Tackling Hermeneutical Injustices in Gender-Affirming Healthcare

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Abstract

Previously proposed strategies for tackling hermeneutical injustices take for granted the interests people have in certain things about them being intelligible to them and/or to others, and seek to enable them to satisfy these interests. Strategies of this sort I call *interests-as-given* strategies. I propose that some hermeneutical injustices can instead be tackled by doing away with certain of these interests, and so with the possibility of their unfair non-satisfaction. Strategies of this sort I call *interests-in-question* strategies. As a case study in when such an interests-in-question strategy ought to be pursued, I look at how to tackle hermeneutical injustices arising in the context of gender-affirming healthcare as provided to adults by the National Health Service in the UK. I argue that considerations of trust, privacy, and respect all support pursuing such a strategy. One way to do so, I suggest, would be by replacing the existing gatekeeping model with an informed consent model for the provision of gender-affirming healthcare. Considerations of hermeneutical justice can hence be added to the already-impressive case for undertaking this shift.

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The problem may not be always or only how to better understand each other (and ourselves)…

- Adam Phillips, *Going Sane* (2006, 172)

HAROLD GARFINKEL: How do you justify your lies?
AGNES: How do you justify your questions?

- Chase Joynt dir., *Framing Agnes* (2022)

There are, I propose, two basic sorts of strategy for tackling hermeneutical injustices. The first sort of strategy aims at enabling people to satisfy their interests in things about themselves being intelligible to them and/or to others – these being the interests that go unfairly unsatisfied when they suffer hermeneutical injustices. Since strategies of this sort take for granted the possession of these interests, I propose to call them *interests-as-given* strategies. The various strategies for tackling hermeneutical injustices previously proposed in the literature, such as the amelioration of relevant concepts and the cultivation of a virtue of hermeneutical justice, are all of this sort. The second sort of strategy aims instead at doing away with certain of these interests, and so with the possibility of their unfair nonsatisfaction. Since strategies of this sort refuse to take for granted the possession of at least some of these interests, I propose to call them *interests-in-question* strategies. Generally speaking, strategies of this second sort are more materialist in spirit than strategies of the first sort. <1> The idea is to rearrange the world in such a way that it no longer makes a difference to someone whether or not something about themselves is intelligible to them and/or to someone else.

As a case study in when such an interests-in-question strategy ought to be pursued, I look at how to tackle hermeneutical injustices arising in the context of gender-affirming healthcare as provided to adults by the National Health Service (NHS) in the UK. <2> In addition to serving as a proof of concept for interests-in-question strategies, this case study will cast some light on the epistemic dimensions of trans oppression. Under the existing gatekeeping model, the NHS makes access to gender-affirming healthcare contingent on any given person's need for that care being intelligible to multiple doctors – so giving them an interest in something about themselves being intelligible that they might not otherwise have. It turns out that trans patients sometimes find themselves unfairly hindered from rendering their needs in this regard intelligible to the relevant doctors, and so from satisfying these interests. An interests-in-question strategy ought to be pursued to tackle these hermeneutical injustices, I argue, because considerations of trust, privacy, and respect all indicate that the NHS ought not to be giving trans patients these interests in the first place. One such strategy would consist in replacing the existing gatekeeping model with an informed consent model. Under the latter, pretty much all that a well-informed person capable of consent would have to do to access gender-affirming healthcare would be to ask for it. This would mean doing away with that person's interest in their need for gender-affirming healthcare being intelligible to multiple doctors, and so with the possibility of that interest's unfair nonsatisfaction. In this way, considerations of hermeneutical justice turn out to support a radical overhaul of the way in which the UK's publicly-funded healthcare system provides gender-affirming healthcare.

I begin in §1 by explaining in greater detail what a hermeneutical injustice is. In §2 I survey the strategies previously proposed for tackling hermeneutical injustices, contrast these with an example of an interests-in-question strategy, and offer some preliminary considerations as to when each sort of strategy is appropriately pursued. In §3 I turn to my case study of gender-affirming healthcare as provided by the NHS, offering three real-life examples of hermeneutical injustices arising in that context. In §4 I make the case for pursuing an interests-in-question strategy to tackle such injustices, and conclude by showing how replacing the gatekeeping model with an informed consent model would fit the bill in this regard.

1. The Idea of Hermeneutical Injustice

That there is a distinctive sort of injustice appropriately labelled *hermeneutical injustice* is an idea of Miranda Fricker's (2006; 2007). Fricker illustrates this idea using the story of Carmita Wood as told by Susan Brownmiller in her memoir of the second-wave, *In Our Time* (1999, 280-281). <3> In 1974 Wood was an employee in Cornell's physics department, and while there was sexually harassed by a professor. This led to her developing physical symptoms of stress, including (at least according to Brownmiller) chronic pain in her neck and back. Lacking another way to escape the harassment, Wood quit her job. Needing the money, she applied for unemployment benefits. Yet when asked by a Department of Labor bureaucrat to explain why she had quit her job, Wood found herself (at least according to Brownmiller) 'at a loss to describe the hateful episodes', managing to say only that her reasons were 'personal' (1999, 280). Unsatisfied by this answer, the bureaucrat turned down her application for unemployment benefits. Wood later recounted what she had gone through to a feminist consciousness-raising group organized by a colleague at Cornell, Lin Farley. It was there that the concept SEXUAL HARASSMENT was formulated for the first time, as a label for the sort of behavior to which the professor had subjected Wood. <4>

Fricker wants to say that Wood suffered a hermeneutical injustice in her interaction with the bureaucrat. <5> Wood had an interest in what she had gone through being intelligible to him, since if he had grasped that she had been seriously wronged he would likely have upheld her benefits claim (2007, 162). Yet she was hindered from rendering what she had gone through intelligible to him, Fricker suggests, by having 'at best ill-fitting' concepts available to her with which to do so (2007, 148). <6> As a result, her interest in what she had gone through being intelligible to him went unsatisfied – and by definition an interest going unsatisfied is a harm (2007, 162; see also Feinberg 1984, 33). Fricker herself does not say much to elucidate this key notion of a concept's fittingness. Thankfully, Rachel Fraser suggests a plausible way to plug this gap (2018, 735-737). <7> Fraser's proposal is that a concept's fittingness for the purposes of rendering something about oneself intelligible to someone can profitably be understood in terms of the inferences that person is liable to draw from and to claims in which the concept appears. Consider the concepts Wood had available to her with which to try to render what she had gone through intelligible to the bureaucrat: for instance, BEING-MADE-TO-FEEL-UNCOMFORTABLE or EXCESSIVE-FLIRTING (Fricker 2007, 153). These would have been ill-fitting for the purpose of rendering what she had gone through intelligible to the bureaucrat, since he would not have been liable to infer "Wood was seriously wronged" from claims like "The professor made me feel uncomfortable" or "The professor flirted excessively towards me". By contrast, Wood could well have found the concept SEXUAL HARASSMENT well-fitting for the purpose of rendering what she had gone through intelligible to the bureaucrat, since he could well have been liable to infer "Wood was seriously wronged" from a claim like "I was sexually harassed". Yet this concept was not available to her.

How come Wood had at best ill-fitting concepts available to her? Fricker suggests plausibly that this can be attributed at least in part to women's *hermeneutical marginalization*, by which she means women's exclusion from and/or subordination within those practices that generate

and propagate concepts (2007, 153). 'Most obvious' among such hermeneutically powerful practices, Fricker suggests, are those 'sustained by professions such as journalism, politics, academia, and law' (2007, 152). Fricker's idea is that women would likely have generated and propagated a concept like SEXUAL HARASSMENT sooner if only they had been in a better position to do so – given that doing so would have been in their interest (2007, 152). A further point is that women's hermeneutical marginalization is symptomatic of their broader relative social powerlessness (2007, 155). Thus if we accept that Wood's interest going unsatisfied was at least in part a result of women's hermeneutical marginalization, we can say that she was harmed in virtue of belonging to a relatively socially powerless group – something that seems straightforwardly discriminatory (2007, 155). Moreover, a harm that is discriminatory or otherwise unfair amounts to an injustice (2007, 151). Hence Fricker's claim that in her interaction with the bureaucrat, Wood suffered a *hermeneutical injustice*.

Generalizing from this case, hermeneutical injustice can be defined as follows. A person *A* suffers a hermeneutical injustice iff both: (i) *A* has an interest in something about themselves being intelligible to *B*; and (ii) this interest goes unsatisfied because *A* has, at least in part as a result of hermeneutical marginalization, at best ill-fitting concepts available to them with which to render this thing about themselves intelligible to *B*. <8> One caveat: *A* and *B* could be different people, as with Wood and the bureaucrat; but they could also be one and the same person, as in the case of Wendy Sanford (discussed briefly in the next section).

2. Two Sorts of Strategy for Tackling Hermeneutical Injustices

We can use this definition to distinguish the two basic sorts of strategy for tackling hermeneutical injustices outlined in the introduction. The point is that so long as (i) and/or (ii) does not obtain then *A* will not suffer a hermeneutical injustice. Thus *interests-as-given* strategies allow (i) to obtain and aim to prevent (ii) obtaining. The idea is to enable *A* to render the relevant thing about themselves intelligible to *B*, so satisfying *A*'s interest. By contrast, *interests-in-question* strategies aim to prevent (i) obtaining, in which case trivially (ii) will not obtain either. The idea is to do away with *A*'s interest and so with the possibility of its unfair nonsatisfaction. So far as the literature on hermeneutical injustice is concerned, this latter sort of strategy is novel.

