A Critique of the Legal Recognition of Transsexuals in UK Law

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Abstract

The Gender Recognition Act 2004 has been hailed as radical[1] and ground-breaking[2] legislation and it can clearly be considered to be a successful piece of legislation because between coming into force on 4 April 2005 and the third quarter of financial year 2013/14 it provided full legal recognition of one's gender identity to 3,664 individuals and interim recognition to 173 individuals; only 180 applications had been refused and 93 applications have been withdrawn.[3] So clearly the law is doing what it was intended to do. However the legislation is not without its problems and it is far from perfect. This thesis argues that the UK Government, when enacting the legislation, adopted the medical model of transsexualism as understood within medicine in 2003/04 which resulted in the legislation enacting strong gatekeeper roles for medical professionals and the Gender Recognition Panel which means that it is difficult for one to obtain legal recognition of one's gender identity under UK law. The thesis proposes that an alternative model of legal recognition based on gender self-declaration is possible and would achieve the same outcome but with less difficulties for the individual.

[1] S Jeffreys (2008) 'They know it when they see it: the UK Gender Recognition Act 2004' (2008) *British Journal of Politics & International Relations* 10(2):328-345, 328.
[2] S Cowan 'Looking back (to)wards the body: medicalization and the GRA' (2009) *Social and Legal Studies* 18(2):247-252, 247.
[3] Gender Recognition Certificate Statistics: April to June 2014 tables available from <www.gov.uk/government/statistics/gender-recognition-certificate-statistics-april-to-june-2014>accessed 14 September 2014.

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Council Directive 76/207/EEC (Equal Treatment Directive)

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Buggery Act 1533

Criminal Law Amendment Act 1885

Equal Pay Act 1970

Equality Act 2010

Gender Recognition Act 2004

Human Rights Act 1998

Marriage and Civil Partnership (Scotland) Act 2014

Marriage (Same Sex Couples) Act 2013

Marriage (Scotland) Act 1977

Matrimonial Causes Act 1973

Offences (Aggravation by Prejudice)(Scotland) Act 2009

Prostitution (Public Places)(Scotland) Act 2007

Protection from Harassment Act 1997

Registration of Births, Deaths and Marriages (Scotland) Act 1854

Sex Discrimination Act 1975

Sex Discrimination (Amendment of Legislation) Regulations 2009

Sex Discrimination (Gender Reassignment) Regulations 1999

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Author's declaration

I declare that, except where explicit reference is made to the contribution of others, that this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Signature 

Printed name: Carolynn Gray

Introduction

Introduction

The purpose of this thesis is to show that the Gender Recognition Act 2004 (GRA 2004) is reliant upon the medical model of transsexualism as it existed in 2004 as the basis of providing legal recognition of gender identity and that this approach raises problems which need not arise. The thesis argues that the result of basing the legislation on such an understanding of transsexualism is that the legislation gives third parties, in particular medical professionals and the Gender Recognition Panel (GRP) an unduly strong gatekeeper function in relation to the acquisition of legal recognition of one's gender identity. This approach is flawed for a number of reasons namely; (i) the medical understanding of transsexualism is dynamic and has already developed beyond that which dominated at the time the legislation was enacted, (ii) there are alternative means of providing legal recognition both within the Council of Europe member states, as shown by Denmark, Malta and Ireland, and globally, as exists in Colombia and Argentina which places the emphasis on the individual's sense of self rather than on the determination of medical professionals; the gender self-declaration model, (iii) many of the concerns of the legislature when enacting the legislation are no longer valid concerns e.g. avoiding same sex marriage, and (iv) recent calls for more diverse gender identity recognition in law other than merely male and female and the potential for this to be reflected in law has implications for the GRA 2004 which means that it is now an appropriate time to reflect on the legislation to determine if it requires reform and if so how.

This thesis argues that rather than use an evolving and dynamic medical model of transsexualism as the foundation for the provision of legal recognition of one's gender identity it would have been possible at the time for the UK Government to have enacted legislation which has the same outcome: legal recognition, save for certain specified exceptions, of those seeking to permanently live as member of the other sex based on nothing more than individual self-declaration of gender identity thus avoiding the problems which arise as a result of adopting the medical model of transsexualism. Despite the fact that the legislation has now been in force for over 10 years it is not too late to reform the law to take such an approach. Therefore the thesis is based on three underlying propositions which will be proven throughout: (i) that the GRA 2004 is indeed based on a particular medical model of transsexualism, (ii) that this medical model is deeply flawed in

relation to its suitability as a foundation for law and (iii) that a better model of providing legal recognition of one's gender identity is possible.

Deriving a Research focus

This thesis has particular personal importance for myself because the object of enquiry derives from numerous conversations with friends from the Scottish transgender community. The result of these conversations and discussions highlighted numerous difficulties which individuals faced on a daily basis and the fear that many experienced in relation to actual or potential discrimination. In addition to this, one common theme discussed regularly was the way in which individuals felt they interacted with the medical profession, particularly the difficulty of being accepted and the fear of not being able to meet the expected diagnostic narrative; a sense of medical professionals having power to enable or deny their progress in their quest to find peace with their identities and be able to take the necessary steps to be 'comfortable in their own skin'. These anecdotal examples led me to consider whether or not these concerns are reflected in the available literature and to see if the concerns expressed by these friends had been experienced by other trans* individuals in interaction with the medical profession.[4]

As a legal academic and member of the LGBTQI[5] community, the experiences of these friends concerned me and I sought to explore this from a legal perspective. Having taught both family law and medical law for a number of years I was fully aware of the legal process of changing one's sex and also of the consequences of not being able to do so but also I was able to appreciate that this particular issue encompassed aspects of medical law in addition to other areas of law such as family law and human rights. One of the early themes which developed from this perspective was the question *'what can be done if the individual is denied a diagnosis?'* My appreciation of medical law indicated that ultimately what the individual would seek to do would be to challenge a clinical decision and this is rarely, if ever, entertained by UK courts.[6] So then this led me on to considering how important the diagnosis is within the provisions of the GRA 2004: I began to see that without the initial diagnosis the individual cannot progress with their legal change of sex.

[4] Note that trans* is used to cover all identities covered by the transgender umbrella.

[5] Although traditionally the abbreviation is LGBT which is used to denote Lesbian, Gay, Bisexual and Transgender I prefer to use the broader abbreviation LGBTQI to highlight the various different identities which comprise this diverse spectrum. LGBTQI denotes Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex individuals. See <http://lgbt.ucla.edu/documentsLGBTTerminology.pdf> accessed 25 July 2014.

[6] See *inter alia: R v Secretary of State for Social Services ex parte Hincks* (1979) 123 S.J. 436*; R v North and East Devon Health Authority ex parte Coughlan* 2001 QB 213 (CA); *R v Secretary of State for Social Services ex parte Walker* [1987] 3 BMLR 32; *R v Cambridge District Health Authority* [1995] 25 BMLR 5.

Throughout the process of completing this thesis I have continued to revise and refine my area of enquiry and I now believe that I have a much stronger thesis which takes a novel approach to the issue of legal recognition of gender identity in the UK. The frustration with seeing that the medical profession held the power to enable or deny an individual's quest to have his or her gender identity recognised in law forced me to consider the actual scope of my enquiry: was I going to consider all transgender individuals, or was I going to only focus on transsexuals? Although the terms transgender and transsexual are quite often used interchangeably they do have particular meanings which render this interchangeability wrong. Currah *et al* note that: the term *transgender* "is now generally used to refer to individuals whose gender identity or expression does not conform to the social expectations for their assigned sex at birth."[7]

This has meant that the term *transgender* is currently accepted as a broad term used to denote the wider trans*[8] community in general and as such it is an 'umbrella term' which encompasses the broad spectrum of gender non-conforming individuals.[9] Stryker explains that the term:

> refers to all identities or practices that cross over, cut across, move between or otherwise queer socially constructed sex/gender boundaries. The term includes, but is not limited to, transsexuality, heterosexual transvestism, gay drag, butch lesbianism, and such non-European identities as the Native American Berdache or the Indian Hijra.[10]

So the defining characteristic of those individuals labelled transgender is that they do not conform to expected gender norms and expressions.[11] What is less clear is that there can be considerable movement between these trans* identities and the position which one takes up within the trans* community may change at different times of a person's life. So technically the term *transgender* encompasses this broad spectrum of gender diverse individuals "whose lifestyles appear to conflict with the gender norms of society"[12] of

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[7] P Currah, R M Juang and S P Minter (eds) *Transgender Rights* (University of Minnesota Press 2006) xiv.
[8] See M Walker 'Gender and language: examining the use of diagnostic language in the discussion of gender variance' (2014) *International Journal of Child, Youth and Family Studies* 5(2): 332-345, fn 3.
[9] For more on this see *inter alia*: E M Bodoin, C T Byrd and R K Adler 'The clinical profile of the male-to-female transgender person of the 21st century' (2014) *Contemporary Issues in Communication Science & Disorders* 41:39-54; S Hines *(Trans)Forming Gender: Social Change and Transgender Citizenship* in E Oleksy (ed) *Intimate Citizenships: Gender, Sexualities , Politics* (Routledge/Taylor & Francis 2009) 79-99.
[10] S Stryker 'Gender pluralisms under the transgender umbrella' in Currah Juang and Minter (n 7) 5.
[11] V L Bullough 'Legitimatizing transsexualism' (2007) *International Journal of Transgenderism* 10(1):3-13; 4
[12] S Whittle, L Turner and M Al-Alami *Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination* (Equalities Review 2007) 6

which *transsexual* is merely one position on that spectrum. Therefore the prefix trans* in the context of sex (as in transsexual) or gender (transgender) has multiple meanings: to cross, to transcend, to go beyond, to transgress. The slippage between the usage of transgender and transsexual can somewhat be explained by Ekins and King's use of the term 'transgendering'. Ekins and King use 'transgendering' to refer both to those who seek to permanently change sex (transsexuals) to those who transcend conventional understandings of sex and gender (transgenders).[13] In discussion with trans* individuals Ekins and King developed four narratives to describe the varieties of trans* experiences: *migrating* (moving from one to the other), *oscillating* (moving backwards and forwards between male and female), *erasing* (expunging one's gender altogether) and *transcending* (moving beyond the male/female binary system into a third space). Again Ekins and King's research highlights the diversity of trans* experiences and although *oscillating, erasing,* and *transcending* are clear examples of *transgender* individuals, *migrating* is not: *migrating* from male to female or vice versa implies a desire to permanently move i.e. it is more appropriate to use the term *transsexual* in relation to this specific group. So although the terms are often used interchangeably to include all gender variant individuals and transsexuals this thesis will continue to use the sub-categories of *transsexual, transgender* and *transvestite* as these categories become particularly important in the medical and legal context as will be shown throughout this thesis. It is the particular group labelled transsexual which will be the focus of this thesis. Largely this was determined by the PhD project in itself rather than actively by myself because I was primarily concerned with those who sought to utilise the GRA 2004 to live full time as members of the opposite sex and so I was necessarily limiting my focus to those who identified as transsexual, however this in itself has raised the possibility of future research exploring the ways in which transgender individuals fit within the UK legal system.[14] Indeed, as Chapter Six will show there is now a growing acknowledgement that law ought to provide recognition for those whose gender identity exceeds that currently recognised in law.

This then led me to the question *'what is the difference between legal and physical sex change?'* Although in theory at the start of this PhD process I was aware that one did not

[13] R Ekins and D King 'Towards a sociology of transgendered bodies' (1999) *The Sociological Review* 47(3):580-602.

[14] This has formed the basis for two presentations which I have delivered recently: the first titled 'Law as Symbolic Other in the process of achieving transsexual personhood' was presented at the 2012 Socio-legal Studies Association annual conference and the second was called 'The (Gender)Queer in UK Law: Why current protections are insufficient' which was presented at the 2013 Identity and Belonging workshop held at Edinburgh University.

require to change one's body prior to obtaining a Gender Recognition Certificate (GRC), I was not fully appreciative of what this meant. Therefore considerable time was spent exploring, and ultimately discarding, the human rights and medical literature on body modification. This literature formed an initial point of examination for me but I quickly realised that it was largely redundant to the central point of this thesis: whether or not one chooses to alter one's body is completely separate from obtaining a GRC and I was much more concerned with the stage before body modification – the diagnosis of gender dysphoria because it is this stage which amounts to the gate through which an individual must pass before being able to progress in their quest to be accepted as members of the opposite sex and have their internal gender identity recognised for legal purposes.

Once the complicated legal issues of body modification had been largely discarded as irrelevant to this thesis my focus was becoming much clearer. I then decided it was necessary to examine the topic from both a medical and legal perspective because this is where I saw the potential problems. So I found it necessary to consider how the medical profession deal with transsexual individuals. I explored the development of the condition resulting in the contemporary diagnostic criteria and I then explored the constituent parts of the medical process of diagnosing and treating transsexualism. On exploring the legal aspect of sex change I was struck by how law and medicine, until 2004, took very different approaches to transsexual individual: medicine was concerned with ensuring that the individual was not harmed and that he or she was provided with whatever treatment best suited their needs whereas UK law was, and continues to be, primarily concerned with certainty of sex, consistency between judgments and the impact that transsexuals have in relation to the wider community. The question of law being involved in the acknowledgment of gender identity and of giving rights to transsexuals is largely seen as a positive thing as it protects the rights of such individuals. In recent years, as a result of a focused legal campaign by individuals regarding rights for transsexuals, in both the UK and European Courts[15] there has been growing recognition, and legal protection,[16] of the

[15] As evidenced by the cases of *Rees v United Kingdom* (1987) 9 EHRR 56; *B v France* (1993) 16 E.H.R.R. 1; *Van Oosterwijck v. Belgium* 3 EHRR 557; *Goodwin v United Kingdom* (2002) 35 EHRR 18; *Van Kück v Germany* (2003) 37 EHRR 51; *L v Lithuania* (2008) 46 EHHR 22; *X, Y and Z v United Kingdom* (1997) 24 EHRR 143; *Cossey v United Kingdom* (1991) 13 EHRR 622; *Sheffield and Horsham v United Kingdom* (1999) 27 EHRR 163.

[16] Such as the Equal Treatment Directive (76/207/EEC) as interpreted in the case of *P v S and Cornwall County Council* (C13/94 [1996] 2 CMLR 247 as prohibiting discrimination in the workplace on the basis of an employee's sex re-assignment; Council Directive 2006/54/EC; the Gender Recognition Act 2004; The Sex Discrimination (Gender Reassignment) Regulations 1999 SI 1999/1102 which amended the Sex Discrimination Act 1975; the Sex Discrimination (Amendment of Legislation) Regulations 2009; The

rights of such individuals to be able to live as members of the sex opposite to their birth sex and to participate fully in civil, economic and social society as such. Human rights laws, such as the right to one's gender identity (as part of respect for private life under Article 8) and the right to marry protected by Article 12 of the European Convention on Human Rights and Fundamental Freedoms 1950 (ECHR),[17] are considered by those campaigning in this field to be a step towards legal protection of transsexual rights.[18]

So although there has been a growing transsexual rights movement the question of the role of the medical profession is only recently being considered. The clinician who is responsible for providing a diagnosis to a transsexual individual will either use the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* Fifth Edition (DSM 5) or the World Health Organisation's *International Statistical Classification of Diseases and Related Health Problems* 10th Revision (ICD-10). The issue of depathologisation[19] of gender identity by removing it from the DSM and ICD was proposed by *The Advocate* as early as 1996[20] however the question of the extent to which the medical profession should be involved has been a sustained focus of enquiry only recently with the revision of the DSM and the ICD. The American Psychiatric Association had been involved in the revision of the latest version of the DSM from 1999 until 2013 and the World Health Organization is currently revising the ICD.[21] One of the issues which was explored in these revision processes was whether or not to remove gender identity disorder from DSM 5[22] and transsexualism from ICD-11.[23] A side issue

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Protection from Harassment Act 1997; the Equality Act 2010 s.7; the Offences (Aggravation by Prejudice)(Scotland) Act 2009.

[17] *Van Kück v Germany* (2007) 37 EHRR 51; *I v United Kingdom* (2003) 36 EHRR 53; *Goodwin v United Kingdom* (2002) 35 EHRR 18. The importance of Articles 8 and 12 ECHR will be discussed in more detail in Chapters Two and Three.

[18] Declaration of Montreal (2012); The Yogyakarta Principles: principles of the application of international human rights law in relation to sexual orientation and gender identity (2007).

[19] Depathologisation refers to removal of the condition from the DSM and allowing the individual to determine for himself or herself his or her own gender identity. For some work on this please see *inter alia* A Ault and S Brzuzy 'Removing Gender Identity Disorder from the *Diagnostic and Statistical Manual of Mental Disorders:* a call for action' (2009) *Social Work* 52(2):187-189; E Atienza-Macías 'Some Legal Thoughts on Transsexuality in the Healthcare System after the New Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)' (2015) *Sexuality & Culture* 19(3):574-576.

[20] J Richardson 'Setting limits on gender health' (1996) *Harvard Review of Psychiatry* 4(1):49-53.

[21] ICD-11 is scheduled to be published in 2018.

