Danish government tacitly complicit in this limitation of the 2014 reforms. Yet a more normative critique would be that the CPR law was overtly limited from the outset. Rather than seeking to transform trans people's everyday experiences of law, the main intention of the 2014 reforms could be read as an attempt to cultivate a symbolic appearance of liberalisation, while ultimately bolstering jurisdictional divisions between law and medicine.

In what remains of this article, I read this finding though the distinction Dorsett and McVeigh draw between jurisdictions of 'civility' and 'conscience'.[124] Jurisdictions of

[122] id. p. 85.
[123] Valverde, op. cit., n. 12, p. 145.
[124] Dorsett and McVeigh, op. cit. n. 79, ch. 5.

conscience have traditionally arisen in relation to spiritual matters, historically delineated in canon or ecclesiastical law.[125] Touching upon questions of ethics and morality, they provide 'the institutional structure of the legal subject and the institutional means of achieving forms of subjectivity.'[126] In contemporary jurisprudence, issues of conscience are associated with liberal ideals such as dignity and human rights. Jurisdictions of civility, on the other hand, arise in matters of common law and civil government, prioritising issues of public order and the management of legal subjects. While conscience requires legislators to weigh different justifications for pursuing one course of conduct over another, civility limits concern to the question of how that conduct should be ordered or administered.[127] Based upon the preceding analysis, it would be possible to map this distinction directly onto the Danish reforms; with civility describing the administrative questions about population registration addressed in the CPR law, and conscience representing the ethical issues – including access to health care and body modification – left to professional regulators.

Yet to apply this distinction so straightforwardly would constitute a basic reading of Dorsett and McVeigh's work. As I have noted, they, like Valverde, are attentive to jurisdictional plurality. The question becomes not so much which jurisdiction arises from a law or judgement, but how different jurisdictions are positioned in relation to one another. This pluralistic framing is exemplified by their analysis of contrasting jurisdictional arrangements regulating physician-assisted dying in Australian Northern Territories legislation, the Rights of the Terminally Ill Act 1995, and a US Supreme Court decision, in Washington v Glucksberg[128] and Vacco v Quill.[129] While the Rights of the Terminally Ill Act 1995 limited itself to questions of civility, granting medical professionals legal immunity from

[125] id. p. 82.
[126] id. pp. 82-83.
[127] id.
[128] 521 U.S. 702 (1997).
[129] 521 U.S. 793 (1997).

criminal law, without framing this as a 'right to die',[130] the justices of the US Supreme Court reflected upon matters of liberty, freedom, dignity, and conscience.[131] But although these matters took up a portion of the US justices' reasoning, they did not prove decisive. Matters of conscience were weighed against, and ultimately trumped by, public interest concerns. Jurisdictional plurality is also reflected in the Rights of the Terminally Ill Act 1995; which, though largely concerned with matters of administrative governance, still avoided being represented as subordinate 'to an administrative regime that departs fully from legal normativity.'[132]

A jurisdictionally pluralist reading is instructive when analysing the Danish reforms. When Trine Ingemansen, who represented the Department for Gender Equality in the working group, was asked whether legislators had considered going beyond a minor amendment of the CPR, she stressed how an administrative jurisdiction would benefit trans people, stating:

> **Trine Ingemansen**: The Government was very focused […] that this legal gender change was only an administrative issue; and it would make life so much easier for a group of people that already have a difficult time.

Similarly, when asked if the working group had considered re-designing the CPR system, Grethe Kongstad, a representative of the CPR Office, replied:

> **Grethe Kongstad**: The working group concerning the transgender people was not going into a discussion concerning the whole CPR system – not at all. It was only a question of finding different models for making a transgender solution that satisfied the Government.

The first quotation addresses a matter of conscience, with Ingemansen identifying an intention to "make life so much easier for a group of people that already have a difficult time."

[130] Dorsett and McVeigh, op. cit. n. 79, pp. 85, 88.
[131] id. pp. 92-94.
[132] id. p. 88.

Yet this positive statement of intent ought not to divert attention away from how it is ultimately subsumed under the imperative that legislation was "only an administrative issue". As in Washington v Glucksberg and Vacco v Quill, what at first looks like a matter of conscience is 'in the end […] subordinated to the interests of state.'[133] The second quotation delineates the same interests more explicitly, as Kongstad describes the entire legislative process as "a question of finding different models for making a transgender solution that satisfied the Government". While divergent concerns could have been held in tension by members of the working group, any pretence that the CPR law primarily concerned matters of conscience fell away once maintaining divisions between medicine and law became paramount.[134]

Although jurisdictional imperatives weighed heavily on those professionally involved in the legislative process, they held less appeal for the trans people interviewed about how they had been personally affected by the reforms. When asked if they could change one thing about the regulation of trans embodiment in Denmark, interviewees repeatedly cited the requirement to undergo sustained psychiatric diagnosis:

> **Adam** (Male, 30): I basically don't see the need for this system; why I can't just sign a form that says I understand what it is I'm doing – informed consent. I don't understand why that it is not enough. I don't understand why people can go to a plastic surgeon and have a lot of things done and yet it's illegal in Denmark to have your breasts removed. You can't do that, unless you're a woman who's afraid of cancer. But if you go to them and say: "I'm a transgender man, and I don't want to have breasts," it's not going to be legal – even in private clinics – which is weird.

