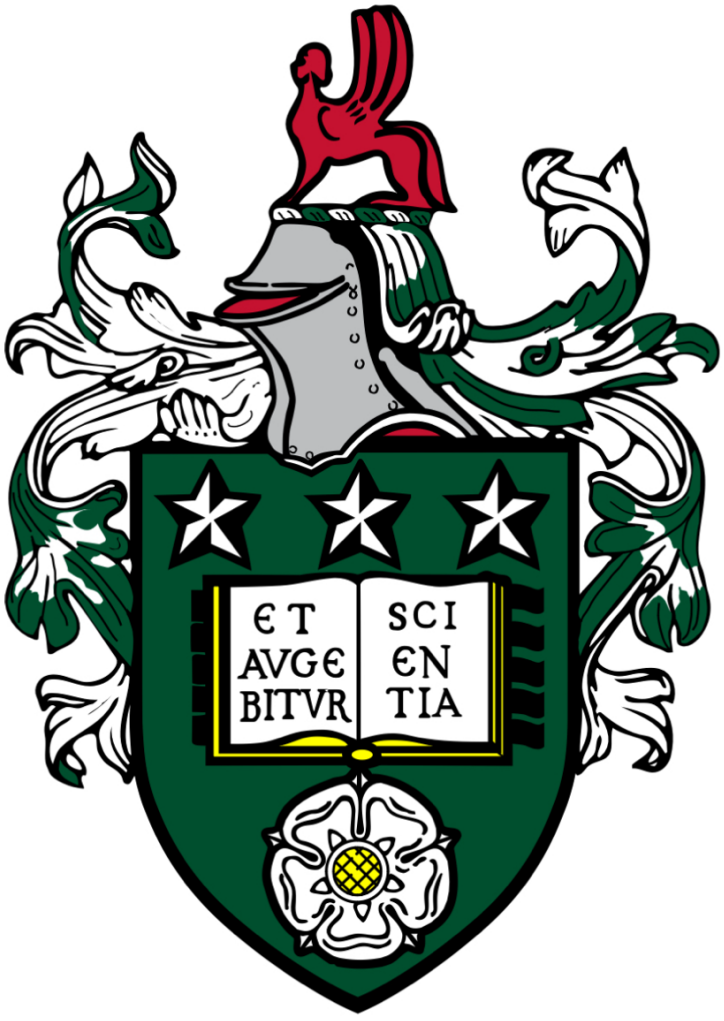
An Analysis of the Extent to Which the Clinical Guidelines pertaining to Gender Dysphoria Sufficiently Promote Autonomy



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Abstract

The intricate landscape of the clinical guidelines surrounding gender dysphoria which, despite undergoing changes, has still been subject to much scrutinisation. These guidelines serve as the framework dictating the standards of care that transgender individuals must adhere to in order to access gender-affirming care. This dissertation aims to determine whether the clinical guidelines afford a sufficient level of autonomy for transgender individuals. To achieve this objective, this dissertation will analyse the conflicting understandings of autonomy within medical discourse, aiming to establish a nuanced understanding of autonomy in the context of transgender healthcare. Subsequently, this dissertation will examine the advantages and challenges posed by the current clinical guidelines and their efficacy in upholding autonomy. Through this investigation, this dissertation will evaluate the potential for reform to better promote autonomy for transgender individuals. In the pursuit of promoting autonomy, this dissertation will advocate for the adoption of the relational theory of autonomy over alternative theories. Furthermore, it will be contended that the current clinical framework falls short of adequately promoting personal agency, particularly concerning the alignment with legal principles and the relational application of autonomy. By highlighting these discrepancies, this dissertation will emphasise the necessity of reforming the guidelines to better align with these principles. Ultimately, this dissertation aims to contribute to the advancement of transgender healthcare practices that truly empower individuals to make autonomous decisions concerning their care.

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Introduction

The provision of gender-affirming care represents a critical aspect of healthcare delivery for transgender individuals, whose gender identity diverges from the one assigned to them at birth.[1] However, the landscape of clinical guidelines governing this care has been subject to significant legal scrutiny concerning its affordability to personal agency. Autonomy is a fundamental principle that is enshrined in the legal framework of the United Kingdom (UK) through *Article 8 of the Human Rights Act [1998].*[2] This grants and safeguards individuals' inherent right to make decisions regarding their own lives free of undue interference from institutional structures. Despite this legal foundation supporting the promotion of autonomy, the clinical guidelines pertaining to gender-affirming care for transgender individuals have faced substantial criticism for encroaching upon this fundamental principle. The prerequisites of a 'gender dysphoria' (GD) diagnosis and capacity assessments as a gateway to accessing gender-affirming care seem to reflect a paternalistic approach within the clinical guidelines. While these prerequisites are established to safeguard transgender individuals, they can serve as gatekeepers to such services. This standardisation and pathologisation of GD can contribute to the undermining of individual autonomy. This dissertation will employ a doctrinal methodology to interrogate the tension between safeguarding individuals and promoting autonomy in the realm of gender-affirming care for adults with sufficient mental capacity. By unpacking the complexities inherent in the clinical guidelines, this dissertation aims to assert that the existing guidelines exhibit excessive paternalism, consequently limiting the autonomy of transgender individuals. It contends that despite the purported flexibility of these guidelines, their practical application fails to acknowledge human diversity, thereby exacerbating their impact on individual autonomy.

[1] Government Equality Office, 'Trans people in the UK' (UK Government, 2018) <https://asserts.publishing.service.gov.uk/media/5b3a478240f0b64603fc181b/GEO-LGBT-factsheet.pdf> accessed 14 March 2024.
[2] Article 8 Human Rights Act [1998].

To address this research question, this dissertation will undertake a comprehensive analysis of academic literature pertaining to autonomy and its application in the context of transgender healthcare. Chapter one will delve into an in-depth examination of contrasting autonomy theories, aiming to illuminate the perspective they offer and the implications they hold for transgender individuals seeking gender-affirming care. Chapter two will focus on the practical realm by evaluating the current clinical guidelines governing gender-affirming care. It will assess the extent to which these guidelines sufficiently uphold autonomy for transgender individuals and their access to care. Finally, in Chapter three, having identified the advantages and shortcomings in the current clinical guidelines, this dissertation will explore potential reforms aimed at enhancing autonomy for transgender individuals.

Conflicting Theoretical Understandings of Autonomy

Introduction

To successfully evaluate the research question, it is essential to explore the conflicting theoretical understandings of autonomy and examine the benefits and obstacles they present in the context of one's personal decision-making. Autonomy is a fundamental concept that is deeply entrenched in UK law, underscoring the principles of freedom of choice, independence and the capacity to self-govern.[3] Dworkin suggests that autonomy and independence intersect with one another, enabling individuals to make decisions for themselves.[4] However, the complex dimensions of autonomy leads to conflicts regarding its perceived application in healthcare settings. Examining various theories of autonomy allows for a more nuanced understanding of self-determination and its application within the clinical framework of GD. This chapter will critically evaluate the strengths and weaknesses of the paternalism, liberalism and relational theory of autonomy and the level of personal agency they afford to individuals.

The Paternalism Theory

The paternalism theory of autonomy empowers authorities to make decisions on behalf of individuals in their best interest, even if it requires overriding their individual autonomy.[5] Despite potentially limiting personal agency and decision-making, its objective is to safeguard individuals from potential harm and ensure their wellbeing is protected.[6] While paternalistic decisions may enhance welfare and provide protection, criticism arises from its infringement on individuals' self-determination.

[3] Anderson, 'Regimes of Autonomy' [2014] 17(3) Ethical Theory and Moral Practice, 266-68.
[4] Dworkin, 'The theory and practice of autonomy' [1988] Cambridge University Press.
[5] Conly, 'Against autonomy: Justifying coercive paternalism' (Cambridge University Press 2012) 16-73.
[6] Trout, 'Paternalism and Cognitive Biases' [2005] 24(4) Law and Philosophy, 292-434.

Conly contends that interference for the benefit of individuals is acceptable when it serves the interest of fostering a better quality of life.[7] This perspective suggests a moral obligation to intervene on behalf of the patients, particularly when it aims to protect their well-being in situations where they may be vulnerable to adverse mental health issues. Similarly, Kleinig articulates *"X acts to diminish Y's freedom, to the end that Y's good may be secured."*, thus aligning with the paternalistic approach to autonomy.[8] This viewpoint emphasises the importance of paternalism in acting on behalf of the individual to promote their wellbeing. Fates-Moghadam and Guzman reinforce that paternalism's adamance on authoritative intervention for the prevention of harm can enhance autonomy.[9] This contention is convincing as it highlights the necessity of state intervention to safeguard individuals rather than restrict them. This interpretation suggests that paternalism can be seen as a mechanism for promoting autonomy rather than curtailing it. This emphasises the genuine concern for autonomy inherent in paternalistic interventions which are designed to simultaneously prevent harm and promote individual well-being. However, according to Marneffe, authoritative intervention inherently restricts individual decision-making.[10] This is a persuasive argument, as it fails to respect self-determination and one's ability to be in control of their healthcare as dictated by Anderson, thereby acting as a hindrance to autonomy.[11] Trout's contention supports this, arguing state interference is fundamentally inconsistent with the principle of autonomy, because of such impediments.[12] Paternalism's failure to allow individuals to truly be in control of their healthcare limits the respect of individual autonomy. Because of such, this raises concerns about the inconduciveness of the theory to sufficiently promote autonomy.[13]

Husak's assertion that HP assistance can enhance individual autonomy illuminates the benefit of the paternalistic framework.[14] This suggests that paternalism recognises and