[22] Ault and Brzuzy (n 19); M Davidson 'Seeking refuge under the umbrella: inclusion, exclusion, and organizing within the category transgender' (2007) *Sexuality Research & Social Policy* 4(4):60-80; J Drescher 'Transsexualism, Gender Identity Disorder and the DSM' (2010) *Journal of Gay & Lesbian Mental Health* 14;109-122; SR Vance, PT Cohen-Kettenis, J Drescher, HFL Meyer-Bahlburg, F Pfafflin, KJ Zucker 'Opinions about the DSM gender identity disorder diagnosis: results from an international survey administered to organizations concerned with the welfare of transgender people' (2010) *International Journal of Transgenderism*; 12:1-14; J Drescher 'Queer diagnoses: parallels and contrasts in the history of homosexuality, gender variance, and the Diagnostic and Statistical Manual' (2010) *Archives of Sexual Behavior* 39(2): 427-460; MC Paap, BP Kreukels, PT Cohen-Kettenis, H Richter-Appelt, G de Cuypere, IR

then became if the condition was to be retained in either classification system how should it be defined?[24] Ultimately gender identity disorder as a medical condition was removed from DSM 5 however it was replaced by gender dysphoria which retains the medical profession's role in the process of determining one's gender.[25] It remains to be seen whether transsexualism will continue to be included in ICD-11 when it is published in 2018. The issue of the potential depathologisation of transsexualism by its omission from DSM 5 and ICD-11 at the start of the process of completing this PhD was merely a theoretical possibility and unfortunately it remains as such as a result of the retention of the condition, albeit renamed as gender dysphoria in DSM 5. The retention of these medical conditions in the diagnostic manuals and therefore their continued pathologisation led me to question the *difference between pathologisation and medicalisation*.

There is considerable literature on medicalisation as an academic discipline and it was never my intention to examine this literature in depth as I am not concerned with medicalisation *per se* but rather the involvement of the medical profession in determining whether or not an individual can be given a diagnosis of *gender dysphoria* if the clinician is using the DSM 5 or of *transsexualism* if using the ICD-10. However, it is important at this point to clarify what is meant by both *medicalisation* and *pathologisation* as these are concepts which, although not discussed in any depth in the thesis, underpin much of the arguments being made in the thesis. Medicalisation "occurs when previously non-medical problems are defined and treated as medical problems, usually in terms of illnesses or disorders."[26] Skolbekken claims that one of the characteristics of medicalisation is that it results in "the constant widening of categories of symptom-free individuals in need of medical attention."[27] Those working in the sociology of medicine and health argue that many life experiences have been medicalised. A search of the literature suggests that

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Haraldsen 'Assessing the utility of diagnostic criteria: a multisite study on gender identity disorder' (2011) *Journal of Sexual Medicine* 8:180-90; S Rochman 'What's up, doc? Would removing transgender from the list of mental disorders do more harm than good?' (2007) *The Advocate* 32-35; G de Cuypere, G Knudson and W Bockting 'Response of the World Professional Association for Transgender Health to the proposed *DSM 5* criteria for gender incongruence' (2010) *International Journal of Transgenderism* 12(2):119-123.

[23] J Drescher, P Cohen-Kettenis and S Winter 'Minding the body: situating Gender Identity Diagnoses in the ICD-11 (2012) *International Review of Psychiatry* 24(6):568-577.

[24] H Richter-Appelt and DE Sandberg 'Should disorders of sex development be an exclusion criterion for gender identity disorder in DSM 5?' (2010) *International Journal of Transgenderism* 12(2):94-99.

[25] M Walker 'Gender and language: examining the use of diagnostic language in the discussion of gender variance' (2014) *International Journal of Child, Youth and Family Studies* 5(2): 332-345.

[26] P Conrad and V Leiter 'Medicalization, Markets and Consumers' (2004) *Journal of Health and Social Behavior* 45(extra issue):158-176; 158.

[27] J Skolbekken 'Unlimited medicalization? Risk and the pathologization of normality' in A Petersen and I Wilkinson (eds) *Health, Risk and Vulnerability* (Routledge 2008) 17.

experiences such as: pain,[28] childbirth,[29] breastfeeding,[30] menstruation,[31] fertility,[32] (male) circumcision,[33] eating,[34] sexual orientation[35] and indeed behaviour[36] have all been subject to the gaze of medicine and therefore have become medicalised. Indeed Skolbekken argues that life itself has become medicalised and he states that this has been as a result of the "pathologisation of normality"[37] It is important to outline the impact that medicalisation of a characteristic, trait or behaviour has on how it is contemporaneously understood. One of the major consequences of particular human traits coming under the gaze of medicine is that this process, the medicalisation of them, results in how those traits or behaviours are perceived. No longer is the trait or behaviour perceived as a normal variant of human experience but rather it transforms into a deviation from normality: in the case of transsexualism those who identify as members of the sex opposite to their birth sex are not generally thought of as merely exhibiting natural gender variance but rather can be diagnosed as transsexual and treatment can be provided to alleviate their psychological suffering.[38]

This is hugely important because, as Chapter One will show, variance in sexual behaviour, which may be thought of as completely normal and natural, was in the 1500s classed as deviant and sinful which led to the punishment of those who practices such sexual activities. This then led to the identification of a group of people; transsexuals. Over the course of almost a century the medical profession continued to refine what this term 'transsexual' actually meant thus taking gender variance (a natural occurrence) and

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[28] G A Bendelow and S J Williams 'Transcending the dualisms: towards a sociology of pain' (1995) *Sociology of Health & Illness* 17(2):139-165.

[29] C K Reissman 'Women and Medicalization' (1983) *Social Policy* 14:3-18.

[30] M Ryan, M Victoria, K Grace 'Medicalization and women's knowledge: the construction of understandings of infant feeding experiences in post-WWII New Zealand' (2001) *Health Care for Women International* 22(5):483-500; R D Apple 'The medicalization of infant feeding in the United States and New Zealand: two countries, one experience' (1994) *Journal of Human Lactation* 10(1):31-37.

[31] E Bransen 'Has menstruation been medicalised? Or will it never happen…' (1992) *Sociology of Health & Illness* 14(1):98-110.

[32] G Becker and R Nachtigall 'Eager for medicalisation: the social production of infertility as a disease' (1992) *Sociology of Health & Illness* 14(4):456-471; D Dempsey 'ART eligibility for lesbians and single heterosexual women in Victoria: How medicalisation influenced a political, legal and policy debate' (2008) *Health Sociology Review* 17:267-279.

[33] L M Carpenter 'On remedicalisation: male circumcision in the United States and Great Britain' (2010) *Sociology of Health & Illness* 32(4):613-630.

[34] J H White 'Feminism, eating and mental health' (1991) *Advances in Nursing Science* 13(3):68-80.

[35] P Conrad and A Angell 'Homosexuality and remedicalization' (2004) *Society* 41(5):32-39.

[36] P Conrad and J W Schneider *Deviance and Medicalization: from Badness to Sickness* (Mosey 1980); I K Zola 'Medicine as an Institution of Social Control' (1972) *Sociological Review* 2:487-504.

[37] J Skolbekken 'Unlimited medicalization? Risk and the pathologization of normality' in A Petersen and I Wilkinson (eds) *Health, Risk and Vulnerability* (Routledge 2008) 17.

[38] It is appropriate to use the word 'suffering' here because a core aspect of the medical condition Gender Dysphoria (GD) is that the individual experience suffering which occurs due to the condition: those who do not experience this psychological distress cannot obtain a diagnosis of GD.

recreating it as a medical concern; a condition, and indeed identity, completely owned by the medical profession – one could not be transsexual unless the medical profession, applying certain tests and standards, agreed that one was in fact transsexual.

There is a clear link between the medicalisation of human conditions such as gender variance and their pathologisation. Medicalization brings it within the realm of medicine and pathologisation renders it abnormal. Gender variance is a natural aspect of the human condition but through the work of early sexologists it became pathologized i.e. abnormal. This pathologisation continued through the 20th century and was further developed in each iteration of the diagnostic manuals where transsexualism as a medical condition was refined. As Butler writes in relation to gender variance "[t]he [diagnosis of GD] can operate in several ways, but one way it can and does operate […] is as an instrument of pathologisation"[39] and that "[t]o be diagnosed with [GD] is to be found, in some way, to be ill, sick, wrong, out of order, abnormal, and to suffer a certain stigmatization as a consequence of the diagnosis being given at all."[40]

There is an ongoing debate surrounding the cost-benefit of having GD within the diagnostic manuals. One the one hand it is argued that removing the diagnosis would result in individuals being unable to access the medical procedures they require to transition. However on the other there are strong arguments for removing the condition from the diagnostic manuals – it is through being in these manuals that what it means to have GD is determined and 'brought into being' i.e. GD (as a medical condition) does not exist outwith the medical profession and the diagnostic manuals. Raymond argued in 1979 that it was the medical profession which created transsexualism, and as Chapter One will show, she is right. According to Raymond medicine has created an empire around transsexualism whereby "a number of medical specialists [combine] to create transsexuals – urologists, gynaecologists, endocrinologists, plastic surgeons, and the like."[41] The input of medicine has been to 'create' a condition and then develop a means of treating it. She claims that "without [medicine's] sovereign intervention, transsexualism would not be a reality."[42] That is not to say that before medicine identified the condition of transsexualism no one experienced feelings of being the opposite sex. Chapter One will clearly show that through

[39] J Butler *Undoing Gender* (Routledge, 2004) 76.
[40] ibid.
[41] J Raymond *The Transsexual Empire* (The Women's Press, London 1979) xv.
[42] ibid.

the centuries there have been such individuals. However the question then is to what extent is gender variance natural or pathological?

A review of literature would suggest that gender variance is not an unnatural act, indeed it may well be that those who could be said to be 100% male or 100% female are in the minority…if such a thing could actually be determined. It is important to consider at this point what is meant by the terms sex and gender. Sex refers to one's physical body and gender refers to one's physiological identification as male or female. Human beings are, by in large, a diamorphic species; either male or female. Howson claims the:

> 'natural attitude' towards sex and gender in the West assumes that people belong to one of two possible distinct categories determined on the basis of given biological and anatomical characteristic.[43]

However the natural attitude is merely that, an attitude, not a universal truth. This means that sex and indeed gender is a spectrum and there are a variety of different ways of experiencing one's gender and living one's gender. Personally I am of the opinion that determining how one identifies as male or female should not be a question for another individual to make i.e. a medical professional, or for the law. However it remains the case that law and medicine do not support this perspective and in both UK law and worldwide medicine transsexualism remains a medical condition. This means then that it is crucial to examine it as both a legal and medical issue and to consider the extent to which medicine has impacted on the legal ability of UK domiciled transsexuals to have their gender identity recognised for legal purposes.

So, although this thesis derived from personal conversations with friends and a personal need to fully understand the process of physically and legally changing sex it quickly developed into an academic enquiry into the role of law and medicine in relation to the issues presented by transsexual individuals. The process of completing the PhD has not been easy, that is to be expected, and as noted above a number of sub-topics required to be fully explored to ensure that this thesis was as comprehensive as it could be in 100,000 words. Although several of the sub-topics I explored do not find their way into this thesis the time I spent on them and the work I have done in exploring them has not been wasted. The wider exploration of the various issues raised have primarily given me a much fuller appreciation of the subject of this thesis but it has also provided inspiration for a number of

[43] A Howson *The Body in Society: An Introduction* (Polity Press 2004) 42.

future projects which I have begun to explore. Although the past seven years has seen various iterations of this thesis the questions which always remained constant and to which I always returned were to what extent has the medicalisation of cross-sex identities impacted on the GRA 2004, what are the consequences of this for the individuals involved and is it possible to develop a better approach to gender identity recognition in UK law?

This developed into the focus of my research: ***to show how the GRA 2004 adopted a particular medical model of transsexualism as the basis for the provision of legal recognition of gender identity which in turn provides for a particularly strong gatekeeper role for medical professionals, that this model upon which the GRA 2004 is built is flawed, and that there is a better alternative approach available.***

Overview of Chapters

To examine this the thesis is split into three parts which map to the three underlying propositions which are set out above. Part I examines how transsexualism as a medical condition emerged from various sexological and medical enquiries in the nineteenth and twentieth centuries. Chapter One shows how the medical model of transsexualism which underpins the GRA 2004 was, in 2003/4, inevitable as a result of over a century of investigation into the causes of gender variance resulting in those individuals who expressed gender variance, of any kind, being deemed unwell. Conrad note that this process is one of the key characteristics of medicalisation so in effect it is possible to say that the emergence of transsexualism as a medical condition in the late twentieth century was a result of the medicalisation of gender variance which occurred over the preceding century. The medicalisation of gender variance has resulted in gender variance being classified, in a variety of ways, in diagnostic manuals and an entire medical discipline has developed to diagnose and treat such individuals. It is only in very recent years, after the enactment of the GRA 2004, that calls to both demedicalised – remove any form of medical input into the determination of gender identity - and depathologise – remove gender variance from the diagnostic manuals - gender variance have been made.

Once the emergence of transsexualism as a medical condition has been established Chapter Two examines the way in which law dealt with those individuals who partook of the medical advances which were set out in Chapter One. Through a detailed examination of case law, Chapter Two explores the legal consequences for individuals of not being able to

acquire legal recognition of their gender identity. The purpose of this is to show the impact that non recognition has on those individuals whose gender identity is unrecognised before UK law. Chapter Three then explores the possibilities for reform which arise from the case of *Goodwin.*

Chapter Four critically examines the legislation and outlines the provisions of the GRA 2004 and shows how the GRA 2004 works and what criteria need to be fulfilled to enable the individual to acquire legal recognition of his or her gender identity. The focus of this chapter is to show how the GRA 2004 specifically legislates based on a medical model of transsexualism for the provision of legal recognition of gender identity in two particular ways: (i) through the requirement for a diagnosis and (ii) through the test placed on the GRP to ensure that only 'true' transsexuals are able to acquire legal recognition. The requirements that one obtains a diagnosis of GD and also that their application is scrutinised by the GRP are fundamental problems because they acts as potential points, gatekeeper points, at which the individual may be stopped by a third party from being able to access the protections in the GRA 2004.

Part II of the thesis explores the second central proposition – that the medical model in the GRA 2004 is deeply flawed in relation to its suitability as a foundation for law. In so doing Chapter Five shows how the medical model operates in practice. The issue of medical professionals acting as gatekeepers will be explored. Although the gatekeeper function of medical professionals has been long accepted, particularly when considering such medical procedures as cosmetic surgery and fertility treatment *etc.* what is less familiar is the idea that medical professionals will act not as gatekeepers to treatment *per se* but rather the GRA 2004 establishes the medical profession as gatekeepers of legal identity because without the individual being able to obtain a diagnosis of Gender Dysphoria (GD) as required by the legislation the individual cannot then make an application to have his or her gender identity recognised in UK law; therefore the diagnostic stage is crucial within the current model of legal recognition in the UK. This chapter shows how the diagnosis is made and argues that at various points during the diagnostic stage the individual can be halted in his or her quest for legal recognition. In addition the chapter explores the gatekeeping role placed on the GRP. In doing so the various subsections of s.2 of the GRA 2004 will be critiqued to show that the law actually requires that the GRP only let those pass who could be said to be true transsexuals i.e. those who fit the medical model of transsexualism in 2003/4. The key point of this is to show that the various tests in s.2 of the

GRA 2004 are potentially very difficult to satisfy because they are not about ensuring that everyone who seeks legal recognition will get it but rather their purpose is to limit who obtains legal recognition to a proportion of the transgender community – those who seek to live forever as a member of the opposite sex. Indeed it could even be said that those who are able to pass through the s.2 test are likely to be those who could be called 'classic' transsexuals i.e. who have already undergone body modification prior to applying for a GRC: these issues are explored in depth in Chapter Five. However not only is there a problem with the GRA 2004 requiring a diagnosis of GD and requiring that a panel scrutinise application but there is also a fundamental problem with basing the law on a medicalised approach to gender variance *per se*. Chapter Five also explores how the accepted medical position on gender variance in the 2004 Act is in itself a weak foundation for gender identity recognition laws because medical knowledge continues to develop beyond that which existed in 2003/4. This chapter shows that the medical understanding of gender variance in 2003/4 is substantially different from that in existence in 2015 and the changes within medicine fundamentally challenge the UK's approach to the provision of legal recognition of gender identity. Chapter Five outlines how the specific requirements in the GRA 2004 places very strict boundaries around who will be able to achieve legal recognition of their gender identity and argues that this approach is contrary to the way that the medical profession currently understands gender variance. As the GRA 2004 provisions have remained static while the medical understanding of gender variance has developed the GRA 2004 therefore acts in a way which excludes other individuals who do not meet the provisions within the Act despite them potentially being able to obtain a diagnosis of GD from the medical profession.

Since the issues contained in the Chapter Five undermine the suitability of the medical model of transsexualism as a foundation for gender recognition laws it is then necessary to examine the possible alternative approach which could be taken. Part III of the thesis turns to developing an alternative means of providing legal recognition of gender identity in UK law, one in which there is no third party role in determining one's gender identity. This thesis argues that a model of recognition of gender identity which is based on gender self-declaration is possible and indeed desirable. Chapter Six explores how the self-declaration model can give rise to a more inclusive, and thus better, approach to gender identity recognition than currently exists in the GRA 2004. When embarking on the research for this thesis it was not possible to show that other non-medical models of gender identity recognition existed in law however during the process of researching and writing this

thesis five jurisdictions amended their legislation: Argentina, Colombia, Denmark, Ireland, and Malta. The approach taken in each of these countries is to remove the input of any medical professional in the process of individuals being able to acquire legal recognition of their gender identity. Indeed they all go further than that and remove any third party intervention into the legal process:[44] this approach, the self-declaration model is, as will be argued in Chapter Six, a much better model on which to base legislation because it removes the gatekeeper roles of the medical professional and third parties in this process and therefore allows the individual's sense of self as male or female to be acknowledged and recognised in law without first having to be tested for accuracy or underlying causes.