In the rest of this section I will do three things. First, I will survey the various interests-as-given strategies previously proposed in the literature. Second, I will contrast these with an example of an interests-in-question strategy. Third, I will offer some preliminary thoughts on when it is appropriate to pursue each sort of strategy.

a. Interests-as-Given Strategies

Condition (ii) will not obtain if *A* has well-fitting concepts available to them with which to render the relevant thing about themselves intelligible to *B*. For instance, Carmita Wood would not have suffered a hermeneutical injustice if she had had a well-fitting concept of SEXUAL HARASSMENT available to her with which to render the professor's behavior intelligible to the bureaucrat. With this in mind, most of the strategies previously proposed in the literature

aim at generating and propagating new well-fitting concepts and/or at making existing concepts better-fitting.

For instance, Fricker implicitly endorses consciousness-raising in combination with political activism as a strategy for generating and propagating new well-fitting concepts (2007, 150-151; more explicitly Hull 2017, 585). <9> In consciousness-raising as it was practiced during the second wave, 'women met in small groups to discuss and better understand experiences of gender oppression which they often had not previously recognised as such' (Finlayson 2016, 22). Frequently, this involved generating new well-fitting conceptualizations of that oppression. That is exactly what happened when someone in the consciousness-raising group at Cornell came up with a conceptualization of the professor's behavior as SEXUAL HARASSMENT. Members of the group then held a speak-out, advertised on posters as a speak-out against *sexual harassment* (Brownmiller 1999, 281). Such activism served to propagate the newly-generated well-fitting concept SEXUAL HARASSMENT.

A number of proposed strategies aim at making existing concepts better-fitting. One such strategy is the practice of pride, understood as 'the politically motivated celebration of difference' (Barnes 2016, 181). For instance, it is common in our ableist society for able-bodied people to think it a tragedy to be disabled (Barnes 2016, 176). They are liable to infer things like "if she is flourishing, it must be in spite of her disability" and "she must be hoping for a cure" from "she is disabled" (Barnes 2016, 171; see also Clare 2017). If a disabled person in fact does not hope for a cure and is flourishing in part *because* she is disabled, the concept DISABILITY will be ill-fitting for the purpose of rendering her disability intelligible to able-bodied people liable to draw such inferences. Elizabeth Barnes suggests that the practice of disability pride aims among other things at making DISABILITY a better-fitting concept for this purpose (2016, 183). The idea is for disabled people to display to able-bodied people who think it a tragedy to be disabled that in fact they consider their disabilities worthy of celebration. It has likely never before occurred to many such able-bodied people that anyone could consider a disability to be worthy of celebration. Yet now they are confronted by people in an excellent position to know whether or not at least some disabilities are worthy of celebration who *do* consider their disabilities so worthy. The hope is that, forced to take this possibility seriously for the first time and conscious of disabled people's epistemic authority over the matter at hand, they will be won round to the idea that at least some disabilities are worthy of celebration. Nothing worthy of celebration straightforwardly inhibits flourishing or stands in need of a cure. Thus able-bodied people won round to the idea that at least some disabilities are worthy of celebration will cease to be liable to infer "if she is flourishing, it must be in spite of her disability" and "she must be hoping for a cure" from "she is disabled". Suppose the disabled person who does not hope for a cure and is flourishing in part because she is disabled wants to render her disability intelligible to an able-bodied person newly won round to the idea that at least some disabilities are worthy of celebration. The concept DISABILITY will now be better-fitting for this purpose. <10>

We can think of education as another such strategy (Jenkins 2017, 201-202). For instance, it is common under heteropatriarchy for people to believe various insidious myths about rape, such as that victims of rape always physically resist (Jenkins 2017, 192; 2021, 38). In other words,

it is common for people to be liable to infer “she was not raped” from things like “she did not physically resist”. If a victim of rape did not physically resist, the concept RAPE will be ill-fitting for the purpose of rendering what she went through intelligible to anyone who is liable to draw such an inference. <11> One way to make RAPE a better-fitting concept for this purpose is to educate people about rape myths. This could mean teaching jurors about rape myths at the start of trials, incorporating material on rape myths into high school sex-ed curricula, and running advertising campaigns to reach the general public (Jenkins 2017, 201-202). The idea would be once people learn that the rape myths to which they currently subscribe are false, they will cease to be liable to infer “she was not raped” from things like “she did not physically resist”. Suppose the victim of rape who did not physically resist wants to render what she went through intelligible to someone who has learnt it is a myth that victims of rape always physically resist. The concept RAPE will now be better-fitting for this purpose. <12>

One proposed strategy aims both at generating and propagating new well-fitting concepts and at making existing concepts better-fitting. This is diminishing and eventually eliminating hermeneutical marginalization (McCollum 2012, 196; Fricker 2016, 175; Romdenh-Romluc 2017, 12; Goetze and Crerar 2022, 100). Participation in hermeneutically powerful practices is an important means both of generating and propagating new well-fitting concepts and of making existing concepts better-fitting. For instance, feminist participation in academia has generated many new well-fitting concepts – HERMENEUTICAL INJUSTICE among them (Langton 2010, 463). Feminist participation in the law has helped to propagate the well-fitting concept SEXUAL HARASSMENT (MacKinnon 1987, 103-104; Strebeigh 2009, Chs.14-20). And feminist participation in politics has helped to make the concept RAPE better-fitting (Jenkins 2017, 197). Hermeneutical marginalization inhibits a group’s access to this important means both of generating and propagating new well-fitting concepts and of making existing concepts better-fitting. This matters because in general it is members of the group who will be most concerned to ensure that there are well-fitting concepts available with which to render intelligible things about *them* (Fricker 2007, 152-153). Diminishing and eventually eliminating the group’s hermeneutical marginalization would give members of the group greater access to an important means of making available well-fitting concepts with which to render intelligible things about them. There are a great many ways to go about trying to diminish a group’s hermeneutical marginalization. For instance, putting together all-female shortlists when selecting electoral candidates, citing female scholars when doing academic research, and enforcing sexual harassment law are all ways to go about trying to diminish women’s hermeneutical marginalization. <13>

Finally, one previously proposed interests-as-given strategy aims neither at generating and propagating new well-fitting concepts nor at making existing concepts better-fitting. This is the cultivation of what Fricker calls the *virtue of hermeneutical justice* (2007, 169-175). The idea is to enable *A* to render the relevant thing about themselves intelligible to *B despite* having at best ill-fitting concepts available to them with which to do so. Imagine a scenario in which *A* attempts to render the relevant thing about themselves intelligible to *B* but struggles to do so because they have at best ill-fitting concepts available to them. *B* displays the virtue of hermeneutical justice if they are sensitive to the possibility that having at best ill-fitting concepts available to them explains *A*’s struggles to render the relevant thing about themselves

intelligible, and adjusts their credence in what *A* has to say accordingly (2007, 169-170). For instance, suppose Wood had given the bureaucrat a bare description of how the professor had behaved towards her and then asserted the normative upshot "I was seriously wronged and so deserve to be paid unemployment benefits". In the absence of a well-fitting concept like SEXUAL HARASSMENT to mediate the inference from the bare description to the normative upshot, the bureaucrat might well have failed to see that the normative upshot followed from the bare description (Fraser 2018, 738). Still, he could have been sensitive to the possibility that Wood having at best ill-fitting concepts available to her explained his failure to see that the normative upshot followed from the bare description, and increased his credence in the normative upshot accordingly. Doing so would have displayed the virtue of hermeneutical justice. In this way Wood's interest in what she went through being intelligible to the bureaucrat could have been satisfied in spite of the lack of well-fitting concepts available to her.

One problem with the strategy of cultivating the virtue of hermeneutical justice is that there are plenty of cases of hermeneutical injustice in which it seemingly will not get purchase. For instance, consider what (at least according to Brownmiller, even if not in actual fact) happened in Wood's case. Deterred by having at best ill-fitting concepts available to her, Wood said only that her reasons for quitting her job had been "personal". In other words, she did not even try (in this telling) to render what had happened to her intelligible to the bureaucrat. This is an instance of what Kristie Dotson calls *testimonial smothering* – the phenomenon of a speaker refraining from offering a piece of testimony because they anticipate that their audience will not give what they have to say 'appropriate uptake' (2011, 244). As a result, it is hard to see how in this scenario the bureaucrat possessing the virtue of hermeneutical justice could have helped. For this reason the cultivation of the virtue of hermeneutical justice would appear to be a somewhat limited strategy for tackling hermeneutical injustices. <14> Still, it is possible to imagine it being helpful at the margins.

b. An Example of an Interests-in-Question Strategy

We have seen that the various strategies for tackling hermeneutical injustices previously proposed are all of the same basic sort. They all allow (i) to obtain and aim to prevent (ii) obtaining. The idea I want to explore is that it is possible to pursue a different basic sort of strategy, aimed at preventing (i) obtaining. To get a sense of what strategies of this sort could look like, consider one last time the case of Carmita Wood. Wood had an interest in what she had gone through being intelligible to the bureaucrat. Yet that she had this interest was a result of the particular way in which the welfare system was set up, nothing more. After all, no one who had resigned from their job could access unemployment benefits unless they had what the Department of Labor could recognize as a good reason for quitting. This rule made access to the income Wood needed to get by contingent on what she had gone through being intelligible to the bureaucrat. Yet suppose this system were to have been replaced with a suitably generous scheme of universal basic income. <15> Access to the income Wood needed to get by would then not have been contingent on what she had gone through being intelligible to the bureaucrat. It seems obvious that in these circumstances Wood would not have had an interest in what she had gone through being intelligible to *him*, a random Department of Labor

bureaucrat. Thus we can think of the implementation of a suitably generous scheme of universal basic income as an interests-in-question strategy for preventing hermeneutical injustices like the one suffered by Wood.

c. When Is It Appropriate to Pursue Each Sort of Strategy?