[7] Ibid.
[8] Kleinig, *'Paternalism'* (Manchester University Press 1983),18.
[9] Fates-Moghadam and Guzman, 'Governing [through] Autonomy. The Moral and Legal Limits of Soft Paternalism"' [2014] 17(3) Ethical Theory and Moral Practice 383-397.
[10] Marneffe, 'Avoiding Paternalism' [2006] 34(1) Philosophy and Public Affairs, 68-94.
[11] Anderson, 'Regimes of Autonomy' [2014]
[12] Trout, 'Paternalism and Cognitive Biases' [2005].
[13] Mill, 'On Liberty' (4th edn, London: Longman, Robert's, & Green Co. 1869).
[14] Husak, 'Paternalism and Autonomy' [1981] 10(1) Philosophy and Public Affairs, 27-46.

prioritises the welfare of individuals and informed decision-making to exercise their autonomy effectively. Marneffe supports this notion, emphasising the promotion of welfare interests alongside the respect for rights, which solidifies the ethical foundation of paternalistic interventions.[15] Given the complexity of medical decision-making, this approach is acceptable because of the expertise HPs possess. Scoccia substantiates this claim by asserting the role of HPs as crucial in navigating the intricacies of healthcare choices, thus highlighting the benefit of HP interventions and their ability to promote autonomy with such support.[16] Komrad's strengthens this perspective by highlighting the duty of care HPs owe their patients.[17] This emphasises the ethical imperative of paternalistic interventions as a means of balancing the need to protect individuals from self harm with the recognition of their autonomy in decision-making. HP interventions provide individuals with the necessary support, ultimately promoting their personal agency. Nevertheless, Sherwin highlights a fundamental flaw in the theory with its neglect of the influence of social factors.[18] By operating under generalised assumptions of what is best for individuals, paternalism overlooks the unique preferences and values of individuals. Warren supports this notion, asserting that paternalism relies on ordinary experiences and lacks consideration for the complex personal issues that individuals face.[19] This emphasis on a one-size-fits-all approach fails to account for the intricacies of human diversity and can perpetuate systemic inequalities within society because of the failure in adequately addressing the diverse needs of individuals. This disregard undermines the principles of self-determination as it leaves individuals open to coercion to conform to decisions based on external norms and values that do not align with their personal beliefs or preferences. Meyer's argument that paternalism neglects the self underscores the theory's failure to recognise and respect individuals as diverse autonomous agents.[20] By prioritising paternalistic decision-making, this theory disregards the diversity of individuals,

[15] Marneffe, 'Avoiding Paternalism' [2006].
[16] Scoccia, 'Paternalism and Respect for Autonomy' [1990] 100(2) Ethics, 318-334.
[17] Komrad, 'A Defence of Medical Paternalism: Maximising Patients' Autonomy' [1983] 9(1) Journal of Medical Ethics, 38-44.
[18] Sherwin, 'Feminist and Medical Ethics: Two Different Approaches to Contextual Ethics' [1989] 4(2) Hypatia, 57-72.
[19] Warren, 'Feminist Directions in Medical Ethics' [1989] 4(2) Hypatia, 73-87.
[20] Meyer, 'Personal autonomy and the paradox of feminine socialization' [1987] 84(11) The Journal of Philosophy, 619-628.

undermining the ability of individuals to exercise true autonomy and self-determination over their own lives.

Having encapsulated the discussion regarding the paternalism theory of autonomy, this chapter will now explore the liberal theory of autonomy which aims to promote the independence of individuals.

The Liberalism Theory

The fundamental aspect of the liberal theory is deeply rooted in the belief that individuals are best suited to navigate the complexities of their health and possess full authority over the exercise of their autonomy.[21] It intends to safeguard this basic liberty and grant individuals' control, rather than allowing state authorities to exert influence over their autonomy. Nevertheless, there is contention regarding the liberal theory's ability to shield individuals from potential harm due to its insistence on minimal state involvement.[22]

Christman highlights the value of individualism within the liberal framework emphasising the need for a shift toward a more patient-centred approach.[23] This advocation for the protection of autonomy for individuals prioritises personal agency and self-determination.[24] Levey argues for the fundamental respect of the basic liberty and freedom of choice.[25] This envisionment of individuals as capable agents who act in accordance with their own values and beliefs recognises their inherent capacity to exercise self-determination rather than being dictates solely by external influences. Weberman supports this notion, asserting that the liberal theory promotes a society where individuals can pursue their welfare as they

[21] Mason, 'Autonomy, Liberalism and State Neutrality' [1990] 40(161) The Philosophical Quarterly (1950-) 433-452.
[22] Coggon and Miola, 'Autonomy, Liberty, and Medical Decision-Making', [2011] 70(3), The Cambridge Law Journal 523-547.
[23] Christman 'Liberalism, Autonomy, and Self-Transformation' [2001] 27(2) Social Theory and Practice 185-206.
[24] Ibid.
[25] Levey, 'Liberal Autonomy As a Pluralistic Value' [2012] 95(1) The Monist 103-126.

see fit, thus promoting autonomy as a fundamental human right.[26] This theory challenges the paternalistic approach by critiquing its tendency to restrict individual autonomy in favour of authoritative control. By advocating for a more empowering approach to autonomous decision-making, liberalism seeks to alleviate impediments to individual autonomy. The emphasis on personal agency within the liberal framework highlights the importance of recognising and respecting freedom from control, thereby sufficiently promoting individual autonomy.

Elsner and Rampton's critique of the liberal approach to autonomy highlights a fundamental concern regarding its emphasis on individualism and detachment from personal relationships.[27] They argue that its focus overlooks the intricacy between individuals and their social environments, thereby leading to a constricted understanding of autonomy.[28] By neglecting social factors, the liberal perspective fails to recognise the significant impact external influences and relationships have on shaping individuals' decision-making. Weberman supports this sentiment, emphasising that true independence is an illusion as no individual exists in isolation from external forces.[29] The contention challenges the notion of autonomous decision-making under the liberal theory, revealing that external influences invariably shape preferences, values and decisions.[30] This perspective underscores the complexity of autonomy, suggesting it cannot be fully understood without considering the social dimensions that shape individuals' decision-making processes. The liberal theory's conceptualisation of autonomy solely within the framework of individual choice disregards how societal structures and cultural norms shape personal agency. Its failure to capture the nuanced realities of autonomy and how individuals navigate their social contexts underscores its limitations, thereby hindering its ability to sufficiently foster personal agency.

[26] Weberman, 'Liberal Democracy, Autonomy, and Ideology Critique' [1997] 23(2) Social Theory and Practice 205-233.
[27] Elsner and Rampton, 'Accompanied Only by My Thoughts: A Kantian Perspective on Autonomy at the End of Life'[2022] 47(6) The Journal of Medicine and Philosophy 688-700.
[28] Ibid.
[29] Weberman, 'Liberal Democracy, Autonomy, and Ideology Critique' [1997].
[30] Levey, 'Liberal Autonomy As a Pluralistic Value' [2012].

Additionally, Christman maintains that this principle of state neutrality is essential for autonomous decision-making according to individuals' preferences and values.[31] This fostering of autonomy without undue interference allows individuals to exercise their personal agency as there are no unnecessary constraints or coercion from external sources. Levey strengthens this argument by asserting authoritative interference is restricting on autonomy. [32] The notion supports Christman's claim, exacerbating that limited state interference promotes autonomy further.[33] Such freedom from undue interference allows individuals to shape their lives according to their own aspirations and principles rather than being dictated by societal norms.[34] This liberal approach to autonomy upholds individuals' freedom of choice and respects self-determination. By prioritising such, it contributes to the development of a diverse society, where individuals can sufficiently exercise their autonomy in alignment with their preferences and values.

Nevertheless, the advocacy for state neutrality raises concerns about the potential lack of support and inadequate social safety net for individuals. Mason asserts that state intervention becomes necessary to prevent serious harm to individuals, positioning it as a means of respecting autonomy while simultaneously safeguarding individuals from potential adverse mental health issues.[35] While still upholding the promotion of self-determination, this perspective highlights the potential harm that unrestricted independence might pose to individuals. This exclusive focus on independence fails to acknowledge the intersection between autonomy and what may actually benefit individuals, recognising that safeguarding is an important aspect of autonomy.[36] Coggon argues that personal agency should not be an absolute or unrestricted concept, advocating for certain limitations on the exercise of independence.[37] This perspective introduces the notion that autonomy, though vital and deserving of respect, should not disregard the potential consequences of one's choices. Coggon and Miola support this

[31] Christman 'Liberalism, Autonomy, and Self-Transformation' [2001].
[32] Levey, 'Liberal Autonomy As a Pluralistic Value' [2012].
[33] Christman 'Liberalism, Autonomy, and Self-Transformation' [2001].
[34] Mason, 'Autonomy, Liberalism and State Neutrality' [1990].
[35] Ibid.
[36] Weberman, 'Liberal Democracy, Autonomy, and Ideology Critique' [1997].
[37] Coggon, 'Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism? [2007] 15(3), Health Care Analysis 235-255.

statement, arguing that the absence of state influence can be just as damaging to autonomy as these individuals may make decisions that are not objectively in their best interests and lead to negative impacts on their mental and physical well-being.[38] The liberal approach's inclination towards limited state involvement may be perceived as potentially problematic as it fails to provide sufficient support and protection. The call for state intervention reflects a recognition that autonomy should not be pursued at the expense of leaving individuals exposed to harm, emphasising the need to help promote autonomy in this way.[39] Such criticism highlights the complexity of balancing independence with considerations of protection from harm. This challenges the liberal approach's notion of autonomy as an absolute principle and emphasises the importance of evaluating the consequences of unrestrained individual autonomy.