[44] Unless the applicant in Ireland in aged 16 or 17 in which case he or she needs parental permission and medical intervention.

1. The Emergence of Transsexualism as a Medical Condition

Introduction

Transsexualism as a medical condition first appeared as a distinct condition in the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1980. Although this might suggest its recognition is relatively recent, the medical focus on gender variance began in the 1800s and thus as, Sharpe claims, contemporary transsexualism has a long and complex genealogy.[45] This chapter explores how transsexualism developed and emerged as a medical condition in the mid 1950s as a result of sustained focus on gender variant individuals and homosexual behaviour which began to be the concern of sexologists in the late 1800s. The purpose of this chapter is to show how gender variance and homosexuality, naturally occurring variances of human beings, led to the development of a particular way of thinking about gender variant individuals in particular as being unwell. This particular way of thinking about those who would become labelled as transsexuals in the 1950s led to the legislation adopting the medical model of transsexualism as its basis for legal recognition of gender identity. It should be noted that the contemporary medical condition in DSM 5 is named gender dysphoria whereas in earlier versions of the DSM it was referred to as Gender Identity Disorder (GID). In the World Health Organisation's *International Classification of Diseases and Related Health Problems* 10th Revision (ICD-10) the condition is referred to as transsexualism. So, where appropriate, the terms transsexualism, GID and GD will be used interchangeably.

The history of transsexualism can be split into three distinct periods. The first period began in the late 1800s where the primary researchers were sexologists and the focus was on homosexual behaviour. The second period was from the 1920s to the 1970s when medical science was developing at a fantastic rate, particularly in relation to the identification, and artificial creation, of hormones and advances in surgical and aseptic techniques which resulted in tensions within medicine itself, particularly between psychiatrists and surgeons and endocrinologists in relation to the aetiology of gender variance and its treatment. The third distinct period is from 1970 to today which is dominated by the work and influence of

[45] A N Sharpe 'Institutionalizing heterosexuality: the legal exclusion of 'impossible' (trans)sexualities' in L J Moran, D Monk and S Beresford *Legal Queeries: Lesbian, gay and transgender legal studies* (Cassell 1998) 26-41, 28.

pioneering sexologist, Harry Benjamin. This chapter will now explore each of these distinct periods in the history of the emergence of transsexualism as a medical condition and will show how the medical profession dealt with individuals who presented as, or professed to be of, the opposite sex to their birth sex. The purpose of doing this is to show how the foundation for the GRA 2004 was created because it was through this medical development of the condition of transsexualism that the resultant legislation became framed in such a way as to include certain individuals and exclude others, based on a medical assessment of their self-defined gender identity.[46]

Stage 1: the initial focus of sexologists on non-procreative sexual behaviour

The contemporary understanding of transsexualism began with the work of nineteenth and early twentieth century sexologists working in the field of deviant sexuality. Weeks claims that "[f]rom the mid nineteenth century the medical profession began to break down the formerly universally execrated forms of non-procreative sex into a number of 'perversions and deviations'".[47] The task of theorists and sexologists was to catalogue the emerging deviant sexualities and to find a cause for such behaviour.[48] The norm was seen as heterosexual procreative, or at least potentially procreative, sex. Anything which deviated from this supposed norm was seen as a perversion which must have been caused by something; it was certainly not seen as natural. The early sexologists were therefore not concerned with gender variance *per se* but with classifying sexual behaviour and attempting to argue that it was a result of a person's nature and not sinful desire. As will be seen from the following discussion homosexuality began to emerge as a distinct category following this initial research. Once homosexuality was studied and categorised, other 'deviant behaviour' could be distinguished from it. It was from this recognition of homosexuality that such behaviours as transvestism were identified and, then later, transsexualism. So, while in the early 1800s, transsexual individuals were not considered to be a distinct group separate from other minority groups such as homosexuals it was through this early work on homosexuality that transsexualism came to be recognised as a distinct condition. Furthermore, as Hill notes, this work identifying a "proliferation of "perverse sexuality" was met with a corresponding rise in the social control of sexuality,

[46] This will be returned to in the remaining chapters of this thesis, particularly Chapter Five, where the problems with the legislation are examined in detail.
[47] J Weeks *Coming Out: Heterosexual Politics in Britain, from the Nineteenth Century to the Present* (Quartet Books 1977) 25.
[48] S Hines *Transforming Gender: Transgender practices of identity, intimacy and care* (The Policy Press, 2007) 10.

which was increasingly medical and psychiatric"[49] and which will be discussed in more detail later this chapter, when the work of the sexologists is examined.

The historical legal context

The legal context in which the early sexologists were working was such that homosexuality was a criminal offence. The anti-homosexuality legislation, which formed the basis from which the sexologists in the late nineteenth and early twentieth centuries would eventually distinguish between homosexuals and transsexuals, derived from anti-buggery laws, which had much earlier history. Fone writes that:

> [i]n 1533, the twenty-fifth year of the reign of Henry VIII, Parliament noted that as yet England had no "sufficient" punishment for "the detestable and abominable vice of buggery committed with mankinde or beast."[50]

So, in 1533, in an effort to provide such a sufficient punishment the Buggery Act was passed which criminalised all male homosexual sexual activity alongside other forms of sexual behaviour which could be classified as sodomy e.g. heterosexual non-vaginal intercourse; the punishment being death.

In 1553 the Buggery Act was repealed by Mary Tudor.[51] However, in 1558 Queen Elizabeth I reinstated the earlier Buggery Laws as passed by Henry VIII.[52] As will be shown throughout this chapter this legacy of criminalisation of such behaviour was to continue throughout the centuries with particularly negative implications for those who identified not only as homosexual but also for those who identified as members of the sex opposite to their birth sex i.e. those who, in the 1950s, came to be called transsexuals. It was these initial laws which, centuries later, prompted the research into so-called deviant sexuality and the evolution of the medicalisation of transsexualism.

Therefore, buggery and sodomy had been statutory criminal offences in England and Wales since the early 1500s. In Scotland, such acts were criminalised under the common law crime of lewd, indecent and libidinous practices.[53] The law in both jurisdictions was

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[49] D B Hill 'Sexuality and gender in Hirschfeld's *Die Transvensiten*: a case of the "elusive evidence of the ordinary."' (2005) *Journal of the History of Sexuality* 14(3):316-332; 317.
[50] B Fone *Homophobia: A History* (Picador, New York, 2000) 215.
[51] ibid 218.
[52] ibid.
[53] B Dempsey 'Piecemeal to equality; Scottish gay law reform' in L Moran *et al* (eds) *Legal Queeries* (Cassell, London, 1998).

concerned with behaviour, not individuals, and was concerned with sexual acts which were deemed to be a "sin against nature".[54] As Weeks claims, "all acts of sodomy were equally condemned as being 'against nature', whether between man and woman, man and beast, or man and man."[55] The Buggery Act 1533 was finally repealed by s.1 of the Offences Against the Person Act 1828 however the offence was merely replaced by s.15 of the 1828 Act. The name given to such activities in s.15 of the 1828 Act was sodomy. The death penalty for buggery was only abolished in England and Wales in 1861 and in Scotland in 1889.

However, despite the death penalty as punishment for this behaviour being abolished, the law was not about to take a lenient approach to homosexual behaviour. In 1885, the Criminal Law Amendment Act (CLAA 1885), by means of the Labouchère Amendment, criminalised gross indecency in both England and Wales and Scotland. The Labouchère Amendment became s.11 of the CLAA 1885 which provided that:

> [a]ny male person who, in public or private, commits, or is a party to the commission of, or procures or attempts to procure the commission by any male person of any act of gross indecency with another male person, shall be guilty of a misdemeanour, and being convicted thereof shall be liable at the discretion of the court to be imprisoned for any term not exceeding two years, with or without hard labour.

This section was often used to prosecute male homosexual acts,[56] indeed it has been argued that the Labouchère amendment enabled the state to prosecute those who engaged in male homosexual behaviour where it was not possible to prove that buggery or attempted buggery had taken place.[57] Those who engaged in particular sexual acts and those who were deemed to be cross-dressers (contemporary transsexuals as well as transvestites and transgendered individuals) were considered to be sodomites and were severely punished.[58] Weeks notes that "[s]odomy was a portmanteau term for any forms of sex that did not have

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[54] J Weeks (n 48) 11.
[55] ibid 12.
[56] ibid14. See, for example *R v Jones and Bowerbank* [1896] 1 Q.B. 4.
[57] M Cook *A Gay History of Britain* (Greenwood World Publishing, 2007) 133.
[58] It has to be noted that there was no specific legislative offences which covered lesbian sex. It is thought that this omission from the statute books was merely because it was not a social concern when the 1885 Act was being passed. It may well have been possible to criminalise women who participated in lesbian sex by means of common law provisions covering indecency law. It was possible to accuse transsexual men and cross-dressing men of procuring or attempting to procure acts of 'gross indecency' with other men as, transsexual men in particular, presented as female. Any attempt by a male transsexual or a cross-dressing male to engage another man in flirtatious behaviour would therefore amount to an attempt to procure an act of 'gross indecency'. For more on this see J Weeks (n 48). This provision is similar to those legislative provisions which attempt to regulate street prostitution where merely loitering may be seen as an attempt to procure sex. See the Prostitution (Public Places)(Scotland) Act 2007 s.1.

conception as their aim, from homosexual acts to birth control" [59] i.e. a more contemporary form of the anti-buggery provisions which the offence of sodomy contained in the s.15 of the 1828 Act replaced. Weeks argues that:

> [t]he gross-indecency clause of the Criminal Law Amendment Act has to be set against a background of a sharpening definition of and hostility towards homosexuality in the late nineteenth century, not only in Britain but in other European Countries, especially Germany.[60]

It is important that other European countries were criminalising homosexual behaviour at this time, as much of the work of early sexologists derived from continental Europe in which similar legal and social changes were occurring. For example, in 1870 the Prussian Penal Code criminalised male homosexual behaviour (other than mutual masturbation) in all German states.[61] Even in countries where homosexual acts were not illegal *per se* "social hostility sharply increased towards the end of the [nineteenth] century."[62] In the United Kingdom, the social condemnation and further criminalisation of homosexual behaviour can be traced to the social purity movement of the 1880s.[63] The social purity movement, to simplify, was largely concerned with public sexuality in the form of prostitution, particularly as it related to the 'white slave trade'. However as Weeks claims, prostitution and male homosexuality soon became seen as part of the "continuum of undifferentiated lust, products of men's sexual selfishness."[64] In the minds of the moral crusaders of the late nineteenth century "the syndromes of schoolboy masturbation, public-school 'immorality' (meaning homosexuality) and prostitution were closely intertwined."[65] Alongside this condemnation of sexual practices deemed harmful to the social order was the increase in dominance of the concept of the family which, according to Weeks, had by the 1880s "become the paradigm of a stable society."[66] Inherent within this model of the family was heterosexual procreative sex.[67] At this point in social history, major changes were happening such as the calls for children's protection in the workplace and other calls for reform of the law such as those focusing on sex, child protection from neglect and

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[59] Weeks (n 48) 14.
[60] ibid 15.
[61] ibid.
[62] ibid.
[63] For more on this movement see, among others, S Jeffreys *The Spinster and Her Enemies: Feminism and Sexuality 1880-1930* (Spinifex Press, Melbourne, 1985); J R Walkowitz *City of Dreadful Delight: Narratives of Sexual Danger in Late-Victorian London* (Virago 1992); M Pearson *The Age of Consent: Victorian Prostitution and its Enemies* (David & Charles 1972).
[64] Weeks (n 48) 16.
[65] ibid 16-17.
[66] ibid 18.
[67] ibid 18.

abuse, employment, education *etc.*[68] and this influenced the approach taken to homosexuality. However, these acts of criminalisation and social condemnation did not prevent the behaviour; individuals still practiced non-heterosexual and non-procreative sex and some individuals presented as members of the opposite sex as evidenced in the literature being explored in this chapter. It was within this context of illegality and social condemnation that the early sexologists began to differentiate between homosexuals and transsexuals.

The Early Sexology Work: 1880s-1920s

One of the first sexologists to attempt to classify the sexual impulses of individuals was Richard von Krafft-Ebing. In 1877 Krafft-Ebing's *Psychopathia Sexualis* was first published in which he undertook "a vast taxonomic project"[69] which sought to classify particular features of a number of case studies he carried out. The study was predicated on the belief held by Krafft-Ebing that "any departure from procreative heterosexual intercourse represents a form of emotional or physical disease."[70] In fact, according to Stryker and Whittle "Krafft-Ebing considered homosexuality to be a form of gender variance."[71] Although current understandings of homosexuality and transsexuality would clearly make demarcations between both of these identities, for the early sexologists they were manifestations of one another and there was no simple separation of homosexuality and transsexuality. So, rather than use the word homosexuality to describe the sexual desires which he observed in patients Krafft-Ebing used the term *antipathic sexual instinct.*[72] For Krafft-Ebing one's gender identity (although he never used this term) followed one's physical development and sexual maturation. He noted that "[i]f the sexual development is normal and undisturbed, a definite character, corresponding with the sex, is developed."[73] So, all being well, male children mature and develop a male gender identity and desire females and vice versa for female children. He continued:

> [i]f the original constitution is favourable and normal, and factors injurious to the psycho-sexual development exercise no adverse influence, then a psycho-sexual personality is developed which is so unchangeable and corresponds so completely

[68] L A Hall *Sex, Gender and Social Change in Britain since 1880* (Palgrave Macmillan 2000); J Weeks *Sex, Politics and Society: The Regulation of Sexuality since 1800* (Longman 1989).
[69] S Stryker and S Whittle (eds) *The Transgender Studies Reader* (Routledge 2006) 21.
[70] ibid 21.
[71] ibid.
[72] R von Krafft-Ebing *Psychopathia Sexualis* (Arcade Publishing 1965); 186-188. Antipathic sexual instinct can be defined as sexual instinct which is contrary to what would be expected to develop i.e. same sex attraction and identification as members of the opposite sex.
[73] ibid 187.

> and harmoniously with the sex of the individual in question, that subsequent loss of the generative organs (as by castration) or the *climacterium* or senility, cannot essentially alter it.[74]

He explored the possibility that development of one's gender identity, which he termed psychosexual development, was influenced by one's "generative glands"[75] i.e. one's testes and ovaries. He concluded that there must be some role for the testes and ovaries, although their exact role was unclear to him.[76] The fact that such a role was unclear in the late nineteenth century when Krafft-Ebing was conducting his study is not a surprise. As will be discussed below, it was only in the early twentieth century that hormones were discovered by scientists and their role in psychosexual development began to be theorised and explored. However, for Krafft-Ebing gender identity was not solely determined by physiology. He observed:

> that the physical processes taking place in the genital organs are only co-operative and not the exclusive factors, in the process of development of the psycho-sexual character, is shown by the fact that, notwithstanding a normal anatomical and physiological state of these organs, a sexual instinct may be developed which is the exact opposite of that characteristic of the sex to which the individual belongs.[77]

Therefore the term *antipathic sexual instinct* was used to describe these individuals whose gender identity was opposite to that which could be expected. Of these individuals he stated that:

> since in nearly all such cases, the individual tainted with antipathic sexual instinct displays a neuropathic predisposition in several directions, and the latter may be brought into relation with hereditary degenerate conditions, this anomaly of psycho-sexual feeling may be called, clinically, a functional sign of degeneration.[78]

This is important. The classification of those who would today be called transsexuals within the heading of antipathic sexual instinct meant that for the first time those who identified as members of the opposite sex were considered to be ill. He determined that there were two types of antipathic sexual instinct: acquired and congenital.[79] Of congenital antipathic sexual instinct he stated:

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[74] ibid. Note that *climacterium* is the process of bodily and psychic changes which accompany the aging process from middle to late age.
[75] ibid.
[76] ibid.
[77] ibid.
[78] ibid.
[79] Stryker and Whittle (eds) (n 70) 21.

> [t]his inverted sexuality appears spontaneously, without external cause, with the development of sexual life, as an individual manifestation of an abnormal form of the sexual life.[80]

Of acquired antipathic sexual instinct he stated "it develops upon a sexuality the beginning of which was normal, as a result of very definite injurious influences."[81] It is the congenital antipathic sexual instinct which, for Krafft-Ebing, gave rise to a condition which included those covered by the term *metamorphosis sexualis paranoica*[82] which was considered "the most extreme, and therefore the most pathological, form of gender deviation in Krafft-Ebing's conceptual framework."[83] It is this group, first identified by Krafft-Ebing as exhibiting a pathological sexual preference, which we now understand as transsexuals; those with a desire to change their bodies to appear as members of the opposite sex. So, as can be seen Krafft-Ebing's work was really the beginning of a sustained enquiry into deviant sexuality which gave rise to identifying different forms of antipathic sexual instinct which, when further explored and delineated gave rise to the possibility of transsexuals emerging as a distinct category of individuals in the sexology literature at a later date.