If there are two basic sorts of strategy for tackling hermeneutical injustices, the obvious question to ask is: when is each sort of strategy appropriately pursued? The first thing to say is that there are pretty much always good reasons to pursue interests-as-given strategies. Hermeneutical marginalization is bad in and of itself, which is a good reason to try to diminish and eventually eliminate it (Romdenh-Romluc 2017, 12). There are countless contexts in which having well-fitting concepts available to one could turn out to be useful, which is a good reason to continue generating and propagating new well-fitting concepts and/or making existing concepts better-fitting. And it could only be a good thing if people became more sensitive to the possibility that their interlocutor was struggling to render something about themselves intelligible due to having at best ill-fitting concepts available to them, which is a good reason to cultivate the virtue of hermeneutical justice. So to be clear, I am not in favor of ceasing to pursue interests-as-given strategies.

The second thing to say is that interests-in-question strategies cannot be pursued in every case. Rather, they can only be pursued in cases where *A*'s interest in something about themselves being intelligible to *B* is merely instrumentally held. Plausibly, Wood's interest in what she went through being intelligible to the bureaucrat was merely instrumentally held. But not every case of hermeneutical injustice is like this. Consider another of Fricker's paradigm cases, that of Wendy Sanford (Brownmiller 1999, 182; Fricker 2007, 148-149). Sanford, a woman living in Boston in the late 1960s, felt depressed after the birth of her son. Without the well-fitting concept POSTPARTUM DEPRESSION available to her, she instead conceptualized what she was going through as the result of a PERSONAL DEFICIENCY and inferred from this that she was to blame for feeling depressed. Plausibly, it was intrinsically in Sanford's interest for it to be intelligible to her that she was not to blame for feeling depressed. If this is right then no interests-in-question strategy could have been pursued in this case.

Still, we can ask whether interests-in-question strategies are at least sometimes worth pursuing alongside interests-as-given strategies. Here it will be useful to look at a case study. Thus in the rest of this paper I argue for pursuing an interests-in-question strategy to tackle hermeneutical injustices arising in the context of gender-affirming healthcare, as it is currently provided to adults by the UK's National Health Service. In the next section I will outline the gatekeeping model under which the NHS currently provides this care and argue that trans people are significantly hermeneutically marginalized. I will then give three real-life examples of hermeneutical injustices arising in this context as a result of that hermeneutical marginalization. In §4 I will put forward a number of reasons for pursuing an interests-in-question strategy to tackle such injustices, and outline one way in which this could be done.

3. Hermeneutical Injustices in Gender-Affirming Healthcare

a. The Gatekeeping Model

The provision of gender-affirming healthcare by the NHS is commonly said to operate under a *gatekeeping model*, which is based on a 'somewhat conservative' interpretation of the *Standards of Care* produced by the World Professional Association for Transgender Health (WPATH) (Pearce 2018, 60). In order to access gender-affirming healthcare, a trans person first needs to be referred by their general practitioner (GP) to a gender identity clinic (GIC). In England, Wales, and Northern Ireland they then need to receive a diagnosis of or relating to gender dysphoria from at least two different doctors at the GIC, who they will have separate appointments with several months apart (Pearce 2018, 64). In Scotland the required diagnosis can be received after just one such appointment with a single doctor (Pearce 2018, 69-70). At these appointments they will be asked about 'their gendered feelings, past and present experiences of gender presentation, their relationship with their body and (often) sexual fantasies and experiences' (Pearce 2018, 64). Since answers to these questions inevitably take the form of a self-narrativization, a trans person's autobiography can be thought of as their 'proffered symptom' (Prosser 1998, 104). In England, Wales, and Northern Ireland they will also need to undertake Real Life Experience (RLE) 'in order to access surgeries, and sometimes also before they can access treatments such as hormone therapy, speech therapy and facial hair removal' (Pearce 2018, 64). In Scotland RLE is required only in order to access genital reconstruction surgeries (Pearce 2018, 70). For someone to undertake RLE means spending 'a period of time living in their new gender role: presenting socially in their preferred gender, changing their name and identification documents, coming out to friends, family and work colleagues' (Pearce 2018, 65). Documentary evidence that this period of time has been completed must typically be provided to doctors at the GIC (Pearce 2018, 65). The upshot is

> the positioning of health professionals as qualified to *decide whether or not a patient is trans* (enough). The common requirement for at least two diagnoses demonstrates that these assessments are not simply a matter of screening for troublesome co-morbidities, creating a care plan and ensuring that patients provide informed consent in line with the *Standards of Care*. Instead, the assessment procedure is one in which practitioners exercise their *judgement* as to whether or not a patient should receive treatment (Pearce 2018, 66; emphases in the original).

A trans person seeking access to gender-affirming healthcare under a gatekeeping model thus has an interest in their need for that healthcare being intelligible to multiple doctors.

Here someone might object as follows: a trans person seeking access to gender-affirming healthcare under a gatekeeping model in fact does not have an interest in their need for that healthcare being intelligible to multiple doctors; rather, they have an interest only in multiple doctors *thinking* that their need for such interventions is intelligible to them. Consider in this regard the case of Agnes, a trans woman who in 1958 approached psychiatrist Robert Stoller at the UCLA Medical Center seeking access to gender confirmation surgery (Preciado 2013, 381-387; Gill-Peterson 2018, 137-8). <16> Stoller and his colleagues found Agnes 'to be by their standards a "normal," if "feminine"-looking, "male," with one glaring exception: her gonads produced an incredibly high level of estrogen, no doubt a large part of the reason for

her feminine appearance' (Gill-Peterson 2018, 137). Stoller and his colleagues construed this as 'a starkly biological suggestion of transsexuality' of a sort never before seen, and on this basis recommended Agnes for surgery (Gill-Peterson 2018, 137). In a follow-up interview at UCLA with the sociologist Harold Garfinkel, Agnes revealed that her unusual endocrine profile was in fact the result of having secretly taken estrogen pills prescribed to her menopausal mother ever since she was 13 years-old (Preciado 2013, 385; Gill-Peterson 2018, 138). Thus it turned out that Agnes's need for gender confirmation surgery had not really been intelligible to Stoller and his colleagues after all. But they had *thought* that her need for gender confirmation surgery was intelligible to them, and this had been sufficient for them to recommend her for surgery. Our objector construes this as evidence that Agnes never in fact had an interest in her need for gender confirmation surgery being intelligible to Stoller and his colleagues, but rather only had an interest in them *thinking* that her need for surgery was intelligible to them.

Here is why I think a trans person seeking access to gender-affirming healthcare under the gatekeeping model does in fact have an interest in their need for that healthcare being intelligible to multiple doctors. If a trans person's need for gender-affirming healthcare is not intelligible to the relevant doctors, but still those doctors think that person's need is intelligible to them, then this can only be because that person – like Agnes – has deceived them in some way, deliberately or otherwise. Yet if doctors discover this deception there is always a chance they will delay or deny access to gender-affirming care. Moreover, discovery risks 'contributing to the atmosphere of mistrust' already pervasive in the context of gender-affirming healthcare provision (Pearce 2018, 114) and reinforcing 'the persistent stereotype of transpeople as deceivers' (Bettcher 2007, 47; see also Serrano 2016, 36-40). None of this implies that such deception is not justified when it is the only way for a trans person to access the healthcare they need. As Agnes herself pointed out in her interview with Garfinkel, it is rather the doctors' questions whose justification ought to be asked after in this scenario. <17> The point is simply that, under a gatekeeping model, a trans person will tend to be better off if their need for gender-affirming healthcare really is intelligible to the relevant doctors, and not just seemingly so.

b. Trans People Are Hermeneutically Marginalized

When it comes to determining whether or not a trans person has well-fitting concepts available to them with which to render their need for gender-affirming healthcare intelligible to various doctors, the most obviously relevant hermeneutically powerful practice is that of gender-affirming healthcare itself. So it is notable that with very few exceptions – for instance, Michael Dillon (Prosser 1998, 152-155; Rubin 2003, 49-53) – most practitioners of gender-affirming healthcare historically have been cis. This is especially true of those whose views have enjoyed dominant positions within the practice. For instance, Harry Benjamin is perhaps the most famous practitioner of gender-affirming healthcare, and as Sandy Stone showed in her foundational essay "The *Empire* Strikes Back", the influence on subsequent clinical practice of his conception of TRANSSEXUALITY, as set out in his 1966 book *The Transsexual Phenomenon*, can hardly be overstated (1992, 161). Just as influential was the development of the concept GENDER – as distinct from SEX – by the likes of Lawson Wilkins, John Hampson,

and John Money in the 1940s and 50s (Gill-Peterson 2018, Ch.3). Furthermore, trans people to a considerable extent continue to be excluded from and/or subordinated within the practice of gender-affirming healthcare up to the present day. As recently as 2007 WPATH – formerly the Harry Benjamin International Gender Dysphoria Association (HBIGDA) – had never had trans leadership (Pearce 2018, 175). And still in the UK only 'a (very) small number' of doctors working in this area are themselves trans (Pearce 2018, 174).