This chapter has successfully discussed the implications associated with the liberal theory of autonomy. It will continue to assess the relational approach theory. Positioned as an intermediary stance between paternalism and liberalism, the inquiry will now turn to whether this serves as a preferable alternative in fostering autonomy.

The Relational Approach Theory

The relational approach theory acknowledges that while individuals should have the freedom to make their own choices, they are inevitably influenced by social relationships.[40] While it underscores the importance of supportive environments that allow individuals to navigate their autonomy, there are potential paternalistic implications that can undermine this theory.

The relational approach theory recognises the dual nature of autonomy, aiming to strike a balance between independence and interdependence. Laceulle emphasises the

[38] Coggon and Miola, 'Autonomy, Liberty, and Medical Decision-Making', [2011].
[39] Mason, 'Autonomy, Liberalism and State Neutrality' [1990].
[40] Ells, Hunt, and Chambers-Evans, 'Relational autonomy as an essential component of patient-centered care' [2011] 4(2), International Journal of Feminist Approaches to Bioethics 79-101.

importance of recognising the diversity of individuals in their needs and circumstances.[41] By recognising and addressing these differences, HPs can offer more tailored and supportive care that respects the individual patient's autonomy. Delgado's assertion that autonomy and vulnerability are not mutually exclusive, challenges the notion that autonomy is only attainable for those who are entirely self-sufficient and unaffected by external influences.[42] This is persuasive as the acknowledgement of vulnerability as an inherent human condition highlights the importance of providing support and understanding to individuals as they navigate their autonomy within the context of their social environments. Furthermore, Christman's justification for considering broader factors that impact decision-making reinforces the relational approach's emphasis on understanding autonomy within the context of social influences rather than a solely individualistic pursuit.[43] By acknowledging the role of external factors in shaping individuals' choices, the relational approach promotes a more contextualised understanding of autonomy through its validation of the inherent interconnection with social contexts. The relational approach theory's endorsement of the dual nature of autonomy does promote individual agency and patient-centred care because of such. By emphasising this diversity, the relational approach theory facilitates a more inclusive environment that promotes individual autonomy.

On the other hand, Dove raises concerns that the overemphasis on interdependence can potentially detract from the significance of individuality.[44] The potential neglect of the importance of individual agency and personal values can undermine the adequacy of the relational theory in facilitating autonomy.[45] The emphasis on interconnectedness suggests that autonomy is not solely determined by individual choices but open to external

[41] Laceulle, 'Aging and Self-Realization: Cultural Narratives about Later Life (Transcript Verlag, 2018) 159-188.
[42] Delgado, 'Re-thinking relational autonomy: Challenging the triumph of autonomy through vulnerability' [2019] 5(1) Bioethics Update 50-65.
[43] Christman, 'Relational Autonomy and the Social Dynamics of Paternalism' [2014] 17(3) Ethical Theory and Moral Practice 369-382.
[44] Dove et al, 'Beyond individualism: Is there a place for relational autonomy in clinical practice and research? [2017] 12(3) Clinical Ethics, 150-165.
[45] Delgado, 'Re-thinking relational autonomy: Challenging the triumph of autonomy through vulnerability' [2019].

influences. Molyneux argues that this overemphasis can diminish the significance of individual preferences and values, thus potentially restraining the adequate promotion of autonomy.[46] Despite this, Lacuelle argues that interdependence is an inherent and inescapable reality of human condition.[47] Recognising interconnectedness and the web of social relationships intertwining with individual autonomy contributes to the understanding of unique individual circumstances and needs. Consequently, the relational theory does successfully balance individuality with interdependence with its focus on the patient as the primary decision-maker.[48] This perspective undermines the argument presented by Dove by affirming that relational theory does not neglect individual agency but that it exists within the context of social relationships.[49]

Furthermore, according to Ells, prioritising the individual patient within the relational approach allows for a more intricate and tailored strategy, affording greater respect to personal agency.[50] The emphasis on the individual patient acknowledges the complexity and diversity of human experiences as opposed to treating patients as conforming to generalised social norms. Christman underscores the importance of allowing individuals to guide their lives according to their own perspectives.[51] In this light, the relational theory empowers patients to actively participate in decision-making processes rather than being subjected to standardised protocols. Such analysis suggests that the relational approach prioritises a more participatory and patient-centred model of care.[52] By engaging patients as sufficiently responsible agents in the decision-making process, this approach aims to better serve their individual needs and preferences.[53] The lack of a standardised approach

[46] Molyneux, 'Should Healthcare Professionals Respect Autonomy Just Because It Promotes Welfare? {2009] 35(4) Journal of Medical Ethics, 245-250.
[47] Laceulle, 'Aging and Self-Realization: Cultural Narratives about Later Life (Transcript Verlag, 2018).
[48] Ells, Hunt, and Chambers-Evans, 'Relational autonomy as an essential component of patient-centered care' [2011].
[49] Dove et al, 'Beyond individualism: Is there a place for relational autonomy in clinical practice and research? [2017].
[50] Ells, Hunt, and Chambers-Evans, 'Relational autonomy as an essential component of patient-centered care' [2011].
[51] Christman, 'Relational Autonomy and the Social Dynamics of Paternalism' [2014].
[52] Jennings, 'Reconceptualizing Autonomy: A Relational Turn in Bioethics' [2016] 46(3) The Hastings Center Report, 11-16.
[53] Ells, Hunt, and Chambers-Evans, 'Relational autonomy as an essential component of patient-centered care' [2011].

is more beneficial in the promotion of autonomy as it ensures that healthcare is more effective and relevant to the individual's situation, thus valuing the concept of individuality. Delgado argues that the relational theory of autonomy is better as it recognises the diversity of human experience.[54] By valuing individuality and promoting personal agency, the relational approach challenges the one-size-fits-all paradigm that is often associated with paternalism. This shift towards a more personalised and flexible model of care allows patients to take an active role in their own care giving them a sense of ownership and control over their healthcare decisions.

The recognition of individuals as influenced by their social relationships within the relational theory acknowledges the inherent influences HPs have on autonomous decision-making.[55] Gerritse assert the role of HPs as facilitators and collaborators in a patient's journey towards decision-making rather than assuming a position of authority over their decisions.[56] This perspective aligns with the relational theory's emphasis on the importance of supportive relationships in fostering autonomy. The relational theory challenges the paternalistic hierarchal approach that places the onus of decision-making on authorities. Instead, it emphasises the significance of HPs in supporting and empowering patients to make decisions that align with their values and preferences.[57] This is a compelling argument as it advocates for shared decision-making, emphasising collaboration and engaging in open dialogue with patients, rather than imposing decisions upon them. Moreover, the relational theory recognises individuals as inherently situated within a complex web of social relationships.[58] This holistic perspective acknowledges the social dimensions of autonomy, emphasising the importance of considering the patient's broader social context in decision-making processes. The recognition of HPs within this framework as crucial in facilitating informed decision-making highlights the importance of

[54] Delgado, 'Re-thinking relational autonomy: Challenging the triumph of autonomy through vulnerability' [2019].
[55] Christman, 'Relational Autonomy and the Social Dynamics of Paternalism' [2014].
[56] Gerritse, 'Decision-making approaches in transgender healthcare: conceptual analysis and ethical implications' [2021] 24(4) Medicine, Healthcare and Philosophy 687-699.
[57] Anderson, 'Regimes of Autonomy' [2014] 17(3) Ethical Theory and Moral Practice, 355-368.
[58] Ells, Hunt, and Chambers-Evans, 'Relational autonomy as an essential component of patient-centered care' [2011].

providing patients with the necessary information and support for decision-making.[59] This deliberative approach to autonomy strikes a balance between protective elements, like ensuring patient well-being and preventing harm, with promoting personal agency. This relationship between HPs and patients shifts away from a hierarchal model found in the paternalism theory, towards one of collaboration. By recognising the influences of social relationships on autonomy, this approach ensures that healthcare provisions are more patient-centred and more robustly promote autonomy.

However, the recognition of social relationships introduces complexities that may lead to the manifestation of paternalistic tendencies. Christman highlights that the concept of autonomy being affected by social factors can complicate its opposition to the paternalism theory's restrictions.[60] Despite the opposition to such restrictions, these relationships can lead to subtle forms of paternalistic interference and undermine the collaborative relationship that is entrenched in this theory.[61] Jennings contends the absence of paternalistic interference is supplemented with social factors, such as the over-influence of HPs in an individual's decision-making process.[62] The potential for paternalistic implications can risk agents' autonomy and promote a sense of authoritative control over their own experiences.[63] Nevertheless, Delgado stresses that the importance of shared decision-making and open communication can help mitigate paternalistic tendencies.[64] The onus the relational theory has on collaboration and the patient as the primary decision-maker reduces the potential of authoritative control over individuals' decision-making. It acknowledges the importance of active participation and empowering individuals to take ownership of their healthcare choices, thus mitigating paternalistic tendencies and sufficiently promoting autonomy.

Conclusion

[59] Jennings, 'Reconceptualizing Autonomy: A Relational Turn in Bioethics' [2016].
[60] Christman, 'Relational Autonomy and the Social Dynamics of Paternalism' [2014].
[61] Ibid.
[62] Jennings, 'Reconceptualizing Autonomy: A Relational Turn in Bioethics' [2016]
[63] Lee, 'Relational approached to personal autonomy' [2023] 18(5) Philosophy Compass, 1-14.
[64] Delgado, 'Re-thinking relational autonomy: Challenging the triumph of autonomy through vulnerability' [2019].