Therefore it can be seen that in the era in which Krafft-Ebing was writing and carrying out his study transsexuals, as contemporaneously understood, were not a separate category of individuals but rather represented a category of homosexuals who were deemed to have a pathological sexual preference. Indeed Stryker and Whittle argue that those individuals identified by Krafft-Ebing as comprising the *metamorphosis sexualis paranoica* sub-group of homosexuals were, according to him "profoundly disturbed, and [he] considered their desire for self-affirming transformation to be psychotic."[84]

Following on the work of Krafft-Ebing was that of Magnus Hirschfeld's famous *Die Transvestiten: eine untersuchung über den erotischen verleidungstrieb*[85] which was first published in 1910. Whereas in its contemporary usage 'transvestite' denotes an individual who, usually male, dresses as a member of the opposite sex and who, normally, experiences sexual arousal from this cross-dressing Hirschfeld did not distinguish between transvestites and transsexuals but rather he used the term 'transvestite' to refer to both

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[80] R von Krafft-Ebing (n 73) 188.
[81] ibid.
[82] This roughly translates as paranoid sexual metamorphosis and in the context of Krafft-Ebing's work is taken to indicate those individuals who, although primarily categorised as homosexual at that time, exhibited a desire and belief that they were of the opposite sex.
[83] Stryker and Whittle (eds) (n 70) 21.
[84] ibid.
[85] This translates into English as *The Transvestites: The Erotic Drive to Cross-Dress.*

groups; those who cross-dressed for sexual pleasure and those who claimed to *be* a member of the opposite sex. Indeed Lukianowicz notes that "Hirschfeld uses several different criteria in his classification of transvestism."[86] It is this complex system of categorisation of transvestites which enables Hirschfeld to encapsulate both erotic cross-dressers and contemporary transsexuals within the one term. According to Lukianowicz it is possible to identify 10 sub-categories of transvestite within Hirschfeld's *Die Transvestiten* only one of which corresponds to the contemporary understanding of 'transsexual': Hirschfeld's 'complete' transvestite who seeks to have his sex changed. These are the same individuals who Krafft-Ebing referred to in the late nineteenth century as exhibiting *metamorphosis sexualis paranoica.*[87] It was at this point that transsexuals really began to emerge in sexology literature as a distinct group separate from homosexuals and cross-dressers and it was this work which separated those who could be called 'complete transvestites' in Hirschfeld's lexicon or those exhibiting *metamorphosis sexualis paranoica* in Krafft-Ebing's who would continue to be the focus of so much research into the nature and causes of this identification.[88]

In this period transsexuals began to be described as 'inverts' which implied that there was a mistake in the natural order of biological body and psychological identity. Ellis, writing in the mid twentieth century, claims that female inverts possessed a "masculine straightforwardness and sense of honor"[89] whereas Krafft-Ebing, writing at the end of the nineteenth century, claimed that such female inverts have a "dislike and sometimes incapacity for needlework"[90] and "an inclination and taste for the sciences."[91] Within the work of these early sexologists was a prevailing biological determinism; men and women behaved in a particular manner appropriate to their biological sex, anyone who did not behave in a gender appropriate manner was an invert. These non-normative preferences and identities became medicalised due to the focus on classifying individual's various behaviours, preferences and identities. Once medicalised by being placed within the domain of medical science and psychiatry the 'perversions' e.g. homosexuality, transsexuality, transvestism *etc.*, became pathologised. As noted in the Introduction to this thesis the link between medicalisation and pathologisation is a close one and often when

[86] N Lukianowicz 'Survey of various aspects of transvestism in the light of our present knowledge' (1959) *Journal of Nervous and Mental Disease* 128:36-61; 37.
[87] See above for further discussion on *metamorphosis sexualis paranoica.*
[88] Please note that at this point in history such behaviour was merely an identification rather than a medical condition as there was no fully accepted medical position on transsexualism until the 1970s.
[89] H Ellis *Studies in the Psychology of Sex: Sexual Inversion* (FA Davis Company 1915), 250.
[90] R von Krafft-Ebing (n 73).
[91] ibid.

characteristics, traits and behaviours become medicalised this results in their pathologisation i.e. being judged against an accepted norm. The pathologisation of these behaviours will be noted below when an examination of the diagnostic manuals is given.

This period in the history of the emergence of transsexuality as a medical condition was dominated by the medicalisation of gender variant behaviour which was examined as a means of developing a taxonomy of sexual behaviours. The enquiry into gender variant behaviours in this period in history is, therefore, an offshoot of a preoccupation with studying, classifying and pronouncing on human sexual behaviour. This work was ground-breaking at the time but was not without its flaws.[92] Hill notes that "[s]exologists were clearly making things up as they went along, guided by theories, clinical observations, and existing wisdom."[93] One of the consequences of this early stage work was that transsexuals began to be thought of as ill rather than as deviant and it was this label of illness which resulted in the pathologisation of gender variant behaviour in later years. Following on from the work of sexologists in the late nineteenth and early twentieth centuries was the development of medical science, particularly in relation to discovery of hormones and the development of aseptic and anaesthetic techniques which further developed the medicalisation of gender variance and further strengthened the medical model of transsexualism. The following section details the impact that developments in medical science had on enabling the emergence of transsexuals as a focus of medicine and the tension which subsequently arose between general medicine and psychiatry.

Stage 2: the 1920s – 1970s and the battle between general medicine and psychiatry

Advances in medical science played a crucial part in the realisation of transsexual identity. While conceptually transsexuals had begun to be separated from homosexuals in the work of the sexologists as outlined above, medicine made it possible for those with cross-sex identities to alter their bodies in such a way to enable a permanent change from one sex to the other. A combination of surgical advances regarding anaesthesia and aseptic techniques, and developments in medical science concerning hormone production and understanding their influence on gender identity and secondary sex characteristics, along with advances in the development of electrolysis, enabled the treatment of those who identified as members of the sex opposite to their birth sex.

[92] Hill (n 50) 331.
[93] ibid 317.

Discovery of hormones and anaesthetics

As noted above, in the early stages of investigation into gender variance, Krafft-Ebing posited that gender variant behaviour was in some way influenced by what he called 'generative glands', but which are contemporaneously known as gonads i.e. testes and ovaries. At the time Krafft-Ebing was writing the role of testes and ovaries in the production of sex hormones was unknown and therefore the link between gender variant behaviour and physiological factors was merely an idea. An investigation into the effects of, what were then called, internal 'secretions' began in the 1880s and was well advanced by the 1940s. This led to the identification of hormones. Initial experiments on animals aided a deeper understanding of how hormones influence the development of one's gender identity.[94] In 1929, the female sex hormone estrone (a form of estrogen) was identified by American scientists Edgar Allen and Edward A Doisy and separately by German scientist Adolf Butenandt.[95] By 1931 it was possible to produce estrone artificially; this was done in both the USA and Germany. Progesterone was then isolated in 1934 and testosterone in 1935. According to Bullough "[t]he availability of injectable hormones allowed a large number of investigators to carry out extensive studies with sex hormones on animals and also on humans."[96]

Therefore, it was now becoming possible to provide treatment, by means of body modification, for those who identified as cross-sex by providing surgical and/or hormonal interventions. In this period in the history of the emergence of transsexualism as a medical condition, the dominant model for characterising what was later to become known as Gender Identity Disorder (GID), then transsexualism and currently as Gender Dysphoria (GD) was the biological model[97] which sought to highlight that those individuals whose gender identity (and gender expression)[98] deviated from the norm were suffering from a condition which had its roots in the physical body.

Although surgical, and indeed endocrinological, treatment was possible, early sex re-assignment surgery was not wholly accepted by the medical profession, in particular psychiatry, which relied upon a psychological root cause of the condition which

[94] M Diamond 'Biased-interaction theory of psychosexual development: "how does one know is one is male or female?" (2006) 55 *Sex Roles* 589-600, 591.
[95] Bullough (n 11) 6.
[96] ibid.
[97] N Sullivan 'The role of medicine in the (trans)formation of 'wrong' bodies' (2008) *Body & Society* 14(1):105-116, 106.
[98] By gender expression I mean how one presents their internally experienced gender identity to the world.

necessitated a psychiatric treatment. For example, in 1953 in the *Journal of the American Medical Association* Weideman[99] and Ostow[100] advocated psychotherapy as the means to treat such individuals; a call to treat the mind rather than the body; it is the important interaction between psychiatry and psychoanalysis on the one hand and surgery and endocrinology on the other which will now be focused on because whereas for psychiatry the aim was to treat the individual's mind in an attempt to reconcile the individual with the reality of his or her body the aim of general medicine, including surgery and endocrinology, was to provide a means of alleviating the dysphoria experienced by the patient through altering the individual's body to correspond with his or her gender identity.

Building on the work of sexologists the 1950s to 1970s marked a period in the history of the development of transsexualism as a medical condition which was dominated by psychiatry and psychology. By the start of this period psychological based literature, often displaying a Freudian psychoanalytic perspective, highlighted a link between transsexual identity and cross-dressing[101] or, particularly in the case of male-to-female (MTF) transsexuals, with an over-close maternal relationship and a paternal relationship characterised by distance.[102] One such theorist was Robert Stoller, an American psychoanalyst who, writing in the 1960s, "believed that male-to-female transsexuality was a pathology of psychosexual development"[103] which originated in childhood as a result of the child's relationship with his mother and father.

Once of the first pieces of work to take this approach was David Cauldwell's *Psychopathia Transsexualis* which was published in 1949.[104] It is thought that Cauldwell was the first to use the term 'transsexual' in the way it is currently used.[105] In this article Cauldwell presents the case of 'Earl': a female who identified as, and sought medical intervention to become, male. In relation to the cause of transsexualism Cauldwell wrote that "[t]heir condition usually arises from a poor hereditary background and a highly unfavourable childhood environment."[106] This is reminiscent of the case studies presented by Krafft-

[99] G H Weideman 'Transvestism' (1953) *Journal of the American Medical Association* 152(12):1167.
[100] M Ostow 'Transvestism' (1953) *Journal of the American Medical Association* 152(16):1553.
[101] R Stoller 'Male childhood transsexualism' (1968) *Journal of the American Academy of Child Psychiatry*, 7: 193-201.
[102] ibid.
[103] Whittle and Stryker (eds) (n 70) 53.
[104] D O Cauldwell 'Psychopathia Transsexualis' (1949) *Sexology* 16: 274-280.
[105] I B Pauly 'Male psychosexual inversion: transsexualism' (1965) *Archives of General Psychiatry* 13:172-181; 173.
[106] D O Cauldwell 'Psychopathia Transsexualis' reproduced in full in S Whittle and S Stryker (eds) (n 70) 40-44, 40-41.

Ebing in the late nineteenth century. In Earl's case Cauldwell identified poor familial relationships. For example the paternal grandfather was a successful man however the "father was a spoiled son, petted and spoiled by his mother and sisters."[107] One older brother was making a successful life away from the family but the other older brother was "feebleminded, never learned to talk, and while in his 20's was committed to a state institution."[108] Earl was "impressed with the adulation with which the men of the family were showered […] *Frequently she was dressed as a boy.*"[109] Earl sought surgical procedures to create a penis and was reportedly incensed with the claim that requested procedures such as these amounted to criminal action by the surgeons.

From the overview of the background and family history of Earl presented by Cauldwell it is clear to see that, for him, transsexualism derives from one's psychology and upbringing. At the time of Cauldwell's interaction with Earl the legality of sex re-assignment surgery was being debated in the USA as a result of the sex re-assignment of Christine Jorgensen.[110] Jorgensen was a USA national who underwent sex re-assignment surgery in Denmark in 1952 and then returned to the USA. Psychiatrists Weideman and Ostow wrote that she ought to have been treated by psychotherapy rather than surgery. The comments by Weideman[111] and Ostow[112] are not surprising given that at the time Jorgensen had her sex re-assignment surgery such procedures were relatively new and indeed transsexuality *per se* was only just becoming noticed by the medical profession at large. The idea that an individual should receive psychiatric interventions to enable them to change their gender identity to correspond with their bodies contrasted with the willingness of some medical professionals to alter the individual's body to correspond with their gender identity. This contrast of approaches to such individuals, according to Bullough, "marked the beginning of a turf war"[113] between psychiatry and surgery regarding the best way to provide treatment for transsexualism. In addition to the disagreement between surgeons and psychiatrists regarding the preference for psychotherapy or surgery, there was also

[107] ibid 41.
[108] ibid.
[109] ibid (emphasis added).
[110] For example see D B Billings and T Urban 'The socio-medical construction of transsexualism: an interpretation and critique' (1982) *Social Problems* 29(3):266-282; 267; D W Hastings 'postsurgical adjustments of male transsexual patients' (1974) *Plastic Surgery* 1:335-344; J P Holloway 'Transsexuals: legal considerations' (1974) *Archives of Sexual Behavior* 3:33-50.
[111] Weideman (n 100).
[112] Ostow (n 101).
[113] Bullough (n 11) 6.

disagreement between groups of physicians some of whom questioned the desirability of doctors engaging in what was seen as "deliberate mutilation"[114] of patients.

It was the "hostile reactions of psychoanalysts"[115] to the possibility of body modification procedures for what they viewed as "undifferentiated perversions"[116] in opposition to the work being carried out by surgeons and endocrinologists which created the impasse in the 1950s and 1960s. The opinion of the psychoanalysts at the time was that surgery to alter one's secondary sex characteristics was untherapeutic.[117] For Volkan and Bhatti such requests for surgery amounted to a "surgical acting out of psychosis"[118] and, in the opinion of Meerloo, surgeons who operated on such patients were "guilty of collaboration with psychosis."[119] Transsexual individuals during this period were characterised by psychoanalysts as borderline psychotics[120] or as victims of "paranoid schizophrenic psychosis".[121] Although sexologists at the end of the nineteenth and beginning of the twentieth centuries had begun to distinguish between transsexuals and homosexuals and between transsexuals and transvestites by the end of the 1960s the difference between the groups remained controversial, at least within the psychoanalytic community of the time. In 1968 in the introduction to a special edition of the *Journal of Nervous and Mental Diseases* which sought to explore the phenomenon of transsexualism and sex re-assignment procedures Kubie and Mackie noted that what was meant by transsexualism "in contradistinction to "transvestite" or "homosexual" is not clear."[122] So despite the work of early sexologists in beginning to delineate between these groups of people, the differences were not being fully appreciated by the wider medical community who often failed to distinguish between transsexuals and transvestites and between transsexuals and homosexuals. As Billings and Urban put it, it was this "professional opposition to sex-change surgery and disputes over its legality [which] inhibited recognition of transsexualism as a disease for several years."[123] It was the pioneering work of sexologist Harry Benjamin which drove forward the endocrinal and surgical treatment for individuals

[114] ibid 7.
[115] Billings and Urban (n 111) 267.
[116] ibid.
[117] ibid 269.
[118] V Volkan and T Bhatti 'Dreams of transsexuals awaiting surgery' (1973) *Comprehensive Psychiatry* 14(3):269-279.
[119] J Meerloo 'Change of sex and collaboration with the psychosis' (1967) *The American Journal of Psychiatry* 124(2): 263-264.
[120] ibid 263.
[121] C Socarides 'A psychoanalytic study of the desire for sexual transformation ('transsexualism'): the plaster-of-Paris man' (1970) *International Journal of Psychoanalysis* 51:341-349.
[122] L S Kubie and J B Mackie 'Critical issues raised by operations for gender transmutation' (1968) *Journal of Nervous and Mental Diseases* 147(5):431-443; 431.
[123] Billings and Urban (n 111) 267.

who identified as members of the opposite sex and it was ultimately Benjamin's work which led to the development of diagnostic and treatment protocols which led to the wholesale medicalisation of gender variance, and its impact on the current law in the UK.

Stage 3: 1970 - 2003

Following on from the work of Cauldwell Borras *et al* claim that Harry Benjamin then "delimitated the framework of this disorder and was the first to apprehend it as an autonomous entity, as distinct from psychosis, homosexuality, or sexual perversions."[124] Benjamin himself first used the term 'transsexual' in an article in the *International Journal of Sexology*[125] in 1953 where it was used to apply to those individuals who exhibited such severe gender dysphoria that sex re-assignment surgery and hormonal therapy to enable the individual to change their body was deemed the appropriate course of treatment.[126] Therefore, according to Richard Ekins, Harry Benjamin "is the founding father of contemporary western transsexualism."[127] It was Harry Benjamin who "took the revolutionary step of seeking to secure 'sex change' surgery for suitable applicants"[128] and who pioneered research into transsexualism, establishing the first Gender Identity Clinic at Johns Hopkins University. As such, "Benjamin's influence was paramount."[129] Benjamin was a sexologist, not a research scientist or a theorist. He was "part of what might be called the liberal wing of sexology which was tolerant of sexual variation and diversity."[130] He began his work from the perspective of aiding those individuals who claimed to be trapped in the wrong body. He posited that there were three groups of transsexual; firstly those who did not seek surgery, secondly those with moderate intensity desire to alter their bodies and finally those with high intensity desire for surgery. He created a sex orientation scale which, in his opinion, represented the sexed identity of the human population. His scale consisted of his three types of transsexual further categorised by six subcategories as follows:

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[124] L Borras, P Huguelet, and A Eytan 'Delusional "pseudotranssexualism" in schizophrenia' (2007) *Psychiatry* 70(2):175.
[125] H Benjamin 'Transvestism and transsexualism' (1953) *International Journal of Sexology* 7: 12-14.
[126] H Benjamin 'In Re: Trans(s)exualism' (1974) *The Journal of Sex Research* 10(2):173-175; 174.
[127] R Ekins 'Science, politics and clinical intervention: Harry Benjamin, transsexualism and the problem of heteronormativity' (2005) *Sexualities* 8(3):306-328; 306.
[128] ibid 309.
[129] ibid 310.
[130] ibid 311.

Transsexual Group	Type	Diagnosis
---------	0	Normal
1	1	Pseudo transvestite
	2	Fetishistic transvestite
	3	True transvestite
2	4	Transsexual – non surgical
3	5	Transsexual – moderate intensity
	6	Transsexual – high intensity.