This matters because influential practitioners of gender-affirming healthcare have not always been primarily interested in trying to understand and respond to their patients' needs. For instance, historian Jules Gill-Peterson argues that Hampson and Money found themselves in the mid-twentieth century faced with 'the potential conceptual collapse of binary sex' in the wake of recent advances in endocrinology (2018, 98), and that consequently their primary aim in developing the concept GENDER was in fact 'cementing the sex binary once and for all' (2018, 96). Susan Stryker argues similarly that university-based gender clinics of the 1960s and 70s, such as the one Robert Stoller ran at UCLA, were part of 'a socially conservative attempt to maintain traditional gender configurations in which changing sex was grudgingly permitted for the few seeking to do so, *to the extent that the practice did not trouble the gender binary for the many'* (Stryker 2017, 118; my emphasis). At the same time, the prestige enjoyed by these practitioners has often served to crowd out other voices. As sociologist Ruth Pearce remarks, their status as experts has often worked 'to delegitimise accounts emerging *from trans people* working in the social sciences and humanities, reflecting wider epistemic hierarchies in which work on gender from marginalised peoples (as in feminist scholarship) is framed as partially outside the realm of proper knowledge' (2018, 27; emphasis in the original).

In addition, trans people in the UK are hermeneutically marginalized more generally. Journalist Shon Faye puts the point powerfully in her recent book *The Transgender Issue*:

> At the time of writing, despite the media myth of a powerful trans lobby, in the UK there are no openly trans newspaper editors and no trans staff writers at any major newspapers, no trans television commissioners, no trans High Court judges, no trans MPs, no trans members of the devolved legislatures of Wales, Scotland or Northern Ireland, and no trans chief executives at major charities. (Jay Stewart, chief executive of the youth charity Gendered Intelligence, is the only trans person to head any of the British charities specifically campaigning on trans issues.) This, then, is a question of power: the terms of the conversation that is happening *about* trans people are rarely set *by* trans people. <18> (2021, 9; emphases in the original)

In other words, trans people in the UK are excluded from and/or subordinated within the powerful hermeneutical practices sustained by the professions of journalism, politics, and the law. We could add that they are also excluded from and/or subordinated within various academic disciplines, philosophy included (Salamon 2009, 226; Dembroff 2020, 399-400). Trans people thus lack access to some of the most important means of generating and propagating concepts well-fitting for the purpose of rendering their need for gender-affirming healthcare intelligible to relevant doctors, as well as of making existing concepts better-fitting for this purpose.

c. Three Examples of Hermeneutical Injustices in Access to Gender-Affirming Healthcare

In combination with the gatekeeping model, trans people's hermeneutical marginalization makes those seeking access to gender-affirming healthcare structurally vulnerable to suffering hermeneutical injustices. The gatekeeping model gives them interests in their need for gender-affirming healthcare being intelligible to multiple doctors, and trans people's hermeneutical marginalization makes it much more likely than it otherwise would be that they will have available to them at best ill-fitting concepts with which to satisfy these interests. It is thus unsurprising that trans people seeking access to gender-affirming healthcare on the NHS in doing so sometimes suffer hermeneutical injustices. The following three examples are all taken from Ruth Pearce's *Understanding Trans Health: Discourse, power and possibility*, in which she reports on an ethnographic study of trans healthcare in the UK she carried out between 2010 and 2017 (2018, 10).

The first example concerns a doctor working with a heterosexist conception of what it means to be a TRANS MAN. A trans male participant in Pearce's study, Joshua, reports having been asked about his sex life as part of his initial assessment at the GIC. <19> In reply, he mentioned having had penetrative intercourse with his cis male partner. In Joshua's own words, the doctor's response 'was like 'omg you can't be trans!'' (Pearce 2018, 141). This doctor was seemingly liable to infer "you do not need gender-affirming healthcare" from "you had penetrative intercourse with a cis male partner". This made it very difficult for Joshua to render his need for gender-affirming healthcare intelligible to the doctor in question. Joshua's difficulty on this point can plausibly be traced back at least in part to the hermeneutical marginalization of trans people, which among other things has meant limited opportunities for trans people to realistically portray their own sex lives for a popular audience and in doing so shape the inferential networks people associate with a concept such as TRANS MAN. <20> As such, Joshua would seem here to suffer a hermeneutical injustice.

The second example concerns a doctor working with a non-binary-exclusionary conception of what it means to be TRANS. An important piece of background information here is that gender-affirming healthcare as provided by the NHS 'is generally subdivided into two parallel routes: a 'masculinising' route (involving treatments such as testosterone supplements and chest reduction) and a 'feminising' route (involving treatments such as estrogen supplements and facial hair removal). In this way, even treatment for non-binary and genderqueer patients (where provided) is conceptualised in binary terms' (Pearce 2018, 61). A non-binary participant in Pearce's study, Reubs J Walsh, reports a doctor at the GIC finding it unintelligible how someone who had deliberately adopted such an 'ambiguous' first name could be in need of interventions found along the "feminizing" route (Pearce 2018, 114). Pearce notes that 'there are two presumptions at work here: firstly, that transitioning patients should define themselves in line with a binary gender category, and secondly, that the category of womanhood cannot expand to incorporate a more ambiguous name' (2018, 115). Plausibly, the prevalence of both presumptions can be attributed at least in part to the hermeneutical marginalization of trans people. Moreover, Pearce reports that incidents such as this 'often lead to patients being delayed in their journey along the treatment pathway, or being denied treatment altogether'

(2018, 114; for further anecdotal evidence see Faye 2021, 91). As such, Walsh would seem here to suffer a hermeneutical injustice.

The third example concerns trans people struggling to get across the *urgency* of their need for gender-affirming healthcare to doctors working with a cissexist conception of what it means for a medical intervention to be IRREVERSIBLE. Pearce notes that doctors working in GICs frequently justify the lengthy delays common in the provision of gender-affirming healthcare by appealing to 'the importance of their role in reducing the *risk* of an inappropriate transition, which could result in regret over irreversible physical changes' (2018, 66; emphasis in the original). <21> For one thing, this greatly overestimates the likelihood of gender-affirming interventions being regretted. As Shon Faye points out, multiple studies have shown that the regret rate for gender reassignment surgery stands somewhere between 0% and 2% (2021, 72). Moreover, as CN Lester notes:

> Some people who are counted under cases of 'regret' do not regret their treatment at all, but simply needed to pursue some further treatment to complete their transition. This is often the case for people who do not fit comfortably within the gender binary, as the treatment pathways available rarely offer support and options for people who may desire a mix of sexed traits. Other trans people who have expressed regret in the medical and community literature feel regret not over transitioning, but regret in their choice of surgeon and the results of their surgery. […] It doesn't surprise me that a trans person who cannot have a fistula repaired, for example, would regret choosing the surgeon who refuses to fix the results of their work. (2017, 57)

At the same time, this greatly underestimates the likelihood of regretting gender-affirming interventions not happening *now* (see Malatino 2022, Ch.1). For one thing, delays in the provision of gender-affirming healthcare have been shown to be correlated with increases in suicidal ideation among those affected (Pearce 2018, 152). For another, endogenously-produced irreversible physical changes occurring specifically in the absence of intervention can intensify dysphoria – for instance, balding can have this effect. Yet seemingly many doctors working in GICs are not liable to infer the possibility of regret from the irreversibility of *these* physical changes. Once again, doctors' thinking this way can plausibly be attributed at least in part to the hermeneutical marginalization of trans people. As such, a trans person who finds themselves hindered from rendering intelligible the urgency of their need for gender-affirming healthcare in the way described would seem to suffer a hermeneutical injustice.

4. Tackling Hermeneutical Injustices in Gender-Affirming Healthcare

In a co-authored paper on epistemic injustice and trans experiences, Fricker and Jenkins recognize that 'difficulty in rendering their identities intelligible to medical practitioners has meant that trans people have found it hard to access medical care related to transition' (2017, 274). To tackle such hermeneutical injustices, they recommend pursuing an interests-as-given strategy consisting in propagating well-fitting concepts already in circulation within the trans community out into the wider world via activism (2017, 276). In many ways this is an admirable strategy, and it has seen some success (see Pearce 2018, 194). Yet it is hard to

imagine this strategy on its own bringing an end to these hermeneutical injustices any time soon, especially if it has to contend both with some doctors' willful hermeneutical ignorance and with the wider hermeneutical backlash currently ongoing against trans people (on the former, see Pohlhaus 2012; on the latter, see George and Goguen 2021). So we should ask whether other strategies are also worth pursuing.