Adam expresses frustration at what has become known as 'trans exceptionalism'; referring to instances where additional hurdles are placed in front of trans people as a direct consequence of them being identified as trans.[135] The procedure that he mentions is a double

[133] id. p. 94.
[134] id.
[135] C.J. Heyes and J.R. Latham, 'Trans Surgeries and Cosmetic Surgeries: The Politics of Analogy' (2018) 5(2) Transgender Studies Quarterly 174. This corresponds with 'abortion exceptionalism' identified by health law scholars; C.E. Borgmann, 'Abortion Exceptionalism and Undue Burden Preemption' (2014) 71 Washington and Lee Law Review 1047.

mastectomy.[136] The same argument could be made in respect of almost any 'trans-related' surgery (even though the vast majority of such body modification technologies were not originally developed for use on trans patients).[137] Before 2012, trans people in Denmark were not able to access hormones and surgeries on demand. But some were treated on an informed consent basis by endocrinologists, gynaecologists, and psychologists working in private-sector clinics. Of all the regulations affecting trans people before 2014, this is the practice which interviewees would have most liked to see consolidated and expanded, rather than prohibited. Instead, the effect of the 2014 reforms was that those who wished to access body modification technologies had to first engage with a medical jurisdiction which did not coincide with the personal jurisdiction developed for the purposes of reforming civil registration. It was only after medical guidelines were reformed again – three years later – that it became possible to access hormones without being subjected to sustained psychiatric diagnosis at the Sexological Clinic.

Illuminating jurisdictional boundaries may invoke demands to overcome them; such as in abortion law, where the statutory framework has fallen so far behind health care practice that it has drawn calls to abolish this law and regulate abortion care like most other forms of health provision instead.[138] But this will not always be the case. For all the flaws in the development of Gillick, most commentators envisage active roles for medicine and law in assessing (in)capacity among minors.[139] There may be compelling reasons for ensuring that

[136] A mastectomy is a breast removal procedure which cis (that is, non-trans) men and women undergo without the need for psychiatric diagnosis. Trans people must be diagnosed to undergo such an operation.
[137] Phalloplasty was developed in the aftermath of the First World War to treat the victims of landmines; D. Schultheiss, A.I. Gabouev, and U. Jonas, 'Nikolaj A. Bogoraz (1874–1952): Pioneer of Phalloplasty and Penile Implant Surgery' (2005) 2(1) The Journal of Sexual Medicine 139. 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; K. Nitkin, 'First-Ever Penis and Scrotum Transplant Makes History at Johns Hopkins' Johns Hopkins, 23 April 2018, <https://hopkinsmedicine.org/news/articles/first-ever-penis-and-scrotum-transplant-makes-history-at-johns-hopkins>.
[138] S. Sheldon, 'The Decriminalisation of Abortion: An Argument for Modernisation' (2016) 36(2) Oxford Journal of Legal Studies 334; Sheldon, op. cit. n. 73.
[139] E. Cave, 'Goodbye Gillick; Identifying and Resolving Problems with the Concept of Child Competence' (2014) 34(1) Legal Studies 103.

certain procedures, which demand specific skills, are undertaken by trained professionals. This is what distinguishes laws permitting physician-assisted suicide in the Netherlands and Belgium from those in Switzerland, where assistance can be provided by volunteers from non-profit organisations.[140] Hannah Arendt's argument in favour of retaining technical expertise in matters which demand specialisation could be applicable within health contexts.[141] Within trans studies, few advocate complete de-medicalisation of trans identities. Instead, strategic calls for de-pathologisation – abolishing psychiatric monopolies over trans phenomena – are more widespread.[142] While the need to re-balance the power dynamic between doctors and trans patients is noted, acknowledging conscience need not amount to superseding medical expertise. Demands for treatment by informed consent are heard more often than those for 'completely unfettered' access to treatment on demand.[143] It is perhaps unsurprising, then, that most interviewees were not hostile towards the medical profession as a whole. Several who had previously been treated by practitioners in private-sector clinics were keen to acknowledge the quality of the care they received:

> **Peter** (Male/FTM, 27): He [the doctor] was being really responsible about it – he checked me out totally, and talked to me about how I was feeling, and if my family was on-board. And he gave me contact information for a shrink, and for a gender therapist that had experience in the whole thing. It's not like you just walked in and walked out with the hormones; he did actually check you out. So that made me feel taken care of – and just great to be able to start.