Although Benjamin acknowledged the influence of environmental factors, he was of the opinion that the root cause of transsexualism was biological; if the possibility for transsexualism did not occur in the body, then environmental factors would be of little influence. [131] Benjamin wrote "[i]f the [body] is healthy and normal no severe case of transsexualism, transvestism or homosexuality is likely to develop in spite of all provocations."[132]

Therefore, Benjamin adhered to the nature plus nurture model of transsexualism, although his primary emphasis was firmly on nature. Benjamin believed that the crucial stage in the development of transsexualism was when the individual was *in utero* where exposure to certain sex hormones influenced the (sexed) brain development of the unborn child. This *in utero* development provided the building blocks, the predisposition to a particular identity which the child's environment would either enable or repress. Benjamin was critical of 'nature only' advocates such as the US psychiatrists of the 1940s and 1950s.[133] What was ground-breaking about Benjamin's work was the fact that he advocated surgical intervention for those who could be considered in need of it. Ekins writes that:

> [w]hereas other health professionals had wanted to treat the 'psychopathology' by seeking to cure the patient of his wish for 'sex change', Benjamin [...] took the revolutionary step of advocating a change of body for select patients.[134]

Benjamin's focus and drive to understand transsexualism and to advocate for a surgical means to 'cure' it meant that he developed a clinical sub-specialism; the science of gender

[131] ibid 312.
[132] Benjamin (n 126) 13.
[133] Ekins (n 128) 313.
[134] ibid 318.

dysphoria.[135] The development of a medical model of transsexualism, which began in the late nineteenth century with the work of sexologists keen to understand what, at the time, amounted to perverse sexualities and which then continued through to the work of Harry Benjamin, meant that the patients could be provided with a means of altering their bodies to alleviate their dysphoria, but more importantly, it also meant that those who were previously considered deviant were now considered ill. The early sexology work sought to understand those who participated in homosexual and non-procreative heterosexual practices but it was from this work that the category of transsexual began to emerge. It was therefore this early work which created the conditions whereby it was possible not only for transsexuals as a group to emerge but also transsexualism as a medical condition to be developed. The work of the early sexologists which sought to provide an understanding of why individuals engaged in non-procreative heterosexual activities largely determined that a small number of such individuals engaged in such activities because they were more like members of the opposite sex than their birth sex; thus the category of transsexual was born (although not fully named until the 1950s). However it was in this stage of the emergence of transsexualism as a medical condition that the medicalisation of gender variance really took hold; had the work of the early sexologists taken a different track then it could be argued, although not proven, that the development of transsexualism would have been very different. It may well be argued that the separation of those who could be classed as transsexual and those who could be classed as homosexual would not have happened and that those who identified as members of the opposite sex would have continued to be considered to be homosexual. However this is merely supposition; transsexualism began to emerge at the end of the 1800s as a distinct phenomenon which merited further investigation by the medical and scientific communities. As noted above this resulted in links between hormones and gender identity being developed and it also resulted in an aetiological dispute arising: did gender variance occur as a result of one's abnormal physiology or one's abnormal psychology (or indeed a combination of both)? What is important to take from this medical and scientific enquiry into cross-sex identification was that it was deemed contrary to normal psychosexual development and therefore must occur as a result of a defect within the individual. By the time Harry Benjamin began his research the category of transsexual was firmly established albeit that there was dispute within medicine as to its aetiology. However, the work by Benjamin was ultimately self-fulfilling. As he interviewed clients and determined who was or was not transsexual he, perhaps

[135] ibid.

unwittingly, reinforced his own theory as to the causes of transsexualism thereby strengthening the medicalisation of gender variance. As Ekins notes:

> [a]s sex-reassignment surgery became more widely available given certain (heteronormative) criteria, there is little doubt that clients began to conform to these criteria in their presentations of themselves.[136]

As Benjamin's theories on transsexualism developed and became more widely available a model of what it meant to be transsexual began to develop and, some have argued, this led to individuals who sought access to body modification procedures adopting the narrative which Benjamin expected to hear[137] which continues to have an impact on who is considered transsexual by the medical profession and therefore impacts on who can access the provisions in the GRA 2004.

Gender variance becomes pathologised: the diagnostic manuals

The work of Benjamin was crucial not only in fully medicalising gender variance but also in pathologising it. His work resulted in gender variant behaviour being included in medical diagnostic manuals, thereby fully pathologising it, and his work also resulted in an entire industry growing to support the diagnosis and treatment of such individuals. The two diagnostic manuals which contain classifications used to diagnose transsexualism were mentioned in the Introductory chapter to this thesis but to recap these are the World Health Organisation's *International Classification of Diseases and Related Health Problems* currently in its tenth edition (ICD-10)[138] and the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* currently in its fifth edition (DSM 5).[139] The DSM "delineates *the* authoritative nomenclature of psychiatric nosology within the western world."[140] As such, it is used as a diagnostic classificatory authority by a number of groups, in particular psychiatrists and general practitioners.[141] The ICD is an international classificatory system which can be used alongside the DSM or as an

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[136] Ekins (n 128) 320.
[137] D Irving 'Normalized transgressions: legitimizing the transsexual body as productive' (2008) *Radical History Review* 100:38-61; V A Rosario '"Qué joto bonita!": transgender negotiations of sex and ethnicity' (2004) *Journal of Gay & Lesbian Psychotherapy* 8(1-2):89-97.
[138] World Health Organisation *International Statistical Classification of Diseases and Related Health Problems* 10th Revision [online version] <http://apps.who.int/classifications/icd10/browse/2010/en> accessed 24 September 2014.
[139] American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* Fifth Edition (American Psychiatric Association 2013).
[140] A I Lev 'Disordering gender identity: Gender Identity Disorder in the DSM-IV-TR' (2005) *Journal of Psychology and Human Sexuality* 17(3/4):35-69; 36.
[141] H Bower 'The gender identity disorder in the DSM-IV classification: a critical evaluation' (2001) *Australian and New Zealand Journal of Psychiatry* 35(1):1-8; 2.

alternative to the DSM. Following the work of Benjamin, as outlined above, transsexualism first appeared in the ICD-9 in 1975 followed shortly thereafter by its inclusion in the DSM-III in 1980.[142] Drescher notes that prior to 1975 there had been no mention of transsexualism in previous versions of the ICD and although ICD-8, published in 1965, included a category of *transvestitism* it is not clear that this referred to contemporary transsexualism because "[d]efinitions of diagnostic categories were not provided in the ICD-8."[143] This conceptual uncertainty is not a surprise given that at this time there were debates and disputes within medicine itself concerning transsexualism as a medical condition particularly in relation to the aetiology, as will be shown below. In addition there were disputes surrounding the most appropriate means of providing treatment to such individuals as already noted above in the discussion surrounding the dispute between psychiatry and general medicine.

With its inclusion in the two diagnostic manuals in 1975 and 1980 gender variance had become a specific medical concern whereby the patient has a desire to change his body to live full time as the opposite sex. In placing transsexualism in these diagnostic manuals those who expressed any form of gender variance and indeed cross-sex identification became firmly pathologised. As noted in the Introductory chapter the link between medicine and pathologisation is strong: medicalisation occurs when human traits, behaviours and characteristics become the focus of the medical profession such that it becomes almost impossible to conceive of them as anything other than a medical process or a medical condition and they become pathologised when compared to a norm. In relation to transsexualism, cross-sex identification was not seen as a form of natural gender variance whereby gender expression and experience of one's gender exists on a spectrum but rather it was, by 1975, fully accepted as a deviation from the norm which must have occurred as a result of a problematic psychosexual development and thus transsexualism as a delineated medical condition was born which had complex diagnostic criteria which were outlined in the DSM-III and ICD-9, and subsequent versions, and an industry began to develop to care for and treat such individuals: the medical model of transsexualism was being established and then strengthened through these developments.

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[142] P T Cohen-Kettenis and F Pfäfflin 'The DSM diagnostic criteria for Gender Identity Disorder in adolescents and adults' (2010) *Archives of Sexual Behavior* 39(2):499-513; 499.

[143] J Drescher 'Gender identity diagnoses: history and controversies' in B C P Kreukels, T D Steensma and A L C de Vries (eds) *Gender Dysphoria and Disorders of Sex Development: Progress in Care and Knowledge* (Springer, New York, 2014); 142.

Aetiology of Transsexualism

So, although by 2004 the diagnostic requirements were clearly established there was considerable debate concerning the aetiology of transsexualism.[144] In determining the aetiology of transsexualism, common themes began to emerge. As discussed above the 1940s to 1970s was dominated by a 'turf war' between psychiatrists and physicians regarding the appropriate means of treating the cross-sex identifying patients. This disagreement arose, to some extent, from differing opinions regarding the aetiology of the condition. It is possible to theme the literature on aetiology into that which proposes a physiological cause (nature), a psychological cause (nurture), or a combination of both (nature and nurture).[145] Not only was there debate surrounding the most appropriate means of treating those who exhibited gender variance as outlined above, it can also be observed from the thousands of articles on the aetiology of gender variance there was also considerable debate concerning the causes of the condition itself. It is the development of aetiological research which will now be considered as, despite the thousands of articles written on this subject, it remains impossible to provide consensus on the aetiology of transsexual identification which in turn highlights that the medical model, although outwardly appearing to be coherent, in fact can be undermined from within medicine itself by production and examination of counter-narratives such as the work on aetiology as will now be shown and indeed as the following chapter will show the debate surrounding aetiology was crucial in the cases before the European Court of Human Rights in the 1980s and 1990s.

Studies have highlighted various connections between a patient's physiology and their gender variance. It has regularly been posited that transsexual identification can occur as a result of exposure to certain hormones during foetal development. Although the foetus will be exposed to certain hormones from the mother during pregnancy, endogenous hormone exposure, and this may potentially impact on the individual's psychosexual development the research focused primarily on exogenous hormone exposure. Hormones were artificially administered during pregnancy as part of medical treatment from the middle of the twentieth century although the long term impact of this was not foreseeable in all

[144] As noted above some medical professionals slowly began to accept transsexualism as a medical condition in the 1950s and 1960s. However, as was highlighted, this acceptance was not universal and debate continued regarding the cause of the condition and the treatment of it. Once in the DSM it had been, almost, universally accepted as a legitimate medical condition.

[145] For a discussion of the multi-faceted aetiology of GD see for example Diamond (n 95); P T Cohen-Kettenis and L J G Gooren 'Transsexualism: a review of etiology, diagnosis and treatment' (1999) *Journal of Psychosomatic Research* 46(4):315-333.

respects: one such impact of artificially administering hormones in this way was the possible link with the child developing a transsexual identity, which only began to come to light decades later. In 1981 Beral and Colwell reported on an experiment carried out in 1950 which sought to evaluate the effect of "high doses of stilboestrol and ethisterone on the outcome of pregnancy of diabetic mothers."[146] The aim of the original study was to determine whether or not administering oestrogens and progestogens during pregnancy reduced the rate of miscarriage and stillbirth. The report by Beral and Colwell was a 27 year follow up in relation to the earlier study. They note that "[o]ver the years it has become increasingly clear that *in utero* exposure to exogenous sex hormones may have adverse long-term effects."[147] As evidence of this, for example in 1958 Wilkins *et al* reported the masculinisation of the genitalia of female children exposed to exogenous progestins *in utero*.[148] In 1959 Kaplan reported feminisation of male children exposed to female hormones *in utero*.[149]

It is clear from these studies then that exposure to hormones *in utero* can have a physical effect on the foetus. However, for the purpose of this thesis the link between cross-sex hormone exposure *in utero* and its impact on the individual's psychosexual development needs to be explored. The link was theorised as early as the 1950s.[150] Research by Phoenix *et al* in 1959, which has been described by Diamond as the "classic experimental research on the influence of testosterone",[151] demonstrates that exposure to sex hormones *in utero* can affect the behaviour of the resultant offspring. The study by Phoenix *et al* showed that when testosterone was administered to pregnant guinea pigs, female offspring behaved, in terms of attempted mating behaviour, as though they were male.[152] Almost 30 years later Goy *et al* showed that administration of testosterone during pregnancy in primates resulted in female offspring behaving as male even if there was no external evidence of the

[146] V Beral and L Colwell 'Randomized trial of high doses of stilboestrol and ethisterone therapy in pregnancy: long-term follow-up of the children.' (1981) *Journal of Epidemiology and Community Health* 35(3):155–160; 155.
[147] ibid.
[148] L Wilkins, H W Jones, G H Holman and R S Stempfel 'Masculinization of female fetus associated with administration of oral and intramuscular progestins during gestation' (1958) *Journal of Clinical Endocrinology & Metabolism* 18:554-585.
[149] N M Kaplan 'Male pseudohermaphrodism' (1959) *New England Journal of Medicine* 261:641-644
[150] Diamond (n 95) 591.
[151] ibid.
[152] C H Phoenix, R W Goy, A A Gerall and W C Young 'Organizing action of prenatally administered testosterone propionate on the tissues of mediating mating behavior in the female guinea pig' (1959) *Endocrinology* 65(3):369-382.

treatment.[153] It would appear that the effect of hormones *in utero* can impact on the behaviour of the resultant offspring despite there being no physical masculinisation of the anatomy of a female or feminisation of a male. Yalom *et al* have also argued that there is evidence that sex hormones influence both the behavioural and anatomical masculinity and femininity of individuals.[154] They note that:

> [h]uman females exposed in utero to androgenic hormones, whether exogenously introduced to the pregnant woman as progestins to avert abortion or endogenously produced as in the andrenogenital syndrome, are both anatomically virilised and behaviourally masculinised.[155]

At the time Yalom *et al* reported their findings, not much information was available in relation to the effect on the male foetus of exposure to estrogen, particularly in relation to humans.[156] As with the report of Beral and Colwell, noted above, Yalom *et al* sought to explore the impact of treating pregnant diabetic women by means of exogenous administration of estrogen and progesterone. Yalom *et al* asked "[w]hat is the psychosexual picture of the male offspring at different developmental time points who were exposed prenatally to these hormones?"[157] To answer the question they sought to compare a group of six year old boys and a group of sixteen year old boys who had been exposed to exogenous estrogen and progesterone *in utero* with control groups. It was found that the group exposed to the hormones *in utero* were "significantly less "masculine" than the contrast […] sample."[158] In relation to heterosexual development and masculine interests Yalom *et al* noted that there was a trend "for the experimental subjects to have had less heterosexual experience and fewer masculine interests than either of the contrast groups."[159] They also note that in relation to the aggression-assertion measurements of the experimental groups the "experimental subjects are less aggressive-assertive than the contrast […] populations."[160] The Yalom *et al* study indicated that *in utero* exposure to exogenous cross-sex hormones is likely to have an impact on the psychosexual

[153] R W Goy, F B Bercovitch, and M C McBrair 'Behavioral masculinization is independent of genital masculinization in prenatally androgenized female rhesus Macaques' (1988) *Hormones and Behavior* 22(4): 552-571.
[154] I D Yalom, R Green and N Fisk 'Prenatal exposure to female hormones. effect on psychosexual development in boys' (1973) *Archives of General Psychiatry* 28(4):554-561.
[155] ibid 554.
[156] ibid.
[157] ibid 555.
[158] ibid 557.
[159] ibid.
[160] ibid.

development of the child; this assertion has been repeated in numerous studies.[161] Although these reports were of the administration of exogenous sex hormones, masculinisation of female foetuses and feminisation of male foetuses can occur as a result of endogenous cross-sex hormones where the mother may naturally produce abnormal levels of sex hormones during pregnancy which, it has been posited, may impact on the child's later psychosexual development. Nevertheless, despite the research outlined above, Lish *et al* reported in 1992 that in a follow-up study of 60 women exposed to diethylstilbestrol *in utero* there were no demonstrable effects of the hormones in relation to the women's behavioural masculinisation or defeminisation[162] Diethylstilbestrol is "a very potent nonsteroidal estrogen"[163] and at the time of the study the link between exposure to sex hormones and the subsequent development of the foetus' central nervous system (CNS) and the sex differentiation of the genitalia was being explored though numerous studies. It was clear at the time that testosterone had a role to play in the development of the genitalia and the CNS.[164] However the Lish *et al* study found that, at the low doses studies, there was little long-term impact on the child in terms of either masculinisation or defeminisation of their play or in relation to the their adult gender-role behaviour. Therefore the science remains uncertain in relation to the effects *in utero* exposure to cross-sex hormones can have on the foetus' psychosexual development and more studies would be required to demonstrate if there is any clear correlation for different hormones, levels and timing of their influence on such development.

Not only has endocrinology been considered as a potential cause of transsexualism, brain development has also been studied by scientists researching in this area and it has been

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[161] See for example: J M Reinish, M Ziemba-Davis and S A Sanders 'Hormonal contributions to sexually dimorphic behavioural development in humans' (1991) *Psychoneuroendocrinology* 16(1-3):213–278; H F L Meyer-Bahlburg, A A Ehrhardt, J F Feldman, L R Rosen, N P Veridiano and I Zimmerman 'The development of gender-related behavior in females following prenatal exposure to diethylstilbestrol' (1989) *Hormones and Behavior* 23(4): 526-541; P Kester, R Green, S J Finch, and K Williams 'Prenatal 'female hormone' administration and psychosexual development in human males' (1980) *Psychoneuroendocrinology* 5(4):269-285; J Money and D Matthews 'Prenatal exposure to virilizing progestins: an adult follow-up study of twelve women' (1982) *Archives of Sexual Behavior* 11(1):73-83; S A Berenbaum and M Hines 'Early androgens are related to childhood sex-typed toy preferences' (1992) *Psychological Science* 3(3):203-206; A A Ehrhardt 'Behavioral effects of estrogen treatment in the human female' (1978) *Pediatrics* 62:1166-1170 and H F L Meyer-Bahlburg 'Behavioral effects of estrogen treatment in human males' (1978) *Pediatrics* 62:1171-1177.