An interests-in-question strategy, I will now argue, is especially worth pursuing here. As things stand, anyone seeking access to gender-affirming healthcare on the NHS has an interest in their need for such interventions being intelligible to various doctors. Any reason for thinking that the NHS ought to cease making that the case is a reason for pursuing an interests-in-question strategy to tackle the sort of hermeneutical injustices I have described. In this section I will offer a menu of such reasons, encompassing considerations of trust, privacy, and respect – hopefully something for everyone. Then I will show how the NHS could achieve the desired result by switching from the existing gatekeeping model to an informed consent model for the provision of gender-affirming healthcare.

a. Trust

In continuing to make it the case that anyone seeking access to gender-affirming healthcare on the NHS has an interest in their need for such interventions being intelligible to various doctors, the NHS displays a wrongful lack of trust. <22> To see that doing so displays a lack of trust, consider what happens when a trans person arrives at the GIC and informs the relevant doctors of their need for gender-affirming healthcare. If the NHS licensed them to do so, the relevant doctors could simply take the trans person's word for it – that is, decide to trust them (Holton 1994). But the NHS does not license the relevant doctors – its representatives – to do this. Instead, the relevant doctors are obliged to get the person in question to render intelligible to them exactly why it is that they need gender-affirming healthcare before any such interventions can be provided. If further evidence of a lack of trust is needed, recall that documentary evidence of the completion of RLE is typically required – the NHS does not typically license the relevant doctors simply to take a trans person's word for it when they say they have spent the required amount of time living in their new gender role (Pearce 2018, 65). Thus it is as a result of not being trusted that someone seeking access to gender-affirming healthcare on the NHS has an interest in their need for such interventions being intelligible to various doctors. This is an instance of a general phenomenon: as political theorist Byung-Chul Han notes, it tends to be in the absence of trust that '[t]he demand for transparency grows loud' (2015, 48). <23>

To see that this lack of trust is wrongful, consider how differently the NHS treats cis people seeking comparable interventions. For instance, take the case of a cis man seeking an orchiectomy (removal of the testicles) to relieve his chronic scrotal pain (Pearce 2018, 68). <24> When he testifies that his testicles cause him distress sufficient to justify an orchiectomy, the NHS licenses doctors to take his word for it – that is, to trust his judgment. Compare what happens when a trans woman seeks an orchiectomy to relieve her dysphoria. The NHS does not license doctors to take *her* word for it when she testifies that her genitals cause her distress sufficient to justify an orchiectomy – to trust *her* judgment. Katherine Hawley suggests a

plausible principle governing different attitudes to trust, like those the NHS displays here. She writes that:

> within certain limits, we can regard quite a large range of different attitudes to trust as both morally and rationally acceptable. But it does not seem acceptable to vary even within that 'acceptable' range based on considerations of race, gender, or class (2017, 77).

A range of different attitudes to trust is both morally and rationally acceptable because there are 'many reasonable attitudes to epistemic risk, many acceptable ways to strike the balance between pursuing true belief and avoiding false belief' (Hawley 2014a, 2040). But allowing considerations of gender to play a role in determining whom one trusts seems both morally and rationally unacceptable. And we have seen that when it comes to a patient's judgment concerning whether their genitals cause them distress sufficient to justify an orchiectomy, the patient's gender modality – that is, whether they are cis or trans (Ashley 2022b) – does play a role in determining whether or not the NHS trusts their judgment. <25> Thus the lack of trust the NHS displays in continuing to give anyone seeking access to gender-affirming healthcare an interest in their need for that healthcare being intelligible to various doctors is wrongful. If the NHS decided to stop trusting cis people seeking comparable interventions, this lack of trust would no longer be wrongful in the way described. But there is no good reason to resolve the asymmetry in this direction and at least one good reason not to do so, namely that doing so would add to the distress experienced by cis people seeking comparable interventions – for instance, prolonging a cis man's chronic scrotal pain. Thus considerations of trust provide one reason to pursue an interests-in-question strategy to tackle the hermeneutical injustices described in §3.

b. Privacy

We have seen that under the gatekeeping model, anyone seeking access to gender-affirming healthcare on the NHS has an interest in their need for that healthcare being intelligible to various doctors. We have also seen that in order to satisfy this interest a trans patient is required to disclose deeply personal information concerning such things as their gendered feelings, their relationship with their body, and their sex lives. For instance, Joshua was compelled to describe the sort of sex acts he engaged in with his partner. This requirement holds whether or not doctors having access to such deeply personal information is wanted – and in many cases it is unwanted. <26> Privacy can be thought of as 'the condition of being protected from unwanted access by others – either physical access, personal information, or attention' (Bok 1989, 10-11). The NHS clearly fails to protect those seeking gender-affirming healthcare from such unwanted access, and as such violates their privacy. So much is recognized by the 'many' participants in Pearce's study who 'described their experience of stringent assessment procedures as […] invasive' (2018, 66). Moreover, a violation of a person's privacy is a harm to their dignity (Bettcher 2017, 160). This too is recognized by the 'many' participants in Pearce's study who described their experience of stringent assessment procedures as 'demeaning' (2018, 66). The NHS could protect trans patients from such unwanted access to deeply personal information about them by ceasing to give them an interest in their need for

gender-affirming healthcare being intelligible to various doctors. Thus considerations of privacy provide another reason to pursue an interests-in-question strategy to tackle the hermeneutical injustices described in §3.

c. Respect

Again, under the gatekeeping model anyone seeking access to gender-affirming healthcare on the NHS has an interest in their need for that healthcare being intelligible to various doctors. In continuing to make this the case, the NHS could have one of two expectations. On the one hand, it could do so in the expectation that not everyone who needs gender-affirming healthcare will be able to satisfy this interest – and thus in the expectation that they will refuse access to gender-affirming healthcare for some who need it. Doing so would display insufficient regard for the right of those thus refused access to have their healthcare needs met by the NHS. Sufficient regard for that right could instead be displayed by providing those people with gender-affirming healthcare despite their need for such interventions not being intelligible to the relevant doctors. That would mean ceasing to make it the case that anyone seeking access to gender-affirming healthcare had an interest in their need for such interventions being intelligible to those doctors.

On the other hand, the NHS could do so in the expectation that everyone who needs gender-affirming healthcare will be able to satisfy this interest – and thus in the expectation that they will provide gender-affirming healthcare to everyone who needs it. Having this expectation would presuppose confidence that the relevant doctors were capable of recognizing every patient's good reasons for needing medical assistance with their transition *as* good reasons. However, the occurrence of hermeneutical injustices like those described in §3 – cases in which doctors fail to recognize patients' good reasons for needing medical assistance with their transition as such – shows that the NHS ought in fact not to be confident in this. So if in operating the gatekeeping model the NHS expects to provide gender-affirming healthcare to everyone who needs it, it displays a misplaced confidence in doctors' capabilities.

Sociologist Richard Sennett suggests a plausible way to understand such misplaced confidence as disrespectful (2004, 120-122). <27> Respecting someone requires treating them as autonomous – so much is familiar from Kant. Treating someone as autonomous involves accepting that they are separate, and so likely in some ways to be different, from you – this is a common theme in the work of object relations theorist D.W. Winnicott (see e.g. 2005 [1971], Ch.1). And taking seriously that someone is separate and thus likely to be different from you requires accepting that you may not understand them in certain respects – this is Sennett's own proposed contribution. Hence 'we grant autonomy to teachers or doctors when we accept that they know what they are doing, even if we don't understand it; the same autonomy ought to be granted the pupil or the patient, because they know things about learning or being sick which the person teaching or treating them might not fathom' (122; similarly Kidd and Carel 2017). Given the occurrence of hermeneutical injustices like those described in §3, it is clear that doctors do indeed sometimes fail to fathom the needs of transitioning patients (not that they are sick *per se*). If in operating the gatekeeping model the NHS nevertheless expects to provide gender-affirming healthcare to everyone who needs it, it shows that it does not recognize

doctors' fallibility in this regard. On Sennett's account, not accepting that doctors are fallible in this regard would amount to a failure to treat transitioning patients as truly autonomous, so disrespecting them. It follows that the NHS could better respect transitioning patients if it ceased to give them interests in their need for gender-affirming healthcare being intelligible to various doctors.

d. From Gatekeeping to Informed Consent

Thus there are a number of good reasons to pursue an interests-in-question strategy to tackle hermeneutical injustices arising in the context of gender-affirming healthcare like those described in §3. One (indeed, perhaps the most obvious) such strategy would consist in replacing the existing gatekeeping model with an informed consent model for the provision of gender-affirming healthcare. <28> In his rich collection of essays *Something That May Shock and Discredit You*, Daniel M. Lavery writes that '[t]he best reason for transition, as I understand it, is "because I particularly wish it"' (Lavery 2020, 50). Andrea Long Chu writes similarly that 'surgery's only prerequisite should be a simple demonstration of want' (2018). Switching to an informed consent model would implement the spirit of these remarks. Under an informed consent model, a doctor would explain to a patient what a particular gender-affirming intervention will involve, what results it is likely to produce, and what its possible side-effects might be. For instance, a doctor might explain to a trans female patient that hormone replacement therapy will for her mean taking estrogen in some form; that over a certain timetable, this is likely to produce changes including breast growth, softened skin, and a redistribution of body fat; and that among other things taking estrogen brings with it a heightened risk of thrombosis, particularly if she smokes. It would then be up to the patient whether or not to go ahead with that intervention (Pearce 2018, 46). This notably closely resembles the model under which the NHS at least sometimes provides comparable interventions to cis people, as discussed in §4a.