To conclude, it is evident that the paternalistic application of autonomy fails to adequately support individuals. While it serves as a tool of protection, it proves overly restrictive due to the imposition of state authority in making choices for the individual. The examination of the liberal theory is beneficial in its allowance of autonomy afforded to individuals, but it is considered too accessible and allows too much freedom for individuals in a way that offers them no protection. The demand for state neutrality and the excessive allowance of independence means that there is no safeguarding from potential harm, thereby condemning the liberal theory as non-conducive in being applied in healthcare. The relational approach emerges as a more opportune application of autonomy as it recognises the need to balance the independence and interdependence of individuals. The acknowledgement of human diversity and collaborative decision-making provides a beneficial alternative to the paternalism and liberal theory of autonomy as it supports and facilitates decision-making rather than controlling it or leaving individuals with no support.

This chapter has concluded it is necessary to adopt a relational approach to autonomy within healthcare to be more accessible and less restrictive on personal agency. This dissertation will proceed to evaluate the clinical guideline framework surrounding GD and analyse its impact on autonomy.

The Advantages and Challenges of the Clinical Framework in Fostering Autonomy

Introduction

The implementation of clinical guidelines for GD presents numerous challenges, sparking debates focused on finding a balance between safeguarding transgender individuals and empowering them to exercise their autonomy. This chapter will delve into the legal standing of autonomy and the clinical framework pertaining to personal agency in the context of GD. This chapter aims to illuminate the complexities and considerations involved in this context. Through examination, this chapter will critically evaluate whether the current clinical framework effectively fosters autonomy for transgender individuals. By dissecting the advantages and challenges presented by the existing clinical guidelines, this chapter seeks to assess their implications on approaches to autonomy, whether they lean towards paternalistic, liberal, or relational perspectives. Through this exploration, this chapter aims to contribute to the ongoing dialogue on gender identity and the goal of affirming the autonomy and rights of individuals experiencing GD.

The Framework of Autonomy and Gender Dysphoria

Legislation regarding autonomy is pivotal in protecting the fundamental rights of individuals, fostering self-determination, and creating a framework for legal decision-making. The legal status of autonomy stems from Article 8 of the Human Rights Act (HRA), integrated into UK law.[65] This article guarantees the right to respect for private life, a principle that has been expansively interpreted to promote the concept of autonomy, especially in matters concerning medical treatment, a focal point within the purview of this discourse.[66] This right encompasses facets of personal autonomy, including the right to make choices about one's own life free from unwarranted interference. This is further cemented by the common law landmark case of *Montgomery v Lanarkshire Health Board [2015]* which emphasises the importance of a patient's right to exercise self-determination

[65] Article 8 Human Rights Act [1998].
[66] Ibid.

over their own bodies and their right to make informed decisions about one's medical care.[67] This creates a legal recognition of an individual's right to autonomy in medical treatment, but only for adult patients who have sufficient mental capacity.[68] This legal framework lays down the bedrock for respecting individual autonomy, ensuring decisions pertaining to medical interventions are made in alignment with the patient's preferences and values, thus upholding their inherent rights.

Within this chapter, it is imperative to highlight the existing clinical provision framework surrounding GD as it dictates the protocols through which individuals can access gender-affirming care and assert their autonomy. GD is defined as the "clinically significant distress or impairment related to gender incongruence, which may include desire to change primary and/or secondary sex characteristics."[69] This condition is established in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which is currently used in the UK. It is pertinent to note the evaluation of terminology from "gender identity disorder" in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders[70] to "gender dysphoria".[71] This shift reflects a conscious effort to depathologise gender nonconformity and pave the way for enhanced accessibility to gender-affirming care.

Furthermore, it is essential to note the specific standards of care that govern the process of gender-affirmation. The Standards of Care for the Health of Transgender and Gender Diverse People (SoC) have set standards that must be fulfilled for individuals to access surgery and hormone therapy, pivotal components of gender-affirming care.[72] In version 7

[67] Montgomery v Lanarkshire Health Board [2015] UKSC 11.
[68] Ibid.
[69] Turban, 'What is Gender Dysphoria?' (*American Psychiatry Association*, August 2022) <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria#:~:text=Gender%20dysphoria%3A%20A%20concept%20designated,and%2For%20secondary%20sex%20characteristics.> accessed 4 March 2024.
[70] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (4th edn, American Psychiatric Association 1994).
[71] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (5th edn, American Psychiatric Association 2013).
[72] Coleman et al, 'Standards of Care for the Health of Transgender and Gender Diverse People, Version 8' [2022] 23(1) International Journal of Transgender Health 1-258.

of the SoC, it was stipulated that a mental health professional was required to conduct an assessment and evaluation of an individual's psychological state and provide a diagnosis of GD.[73] However, Version 8 of the SoC marks a significant departure from this approach.[74] Under this updated version, any healthcare professional possessing competent knowledge in the field is authorised to conduct assessments and diagnose transgender individuals.[75] This represents a notable shift towards redefining clinical provisions surrounding GD, albeit a modest step towards depathologising the condition. Despite this progression, Version 8 of the SoC still mandates HPs to assess the individual's capacity to consent to treatment and understand the risks and benefits of such.[76] Although efforts have been made to mitigate stigma and enhance accessibility to gender-affirming care, the lingering perception of GD as a mental illness within the clinical framework does not release transgender individuals from challenges in accessing such care.

The implementation of the NHS's 'Gender Identity Services for Adults (Non-Surgical Interventions)' (GIS) exemplifies the application of the SoC guidelines within the UK healthcare system.[77] These guidelines state that "Gender dysphoria is not, in itself, a mental health condition.", reflecting a commitment to aligning with principles in the DSM-5 and working towards the depathologisation of GD.[78] Within this framework, medical practitioners and psychologists play pivotal roles in conducting assessments and interventions with patients. These are used to engage patients in discussions about their gender experiences and evaluate their suitability for a diagnosis of GD, a prerequisite for individuals to access gender-affirming care. The approach emphasises a personalised and flexible approach to care, ensuring that patients receive interventions tailored to their

[73] Coleman et al 'Standards of Care for the Health of Transgender and Gender Diverse People, Version 7' [2012] 13(4) International Journal of Transgenderism 165-232.
[74] Coleman et al, 'Standards of Care for the Health of Transgender and Gender Diverse People, Version 8' [2022].
[75] Ibid, 33.
[76] Ibid, 35.
[77] NHS, 'Gender Identity Services for Adults (Non-Surgical Interventions): The Services' (*NHS*, 3 July 2019) <https://www.england.nhs.uk/wp-content/uploads/2019/07/service-specification-gender-dysphoria-services-non-surgical-oct-2022.pdf> accessed 20 February 2024.
[78] Ibid, 2.

unique needs and circumstances. However, the service is described as a "process of obtaining informed consent" which poses certain challenges to the full exercise of patient autonomy.[79] This highlights the complexities inherent in balancing the principles of patient autonomy with the necessity of following protocols within the context of gender-affirming care.

Having laid the groundwork by elucidating the legal underpinnings of autonomy and delineating the clinical guidelines for GD, this dissertation will analyse these guidelines and their efficacy in adequately fostering autonomy for transgender individuals. Through this investigation of the guidelines and their impact on autonomy, this dissertation aims to identify the shortcomings of the framework.

The DSM-5

The evolution of the diagnostic classification reflects a commendable effort to depathologise GD and non-conforming gender identities. However, even with this shift, criticisms arise concerning its lingering risk of still inadvertently perpetuating the perception of inherent mental health problems, thereby inhibiting their autonomous decision-making.

The shift in terminology in the DSM-5 reflects a departure from pathologising transgender experiences towards a more inclusive and affirming approach. Davy contends that the shift in terminology places greater emphasis on the distress experienced by transgender individuals rather than categorising it as a mental disorder.[80] This suggests that by reframing GD in terms of distress, the DSM-5 acknowledges the lack of inherent mental health issues within GD and moves to focus on the psychological impact on their wellbeing.[81] Additionally, this redefinition moves to recognises GD as a natural variation of human experience, further dismantling the mental health connotations previously attached

[79] Ibid, 6.
[80] Davy, 'The DSM-5 and the Politics of Diagnosing Transpeople' [2015] 44(5) Archives of Sexual Behavior 1165-1176.
[81] Faheem et al 'Gender dysphoria in adults: Concepts, critique and controversies' [2022] 8(1) Journal of Current Research in Scientific Medicine 4-11.

to the condition. Removing such stigma allows HPs to better support transgender individuals as they move forward in recognising and affirming transgender identities. Faheem agrees with this contention as they suggest that this shift aims to depathologise GD and move towards affirming approach to the understanding of gender diversity.[82] Although residual mental health connotations persist, this redefinition's focus on distress is less onus on transgender individuals, thereby promoting the validation of transgender experiences more effectively.[83] The shift in terminology fosters a more relational approach to healthcare by empowering transgender individuals to recognise their inherent capacity to make decisions about their own bodies. By acknowledging the inherent variation, there is a clearer emphasis on personal agency which alleviates the constraints imposed by pathologising classifications.