[162] J D Lish, H F L Meyer-Bahlburg , A A Ehrhardt, B G Travis and G Veridiano 'Prenatal exposure to diethylstilbestrol (DES): childhood play behavior and adult gender role behavior in women' (1992) Archives of Sexual Behavior 21(5):423–441.

[163] ibid 424.

[164] ibid.

reported numerous times that the brain is sexed as either male or female.[165] Recent medical studies, specifically those involving scientific research on brain composition, support the theory that transsexual identification is a condition with its root cause in the body's physiology.[166] Kruijver *et al* suggest that cross-sex identification, which manifests itself by a differentiation in the size of the bed nucleus of the *stria terminalis* (BST), appears to be unaffected by adult hormone ingestion.[167] The results of the research show that male-to-female (MTF) transsexuals' BST is akin to that of heterosexual, genetic females' BST.[168] Likewise, the single female-to-male (FTM) transsexual in the study had a BST that was similar in size to that of heterosexual, genetic males.[169] The Kruijver *et al* study indicates that in the case of transsexualism the BST has a sex-reversed structure.[170] In 1995 Zhou *et al* argued that transsexualism was caused by an interaction between the developing foetal brain and sex hormones.[171] Zhou *et al* claim that MTF transsexuals had a female sized central subdivision of the bed nucleus of the stria terminalis; the area of the brain responsible for sexual behaviour.[172] The problem with this research is that it can only be carried out post-mortem and therefore cannot be used to determine whether or not the live individual should be considered male or female. It would appear, however, that the brain sex theory of gender variance has continued through to the present day as it has been mentioned in contemporary case law.

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[165] E Gould, C S Wooley and B S McEwan 'The hippocampal formation: morphological changes induced by thyroid, gonadal and adrenal hormones' (1991) *Psychoneuroendocrinology* 16(1-3):67-84; J M Juraska 'Sex differences in "cognitive" regions of the rat brain' (1991) *Psychoneuroendocrinology* 16(1-3):105-119; M Hines, L S Allen and R A Gorski 'Sex differences in subregions of the medial nucleus of the amygdala and the bed nucleus of the stria terminalis of the rat' (1992) *Brain Research* 579(2):321-326; D F Swaab, E Fliers and T S Partiman 'The suprachiasmatic nucleus of the human brain in relationship to sex, age and senile dementia' (1985) *Brain Research* 342(1):37-44; D Constant and H Rutter 'Sexual dimorphism in the human corpus callosum? a comparison of methodologies' (1996) 727(1-2):99-106; L S Allen, M Hines, J E Shryne and R A Gorski 'Two sexually dimorphic cell groups in the human brain' (1989) *The Journal of Neuroscience* 9(2):497-506; L S Allen and R A Gorski 'Sexual dimorphism of the anterior commissure and massa intermedia of the human brain' (1991) *Journal of Comparative Neurology* 312(1):97-104; A Bao and D F Swaab 'Sex differences in the brain, behavior, and neuropsychiatric disorders' (2010) *Neuroscientist* 16(5):550-565.

[166] F P M Kruijver, J-N Zhou, C W Pool, M A Hofman, L J G Gooren and D F Swaab 'Male-to-female transsexuals have female neuron numbers in limbic nucleus' (2000) *The Journal of Clinical Endocrinology and Metabolism* 85(5): 2034-41

[167] ibid. See also F P M Kruijver, A Fernández-Guasti, M Fodor, E M Kraan and D F Swaab, 'Sex differences in androgen receptors of the human mamillary bodies are related to endocrine status rather than to sexual orientation or transsexuality' (2001) *The Journal of Clinical Endocrinology and Metabolism* 86(2): 818-27.

[168] Kruijver, Zhou, Pool, Hofman, Gooren and Swaab (n 167) 2034.

[169] ibid 2038.

[170] ibid.

[171] J Zhou, M A Hofman, L J G Gooren and D F Swaab 'A Sex Difference in the Human Brain and its Relation to Transsexuality' (1995) *Nature* 378(6552):68-70

[172] ibid 68.

In addition to arguments that the individual is predisposed to identifying as male or female as a result of foetal brain development and exposure to sex hormones *in utero* there has been research which suggests that genetic abnormalities may play a role in cross-sex identification. A genetic aetiology for transsexual identity has been proposed by Sadeghi and Fakhrai, who claim that their study of female monozygotic twins suggests that there may well be a genetic cause for the condition.[173] Links have also been made with conditions such as Congenital Adrenal Hyperplasia (CAH).[174] In addition to CAH Yalom *et al* note that other conditions such as Androgen Insensitivity Disorder (AID) may result in behavioural changes in relation to the male foetus' adult interactions and sense of self. AID is a metabolic condition which results in the male foetus being "unable to utilize androgen being secreted by the testes."[175] The child is born appearing to be female however the child's genetic makeup is 44 + XY indicating a male genetic complement. The children also have "intra-abdominal testes and no ovaries."[176] Therefore the child appears to be female and is raised female and yet is genetically male. This research may lead to the conclusion that the condition is a biological condition, one which some medical experts suggest results in transsexuals being born with a 'birth defect' because their bodies are not in line with their internally felt sexed identity[177] therefore necessitating treatment of a physiological nature to alter the body. What is becoming clear from these various studies is that it is not possible to say with any degree of certainty why an individual develops a cross sex identity, or indeed any degree of gender variance.

However not all researchers agree that the cause of one's GD/transsexualism begins in the body and propose therefore a psychological cause; one more based in the mind or as a result of upbringing. In relation to psychological factors and impact of upbringing on the development of transsexual identity Cohen-Kettenis and Gooren observe that:

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[173] M Sadeghi and A Fakhrai 'Transsexualism in female monozygotic twins: a case report' (2000) *Australian and New Zealand Journal of Psychiatry* 34:862-864

[174] F M E Slijper 'Androgens and gender role behavior in girls with congenital adrenal hyperplasia (CAH)' (1984) *Progressive Brain Research* 61:417–423; R W Dittman, M H Kappes , M E Kappes, D Borger, H Stegner, R H Willig and H Wallis 'Congenital adrenal hyperplasia I: gender-related behavior and attitudes in female patients and sisters' (1990) *Psychoneuroendocrinology* 15(5-6):401–420; R W Dittman, M H Kappes, M E Kappes, D Borger, H F L Meyer-Bahlburg, H Stegner, R H Willig, H Wallis 'Congenital adrenal hyperplasia II: gender-related behavior and attitudes in female saltwasting and simple virilizing patients' (1990) *Psychoneuroendocrinology* 15(5-6):421–434; A L Hurtig, I M Rosenthal 'Psychological findings in early treated cases of female pseudohermaphroditism caused by virilizing congenital adrenal hyperplasia' (1987) *Archives of Sexual Behavior* 16(3):209–223

[175] I D Yalom, R Green and N Fisk 'Prenatal exposure to female hormones effect on psychosexual development in boys' (1973) *Archives of General Psychiatry* 28(4):554-561; 554.

[176] ibid.

[177] L Lax 'Is the United States falling behind? The legal recognition of post-operative transsexuals' acquired sex in the United States and abroad' (2003) *7 Quinnipiac Health Law Journal* 123; 199.

> [p]arental influences, such as extreme closeness to the mother ("blissful symbiosis"), atypical psychosexual development of the parents, father absence, or parental dynamics (such as a maternal wish for a daughter) have been held responsible for the development of [GD].[178]

This perspective has been developed by others.[179] One of the earliest theorists adopting the position that transsexual identity is caused by one's psychology, including the impact that parents have on their child's psychosexual development was Robert Stoller, referred to earlier.[180] In 1979 Stoller posited that transsexuality was caused by parental psychology when raising the child.[181] Stoller argued that MTF transsexuals have powerful masculine mothers, often women who regret not having changed sex and weak, absent fathers.[182] In 1982 Jones and Tinker made the claim that "[a]lthough most professionals agree that family dynamics are associated with gender identity conflicts, the exact nature of this association is unclear and subjective."[183] In exploring the link between family dynamics, psychology and transsexualism numerous theories have been presented.[184] One study carried out in 2003 sought to explore the link between transsexualism and childhood trauma resulting in adult dissociation. Kersting *et al* utilised the Interview for Dissociative Disorders (SCID-D-R), the Dissociative Experiences Scale (DES) and the Childhood Trauma Questionnaire (CTQ) to compare the samples. They found that the transsexual group reported a higher DES result than the psychiatric inpatient group and that this was down to one factor: emotional maltreatment. Therefore, these papers would suggest that childhood experience and attachment with care-givers may have a role to play in an

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[178] P Cohen-Kettenis and L Gooren 'Transsexualism: a review of etiology, diagnosis and treatment' (1999) *Journal of Psychosomatic Research* 46(4):315-333, 317.

[179] See for example R Green *The "sissy boy syndrome" and the development of homosexuality* (Yale University Press, New Haven, Connecticut, 1987); K J Zucker and S Bradley *Gender identity disorder and psychosexual problems in children and adolescents* (Guilford Press 1995).

[180] For example see the work of Robert Stoller: R Stoller *Sex and Gender: On the Development of Masculinity and Femininity* (New York: Science House 1968); R Stoller *Sex and Gender. Volume 2: The Transsexual Experiment* (Hogarth Press 1975).

[181] R Stoller 'Fathers of transsexual children' (1979) *Journal of the American Psychoanalytic Association* 27(4):837-866

[182] ibid 840.

[183] S L Jones and D Tinker 'Transsexualism and the family: an interactional explanation' (1982) *Journal of Family Therapy* 4:1-14; 1.

[184] G Parker and R Barr 'Parental representations of transsexuals' (1982) *Archives of Sexual Behavior* 11(3):221-230; P T Cohen-Kettenis and W A Arrindell (1990) 'Perceived parental rearing style, parental divorce and transsexualism: a controlled study' (1990) *Psychological Medicine* 20(3):613-620; S Marantz and S Coates 'Mothers of boys with Gender Identity Disorder: a comparison of matched controls' (1991) *Journal of the American Academy of Child & Adolescent Psychiatry* 30(2):310-315; K J Zucker, R Green, C Garofano, S J Bradley, K Williams, H M Rebach and C B Lowry Sullivan 'Prenatal gender preference of mothers of feminine and masculine boys: relation to sibling sex composition and birth order' (1994) *Journal of Abnormal Child Psychology* 22(1):1-13; S B Levine and L Lothstein 'Transsexualism or the gender dysphoria syndromes' (1981) *Journal of Sex & Marital Therapy* 7(2):85-113; J K Meyer 'The theory of gender identity disorders' (1982) *Journal of the American Psychoanalytic Association* 30(2):381-418.

individual developing a cross-gender identity and that the causes of transsexualism are complex.

As the above section has shown, the aetiology of transsexualism as a medical condition is constantly evolving as new research uncovers new possible causes of the condition. At the time the legislation was drafted, it was not possible to determine with any certainty the reasons why individuals developed transsexual identities and this remains the case. This has implications for any law which is built upon such an uncertain and ever changing foundation: if transsexual identity within medicine was a condition which did not evolve and change as medical and scientific knowledge evolves and changes then it is arguable that it may be appropriate to base a legal response on this model. However, Chapter Five will show that the continued research into the transsexual condition itself continues to undermine the certainty of the contemporary medical model as a foundation for law because the contemporary medical model of transsexualism is continuing to evolve. For this reason it will be argued in subsequent chapters that any model of legal recognition which is underpinned by the medical model of transsexualism requires itself to be dynamic and able to respond to changes in the medical knowledge which constitutes the medical model of transsexualism at any given point in time. It will be argued that law taking such a responsive approach is undesirable because it would require regular reform and revision as and when the state of medical knowledge changed. For that purpose subsequent chapters will show that it is possible to base legal recognition not on a medical model of transsexualism but rather on a human rights based model which acknowledges that one's gender identity is a deeply held sense of oneself not knowable to others without disclosure from the individual himself or herself; such models are beginning to appear in jurisdictions worldwide.

Conclusion

This chapter has shown how transsexualism as a modern day medical condition developed throughout the nineteenth and early twentieth centuries. The chapter showed how the early criminalisation of non-procreative sexual activity led to the development of research into those who were initially identified as sodomites and, later, as homosexuals. Although homosexuality and transsexualism are very distinct identities and are in no way related it was this early focus on homosexuality which enabled the development of research into transsexual identification, initially as a manifestation of homosexuality, and then later recognised as representing individuals who identified as members of the opposite sex.

Therefore this chapter has shown that it is not possible to fully appreciate the modern day medical model of transsexualism without fully understanding the roots of the phenomenon and without having an appreciation of the conditions which enabled its emergence. By the time Harry Benjamin began researching transsexualism the condition was fully within the realm of medicine and it became impossible to conceptualise it as anything other than a medical condition which needed treatment, either by psychotherapy to 'cure' the mind or by surgery and endocrinology to alleviate the patient's dysphoria. As was noted in this chapter the work of Harry Benjamin was instrumental in developing a treatment model which discounted attempts to 'cure' the patient by means of psychotherapy but rather which favoured physical intervention to reconcile mind and body. Benjamin's sustained research on transsexualism resulted in the inclusion of transsexualism within the third version of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the World Health Organisation's *International Classification of Diseases and Related Health Problems* (ICD) and then in later editions of both diagnostic manuals to the present day. Despite the calls for depathologisation of the condition made by Trans* activists as outlined in the Introduction to this thesis, the current prevailing medical consensus is that transsexual identity cannot be thought of as a choice of the individual but rather a result of abnormal psychosexual development. As will be shown throughout this thesis, this model is one upon which current law is based because by the time the legislation was being debated the medical model of transsexualism was fully accepted as truth and was almost impossible to think of those with cross sex identity as anything other than transsexual. With the label 'transsexual' came the whole medical and psychiatric profession and placed the individual within a system of knowledge which placed boundaries around his or her sense of self which impacted on how the law approached such individuals. The following chapter will outline how UK law dealt with those who engaged with this medical model of transsexualism and transitioned from the sex registered at birth to the opposite sex.

2. The Historical Quest for Legal Recognition of Gender Identity: UK Law's (non)Response to Medical Developments

Introduction

The previous chapter outlined how transsexualism emerged as a medical condition which meant that only those who met the strict diagnostic criteria could be considered to be transsexual and receive treatment to alleviate the dysphoria they experienced when their gender identity did not match their physical sex. In so doing medicine created a category of person; an identity, the transsexual. These developments in medicine, however, had a legal impact on those who transitioned as law did not develop at the same pace as medicine in this area. As a result those who partook of these medical developments and transitioned found themselves in a difficult position of having to seek recognition of their transition from the law which historically was not forthcoming thereby placing these individuals in the position of appearing to be one sex while legally being classified as the opposite and this caused numerous difficulties for these individuals. This chapter, through a thorough examination of case law from 1957[185] until 2001,[186] will show how law dealt with the medical developments outlined in the previous chapter.

Legal Sex in UK Law

In UK law one is either male or female. One's legal sex is "determined at birth, using genital, gonadal and chromosomal factors."[187] However the situation is a lot less complex: the reality is that one's sex is usually determined at birth upon no more than a cursory glance at the child's anatomy. Therefore, the appearance of particular genitalia is the main way by which an individual is attributed a *physical* sex in the UK.[188] The individual acquires a *legal* sex on registration of their birth in an appropriate register. Historically, the only mechanism by which a *legal* sex could be changed was by allowing an alteration to be made to the particular register only if a mistake had been made on initial registration of that person's birth as was established in *X, Petitioner* outlined below.

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[185] *X, Petitioner* 1957 SLT (Sh Ct) 61.
[186] *Bellinger v Bellinger* [2001] EWCA Civ 1140; [2002] Fam. 150.
[187] E Sutherland *Child and Family Law* (2nd edn. Thomson 2008) 105.
[188] It is only if the new-born child's genitalia are ambiguous that gonadal and chromosomal factors will be examined.

X, Petitioner[189]

This case provides a particularly useful example from which to gather an understanding of the ability to alter one's *legal* sex as opposed to one's *physical* sex. The case itself was not about legal recognition *per se* but rather about amending entries in the Register under the Registration of Births, Deaths and Marriages (Scotland) Act 1854 (the 1854 Act) where the individual had undergone sex re-assignment procedures. The case said nothing in itself about how the law determines the legal sex of an individual but it did provide that registered sex cannot be changed unless an error was made when initially registering the child's birth or if a mistake had been noticed subsequently i.e. if the individual was intersex but this was not apparent when the birth was registered. In *X, Petitioner* the petitioner was born male and was registered as such in 1907. When X was born there was no ambiguity as to her[190] sex therefore the registration of her as male was correct. X married a woman in 1939, fathered two children and then in 1945 separated from her wife. Thereafter X sought to live as a woman and underwent some physical changes to appear female. She then sought to alter her entry in the Register of Births, Deaths and Marriages, in particular to change her name and her sex. The Secretary of the Registrar-General's Office brought a petition seeking authority to amend the entry in this Register relating to X. The law on amending Register entries was at the time governed by the 1854 Act s.63 which provided that:

> [i]f any error shall be discovered to have been committed in the entry of any birth in any such Register it shall be lawful for the Sheriff, upon coming to knowledge of such erroneous entry, to summon before him any person concerned in the making of such erroneous entry, or any person interested in the effect of such erroneous entry, and if the Sheriff is satisfied that any error has been committed in any such entry, he shall direct a corrected entry of the birth, in relation to which such error has been committed, to be made in a separate Register book, to be called 'The Register of Corrected Entries'.