It is apparent that under an informed consent model, doctors would be licensed to trust patients' own judgments of their gender-affirming healthcare needs; patients' privacy would be better protected; and the NHS would display a more respectful 'humility' concerning doctors' capabilities in this area (Pearce 2018, 207). Moreover, so long as doctors were doing their job properly it would no longer matter whether it was intelligible to them why a trans patient needed medical assistance with their transition. Doing away with trans patients' interests in intelligibility would also do away with the possibility of their unfair nonsatisfaction, and thus under an informed consent model hermeneutical injustices like those described in §3 ought no longer to arise. In this way, considerations of hermeneutical justice can be added to the already-impressive case for replacing the gatekeeping model with an informed consent model (see e.g. Pearce 2018, 197-207; Faye 2021, 83-4). As the number of people seeking access to gender-affirming healthcare on the NHS continues to grow and waiting lists become ever-longer (Faye 2021, 85), the importance of undertaking such a shift will only continue to mount.

e. Objections and Replies

I want to close by considering two objections to the argument just made. First, one anonymous reviewer observes that undergoing changes induced by gender-affirming medical interventions is frequently a *transformative experience* (see Ivy 2015, 422-423). An experience is *epistemically* transformative if it 'teaches you something you could not have learned without having that kind of experience' (Paul 2015, 761) – for instance, what it is like for you to have that sort of experience. An experience is *personally* transformative if it 'changes you in some deep and personally fundamental way, for example, by changing your core personal preferences or by changing the way you understand your desires and the kind of person you take yourself to be' (Paul 2015, 761). A transformative experience in the relevant sense is an experience that is both epistemically and personally transformative (Paul 2015, 761). The reviewer worries that whenever a patient undergoing changes induced by gender-affirming medical interventions would indeed be epistemically transformative for them, the possibility of their giving informed consent to those interventions would appear to be undermined (see Paul 2014, 136-140).

This worry gets off the ground only on the assumption that for your consent to a medical intervention to count as suitably informed, doctors must provide you with every *possible* piece of information that could make a significant difference to your assessment of the expected value of the intervention in question. It seems to me that for your consent to a medical intervention to count as suitably informed, doctors are rather required only to provide you with every piece of information *that they possess* (or which they could reasonably be expected to possess) that could make a significant difference to your assessment of the expected value of the intervention in question. For consider the following. In one case, a doctor does not inform a patient that taking estrogen will bring with it a heightened risk of thrombosis, particularly if they smoke. Indeed they do smoke, and this in combination with their taking the estrogen offered to them by the doctor results in them suffering a thrombosis. In failing to provide the patient with a piece of information that he possessed (or could reasonably have been expected to possess) which could well have made a significant difference to the patient's assessment of the expected value of taking estrogen, the doctor in this case wrongs the patient. In a second case, when a patient takes the estrogen offered to them by a doctor they learn that what it is like for them to have breasts is not the positive experience they hoped it would be. This piece of information would likely have made a significant difference to the patient's assessment of the expected value of taking estrogen. But since the doctor could not possibly have possessed this piece of information, and so could not possibly have provided it to the patient, the doctor in this case does not wrong the patient. Rather, the patient is a victim of mere bad luck. It seems to me that the point of insisting that patients' consent be suitably informed is to prevent them from being wronged, rather than to protect them from mere bad luck. If this is right, then the epistemically transformative nature of changes induced by gender-affirming medical interventions is no reason not to switch to an informed consent model.

Indeed on the contrary, that the experience of changes induced by gender-affirming medical interventions is frequently transformative arguably provides an additional *pro tanto* reason for undertaking this shift. Call a choice whether to have a transformative experience a

transformative choice. In a recent paper, Farbod Akhlaghi argues that we each have a 'moral right to autonomously decide to discover how one's life will go and who one will become by making a transformative choice' (2023, 8). Akhlaghi's idea is that upholding this right would give us each a degree of self-authorship, by which he means a 'degree of control […] over choosing ourselves to learn who we will become through a choice we make', which in turn 'is crucial for us and others to see ourselves as *our*selves' (2023, 8; emphasis in the original). The corollary of this right is a 'moral duty not to interfere in the autonomous self-making of others, through their choosing to undergo transformative experiences to discover who they will become' (2023, 9). Under the gatekeeping model, doctors interfere in the autonomous self-making of trans patients whenever they unnecessarily delay or deny their access to gender-affirming healthcare. Under an informed consent model, by contrast, doctors would neither delay nor deny trans patients' access to gender-affirming healthcare in the same way. Absent a reason to think that this duty ought to be overridden, then, we have here another reason for undertaking the proposed shift.

Second, another anonymous reviewer worries that replacing the gatekeeping model with an informed consent model, though desirable, may not be politically achievable. Here it is worth noting that this switch has already been achieved elsewhere (including in Argentina and at least some parts of Australia, Canada, and the USA (Pearce 2018, 46)), which seemingly suggests that this is an at least somewhat realistic goal for activism in the UK. Moreover, even if this switch were achievable only in the medium- or even long-term, establishing it as a part of our political horizon would remain a significant result. Doing so would leave us with the question of what to do in the 'unjust meantime' (Jaggar 2019). It is here, perhaps, that interests-as-given strategies such as the one outlined by Fricker and Jenkins (2017, 276) have a particularly significant role to play.

Notes

1. I say "generally speaking" because there is one interests-as-given strategy that is notably materialist in spirit, namely diminishing and eventually eliminating hermeneutical marginalization – see §2a.

2. The scope of my discussion is thus limited in at least three ways. First, I am not here concerned with trans healthcare understood more broadly (cf. Freeman and Stewart 2022). Second, I am not here concerned with privately provided gender-affirming healthcare. On the one hand, hermeneutical injustices like those I describe in §3 are less common in the context of private provision. For instance, 'non-binary diversity has historically been more widely recognised among private practitioners' (Pearce 2018, 73). Consequently, hermeneutical injustices like the one I describe befalling Reubs J Walsh are less common in the context of privately provided gender-affirming healthcare. On the other hand, private provision for most trans people is prohibitively expensive and as a result a majority of those who access gender-affirming healthcare in the UK do so at least in part on the NHS (Pearce 2018, 72). Hence the focus on NHS provision, given limited space. Third, I am not here concerned with gender-affirming healthcare for children and adolescents. For one thing, gender-affirming healthcare for children and adolescents raises additional questions around informed consent which I do

not have space to do justice to here (cf. Ashley 2022a and 2023). For another, NHS provision of gender-affirming healthcare for children and adolescents is currently in flux following the publication of the Cass Report, and its future is in many respects unclear (Gregory 2022).

3. It should be noted that Brownmiller's account of Wood's story is inaccurate in some respects and incomplete in others. A minor inaccuracy is that Wood's chronic pain was located in her hand and arm, rather than in her neck and back (Strebeigh 2009, 220-221). A more significant inaccuracy is that Wood did not tell the bureaucrat that she had quit her job for "personal" reasons. Rather, she told the bureaucrat that she had quit her job for "health" reasons. It was in fact the bureaucrat, not Wood, who deemed these reasons to be "personal" and "non-compelling" (Strebeigh 2009, 221). A minor omission is that Brownmiller does not name Wood's harasser, Boyce McDaniel (Baker 2007, 28). A more significant omission is that after the bureaucrat denied her benefits claim, but before she sought help from Lin Farley and her consciousness-raising group, Wood appealed and successfully secured a hearing for her case. At the hearing she testified that 'McDaniel inappropriately touched female employees in the office', and had this corroborated by two witnesses (Baker 2007, 28). The officer presiding over the hearing nevertheless upheld the bureaucrat's initial judgment that her reasons for quitting her job had been "personal" and "non-compelling" (Baker 2007, 28).

4. Who first coined the phrase "sexual harassment" is unclear: Lin Farley has subsequently claimed that it was she who first coined the phrase; Karen Sauvigné and Susan Meyer, two other members of Farley's consciousness-raising group, have disputed this (Brownmiller 1999, 285). (Here it is perhaps worth noting that Farley has a history of downplaying Sauvigné's and Meyer's roles in activism against sexual harassment (Baker 2007, 38).) What is clear, however, is that Farley was the first to use the phrase in public (Traister 2018, 167).

5. Fricker also claims that a lack of well-fitting concepts hindered Wood from rendering what she had gone through intelligible to herself (2007, 151). As Nora Berenstain has pointed out, this claim seems incompatible with the testimony we now know Wood to have given at her hearing (2020, 741). Just as importantly, this claim seems difficult to reconcile with Wood's decision to seek help from, of all people, Lin Farley and her feminist consciousness-raising group (Mason 2011, 297-298; Nathan 2022, 760). As such, this claim seems doubtful even on Brownmiller's incomplete account of the matter. By contrast, the claim that a lack of well-fitting concepts hindered Wood from rendering what she had gone through intelligible to the bureaucrat looks to stand up not only on Brownmiller's incomplete account of the matter but also on Baker's (2007, 28) and Strebeigh's (2009, 220-221) more recent accounts. For these reasons, I have chosen to focus solely on Wood's interaction with the bureaucrat.

6. For a defense of this reading of Fricker, see Clanchy (2023, 834-835).

7. A similar proposal can be found in Foster and Ichikawa (forthcoming).

8. Fricker most recently defines hermeneutical injustice as 'the injustice of being frustrated in an attempt to render a significant social experience intelligible (to oneself and/or to others) where hermeneutical marginalization is a significant causal factor in that failure' (Fricker and Jenkins 2017, 268). My definition makes three things explicit here left implicit. First, Fricker means to include such things as a person's moods, desires, and social identities among their

'social experiences' (2007, Ch.7; Romdenh-Romluc 2017, 3). In talking instead of 'something about' a person my intention is to more explicitly include such things. Second, in describing something about a person as 'significant' Fricker means that they have an interest in that thing about themselves being intelligible to someone (2007, 151). That this is left implicit in her definition may go some way to explaining why the possibility of pursuing interests-in-question strategies to tackle hermeneutical injustices has not previously been identified in the literature. Third, Fricker leaves implicit the mechanism by which in a case of hermeneutical injustice hermeneutical marginalization frustrates a person's attempt to render something significant about themselves intelligible to someone – namely, that hermeneutical marginalization leaves available to them at best ill-fitting concepts for this purpose. Making this explicit helps me to explain in §2 how certain interests-as-given strategies are supposed to work.