Despite the reframing of GD as distress experienced by the individual, there is an argument that it still inadvertently perpetuates the idea that it is inherently problematic.[84] Ross advocates for the reduction of barriers impeding access to gender-affirming care, particularly in its association with mental health connotations in the DSM-5.[85] Such connotations perpetuate the idea that transgender individuals are innately not of sound mind and unable to have their own autonomy. Cooper reinforces this notion, expressing that the ongoing requirement for mental health assessments implies a lingering association with mental health disorders, thus challenging the DSM-5's aim of depathologising the experience of GD.[86] This raises concerns over the existing framework's efficacy in promoting autonomy and depathologising the mental health aspect of GD. The conjunction of mental health connotations and the mandate for capacity assessments arguably maintains a system where individuals experiencing GD are still beholden to HP, thus perpetuating a paternalistic approach to gatekeeping gender-

[82] Faheem et al 'Gender dysphoria in adults: Concepts, critique and controversies' [2022].
[83] Ashley, 'Gatekeeping hormone replacement therapy for transgender patients in dehumanising' [2019] 45(7), Journal of Medical Ethics 480-483.
[84]American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (5th edn).
[85] Ross et al 'Experiences barriers of care within European treatment seeking transgender individuals: A multicenter ENIGI follow-up study' [2023] 24(1) International Journal of Transgender Health 26-37.
[86]Cooper et al 'The phenomenology of gender dysphoria in adults: A systematic review and meta-synthesis' [2020] 80(1) Clinical Psychology Review 1-11.

affirming care.[87] Dietz and Pearce support this contention, arguing that the implementation of such diagnosis pathologises GD, reinforcing its perception as a mental health issue.[88] Such persisting pathologising connotations lead to the continued devaluation of individual's experiences with GD and diminishment of an individual's access to gender-affirming treatment by imposing unnecessary barriers. The continued inclusion and pathologisation of GD in the DSM-5 highlights the continued paternalistic nature of the clinical framework. The restrictions and stigmatisation it continues to produce heavily impact individuals' self-determination and consequently are misaligned with the legal principles of autonomy.

Having addressed the implications pertaining to the DSM-5 and their impact on the pathologisation of GD and ascertainability of autonomy, this chapter will proceed to examine the intricate issues surrounding the SoC and GIS.

The SoC and GIS

In the pursuit of further understanding the complex challenges surrounding GD, this chapter will delve into an exploration of pertinent issues placing a specific focus on healthcare provisions and their ramifications for individual autonomy. There will be an analysis of the SoC and GIS, including the impact of the clinical framework on the lived experiences of individuals navigating GD, the effects of HPs on individual decision-making processes, and the coherence of these guidelines with the legal principles of autonomy.

The existing framework, to some extent, fosters a patient-centred care approach by acknowledging the importance of understanding each patient's decision-making ability, thus emphasising its existing relational aspects. Rowland argues that these medical interventions are crucial for empowering individuals to affirm their gender identity, serving

[87] Faheem et al 'Gender dysphoria in adults: Concepts, critique and controversies' [2022].
[88] Dietz and Pearce, Depathologising Gender: Vulnerability in Trans Health Law. in Dietz and others (eds), A Jurisprudence of the Body (Palgrave Macmillan 2020).

as a necessary prerequisite for accessing gender-affirming care.[89] This is a compelling argument as the SoC allows HPs to customise interventions to meet the specific needs and preferences of the individual through these capacity assessments.[90] Dietz and Pearce justify this sentiment, suggesting that such experiences are individualised through this relationship, thus ensuring patients benefit from the expertise and support of HPs.[91] Gerritise agrees, highlighting how these assessments encourage consideration of each individual's unique circumstances.[92] This exhibits the flexibility of the SoC and consequently GIS protocols, thus demonstrating responsiveness to diverse individual needs. This acknowledgement of diversity highlights the relational aspects of the current framework, thereby indicating the current framework's ability to promote autonomy for transgender individuals that show some conformity with Article 8 HRA.

Regardless, the demand for capacity assessments and HP approval creates unjust barriers to exercising sufficient autonomy and accessing gender-affirming care. Ashley argues that the imposition of such mandates perpetrates an injustice for individuals as it brings their capacity into question.[93] By requiring individuals to 'pass' capacity assessments, it denies the authority of individuals over their own mental experiences and to make autonomous decisions, further pathologising GD. Tomson concurs that this violates justice and is considerably unethical.[94] This is persuasive as the demand of capacity assessments and authoritative control over gender-affirming care arguably contradicts Article 8 of the Human Rights Act, as it denies individuals' sufficient authority over their health, thereby infringing upon individuals' autonomy rights.[95] Gerritse views it as an unfair obstruction to self-determination, suggesting that the principle of non-

[89] Rowland, 'Integrity and rights to gender-affirming healthcare' [2022] 48(11) Journal of Medical Ethics 832-837.
[90] Coleman et al, 'Standards of Care for the Health of Transgender and Gender Diverse People, Version 8' [2022], 35.
[91] Dietz and Pearce, Depathologising Gender: Vulnerability in Trans Health Law.
[92] Gerritse, 'Decision-making approaches in transgender healthcare: conceptual analysis and ethical implications' [2021].
[93] Ashley, 'Gatekeeping hormone replacement therapy for transgender patients in dehumanising' [2019].
[94] Tomson, 'Gender-affirming care in the context of medical ethics – gatekeeping v informed consent' [2018] 11(1) South African Journal of Bioethics and Law 24-28.
[95] Article 8 Human Rights Act [1998].

maleficence is an inadequate reason for protection.[96] This is a rational argument as the SoC roots its warranting of assessments mitigate regret and detransition, but Wu and Keuroghlian argue that there is no evidence that mental health screening reduces any future regret for individuals experiencing GD.[97] This further underscores the current clinical framework's tendency to unnecessarily restrict access to gender-affirming care and reinforces the notion that its primary objective is to grant rather than promote autonomy.[98] The framework can be considered too paternalistic due to its gatekeeping of care through HP approval and assessments, which reinforces authoritative control over decision-making. Consequently, it proves inadequate for promoting autonomy among individuals seeking gender-affirming care and lacks sufficient alignment with Article 8 HRA.

Moreover, it is proposed that HPs have a facilitating role in the ascertainment of gender-affirming care and the autonomy attached to it. Coleman emphasises the role of HPs as guides, assisting individuals in navigating their journey and facilitating the attainment of their desired goals.[99] While Coleman's assertion does have a level of bias because of their contribution to the SoC, this acknowledgement does highlight theoretical commitment of HPs to reduce the hindering impact they have on autonomy This suggests that the clinical framework acknowledges the relational aspect of HP involvement in promoting autonomy and safeguarding individuals.[100] Furthermore, Conflitti expresses that HP interventions are essential in mitigating psychological stress and adverse mental health outcomes.[101] This corresponds with the protective element inherent in the paternalistic approach, shielding individuals from potential harm. The justification of such is rooted in the belief that transgender individuals should have access to healthcare while concurrently being

[96] Gerritse et al, 'I Should've Been Able to Decide for Myself, but I Didn't Want to Be Left Alone. A Qualitative Interview Study of Clients' Ethical Challenges and Norms Regarding Decision-Making in Gender-Affirming Medical Care', [2003] 1(1) Journal of Homosexuality 1-25.
[97] Wu and Keuroghlian 'Moving Beyond Psychiatric Gatekeeping for Gender-Affirming Surgery' [2022] 158(3) JAMA Surgery 231-232.
[98] Ashley, 'Gatekeeping hormone replacement therapy for transgender patients in dehumanising' [2019].
[99] Coleman et al, 'Standards of Care for the Health of Transgender and Gender Diverse People, Version 8' [2022].
[100] NHS, 'Gender Identity Services for Adults (Non-Surgical Interventions): The Services'.
[101] Conflitti et al, 'Update on bioethical, medical and fertility issues in gender incongruence during transition age' [2023] 46(9) Journal of Endocrinological Investigation 1725-1736.

shielded from any risks of regret or harm to their well-being.[102] The advantages of clinician assessments mean individuals are able to receive the expertise of HPs and determines what is best for them.[103] Gerritse argues that the collaborative role of HPs and the use of assessments allows patients to make informed decisions on what is best for them.[104] The protocols surrounding the role of HPs contribute to the protection of transgender individuals, demonstrating the advantages of integrating the protective measures of paternalism for those seeking gender-affirming care and promoting a degree of autonomy in accordance to Article 8 HRA.

Nevertheless, the SoC framework can be perceived as inherently subjective as authoritative institutions establish criteria for individuals' access to care, thus insufficiently facilitating autonomy.[105] Gerritse contends that determining eligibility for gender-affirming treatment is a subjective phenomenon, indicating that the current SoC falls short in adequately recognising the unique and diverse experiences of individuals.[106] This subjectivity introduces a layer of complexity as it pressures transgender individuals to 'conform' to the criteria imposed onto them, potentially overlooking their unique needs and expressions of gender identity, thus undermining Coleman's argument that HPs are there to assist individuals. This paternalistic approach undermines trans autonomy as individuals are required to meet criteria to access care.[107] Dietz and Pearce maintain this sentiment by highlighting the influential and imposing role of HPs in setting the standards of care for transgender individuals.[108] This illustrates the problems with the current protocol for HP involvement as it entrusts them with the power to dictate eligibility criteria and access to care. This introduces biases that may not fully account for the diverse spectrum of gender

[102] Gerritse et al, 'I Should've Been Able to Decide for Myself, but I Didn't Want to Be Left Alone. A Qualitative Interview Study of Clients' Ethical Challenges and Norms Regarding Decision-Making in Gender-Affirming Medical Care', [2003].
[103] Gerritse, 'Decision-making approaches in transgender healthcare: conceptual analysis and ethical implications' [2021].
[104] Ibid.
[105] Ross et al 'Experiences barriers of care within European treatment seeking transgender individuals: A multicenter ENIGI follow-up study' [2023].
[106] Gerritse, 'Decision-making approaches in transgender healthcare: conceptual analysis and ethical implications' [2021].
[107] NHS, 'Gender Identity Services for Adults (Non-Surgical Interventions): The Services', 6.
[108] Dietz and Pearce, Depathologising Gender: Vulnerability in Trans Health Law.

identities and care needs, thereby reinforcing the framework's paternalistic nature and the limited conformity with Article 8 HRA in respecting individuals' autonomy.[109] The role of HPs in determining eligibility could impede patient agency by limiting individuals' ability to make autonomous decisions, further consolidating HP's authority over treatment for transgender individuals, which does not align sufficiently with the relational approach and the legal principles of autonomy.