It was argued that the sex re-assignment operation should enable an amendment of the Register. However sheriff-substitute Prain disagreed, holding that to amend the Register following sex change was not within the ambit of s.63. He stated that:

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[189] *X, Petitioner* (n 186).

[190] Please note the use of the female pronoun here is deliberate. I have opted to use the female pronoun in relation to this individual as she identified as female and had taken steps to appear female and sought to be accepted by others as female.

> [s]ection 63 is directed towards the correction of an entry which is erroneous as at the date which the information was given. I do not think that it gives any sanction for recording changes which have subsequently occurred.[191]

Stating what was to become the mantra in applications for amendments of birth certificates following sex re-assignment surgery, sheriff-substitute Prain further stated that "[t]he Register is essentially a record of fact at a fixed time; it is not, and is not intended to be, a narrative of events."[192] Prain spent one paragraph of the judgment discussing the medical evidence in the case and noted that:

> [i]n the medical information before me it is said that since childhood X's interests and attitudes have been markedly feminine, and that he "had to make conscious efforts to play the role of a male and to suppress spontaneous behaviour which would betray his effeminacy and bring him into ridicule." […] The medical reports state that X is absolutely and fixedly convinced that he should be a woman, and that there is no evidence of any unsoundness of mind.[193]

Although the discussion of the medical evidence in this case is very weak Prain did highlight that it was medical opinion that the petitioner firmly believed that she was a woman and that this belief did not appear to be derived from any mental abnormality.[194] This is an important distinction to make because *X, Petitioner* predated the medical acknowledgment of the importance of mental pathology in relation to cross-sex identification as medicine had not fully articulated this until transsexualism appeared for the first time in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1980. Prain then re-examined the wording of s.63 and restated that it is clear that the wording allows corrections to be made where a mistake had been made on registering the birth. He stated however:

> the changes which have so far been noted in the condition of X would not justify a correction of the Register even if that course were competent. The doctors are careful to stress that this is not a case of hermaphrodism, but is a genuine case of the very rare condition of trans-sexualism[195].

Although having some degree of sympathy towards X, the sheriff-substitute was unwilling to accept that X had indeed changed from male to female. He took a biological approach to determining X's sex and claimed that:

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[191] *X, Petitioner* (n 186) 62.
[192] ibid.
[193] ibid.
[194] ibid.
[195] ibid.

> skin and blood tests still show X's basic sex to be male and that the changes have not reached the deepest level of sex determination. It seems to me accordingly that while X could be described as an abnormal male, it would not be possible to describe him as a female.[196]

The consequence for X was that she was constrained by the law to appear as a physical female but remain legally male. The position established in *X, Petitioner* continues to be the default position, one's sex remains that registered at birth unless it can be established that a mistake has been made on registering the child's sex, or currently following the enactment of the GRA 2004 a full Gender Recognition Certificate (GRC) has been issued. *X, Petitioner* was heard at a time when sex re-assignment surgery was largely a new phenomenon, as was shown in Chapter One, and this case began the long process of transsexuals seeking legal recognition of their post-operative identity. As the remainder of the chapter shows this had serious implications for the individuals in relation to various aspects of their lives. The law established in *X, Petitioner* was further clarified in the unreported case of *Forbes-Sempill.*

Forbes-Sempill

In this case, decided in 1967, the court was asked to determine whether the second petitioner, Ewan Forbes-Sempill was male or female. The facts of the case were as follows: the second petitioner was registered as female and was named Elizabeth. In 1952, or thereabouts, Elizabeth Forbes-Sempill sought to utilise s.63 of the 1854 Act to amend the entry in the Register of Births substituting the female name Elizabeth for the male one, Ewan, and also substituting the sex designation registered as 'F' for 'M'. The application was based on the argument that although the petitioner had been raised as female subsequent examination found her to be male. The actual issue under dispute was whether or not Ewan Forbes-Sempill could succeed to the Baronetcy of Forbes of Craigievar which descended to male heirs. If Ewan was male he would succeed however if he was female then his cousin, John, the first petitioner, would succeed to the Baronetcy. Lord Hunter sought guidance from Civil Law and noted that the sex to be assigned to someone in the situation of Ewan Forbes-Sempill i.e. someone who today would be labelled as intersex, is the sex which prevails or predominates. Lord Hunter accepted that Ewan Forbes-Sempill was intersex, although the word used then was hermaphrodite, that the male sex characteristics predominated and therefore he ought to be legally male. This case, along with the case of *X, Petitioner,* outlined above, further strengthens the legal separation of

[196] ibid.

those who could be given a change of legal sex and those who could not: those who were transsexual could not change legal sex as their sex at birth had been correctly registered whereas those who were intersex could obtain such a legal change as their identity did not become apparent until some time after their sex was registered and therefore it could be argued that the initial registration was wrong and the subsequent change of the Register of Births was merely a corrective action. By this point in the late 1960s Scots law had begun to lay the foundations for a very restrictive approach to be taken to those who were starting to undertake the procedures being developed in medicine which were outlined in the previous chapter: those who underwent medical procedures to appear as the opposite sex would not be able to change their legal sex but those who could be considered to be intersex were provided with a means of changing legal sex.

Between this case and the next case, *Corbett v Corbett,*[197] medical advances continued and people continued to undergo medical procedures to change their bodies and then request that the law recognise the physical changes. In *Corbett* the Court was asked, once again, to recognise the sex re-assignment of one of the parties but this time for the purpose of entering into a valid marriage under English law.

Corbett v Corbett

Although medicine continued to develop there were no legal developments[198] between the case of *X, Petitioner* and *Corbett* which was according to Sharpe, "[t]he first common law decision to consider the sex claims of a transgender person for purposes of marriage"[199] and it is arguably the case which was most damaging to the transsexual recognition movement. However the *Corbett* judgment is of its time i.e. 1970. The issue is that at the time the case was decided there was no complete agreement between medical professionals regarding the causes and treatment for transsexualism, as can be seen from the discussion in Chapter One, and therefore already the medical model of transsexualism was showing itself to lack internal coherence and certainty which has to be borne in mind when evaluating Ormrod J's judgment below. In addition the *Corbett* judgment was a specific judgment concerning one specific legal issue: could a male-to-female (MTF) transsexual

[197] [1971] P 83.
[198] The Forbes-Sempill case cannot really be considered a development in the law for two reasons: firstly it was unreported and therefore not widely known about at the time and secondly it merely confirmed the position taken in *X, Petitioner* in 1957 that only errors of registration could be corrected.
[199] A N Sharpe 'A critique of the Gender Recognition Act 2004' (2007) *Journal of Bioethical Enquiry* 4:33-42; 34. Although Sharpe uses the term 'transgender' here, in the context of his writing it is clear that he is referring to transsexuals.

enter into a valid marriage with a biological man? Ormrod J's judgment in *Corbett*, although troublesome for transsexuals who later sought legal recognition in the UK courts, was a thorough examination of transsexualism as understood at the time and of the law of marriage in England. In examining how the law ought to respond to the purported marriage between an MTF transsexual and a biological male Ormrod J stated that "[t]he fundamental purpose of law is the regulation of the relations between persons, and between persons and the state or community."[200] This is important because the issue of the rights of the individual seeking legal recognition and the rights and interests of third parties became a key debate in the quest for said legal recognition during the debates surrounding the GRA 2004.[201] In making this statement about the purpose of law Ormrod J was highlighting an important function of the law in this area; that legal recognition of post-operative transsexuals is not just about the individual himself or herself but how that individual interacts with wider society. As will be seen in the discussion surrounding the *Bellinger* case[202] later in this chapter and in Chapter Three the UK courts became very aware of the wider implications of using common law to provide legal recognition of post-operative transsexuals' sex particularly in relation to other areas of law and the rights and interests of others.

Importantly in *Corbett* Ormrod J separated the law into three key areas regarding the importance, or not, of one's sex. He stated:

> [f]or the limited purposes of this case, legal relations can be classified into those in which the sex of the individuals concerned is either *irrelevant, relevant or an essential determinant of the nature of the relationship*.[203]

He continued that largely the law is unconcerned with the sex of an individual[204] i.e. that one's sex is usually not a material factor in relation to many areas of law. This is of fundamental importance in relation to the quest for transsexual legal recognition: to what extent is one's sex a material factor in relation to the legal relationship which one seeks to enter into? This became an important point in subsequent cases before the UK courts,

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[200] *Corbett* (n 198) 105[D].
[201] HL Deb 18 Dec 2003 vol. 655 cc1287-326 [1292], [1306], [1312], [1324]; HL Deb 29 January 2004 vol 656 cc357-436 [360], [422]-[436], HL Deb 11 February 2004 vol 656 cc1093-1095 [1094], HC Deb 23 February 2004 vol 418 cc48-108 [49]-[96]; Joint Committee on Human Rights *Draft Gender Recognition Bill*, 20 November 2003 HL Paper 188-I & II, HC 1276-I & II [77].
[202] Family Division of the High Court [2002] 3 FCR 733; Court of Appeal [2001] EWCA Civ 1140; [2002] Fam 150; House of Lords [2003] UKHL 21; [2003] 2 A.C. 467.
[203] *Corbett* (n 198) 105[E] (emphasis added).
[204] ibid.

namely in the area of family law. Ormrod J stated that in most contractual and tortious obligations and most of the criminal law sex is immaterial.[205] However in relation to some issues of contract law such as life assurance, employment, taxation and pensions sex becomes a relevant, although not an essential factor.[206] Sex is not an essential factor in these instances because:

> there is nothing to prevent the parties to a contract of insurance or a pension scheme from agreeing that the person concerned should be treated as a man or as a woman, as the case may be.[207]

However in relation to marriage Ormrod J stated that:

> [o]n the other hand sex is clearly an essential determinant of the relationship called marriage because it is and always has been recognised as the union of man and woman. It is the institution on which the family is built, and in which the capacity for natural hetero-sexual intercourse is an essential element.[208]

He continued "the characteristics which distinguish [marriage] from all other relationships can only be met by two persons of the opposite sex."[209] So Ormrod J had established that marriage is different from most legal relationships because of the intimate nature of the relationship. The categorisation of legal relationships into these three categories had an impact on UK courts in later cases but was less important before the European Court of Justice (ECJ) and the European Court of Human Rights (ECtHR) which, as will be seen below, decided the cases before themselves on different legal principles and concepts than did the UK courts. The areas in which the UK courts refused to recognise the post-operative sex of individuals can be classified as areas in which the sex of the individual is an essential element: criminal laws in which sex is an important aspect of the offence[210] and in family law particularly in relation to marriage.[211] Although *Corbett* was never intended to be the test for determination of one's legal sex the judgment became such and had a detrimental impact on individuals in a number of areas of personal life for decades following as will be shown below. Some commentators note the anomaly of the *Corbett* judgment becoming such an important piece of law given the court in which it was heard

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[205] ibid.
[206] ibid.
[207] ibid 105[F-G].
[208] ibid 105[G-H].
[209] ibid 105[H]-106[A].
[210] *R v Tan* [1983] QB 1053 (Crim).
[211] *Bellinger* (n 203).

and the lack of appeal and therefore its lack of precedential strength however this did not prevent the *Corbett* case from providing the test for determining legal sex then and now.[212]

The facts of *Corbett* were as follows: Arthur Cameron Corbett and April Ashley participated in a marriage ceremony in Gibraltar on September 10 1963. The petitioner, Corbett, later sought a declaration that the marriage ceremony, in which he partook voluntarily and in full knowledge of Ashley's sex re-assignment from male to female, be declared null and void because the respondent was legally male at the time of the marriage. Failing that, the petitioner alternatively sought a decree of nullity on the basis that the marriage was never consummated. The respondent, Ashley, denied being male and denied that she was unable or unwilling to consummate the marriage, but also sought a decree of nullity on the grounds that Corbett was so unable or unwilling to consummate the marriage. This case then centred on the determination of Ashley's sex. It is imperative that one's legal sex was determined for the purpose of marriage because the law in the UK at the time was clear; if a same sex couple married in a marriage ceremony then the marriage was void *ab initio*.[213]

The basis for the position adopted by Ormrod J as his starting point that marriage is heterosexual is attributed to the dicta of Lord Penzance in the 1866 case of *Hyde v Hyde and Woodmansee*.[214] In *Hyde* Lord Penzance was faced with deciding whether the English Courts of Probate and Divorce would recognise, for the purpose of dissolution, a potentially polygamous marriage entered into by a Mormon couple in Utah. In determining this, Lord Penzance stated that "I conceive that marriage, as understood in Christendom, may for this purpose be defined as the voluntary union for life of one man and one woman, to the exclusion of all others."[215]

The *Corbett* case was decided on two main points; firstly whether an MTF transsexual could be considered as a woman for the purpose of English marriage law and secondly whether an MTF transsexual was capable of consummating a marriage. This raises two

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[212] S Gilmore '*Bellinger v Bellinger* – not quite between the ears *and* between the legs – transsexualism and marriage in the Lords' (2003) *Child & Family Law Quarterly* 15(3):295-311; A Barlow '*W v W (Nullity: Gender)* and *B v B (Validity of Marriage: Transsexual)* – a new approach to transsexualism and a missed opportunity? (2001) *Child & Family Law Quarterly* 13(2):225-240.

[213] This is no longer be the case in England and Wales as a result of the Marriage (Same Sex Couples) Act 2013 and no longer the case in Scotland as a result of the Marriage and Civil Partnership (Scotland) Act 2014.

[214] (1865-69) LR 1 P & D 130.

[215] ibid 133.

particular issues: firstly, given medical advances since the *Hyde* judgment, how one determines the factors which make someone a man or a woman for the purpose of marriage, and indeed the related issue of whether or not marriage is sufficiently different from other legal relationships, such that determining sex for marriage takes on special significance which is not apparent in relation to non-intimate legal relationships such as those regulated by contract law, for example.

The issue of similarity of marriage and other legal relationships was raised briefly in the case where it was argued by counsel for Ashley that as she was treated as female in society then it would be illogical not to treat her as such for the purpose of marriage. Ormrod J responded that "[t]he illogicality would only arise if marriage were substantially similar in character to national insurance and other social situations, but the differences are obviously fundamental."[216] Ormrod J claimed that the submissions of Ashley's counsel as to the illogicality "in effect, confuse sex with gender"[217] and that "[m]arriage is a relationship which depends on sex and not on gender."[218] The second issue faced by the Court concerned the legalities of consummation of marriage and therefore whether or not a post-operative MTF transsexual was capable of consummating a marriage with a biological man.[219]

The focus of the next section will be on how the Court determined Ashley's sex for legal purposes, as the dicta of Ormrod J has been heavily relied upon since in determining how UK law should determine the sex of those seeking legal recognition of their gender identity. The strict physiological test established in this case by Ormrod J had a serious negative impact on those seeking legal recognition in the years to follow as will be shown later in this chapter.

Determining the *legal* sex of April Ashley

Bearing in mind the dictum of Lord Penzance in *Hyde* the question faced by Ormrod J was whether or not the union between Corbett and Ashley could be considered a heterosexual union; if it could not then the 'marriage' would be void. Not surprisingly, counsel for

[216] *Corbett* (n 198) 107[A].
[217] ibid.
[218] ibid.
[219] For the purpose of this thesis it is not important to engage with the discussion regarding consummation of marriage between a transsexual and non-transsexual therefore I will not spend any time outlining the arguments presented in *Corbett* or indeed on the Court's reasoning in relation to this matter.

Corbett and Ashley disagreed on the factors determining sex for the purpose of marriage. Corbett's lawyers argued that:

> [t]he first question to be answered, a unique one, is whether there is anything matrimonial about a ceremony between two men and whether it can have legal consequences. Can two male homosexuals (or lesbians) go through a ceremony of marriage and thereby create the legal consequences of a marriage? How they regard one another is irrelevant. The test for that purpose should not be a subjective one.[220]

Counsel for Corbett relied upon the classic definition of marriage established by Lord Penzance in the case of *Hyde*, as noted above, and argued that primary sex characteristics at the moment of birth and secondary sex characteristics developing naturally at puberty ought to be the basis for determining the sex of Ashley. Therefore the substance, form and function of Ashley's genitalia were considered fundamental to whether or not she could be deemed a woman for the purpose of marriage to Corbett. Counsel for Corbett argued that in relation to Ashley's genitalia that there was a fundamental difference between Ashley's vagina which was wholly constructed and a surgically altered vagina of a person who had been born female. Corbett was arguing that the respondent was not a naturally born woman but "was and is a castrated male who has a passage in the form of an artificial vagina constructed for him but who has not and never has had ovaries or a uterus."[221] Regarding the legal sex of Ashley, counsel for Corbett argued that:

> [w]hen there is a problem as to the sex of a party it seems absurd to look at the matter as at the date of the marriage. In the ordinary case, which this is, one must take the date of birth as the relevant date for investigation. By "ordinary" case is meant a case where the first three criteria of sex are all one way, i.e., excluding psychological factors. A woman is a person chromosomally XX with female gonads and whose apparent sex is feminine. It is accepted that external and internal genitalia must be of the utmost importance.[222]

On the other hand Ashley's lawyers argued that she had been diagnosed intersex and was, for all other legal purposes, classed as female;[223] her lawyers argued that the Court ought to recognise the medical profession's diagnosis of intersex and declare that the marriage between Ashley and Corbett was indeed valid. Her lawyers contended that:

> [m]anhood and womanhood is not decided on the presence or otherwise of a penis or other sexual organs. Sex is the sum of a number of things both external and

[220] *Corbett* (n 198) 86[E]-[F].
[221] ibid 86[G].
[222] ibid 87[F]-[G].
[223] ibid 85[C].