9. For some possible limitations to this strategy, see Elling (2022, 270-275).

10. Note that this is plausibly a mechanism by which a concept such as QUEER could be *reclaimed*. Thanks to an anonymous reviewer for this suggestion.

11. Note that in saying this I am employing the framework for talking about hermeneutical injustices set out in §1, which differs from Jenkins's own. Jenkins's own framework is built on a distinction that Sally Haslanger (2012, 370) draws between *manifest* and *operative* concepts. The manifest concept is the concept as it is defined officially or formally within a given community; the operative concept is the concept as it is defined by the actual usage of that community (Jenkins 2017, 195). If a victim of rape who did not physically resist is frustrated in an attempt to render what happened to her intelligible to another member of her community, then, Jenkins would attribute this to the community's *operative* concept of rape not being 'suitable' for this purpose (2017, 196). Jenkins goes on to note that 'thanks to the hard work of campaigners who have successfully fought for improvements to law and policy', the manifest concept of RAPE to be found in law is today often more suitable for such a purpose than is the operative concept of RAPE (2017, 197). Thus Jenkins conceives of education's role as bringing the operative concept of RAPE into line with the manifest concept of RAPE already to be found in law (2017, 202). My reason for preferring the framework set out in §1 to Jenkins's framework is that in attributing exactly one operative concept of RAPE to a given community, Jenkins's framework seemingly fails to allow for the concept RAPE being used differently by different members of that community in ways that are potentially significant. For instance, suppose that a victim of rape who did not physically resist lives in a community where the majority do not believe the myth that all victims of rape physically resist, but that the particular person she is trying to render her experience intelligible to does believe this myth; or conversely that a victim of rape who did not physically resist lives in a community where the majority do believe this myth, but that the particular person she is trying to render her experience intelligible to does not believe this myth. Jenkins's framework seemingly does not provide us with the resources to acknowledge that in the former case the concept RAPE is not a "suitable" concept for the victim to use for the purpose of rendering her experience intelligible to the person in question, whereas in the latter case it is.

12. Benjamin Elzinga notes a limitation to this strategy, namely that it depends on the hearers it targets being willing to update their understanding of the concept at hand (2018, 78). In other

words, this strategy will not succeed if the hearers it targets are *willfully hermeneutically ignorant* (Pohlhaus 2012). An anonymous reviewer points out that the same is true of the strategy of pride. I would add that the strategy of propagating new well-fitting concepts via political activism likewise suffers from a similar limitation. I come back to this in §4 when I address Fricker and Jenkins's proposed strategy for tackling hermeneutical injustices arising in the context of gender-affirming healthcare provision.

13. One of the functions of sexual harassment being to 'maintain the most highly rewarded forms of work as domains of masculine competence' (Schultz 1998, 1755) – including work in those professions sustaining the most hermeneutically powerful practices.

14. For further criticisms of Fricker's virtue-based approach to tackling epistemic injustices see: Langton (2010, 462-463), Anderson (2012, 167-168), and Samaržija and Cerovac (2021). For a defense of Fricker's approach see Madva (2019). For more demanding versions of the virtue of hermeneutical justice, see Goetze (2018, 85-86) and Beverley (2022, 439-449).

15. There is a comparison to be made here with the case Foucault makes in his Collège de France lectures for the implementation of a guaranteed minimum income in the form of a negative income tax (2008, 203-206). As Mitchell Dean and Daniel Zamora explain in their recent book on this phase of Foucault's career: 'the negative income tax system, since it guarantees a floor of income, has none of the effects of normalization, discrimination or social control that the old social institutions could have. It was precisely this *non-selectivity in the criteria* that would appeal to Foucault' (2021, 62; my emphasis).

16. "Agnes" is a pseudonym; her real name is not known.

17. See my epigraph taken from the recent documentary film *Framing Agnes* (Joynt 2022), in which Garfinkel's interview with Agnes is recreated from as-yet-unpublished archive material held at UCLA. I give some backing to Agnes's position in §4.

18. Since 30th March 2022 there has in fact been one openly trans MP (Allegretti 2022).

19. "Joshua" is a pseudonym.

20. One exception is Juno Roche's *Queer Sex: A Trans and Non-Binary Guide to Intimacy, Pleasure, and Relationships* (2018) – but even that book does not portray a sex life quite like Joshua's, which just goes to show how more such opportunities are needed.

21. Anthropologist Mikey Elster has recently argued that such appeals amount to *insidious concerns*: 'utterances […] that would harm that which they claim to care for or about' (2022, 407).

22. Not necessarily distrust: see Hawley (2014b).

23. In recent work, C. Thi Nguyen argues that demands for transparency often lead to a lack of trust (2022; building on O'Neill 2002, Ch.4). Han is making the inverse claim, namely that a lack of trust often leads to demands for transparency.

24. Riki Anne Wilchins (1997, 63) and Paul B. Preciado (2013, 116) both make similar comparisons involving rhinoplasties.

25. Perhaps misogyny plays a role in this particular case too: it is worth remembering that in general doctors tend to take women's self-reports of pain and distress less seriously than men's (Manne 2020, 86-90).

26. In which case their disclosures can be thought of as instances of *extracted speech* – 'speech that an agent is (in some sense) made to produce' (McKinney 2016, 259).

27. Sennett's may not be the only way in which to understand such misplaced confidence as disrespectful. One anonymous reviewer suggests that such misplaced confidence can be understood as disrespectful because it constitutes a failure to treat trans patients as doctors' *epistemic peers* (see Freeman 2015). Another anonymous reviewer suggests that such misplaced confidence can be understood as disrespectful because it constitutes a failure to treat trans patients as *non-derivative*, in the sense of being more than mere 'reflection[s], projection[s], or expression[s]' of doctors' understanding of the world (Cahill 2011, 32; see also Pohlhaus 2014).

28. This is perhaps not the only area of healthcare in which switching to an informed consent model could help prevent patients from suffering hermeneutical injustices. An anonymous reviewer suggests that access to sterilization procedures such as tubal ligations and vasectomies and access to medically assisted dying are two possible other such areas. While this suggestion strikes me as *prima facie* plausible, substantiating it would require significant further research.

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References

Akhlaghi, Farbod. 2023. Transformative experience and the right to revelatory autonomy. *Analysis* 83 (1): 3-12.

Allegretti, Aubrey. 2022. Jamie Wallis comes out as UK's first openly transgender MP. *The Guardian*, March 30.

Anderson, Elizabeth. 2012. Epistemic justice as a virtue of social institutions. *Social Epistemology* 26 (2): 163-173.

Ashley, Florence. 2022a. Adolescent medical transition is ethical: an analogy with reproductive health. *Kennedy Institute of Ethics Journal* 32 (2): 127-171.

Ashley, Florence. 2022b. ‘Trans’ is my gender modality: a modest terminological proposal. In *Trans bodies, trans selves*, 2nd ed., ed. Laura Erickson-Schroth. Oxford: Oxford University Press.

Ashley, Florence. 2023. Youth should decide: the principle of subsidiarity in paediatric transgender healthcare. *Journal of Medical Ethics* 49 (2): 110-114.

Baker, Carrie N.. 2007. *The women’s movement against sexual harassment.* Cambridge: Cambridge University Press.

Barnes, Elizabeth. 2016. *The minority body: a theory of disability*. Oxford: Oxford University Press.

Berenstain, Nora. 2020. White feminist gaslighting. *Hypatia* 35 (4): 733-758.

Bettcher, Talia Mae. 2007. Evil deceivers and make-believers: on transphobic violence and the politics of illusion. *Hypatia* 22 (3): 43-65.

Bettcher, Talia Mae. 2017. Getting “naked” in the colonial/modern gender system: a preliminary trans feminist analysis of pornography. In *Beyond speech: pornography and analytic feminist philosophy*, ed. Mari Mikkola. Oxford: Oxford University Press.

Beverley, John. 2022. Speak no evil: understanding hermeneutical (in)justice. *Episteme* 19 (3): 431-454.

Bok, Sissela. 1989. *Secrets: on the ethics of concealment and revelation*. New York: Vintage.

Brownmiller, Susan. 1999. *In our time: memoir of a revolution*. New York: Delta Books.

Cahill, Ann J.. 2011. *Overcoming objectification: a carnal ethics.* New York: Routledge.

Chu, Andrea Long. 2018. My new vagina won’t make me happy. *The New York Times*, November 24.

Clanchy, Nick. 2023. Whose hermeneutical marginalization? *Episteme* 20 (3): 813-832.

Clare, Eli. 2017. *Brilliant imperfection: grappling with cure*. Durham, NC: Duke University Press.

Dean, Mitchell, and Daniel Zamora. 2021. *The last man takes LSD: Foucault and the end of revolution*. London: Verso.

Dembroff, Robin. 2020. Cisgender commonsense and philosophy’s transgender trouble. *TSQ: Transgender Studies Quarterly* 7 (3): 399-406.

Dotson, Kristie. 2011. Tracking epistemic violence, tracking practices of silencing. *Hypatia* 26 (2): 236-257.

Elling, Eskil. 2022. Reconstructing the distorted experience of oppression: hermeneutical injustice and ideology. *Constellations* 29 (3): 269-282.