Moreover, the imposition of the current clinical framework appears disproportionately restrictive compared to other forms of medical care. Ashley contends that gender-affirming care does not inherently pose more risk than various other medical treatments where no psychological assessments are mandated.[110] This observation implies that individuals experiencing GD unnecessarily face heightened restrictions on their ability to exercise their autonomy compared to individuals seeking other medical treatment. The requirement of psychological assessments becomes a distinctive barrier, thus raising questions about the equitable exercise of autonomy in healthcare. Rowland emphasises the oppressive nature of the current clinical framework by asserting that individuals should inherently possess existing rights to autonomy without having to qualify through assessments.[111] This is a compelling point, as this chapter has previously established the inadequacy of capacity assessments in promoting autonomy. While Gerritse argues the SoC is vital to provide safe and effective pathways to achieve lasting personal comfort, this chapter has already construed the argument against such as they are unwarranted barriers to accessing care, thereby diminishing the autonomy of transgender individuals.[112] Wu and Keuroghlian highlight the disparities in treatments, as cisgender adults can access cosmetic treatment with simple informed consent and judgement from the surgeon, while transgender individuals are subjected to specific criteria like an additional requirement of an assessment letter for gender-affirming care.[113] These disparities highlight the unequal treatment that transgender adults face in their ability to access gender-affirming care at the

[109] Ibid.
[110] Ashley, 'Gatekeeping hormone replacement therapy for transgender patients in dehumanising' [2019].
[111] Rowland, 'Integrity and rights to gender-affirming healthcare' [2022].
[112] Gerritse, 'Decision-making approaches in transgender healthcare: conceptual analysis and ethical implications' [2021].
[113] Wu and Keuroghlian 'Moving Beyond Psychiatric Gatekeeping for Gender-Affirming Surgery' [2022].

expense of the challenges within the paternalistic aspects of the existing clinical framework. This highlights the need for a more equitable clinical framework that ensures consistent and unbiased access to autonomy in healthcare that aligns more closely with Article 8 HRA.

Regardless, Gerritise[114] argues that the clinical framework does possess sufficient alignment with the legal principles set by *Montgomery [2015]*.[115] As previously highlighted by this chapter, *Montgomery [2015]* recognises the significance of a patient's right to exercise self-determination and the right to make informed decisions about one's medical care.[116] Gerritse argues that the clinical guidelines facilitate informed decision-making by equipping patients with the necessary information to make choices regarding their care.[117] This is reinforced by the SOC, which promote informed decision-making by ensuring patients comprehend the risks and benefits associated with gender-affirming care.[118] Rowland's argument of HPs as guides justifies clinical guidelines as tools that foster informed decision-making and consequently promote autonomy within a relational framework as it still leaves the patients as the primary decision-maker, thus upholding aspects of *Montgomery [2015]*.[119][120] Tomson supports this by emphasising the utilisation of clinical guidelines for patient education.[121] This suggests that the clinical guidelines do promote informed decision-making and self-determination as set out by *Montgomery [2015].*[122] This alignment is significant as it exhibits the clinical guidelines' acknowledgment of transgender autonomy and ability to make informed decisions. The convergence between the clinical framework and *Montgomery [2015]* acknowledges that they have

[114] Gerritse, 'Decision-making approaches in transgender healthcare: conceptual analysis and ethical implications' [2021].
[115] Montgomery v Lanarkshire Health Board [2015].
[116] Ibid.
[117] Gerritse, 'Decision-making approaches in transgender healthcare: conceptual analysis and ethical implications' [2021].
[118] Coleman et al, 'Standards of Care for the Health of Transgender and Gender Diverse People, Version 8' [2022], 6.
[119] Montgomery v Lanarkshire Health Board [2015].
[120] Rowland, 'Integrity and rights to gender-affirming healthcare' [2022].
[121] Tomson, 'Gender-affirming care in the context of medical ethics – gatekeeping v informed consent' [2018].
[122] Montgomery v Lanarkshire Health Board [2015].

adopted relational aspects of autonomy and that they do foster a degree of sufficient autonomy for transgender individuals.

However, Ashley contests this assertion, emphasising the gatekeeping function of the clinical guidelines in determining access to gender-affirming care does not adequately correspond with *Montgomery [2015]*.[123][124] Dietz and Pearce reinforce this notion, arguing that the prerequisite of compatibility with the guideline standards restricts self-determination, thereby limiting the autonomy for transgender individuals.[125] The contradiction of SoC requirements[126], which mandate patient approval prior to care assess[127]; and the principle of self-determination, as advocated by *Montgomery [2015],* highlight the incongruity of the clinical guidelines.[128] By prioritising patient self-determination without unnecessary obstacles or paternalistic oversight, *Montgomery [2015]* underscores the guidelines' divergences from its spirit.[129][130] The guidelines' failure to sufficiently align with legal principles highlights their inadequacy in upholding patient rights. The discrepancies between them emphasise the negative impact on transgender individuals seeking gender-affirming care and the insufficient regard for autonomy, despite its theoretical stance.

Conclusion

In conclusion, this chapter has undertaken a thorough exploration of the positive aspects and challenges the clinical guidelines present in fostering autonomy. The existing framework holds relational implications for fostering a patient-centred approach and de-stigmatising GD. The shift in terminology in the DSM-5 has played a crucial role in

[123] Ashley, 'Gatekeeping hormone replacement therapy for transgender patients in dehumanising' [2019].
[124] Montgomery v Lanarkshire Health Board [2015].
[125] Dietz and Pearce, Depathologising Gender: Vulnerability in Trans Health Law.
[126] Coleman et al, 'Standards of Care for the Health of Transgender and Gender Diverse People, Version 8' [2022], 35-36.
[127] NHS, 'Gender Identity Services for Adults (Non-Surgical Interventions): The Services', 6.
[128] Montgomery v Lanarkshire Health Board [2015].
[129] Gerritse, 'Decision-making approaches in transgender healthcare: conceptual analysis and ethical implications' [2021].
[130] Montgomery v Lanarkshire Health Board [2015].

fostering social inclusivity and assisted in the dismantling of barriers to accessing gender-affirming care.[131] This reframing has validated the experiences of individuals by mitigating self-harm and empowering decision-making more than previously. However, this chapter has concluded that the existing clinical framework is excessively paternalistic, creating barriers to accessing gender-affirming care and the exercise of autonomy that lacks sufficient alignment with Article 8 HRA and *Montgomery [2015]*. This chapter has concluded that these unjust prerequisites outweigh the benefits of the clinical guidelines in promoting autonomy. This chapter has illuminated the need for a more equitable clinical framework that reduces barriers to care to provide sufficient autonomy for transgender individuals.

[131]American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (5th edn)

Fostering Autonomy: Rethinking the Clinical Framework for Gender Dysphoria in the UK

Introduction

In Chapter 2, it was established that there were identifiable drawbacks in the current clinical framework that curtail autonomy and perpetuate unnecessary barriers to accessing gender-affirming care that still render it paternalistic. This chapter seeks to assess how the clinical framework in the UK can be reformed to better align with the legal principles of autonomy. There is a large advocation for a stronger alignment with the Informed Consent Model (ICM), where a patient has assumed capacity and HPs act as facilitators of the consent process. Key changes to the existing framework under consideration include revisions to both the SoC and DSM-5 to further depathologise transgender experiences and promote autonomous decision-making. Furthermore, this chapter explores the adoption of international approaches, particularly in countries like Argentina and Malta. Such insights from these global examples can inform potential reforms in the UK to prioritise self-determination and improve access to care. By advocating for such reforms, this chapter aims to foster a more accessible framework for transgender individuals in the UK that better promotes autonomy.

The Informed Consent Model

The ICM focuses on obtaining explicit consent of the individual for medical interventions, following the provision of relevant information about their condition and treatment options. In this model, HPs act as facilitators of medical processes and individuals need not meet prerequisites in order to obtain the right to make decisions concerning their healthcare.[132] The criteria of informed consent include: the individual's ability to communicate a choice,

[132] Wu and Keuroghlian 'Moving Beyond Psychiatric Gatekeeping for Gender-Affirming Surgery' [2022].

understanding of the medical care being offered, appreciation of the consequences and the recognition that the patient is displaying rational consistent thinking.[133]

The ICM is less onerous in promoting autonomy for transgender individuals, as Gerritse articulates, by highlighting the importance of self-declaration while reducing the involvement of HPs in evaluating an individual's eligibility and capacity to make decisions.[134] This departure from the current framework, where individuals rely on HP approval and face restricted access to care compared to the general population would signify a pivotal change.[135] It would grant patients greater control over their decision-making processes and facilitate enhanced access to gender-affirming care, thereby aligning more closely with the legal principles of autonomy.[136] This transition to the ICM aligns with a relational and patient-centred approach as it encourages open dialogue between patients and HPs and ensures comprehensive information is provided that allows individuals to make decisions that align with their preferences and values. Tomson advocates for the transition, asserting that it upholds the ethical principle of integrity by empowering patients to more actively participate in healthcare decisions.[137] This stands in contrast to standardisation seen in the current framework which does not sufficiently account for the diverse experiences of transgender individuals. Given that the ICM is applied across a broad spectrum of healthcare procedures, like surgeries, its efficient adoption can effectively safeguard patient autonomy and ensure that individuals experiencing GD receive equitable treatment comparable to cisgender patients.[138] This parity with the general population can contribute to the destigmatisation of GD, while simultaneously affirming transgender individuals' self-determination and capacity to make

[133] Lipshie-Willians, 'The peculiar case of the standards of care: Ethical ramifications of deviating from informed consent in transgender-specific healthcare' [2020] 24(4) Journal of Gay and Lesbian Mental Health 392-405.
[134] Gerritse et al, 'I Should've Been Able to Decide for Myself, but I Didn't Want to Be Left Alone. A Qualitative Interview Study of Clients' Ethical Challenges and Norms Regarding Decision-Making in Gender-Affirming Medical Care', [2003].
[135] Weissler et al, 'Gender-Affirming Surgery in Persons with Gender Dysphoria' (2018) 141(3) Plastic and Reconstructive Surgery 388-393.
[136] Article 8 of the Human Rights Act [1998].
[137] Tomson, 'Gender-affirming care in the context of medical ethics- gatekeeping v informed consent' [2018].
[138] Wu and Keuroghlian 'Moving Beyond Psychiatric Gatekeeping for Gender-Affirming Surgery' [2022].

autonomous decisions regarding their healthcare.[139] Ultimately, the more robust adoption of the ICM represents a crucial step towards sufficiently promoting autonomy and reducing barriers to access gender-affirming care.