In a similar vein, this article should not be read as a critique of medical knowledge per se. It does not mean to suggest that clinical expertise is unnecessary in determining how access to body modification technologies ought to be managed within clinics. Nor does it seek to

[140] The doctor's role is limited to assessing the patient's capacity and prescribing the lethal drug; R. Andorno, 'Nonphysician-Assisted Suicide in Switzerland' (2013) 22(3) Cambridge Quarterly of Healthcare Ethics 246.
[141] Harrington, op. cit. n. 14, pp. 60-61, citing H. Arendt, On Revolution (1973) 91.
[142] Z. Davy, A. Sørlie, and A.S. Schwend, 'Democratising diagnoses? The role of the depathologisation perspective in constructing corporeal trans citizenship' (2018) 38(1) Critical Social Policy 13.
[143] Heyes and Latham, op. cit. n. 135, pp. 185-186.

advance my own jurisdictional claim to the expertise to pronounce over this ethical issue,[144] or to underplay the importance of the political and socio-economic debates surrounding access to public resources.[145] Instead, the objective of this article has been to highlight the importance of considering how the effects of a reform constructed within one legal sphere are, and will always be, contingent upon regulations developed within other institutions – including the health care system. Jurisdictional analysis offers one innovative mode through which to account for this. While the temptation may be strong for legislators to respect jurisdictional boundaries, sorting and separating one form of regulation from another in the abstract is not how regulation will be experienced in practice. If matters of conscience are to be granted parity with issues of civility, then it is imperative that reformers seek to conceptualise governing mechanisms relationally, before assessing the effect of different regulations in practice. This is as relevant to abortion care, capacity assessments, and physician-assisted dying as it is to trans health. It may prove to be pertinent to other areas of health law, as well as socio-legal studies more broadly.

CONCLUSION

Jurisdictional analysis has been used to illuminate the entanglement of legal and medical norms in the regulation of (trans) health. Drawing upon the first qualitative research project analysing the impact of the 2014 reforms in Denmark, this article constitutes an original attempt to conduct such analysis of this novel empirical material. From a policy perspective, it identifies lessons that should be learned from the Danish adoption of self-declaration of legal gender status. States that plan to follow Denmark's lead in this context will be better

[144] cf. Veitch, op. cit. n. 13, p. 13.
[145] Veitch, op. cit., n. 43, p. 397-398.

informed of what initially went wrong there than they have been to date. If legislation is designed and implemented in a way which creates and maintains a merely civil jurisdiction – granting a right to self-declare gender status, but nothing more – then it could similarly fail to improve the everyday lives of trans people. Where reforms are unable or unwilling to address issues such as access to health care, self-declaration risks proving ineffectual for those wary of amending their legal status without material support.

While, on balance, the personal jurisdiction established by the CPR law for the purposes of amending legal gender did prove popular amongst trans communities, its full impact will only be realised where civil law is backed up with material support, including health care provision. It is imperative, then, that health law be considered within wider law reform projects. Gender recognition law reforms are unlikely to succeed where legal and medical norms are sorted and separated by jurisdictional manoeuvring – whether deliberately or not. By undertaking a qualitative shift in the terms of engagement common to both gender recognition debates and health law scholarship more generally, this article has found that the Danish adoption of self-declaration constituted little more than a minor amendment of jurisdiction in civil administration. As a direct result of this limitation, the impact of self-declaration was adversely affected, with interviews demonstrating that trans people faced difficulties if they wished to have their newly-amended gender status respected in challenging normative spheres, including the clinical setting.

By applying jurisdictional analysis at the intersection of gender recognition and health law, the article builds upon the existing literature on jurisdiction. In illuminating how jurisdictional divisions were mobilised and maintained in Denmark, it offers pointers as to how similar studies could be conducted in other areas of health law. Jurisdictional analysis enhances our ability to analyse governing processes – including law reform projects – and decipher how governance works in practice. By identifying which forms of regulation are

prioritised and protected, jurisdictional analysis enables scholars to ask critical questions about alternative modes of regulation which may currently be obfuscated. The potential impact of this framework is striking, and so demands attention from scholars working in health law and trans legal studies, as well as in governance and socio-legal studies more broadly. Jurisdictional analysis offers health law scholarship clearer insights into health care practices; both by digging deeper into, and broadening its focus beyond, the doctor-patient relationship. In helping shift the emphasis away from understanding a battle for autonomy as a zero-sum game, and turning attention to other institutions and spheres of influence, jurisdictional analysis forms part of a wider movement to increase transparency in decision-making. This is notably relevant for the purposes of informing future law reform projects, including in the specific context of gender recognition law.

Following the more recent adoption of new medical guidelines in Denmark, it is possible that the situation of trans people there has improved. This hypothesis will have to be tested in future research. But the fact that it took three years from having adopted self-declaration to reach this point is worthy of note. Meanwhile, other states – including the UK – which are considering adopting self-declaration would be well advised to avoid instigating reforms with similar faults. If a gap is created between gender recognition law and health law, then similar problems in terms of the accessibility of both could easily emerge in other states. The policy contribution of this empirical finding is entirely dependent upon the main theoretical contribution made within this article; namely, that jurisdictional analysis is well-suited to the task of understanding the subtle interplay between legal and medical norms in gender recognition and the regulation of trans health. It will be interesting to see how jurisdictional analysis can be developed and supplemented by readers and researchers, in health law and in other related fields.