Elster, Mikey. 2022. Insidious concern: trans panic and the limits of care. *TSQ* 9 (3): 407-424.

Elzinga, Benjamin. 2018. Hermeneutical injustice and liberatory education. *Southern Journal of Philosophy* 56 (1): 59-82.

Faye, Shon. 2021. *The transgender issue: an argument for justice*. London: Allen Lane.

Feinberg, Joel. 1984. *The moral limits of the criminal law vol.1: harm to others*. Oxford: Oxford University Press.

Finlayson, Lorna. 2016. *An introduction to feminism*. Cambridge: Cambridge University Press.

Foster, Jen, and Jonathan Ichikawa. Forthcoming. Normative inference tickets. *Episteme*.

Foucault, Michel. 2008. *The birth of biopolitics: lectures at the Collège de France 1978-1979*, ed. Michel Senellart. London: Palgrave MacMillan.

Fraser, Rachel Elizabeth. 2018. The ethics of metaphor. *Ethics* 128 (4): 728-755.

Freeman, Lauren. 2015. Confronting diminished epistemic privilege and epistemic injustice in pregnancy by challenging a "panoptics of the womb". *Journal of Medicine and Philosophy* 40: 44-68.

Freeman, Lauren, and Heather Stewart. 2022. The problem of recognition, erasure, and epistemic injustice in medicine: harms to transgender and gender non-binary patients – why we should be worried. In *Epistemic injustice and the philosophy of recognition*, ed. Paul Giladi and Nicola McMillan. London: Routledge.

Fricker, Miranda. 2006. Powerlessness and social interpretation. *Episteme* 3 (1-2): 96-108.

Fricker, Miranda. 2007. *Epistemic injustice: power & the ethics of knowing*. Oxford: Oxford University Press.

Fricker, Miranda. 2016. Epistemic injustice and the preservation of ignorance. In *The epistemic dimensions of ignorance*, ed. Rik Peels and Martijn Blaauw. Cambridge: Cambridge University Press.

Fricker, Miranda, and Katharine Jenkins. 2017. Epistemic injustice, ignorance, and trans experiences. In *The Routledge companion to feminist philosophy*, ed. Anne Garry, Serene J. Khader, and Alison Stone. London: Routledge.

George, B.R., and Stacey Goguen. 2021. Hermeneutical backlash: trans youth panics as epistemic injustice. *Feminist Philosophy Quarterly* 7 (4).

Gill-Peterson, Jules. 2018. *Histories of the transgender child*. Minneapolis, MI: University of Minnesota Press.

Goetze, Trystan. 2018. Hermeneutical dissent and the species of hermeneutical injustice. *Hypatia* 33 (1): 73-90.

Goetze, Trystan, and Charlie Crerar. 2022. Hermeneutical justice for extremists? In *The philosophy of fanaticism: epistemic, affective, and political dimensions*, eds. Leo Townsend, Ruth Rebecca Tietjen, Hans Bernhard Schmid, and Michael Staudigl. London: Routledge.

Gregory, Andrew. 2022. NHS to close Tavistock gender identity clinic for children. *The Guardian*, July 27.

Han, Byung-Chul. 2015. *The transparency society*. Stanford, CA: Stanford University Press.

Haslanger, Sally. 2012. What are we talking about? The semantics and politics of social kinds. In *Resisting reality: social construction and social critique*. Oxford: Oxford University Press.

Hawley, Katherine. 2014a. Partiality and prejudice in trusting. *Synthese* 191 (9): 2029-2045.

Hawley, Katherine. 2014b. Trust, distrust and commitment. *Noûs* 48 (1): 1-20.

Hawley, Katherine. 2017. Trust, distrust, and epistemic injustice. In *The Routledge handbook of epistemic injustice*, ed. Ian James Kidd, José Medina, and Gaile Pohlhaus, Jnr.. London: Routledge.

Holton, Richard. 1994. Deciding to trust, coming to believe. *Australasian Journal of Philosophy* 72 (1): 63-76.

Hull, George. 2017. Black consciousness as overcoming hermeneutical injustice. *Journal of Applied Philosophy* 34 (4): 573-592.

Ivy, Veronica [publishing as Rachel McKinnon]. 2015. Trans*formative experience. *Res Philosophica* 92 (2): 419-440.

Jaggar, Alison. 2019. Thinking about justice in the unjust meantime. *Feminist Philosophy Quarterly* 5 (2).

Jenkins, Katharine. 2017. Rape myths and domestic abuse myths as hermeneutical injustices. *Journal of Applied Philosophy* 34 (2): 192-205.

Jenkins, Katharine. 2021. Rape myths: what are they and what can we do about them? *Royal Institute of Philosophy Supplements* 89: 37-49.

Joynt, Chase. 2022. *Framing Agnes* (dir.).

Kidd, Ian James, and Havi Carel. 2017. Epistemic injustice and illness. *Journal of Applied Philosophy* 34 (2): 172-190.

Langton, Rae. 2010. Review of *Epistemic injustice: power & the ethics of knowing* by Miranda Fricker. *Hypatia* 25 (3): 459-464.

Lavery, Daniel M.. 2020. *Something that may shock and discredit you*. New York: Atria Books.

Lester, CN. 2017. *Trans like me: a journey for all of us.* London: Virago.

MacKinnon, Catharine M.. 1987. *Feminism unmodified: discourses on life and law*. Cambridge, MA: Harvard University Press.

Madva, Alex. 2019. The inevitability of aiming for virtue. In *Overcoming epistemic injustice: social and psychological perspectives*, ed. Benjamin R. Sherman and Stacey Goguen. London: Rowman & Littlefield.

Malatino, Hil. 2022. *Side affects: on being trans and feeling bad.* Minneapolis, MN: University of Minnesota Press.

Manne, Kate. 2020. *Entitled: how male privilege hurts women*. London: Allen Lane.

Mason, Rebecca. 2011. Two kinds of unknowing. *Hypatia* 26 (2): 294-307.

McCollum, James. 2012. Hermeneutical injustice and the social sciences: development policy and positional objectivity. *Social Epistemology* 26 (2): 189-200.

McKinney, Rachel A.. 2016. Extracted speech. *Social Theory and Practice* 42 (2): 258-284.

Nathan, Usha. 2022. Moral emotions and unnamed wrongs: revisiting epistemic injustice. *Ergo* 9: 755-781.

Nguyen, C. Thi. 2022. Transparency is surveillance. *Philosophy & Phenomenological Research* 105 (2): 331-361.

O'Neill, Onora. 2002. *A question of trust: the BBC Reith Lectures 2002*. Cambridge: Cambridge University Press.

Paul, L.A.. 2014. *Transformative experience*. Oxford: Oxford University Press.

Paul, L.A.. 2015. Précis of *Transformative experience*. *Philosophy and Phenomenological Research* 91 (3): 760-765.

Pearce, Ruth. 2018. *Understanding trans health: discourse, power and possibility*. Bristol: Policy Press.

Phillips, Adam. 2006. *Going sane*. London: Penguin.

Pohlhaus Jr., Gaile. 2012. Relational knowing and epistemic injustice: towards a theory of willful hermeneutical ignorance. *Hypatia* 27 (4): 715-735.

Pohlhaus Jr., Gaile. 2014. Discerning the primary epistemic harm in cases of testimonial injustice. *Social Epistemology* 28 (2): 99-114.

Preciado, Paul B.. 2013. *Testo junkie: sex, drugs, and biopolitics in the pharmacopornographic era*. New York: Feminist Press.

Prosser, Jay. 1998. *Second skins: the body narratives of transsexuality*. New York: Columbia University Press.

Roche, Juno. 2018. *Queer sex: A trans and non-binary guide to intimacy, pleasure, and relationships*. London: Jessica Kingsley.

Romdenh-Romluc, Komarine. 2017. Hermeneutical injustice and the problem of authority. *Feminist Philosophy Quarterly* 3 (3).

Rubin, Henry. 2003. *Self-made men: identity and embodiment among transsexual men*. Nashville, TN: Vanderbilt University Press.

Salamon, Gayle. 2009. Justification and queer method, or leaving philosophy. *Hypatia* 24 (1): 225-230.

Samaržija, Hana and Ivan Cerovac. 2021. The institutional preconditions of epistemic justice. *Social Epistemology* 35 (6): 621-635.

Schultz, Vicki. 1998. Reconceptualizing sexual harassment. *The Yale Law Journal* 107 (6): 1683-1805.

Sennett, Richard. 2004. *Respect: the formation of character in the age of inequality*. London: Penguin.

Serrano, Julia. 2016. *Whipping girl: a transsexual woman on sexism and the scapegoating of femininity*, 2nd ed.. New York: Seal Press.

Stone, Sandy. 1992. The *Empire* strikes back: A posttranssexual manifesto. *Camera Obscura* 10 (2): 150-176.

Strebeigh, Fred. 2009. *Equal: women reshape American law*. New York: W.W. Norton & Company.

Stryker, Susan. 2017. *Transgender history: the roots of today's revolution*, 2nd ed.. New York: Seal Press.

Traister, Rebecca. 2018. *Good and mad: the revolutionary power of women's anger.* New York: Simon & Schuster.

Wilchins, Riki Anne. 1997. *Read my lips: sexual subversion and the end of gender*. Ithaca, NY: Firebrand Books.

Winnicott, D.W.. 2005. *Playing and reality*. Oxford: Routledge.