Furthermore, the adoption of the ICM would bring forth another significant benefit in its presumption of capacity. Under this model, individuals are presumed to have the capacity to make informed decisions unless a concern regarding their capacity arises during the collaborative process with the HP.[140] This presumption of capacity would represent a significantly positive shift from the existing clinical framework which requires psychological assessments. The removal of such requirements and the increased alignment of the clinical framework with the ICM not only reflects a more relational application of autonomy but also heavily contributes to destigmatising GD. Lipshie-Williams justifies this sentiment, expressing that shifting towards presumed capacity under the ICM removes the inherent contradiction to traditional practices and values patient experiences of GD in healthcare settings.[141] Moreover, it would dismantle the gatekeeping dynamic that often exists between individuals and gender-affirming care, empowering individuals to have agency over their own decisions.[142] This relational adoption to autonomy, while still safeguarding individuals, when necessary, would represent the discontinuation of the paternalistic features present in the current guidelines that have created barriers to care. This emphasises the prioritisation of individual autonomy, while simultaneously upholding protections where necessary as clearly advocated for by this dissertation, thus adding to the imperative to adopt the ICM more firmly. However, Venkataramu and Banerjee contest that GD is a complex condition that can intersect with various mental health concerns.[143] They contend that omitting psychological assessments from the evaluation process may

[139] Lipshie-Willians, 'The peculiar case of the standards of care: Ethical ramifications of deviating from informed consent in transgender-specific healthcare' [2020].
[140] Wu and Keuroghlian 'Moving Beyond Psychiatric Gatekeeping for Gender-Affirming Surgery' [2022].
[141] Lipshie-Willians, 'The peculiar case of the standards of care: Ethical ramifications of deviating from informed consent in transgender-specific healthcare' [2020].
[142] Gerritse, 'Decision-making approaches in transgender healthcare: conceptual analysis and ethical implications' [2021].
[143] Venkataramu and Banerjee 'Gender Dysphoria in Psychiatric Practice: Understanding the Clinical Ambiguity and Management' [2021] 3(2) Journal of Psychosexual Health 124-132.

overlook potential distress that could arise during gender-affirming care.[144] However, HPs still retain the ability to conduct such assessments if they deem it necessary, therefore deeming their argument as insufficient.[145] Using this approach contributes to the depathologisation of GD by recognising it as a legitimate aspect of human diversity rather than a disorder that requires strict diagnostic criteria. Reducing these barriers means transgender individuals can receive support and treatment without unnecessary obstacles, ultimately promoting their autonomy in healthcare.

It is argued that the ICM is less onerous in promoting individual autonomy and does successfully help in depathologising GD. Having advocated for this, this chapter will now discuss the changes in the SoC and DSM-5 to reflect the ICM.

Changes to the SoC

Although the SoC no longer mandates a mental health professional to assess and diagnose an individual with GD, the stipulation remains, albeit broadened to allow any competent HP to fulfil this role.[146] This dissertation argues that this measure falls short in effectively eliminating barriers to care and depathologising GD. It asserts the necessity of going beyond this by eliminating capacity assessments and diagnosis of GD to correspond with a more relational approach to autonomy.

Ashley argues that abandoning assessment would empower transgender individuals to assert authority over their own mental experiences.[147] This shift acknowledges that transgender individuals are experts in their own experiences, eliminating the need to conform to clinical guidelines' criteria. MacKinnon supports this perspective, suggesting it

[144] Ibid.
[145] Ibid.
[146] Coleman et al, 'Standards of Care for the Health of Transgender and Gender Diverse People, Version 8' [2022], 33.
[147] Ashley, 'Gatekeeping hormone replacement therapy for transgender patients in dehumanising' [2019].

would foster patient-centred values.[148] This would enhance individuals' ability to make autonomous decisions as it reduces unnecessary gatekeeping and pathologisation. Lipshie-Williams views the SoC model as imposing unnecessary barriers, emphasising the importance of patient autonomy over external validation from authorities.[149] Removing such criteria would put more emphasis on patient autonomy and away from authoritative structures affirming conditions. Conflitti, however, argues that intervention requirements mitigate psychological stress and depression through this process.[150] While there is worry about such ill mental health, the alignment of the guidelines with the ICM ensures patient safety through open dialogue with HPs. This approach recognises the diversity of individual experiences and prioritises autonomy while addressing mental health concerns. Furthermore, Tomson emphasises the need for empowerment rather than stigmatisation during access to gender-affirming care, advocating for informed consent processes without mental health assessments.[151] Removing requirements for HP validation promotes informed consent and reduces gatekeeping.[152] The pathologisation of GD cannot be limited until individuals are no longer required to be seen by HPs to confirm the validity of their self-proclaimed identity and their capacity to consent to medical interventions.[153] Removing these requirements from the guidelines would give more respect to self-determination, further aligning with the legal principles and promoting relational autonomy for transgender individuals.

Removing capacity assessments and the diagnosis of GD as prerequisites for access to gender-affirming care gives more recognition to the diverse experiences of transgender individuals and gives more weight to their personal autonomy. The reduction in gatekeeping and pathologisation reduces the stigma surrounding GD and paternalistic features that curtail autonomy. As this chapter has affirmed the benefits of the change in

[148] MacKinnon et al, 'Teaching health professionals how to tailor gender affirming medicine protocols: A design thinking project' [2020].
[149] Lipshie-Willians, 'The peculiar case of the standards of care: Ethical ramifications of deviating from informed consent in transgender-specific healthcare' [2020].
[150] Conflitti et al, 'Update on bioethical, medical and fertility issues in gender incongruence during transition age' [2023].
[151] Tomson, 'Gender-affirming care in the context of medical ethics- gatekeeping v informed consent' [2018].
[152] Ashley, 'Gatekeeping hormone replacement therapy for transgender patients in dehumanising' [2019].
[153] Ibid.

SoC which would in turn be replicated within the NHS, there will be a discussion on the necessity of change to the DSM-5 and how this fosters autonomy.

Changes to the DSM-5

The categorisation of GD in the DSM-5 opens transgender individuals up to stigmatisation and pathologisation of their experiences, thus reducing how they are able to access care. While the change of terminology from 'gender identity order' to 'GD' does remove some stigma and pathologisation, this dissertation advocates for its complete removal from the DSM-5 altogether to move to completely depathologise GD.

Copper et al argue that the inclusion of GD in the DSM-5 links it to stigmatisation and social rejection rather than a genuine indicative of a mental disorder.[154] Furthermore, they advocate for its removal to alleviate this which would create greater access to services thus promoting individual autonomy.[155] This would lead to increased availability of gender-affirming care, as services may be more inclined to offer such care without individuals having to meet the prerequisite set by the SoC and GIS. Lipshie-Williams contends that doing such removes GD from the realms of psychiatric illness and diminishes the questioning of one's decision-making capacity, thus becoming less burdensome on their autonomy.[156] As GD is not inherently a mental disorder, its removal from the DSM-5 would help remove the stigma associated with seeking gender-affirming care. This would further the application of the ICM model as it would contribute to the removal of capacity assessments that grant transgender individuals access to care.[157] This would contribute to a more holistic approach to care that addresses individual needs rather than being focused on making sure diagnostic criteria are met. However, Amoretti argues that removing such

[154] Cooper et al 'The phenomenology of gender dysphoria in adults: A systematic review and meta-synthesis' [2020] 80(1) Clinical Psychology Review 1-11.
[155] Ibid.
[156] Lipshie-Willians, 'The peculiar case of the standards of care: Ethical ramifications of deviating from informed consent in transgender-specific healthcare' [2020].
[157] Davy, 'The DSM-5 and the Politics of Diagnosing Transpeople' [2015] 44(5) Archives of Sexual Behavior 1165-1176.

requirements makes it difficult for people wanting such access.[158] They argue that having such requirements allows transgender individuals to receive more specialised care tailored to their physical and mental health needs to affirm their gender identity.[159] While Amoretti makes an excellent point, this isolates transgender individuals into their own subgroup who cannot access gender-affirming care like surgical procedures compared to cis individuals. Furthermore, this dissertation has previously established the adoption of the ICM and relational approach to autonomy would allow for a tailored and nuanced process of care. The removal of GD from the DSM-5 would reduce burdens on transgender individuals, allowing them to exercise their autonomy more effectively. Introducing the ICM alongside this would help eliminate the paternalistic aspects associated with the current understanding of GD and foster a more relational approach that sufficiently promotes individuality and autonomy.

Having affirmed the benefits of removing GD from the DSM-5 and its ability to increase autonomy for transgender individuals by depathologising the condition, this chapter will now assess the possibility of adopting international approaches to promote autonomy.

International Adoption

The existing clinical guidelines used in the UK impose greater burdens on transgender individuals compared to other nations where guidelines have been restructured to prioritise the rights and autonomy of such individuals. Countries like Argentina and Malta have notably enacted comprehensive transgender rights laws, eliminating barriers such as psychiatric diagnosis for accessing gender-affirming care. Embracing similar approaches would serve to advance the rights of transgender individuals in asserting their autonomy.

Dunne contends that adopting international statutes concerning gender-affirming care would better prioritise the lived experiences of transgender individuals and depathologise

[158] Amoretti, 'The Notion of Gender in Psychiatry: a Focus on DSM-5' [2020] 36(139) Notizie di Politeia 70-82.
[159] Ibid.

GD.[160] Argentina's Gender Identity Law 2014, for instance, emphasises the free unfettered development of one's person according to their gender identity, rather than mandating a diagnosis of GD.[161] Similarly, Malta's Gender Identity, Gender Expression and Sex Characteristics Act [2015] upholds the rights to bodily integrity and physical autonomy.[162] These models are widely regarded as best practice and positively impact human rights discourse by recognising individuals' rights to self-determination.[163] By adopting similar measures in the UK, transgender individuals would enjoy improved access to gender-affirming care, thereby honouring their autonomy more robustly than under the current UK guidelines where they are subject to criteria. This approach aligns more closely with Article 8 HRA, conforming to accepted human rights standards.[164] Nitra argues that these laws recognise the diversity of individuals and affirm their right to self-development.[165] This shift would mitigate the paternalistic aspects of the current guidelines by placing greater emphasis on self-identification and give greater recognition to the diverse experiences of transgender individuals. Dunne suggests that the movement towards self-determination represents a radical departure for human rights that produces a more rights-conscious approach.[166] This suggests that such an approach contrasts favourably with the current clinical guidelines in the UK, that amply promotes autonomy that aligns with the legal principles.

However, arguably the adoption of international standards is unnecessary, as it could potentially compromise the requirement of safeguarding individuals accessing treatment. Venkataramu and Banerjee contend that by eliminating these prerequisites, individuals may not receive the essential psychological and medical support required to navigate their

[160] Dunne, 'Rethinking legal gender recognition: recent reforms in Argentina, Denmark and the Netherlands' [2015] 1(1) International Family Law 41-45.
[161] Article 1(b) Gender Identity Law of Argentina [2012].
[162] Article 3(d) Gender Identity, Gender Expression and Sex Characteristics Act of Malta [2015].
[163] Dunne, 'TRA0251- Evidence on Transgender Equality' (UK Parliament, October 2015) <https://committees.parliament.uk/writtenevidence/59648/html/>accessed 20 March 2024.
[164] Article 8 Human Rights Act [1998].
[165] Nitra, 'A Critique of the Model of Gender Recognition and the Limits of Self-Declaration for Non-Binary Trans Individuals' [2021] 32(2) Law and Critique 217-233.
[166] Dunne, 'Rethinking legal gender recognition: recent reforms in Argentina, Denmark and the Netherlands' [2015].

gender transition successfully.[167] Ensuring the protection and well-being of individuals is of paramount importance, necessitating adequate safeguards. However, the adoption of the ICM would protect individuals where necessary while still giving more open access to gender-affirming care.[168] The use of self-identification in replacement of GD diagnoses within international statutes represents a significant minimisation of barriers to care for transgender individuals. This better aligns with the legal principles of autonomy as it gives more respect to the individuals' self-determination and contributes to the reduction in barriers to care. By embracing these international approaches, the UK's clinical guidelines can become less restrictive and foster a more relational approach to autonomy by freeing transgender individuals from the barriers imposed on them.

This chapter has maintained the advantages of international adoption of standards with respect to its removal of GD as a prerequisite to gender-affirming care. Replicating Argentina's and Malta's requirements would further eliminate barriers to care and in turn, increase individuals' ability to exercise their autonomy with more respect to its legal principles.

Conclusion

In conclusion, the implementation of the ICM signifies a notable departure from the conventional approach to accessing gender-affirming care, emphasising patient autonomy and informed decision-making without undue interference from HPs. The ICM prioritises self-determination and works to diminish the barriers to care imposed by the clinical framework, thereby aligning more closely with the legal principles of autonomy. This shift would represent a pivotal change, granting transgender individuals greater agency over their healthcare decisions. Moreover, revisions to the SoC, GIS, and DSM-5 are imperative to further align with the tenets of the ICM. Eliminating capacity assessments and the diagnosis of GD as prerequisites for accessing care would enhance individual autonomy

[167] Venkataramu and Banerjee 'Gender Dysphoria in Psychiatric Practice: Understanding the Clinical Ambiguity and Management' [2021].
[168] Lipshie-Willians, 'The peculiar case of the standards of care: Ethical ramifications of deviating from informed consent in transgender-specific healthcare' [2020].

by further reducing barriers to access. Embracing international approaches, exemplified by countries like Argentina and Malta can serve as models for enhancing transgender healthcare within the UK. By implementing these changes, greater recognition and respect would be afforded to the rights and autonomy of transgender individuals. These changes would foster a more relational approach that acknowledges the diverse experiences of transgender individuals and limit medical interventions by HPs. Ultimately, these adjustments would render gender-affirming care more accessible to transgender individuals and afford them greater respect for their autonomy.

Conclusion

In summary, the exploration of conflicting autonomy theories and the clinical guidelines surrounding GD highlights the insufficiency of autonomy afforded to transgender individuals. While examining varying understandings of autonomy, it becomes apparent that both the paternalism and liberalism theories exhibit extremes in their provisions, whereas the relational theory of autonomy strikes a more balanced approach to promoting and facilitating autonomy. Despite the argument favouring the relational theory and its potential application within the clinical guidelines for GD, the existing framework predominantly exhibits paternalistic tendencies through gatekeeping and pathologisation of GD, thereby erecting barriers to care. Consequently, there arises a necessity to align the clinical guidelines more closely with legal principles such as those outlined in Article 8 HRA and *Montgomery [2015]* to adequately promote the autonomy of transgender individuals. To better affirm these rights of bodily integrity, this dissertation has concluded that by adopting the ICM model more closely, alongside revising the clinical guidelines framework and international statutes, an environment conducive to improved access to gender-affirming care and the depathologisation of GD can be established, thus enhancing the autonomy of transgender individuals.

In the initial chapter, the three primary theories of autonomy: paternalism, liberalism and the relational approach, were examined to evaluate their suitability for application. It was determined that each theory possesses distinct limitations: paternalism places excessive emphasis on authoritative intervention, liberalism tends to prioritise independence without providing ample protection for individuals, and the relational approach is susceptible to incorporating paternalistic elements. Despite these shortcomings, it was observed that the paternalism theory adequately safeguards individuals, thereby facilitating the promotion of their autonomy; the liberalism theory prioritises the patient's role as the decision-maker and underscores a patient-centred approach; and the relational approach acknowledges humans as inherently social beings, recognising autonomy within the context of social relationships. Notwithstanding the merits and drawbacks of each theory, this dissertation concludes that the relational approach offers the most favourable outcome for patients and

their autonomy. By achieving a balance between independence and interdependence, this approach recognises the diversity of human experiences and the inevitable impact of HPs within these social contexts. In doing so, it prioritises the respect and promotion of autonomy for transgender individuals to a greater extent than what is advocated for by the other conflicting theories.

Following this conclusion, chapter two delved into the theoretical application of autonomy within the context of this dissertation, scrutinising whether the clinical guidelines pertaining to GD effectively uphold relational autonomy for transgender individuals. It was determined that while the current framework exhibits notable strengths by embracing the relational approach and fostering collaboration, its paternalistic elements excessively hinder the autonomy of transgender individuals, thus failing to align adequately with legal principles of autonomy. Consequently, this dissertation concludes that the limitations of the clinical guidelines outweigh their benefits, and their practical implementation falls short of the espoused ideals. Nevertheless, it acknowledges the efforts made to address pathologisation and access barriers within the guidelines, albeit asserting that these efforts remain insufficient to fully promote the autonomy of transgender individuals.

Finally, following the analysis presented in the preceding chapters, chapter three centred on proposing modifications to the clinical framework to more closely align with the relational approach to autonomy and corresponding legal principles. It was emphasised that despite the compelling arguments for the adequacy of the current clinical guidelines, revisions are imperative to ensure a more harmonious alignment. Failure to enact such changes would perpetuate the ongoing deprivation of autonomy experienced by transgender individuals. As such, this dissertation has identified key areas for reform, notably advocating for the more robust adoption of the ICM alongside the SoC and the DSM-5. Implantation of these measures would empower transgender individuals to exercise greater control over their decision-making and enhance access to care.

The ongoing debate concerning the clinical guidelines concerning GD has underscored the significance of this dissertation while simultaneously imposing constraints. The central objective of this study was determining the extent to which the current clinical guidelines afford adequate autonomy for transgender individuals. However, a notable limitation of this paper is the absence of empirical evidence to substantiate these assertions. Obtaining data from individuals with GD who lack mental capacity, as well as those who initiate the process of care and have access to it, would bolster the arguments presented in this dissertation. Moreover, gathering insights from transgender individuals regarding their perspectives on the clinical guidelines and DSM-5 would further strengthen the argument. This deficiency curtails the dissertation's capacity to offer practical recommendations aimed at enhancing the clinical guidelines or remedying the deficiencies in healthcare practices, thus hindering a fully comprehensive assessment of their real-world implications for individuals.

Finally, it is contended that additional research is warranted concerning the experiences of regret and detransition among transgender individuals who have undergone gender-affirming care. Furthermore, there is a need for further exploration into the experiences of individuals who do not receive a diagnosis of GD or meet the criteria for gender-affirming care, including the autonomy they have in accessing such care.

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