> internal and pertaining to both body and mind. Consideration must be given to hormonal make up, the person's psychological condition and chromosomal factors.[224]

The lawyers highlighted that as Ashley had been born intersexed the operation to feminise her body was appropriate. The argument was that she was not transsexual but had been mis-identified as male at birth when she was in actual fact female. Counsel for Ashley noted that one's identity as male or female is based on a number of criteria "pertaining to both body and mind"[225] and that "[i]t is superficial, dangerous and illogical to have regard simply to external genitalia."[226]

So, the basic arguments put forward in this case is that sex is essentially fixed at birth and dependent upon one's primary sex characteristics and which are supported by the natural development of secondary sex characteristics on puberty versus the argument that sex is more complicated than biology and includes aspects of one's psychological identification which ought to be recognised by the law.[227]

Establishing the test for determining one's true legal sex

Ormrod J was at pains to determine Ashley's true sex because, as noted above, according to him the existence of a valid marriage was dependent upon this.[228] From the remainder of his judgment it becomes clear that for Ormrod J true sex meant the respondent's biological rather than her psychological sex. The Court heard the expert testimony of several medical professionals and Ormrod J observed that according to the medical experts "there are at least four criteria for assessing the sexual condition of an individual."[229] These were identified as chromosomes, gonads, genitals and psychology.[230] In addition Ormrod J stated that some of the medical experts who led evidence in the case would also add a fifth:

> [h]ormonal factors or secondary sexual characteristics (such as distribution of hair, breast development, physique etc., which are thought to reflect the balance between the male and female sex hormones in the body).[231]

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[224] ibid 85[C]-[D].
[225] ibid 85[C].
[226] ibid 85[F].
[227] ibid 85[C]-[G].
[228] ibid 89.
[229] ibid 100[D].
[230] ibid 100[D]-[E].
[231] ibid 100[E]-[F].

Despite the medical evidence which was presented Ormrod J determined that it was for the court and not the medical profession to determine Ashely's sex. He stated that these medical criteria:

> have been evolved by doctors, for the purposes of systematising medical knowledge and assisting in the difficult task of deciding the best way of managing the unfortunate patients who suffer, either physically or psychologically, from sexual abnormalities. […] *These criteria are, of course relevant to, but do not necessarily decide, the legal basis of sex determination*.[232]

In considering whether or not Ashley had been correctly sexed at birth i.e. was she intersex or transsexual Ormrod J, after weighing up the medical evidence presented, concluded that "the respondent is correctly described as a male transsexual, possibly with some comparatively minor physical abnormality."[233] This is an important distinction to make. Had Ashley been intersex then it would have been possible to assign her the female legal sex based on the dicta of Prain in *X, Petitioner* in relation to being able to correct mistakes made when initially registering a child's sex but because her sex at birth was unambiguous she had been correctly assigned the male sex at birth making her a transsexual and thereby denying her the possibility of altering her birth certificate or indeed her legal sex for all purposes. After declaring Ashley transsexual Ormrod J continued:

> [t]he question then becomes, what is meant by the word "woman" in the context of a marriage, for I am not concerned to determine the "legal sex" of the respondent at large. Having regard to the essentially hetero-sexual characteristic of the relationship which is called marriage, the criteria must, in my judgment, be biological, for even the most extreme degree of transsexualism in a male or the most severe hormonal imbalance which can exist in a person with male chromosomes, male gonads and male genitalia cannot reproduce a person who is naturally capable of performing the essential role of a woman in marriage.[234]

In determining how the law should deal with the criteria used by medicine when determining sex i.e. chromosomes, gonads, genitals, psychology and secondary sex characteristics Ormrod J stated that:

> the law should adopt [...] the first three of the doctor's criteria, i.e., the chromosomal, gonadal and genital tests, and if all three are congruent, determine sex for the purpose of marriage accordingly, and ignore any operative

[232] ibid 100[F]-[G] (emphasis added).
[233] ibid 100[C].
[234] ibid 106[B]-[D].

interventions."[235]

So clearly then legal sex for the purpose of marriage law was intrinsically related to biological sex which was physiologically determined at birth and could not "be changed, either by the natural development of organs of the opposite sex, or by medical or surgical means."[236] The approach taken in *Corbett* was a much narrower interpretation of the criteria used by medicine which, according to Professor Dewhurst providing evidence in *Corbett*, medicine use not to determine with absolute certainty a person's sex but rather to "determine the sex in which it is best for the individual to live."[237] This highlights an important distinction: law requires certainty of sex because, to return to Ormrod J's statement about the role of law, the law is concerned with regulating "the relations between persons, and between persons and the state or community."[238] Medicine, on the other hand, had a different role and even at the time of *Corbett* in the 1970s when, as was shown in the previous chapter, medicine as a whole was only just accepting transsexualism, medicine was not concerned with determining one's sex for all purposes and with any degree of absolute certainty but rather medicine was, on the whole, more concerned with easing the dysphoria experienced by patients whose bodies and psychosexual identities were not congruent. It was here that Ormrod J established the test which would be used by the law to determine one's sex which relied upon physiological criteria alone where the physiological criteria were congruent; it was only where there was some disparity between physiological criteria that the individual's sense of self as male or female i.e. their psychological identification could be taken into consideration.

Because, for Ormrod J legal sex is fixed at birth and unchangeable he held that Ashely was "not a woman for the purpose of marriage but is a biological male and [had] been so since birth."[239] Although Ashley had been diagnosed as transsexual, and this was recognised by Ormrod J when considering her psychological sex, he denied this important aspect of her identity as being irrelevant in law when chromosomes, genitals and gonads are congruent at birth. Accordingly the marriage between Ashley and Corbett was declared void on the basis that both parties were male at the time of the marriage ceremony.

[235] ibid 106[D].
[236] ibid 104[D]-[E].
[237] ibid 100[F]-[G].
[238] ibid 105[D].
[239] ibid 106[E]-[F].

The *Corbett* judgment has had a massive impact on legal sex determination and consequently on the lives of transsexual individuals and families who sought recognition, rights and protection in law. Cowan argues that one particularly important legal outcome of the *Corbett* case was that the law confirmed that "sex is not a matter of choice in law; rather it is an essential biological characteristic."[240] Bell argues that when courts adopt this approach and begin their enquiry with the question of whether a man "who has surgery to change his physical characteristics is still just a man"[241] rather than the more inquisitive enquiry of what is the applicant's "sex after surgery, hormonal therapy, and psychiatric counselling"[242] then "the court's formulation of the question determines the outcome."[243] By adopting the more inquisitive approach and framing their narrative in the latter form, the courts would open up the possibility of finding that someone who has undergone surgery to modify his or her body to make it congruent with his or her gender identity has in fact changed sex. UK Courts, however, as will be shown throughout this chapter, were unwilling to take this approach. The *Corbett* decision highlights what Bell terms the court's "adherence to essentialist modes of inquiry"[244] so that the courts rely upon "a stark distinction between "natural" and "man-made" organs, thus treating sex/gender as truly existing in a single, universal form."[245] *Corbett* was a judgment which allowed for predictability in determination of sex but it was also "the basis of the separation of sex from gender in transsexuality cases."[246] As Cowan argues, "UK courts have adhered to this division [of sex and gender], treating gender as a social/psychological factor that can always be trumped by biological sex (particularly chromosomes)."[247] This is an important issue. Although it may seem that sex and gender can be used interchangeably, and indeed the terms are often confused, each term has a specific meaning. 'Sex' is understood as a person's biological make-up which ranges from chromosomal make-up, possession of a particular type of gonad to widely differing secondary sex characteristics such as body hair. Ormrod J was unable to determine that Ashley was anything other than male because he applied biological criteria to legal sex determination. Ashley could alter her secondary sex characteristics, which indeed she did. She could alter, to some degree, her gonads through castration; however she would never be able to create ovaries to replace the

[240] S Cowan '"Gender is no substitute for sex": a comparative human rights analysis of the legal regulation of sexual identity." (2005) *Feminist Legal Studies* 13:67-96; 74.
[241] M Bell 'Transsexuals and the law' (2004) 98 *Northwestern University Law Review* 1709; 1730.
[242] ibid.
[243] ibid.
[244] ibid 1731.
[245] ibid.
[246] Cowan (n 241) 74.
[247] ibid.

removed testes. She could never alter her chromosomal pattern; Ashley would always be legally male because her 23rd chromosome pairing was XY rather than XX. However biology is not the only means of determining whether or not someone is male or female. The *Corbett* judgment completely ignored Ashley's gender identity. Whereas 'sex' refers to biology, 'gender' refers to psychology and is therefore not as easy to determine definitively as sex. However had the Court been more willing to consider the importance of gender identity and psychological identification then it is arguable that Ashley would have been recognised as female and her 'marriage' to Corbett would have been deemed valid although in doing so the test established by Ormrod J would have been less certain.[248]

However, to return to the question which was posed at the beginning of the discussion of the *Corbett* case: marriage, then, *is* different from other legal relationships in that the law is very much concerned with which bodies individuals inhabit and how these bodies interact with each other in a sexual manner. To a certain extent the law regarding sex determination for the purpose of intimate relationships *must* be about more than merely the right of the individual who identifies as a member of the opposite sex; the law would appear also to be concerned with the rights of those who intimately interact with that individual and who may be affected on a deep, personal psychological level due to the nature of the relationship between the parties. Although the *Corbett* case was about a relationship in which sex was considered an essential element, some subsequent cases strayed into the other two categories of legal relationship i.e. where sex is considered irrelevant or where it is considered relevant but not essential. As noted earlier, this categorisation of the importance of sex within these legal relationships provides some explanation of why transsexuals were given recognition and protection in some areas of life but not in others as can be seen when examining the *Corbett* legacy.

Therefore *Corbett* strengthened the legal position: one might well be able to take advantage of the medical advances and alter one's body but, based on *X, Petitioner,* this did not mean that one's sex had been incorrectly registered at birth, therefore a new birth certificate could not be issued. In addition the result of *Corbett* was that the law fully adopted the position that the changes one made to one's body in an attempt to ease the dysphoria which one experienced were inconsequential to one's legal status: the law continued to provide that one's initially registered sex was one's sex for all legal purposes

[248] As will be shown below Thorpe LJ in the Court of Appeal in *Bellinger v Bellinger* placed a strong emphasis on psychological gender identity and as will be shown in.in Chapter Three so did the European Court of Human Rights in the case of *Goodwin v United Kingdom* (2002) 35 EHRR 18.

unless it could be shown that a mistake had been made on initial registration. In this context a mistake could amount to an administrative mistake or indeed later revelations that the individual was intersex: being transsexual and altering one's body did not amount to evidence that the initially registered sex was wrong.

This then raises two further questions *what was the impact of Corbett* and *how did the law deal with Ormrod J's classifications of the importance of sex when faced with transsexual individuals?* The impact of *Corbett* was much more far reaching than perhaps it ought to have been given the relative weakness of its precedential strength.[249] Both of these questions will be explored throughout the remainder of this chapter.

1970s: developments in EU equal treatment law

Between *Corbett* and the next UK case which concerned the legal recognition of an individual's gender identity[250] the UK Government, in response to developments in EU law, enacted the Sex Discrimination Act 1975 (SDA 1975) which made it unlawful to discriminate on the ground of sex in employment, education and the provision of housing, goods, facilities and services and stemmed from EU equal treatment directives. The SDA 1975 formed the basis for the application in *White v British Sugar Corporation,*[251] which, because it was an employment discrimination case, ostensibly fell within Ormrod J's *irrelevant* category of sex for legal purposes, or at least *sex as relevant but not essential*. However, it quickly becomes apparent that despite this case seemingly falling within the sex as irrelevant, or at least sex as relevant but not essential category the sex of the individual was a material factor in this case because of the specific provisions in the relevant legislation at the time as will be shown below.

In *White* the appellant was born, and registered as, female. There was no question regarding the appellant's physical sex, there was no question of the individual being intersex and no steps had been taken to undergo sex re-assignment. However, he identified as male, dressed in male clothing, used a male name and masculine prefix and wanted to be treated as male. It is clear from this presentation of facts that White was not a post-operative transsexual. He gained employment as an electrician's mate which involved

[249] Gilmore (n 213); Barlow (n 213).
[250] It is important to use the term gender identity here because the individual in the next case which arose in the UK courts was a pre-operative transsexual, a woman who identified as a man but who had taken no steps to alter his body.
[251] [1977] IRLR 121. Please note that the use of the masculine pronoun here is deliberate to acknowledge and respect the individual's identity despite the law sexing him as female.

some work on Sundays. While in employment, he used the male toilets and changing facilities at work. However, rumours about him being female began and he was dismissed. The industrial tribunal held that he was female for the purposes of the SDA 1975. In relation to determining White's sex the Chairman of the Industrial Tribunal, John Else, stated that the dictionary "defines male as of or belonging to the sex which begets offspring or performs the fecundatory function."[252] He noted that the dictionary also defines "female as belonging to the sex which bears offspring."[253] He stated that in the present case, "the applicant […] does not have male reproductive organs and there was no evidence that she could not bear children."[254] As a result of this poor determination of legal sex using dictionary definitions, and paying no consideration to the test established by Ormrod J in *Corbett,* the Industrial Tribunal held that White was female in terms of the SDA 1975. It has to be noted that had the Industrial Tribunal acknowledged the *Corbett* test the outcome would have been the same but at least there would have been a legal rather than linguistic basis for this determination.

The tribunal determined that had a legal male presenting as female been employed as a female and used the female facilities then she too would have been dismissed. Therefore, there was no difference in treatment between White and a male person in that situation. The tribunal also determined that as the Factories Act 1961 s.7(2)(f) prohibited females from working on a Sunday then being male was a genuine occupational requirement thereby making this a case in which the sex of the individual was an essential element of the legal relationship. So, as a result of not taking psychological identity into consideration when determining the sex of this individual it was deemed that his employer's treatment of him was not discriminatory. At the time of this case it would have been unlikely that the courts would have taken psychological identity without corresponding body modifications into consideration based on Ormrod J's clear proclamation in *Corbett* that sex in law is determined by biology and it is only where biology is incongruent that psychology may become a factor. Despite medicine acknowledging that psychological factors influence one's sex law firmly adhered to the *Corbett* test which only acknowledged the person's chromosomes, gonads and genitals at birth. In so ignoring psychology the law was strengthening the *Corbett* test with each subsequent judgment and thereby distancing itself from medical developments.

[252] ibid 123.
[253] ibid.
[254] ibid. Please note that the Industrial Tribunal used the female pronoun to reflect the individual's legal sex and therefore since I am quoting directly from the report it is appropriate to maintain authenticity of the quote by using the female pronoun.

White had sought to rely on the SDA 1975. However there was no provision in the legislation which dealt with transsexuals, pre-operative or post-operative, so the SDA 1975 was no help to him. However it has to be noted that the SDA 1975 derived from the provisions in the Treaty of Rome 1957 in relation to equal pay for men and women therefore the roots of the legislation was in ensuring that men and women were treated equally and therefore was not about transsexuals at all. So, it is not surprising that this legislation provided no help to White or other transsexual individuals and therefore these equality based laws from the EU were of little help to transsexuals at this time. Although a few years later as will be shown below, in the case of *P v S and Cornwall County Council*,[255] it was this strand of law which would first provide an acknowledgement of sex re-assignment surgery for legal purposes in relation to employment and later in the provision of goods and services.

Corbett: from marriage law to the criminal law

Not only had the *Corbett* judgment negatively impacted on the ability of post-operative transsexuals to enter into a marriage with a member of the sex opposite to their post-operative sex it also had an impact in relation to the criminal law even though *Corbett* ought to have been very much restricted in its impact, as discussed above, because of its weak precedential strength and the very narrow aspect of law on which it was centred.

The first case from criminal law to consider a post-operative transsexual individual's legal sex was *R v Tan*[256] which confirmed the *Corbett* test. *Tan* is particularly interesting because the Court spent some time considering the need to maintain consistency in law in relation to subsequent cases and also the need for certainty in this area of law which would be in distinction to the lack of need for certainty in medicine in relation to an individual's sex. At the time of this case medicine was continuing its development in this area such that there was flexibility within the medical approach to transsexuals to recognise that some individuals identified as members of the opposite sex for reasons not fully known or understood. In addition, as a result of the work of key people in this field, notably Harry Benjamin, it was acknowledged in medicine by the 1980s that the most appropriate treatment for such individuals was not to insist that because their chromosomes, gonads and genitals at birth were congruent therefore they had to undergo psychological therapies to reconcile mind and body rather medicine acknowledged that it was more appropriate to

[255] [1996] 2 CMLR 247.
[256] [1983] QB 1053.

alter the person's physical body, where possible, suitable and required, to correspond with the person's sense of self as male or female. Despite this flexibility in medicine, law continued to maintain the need for consistency between judgments and certainty of legal sex. This divergence of approaches can be explained by the functions and roles of the two systems: as mentioned briefly above the function of medicine was to determine in which sex it was most appropriate that the individual would live because the role of medicine was to ease the dysphoria experienced by the patient. Whereas the function of law was to definitively determine which legal sex one should be classified as because the role of law was to regulate "the relations between persons, and between persons and the state or community"[257] So the separation of the roles and functions of the two systems which began to be articulated by Ormrod J in *Corbett* becomes clearer through the analysis of the Court's judgment in *Tan*.

In *R v Tan* Moira Tan had been convicted, along with the other appellant, Gloria Greaves, of keeping a disorderly house. Greaves was also convicted of living on the earnings of prostitution contrary to s.30 of the Sexual Offences Act 1956 s.30 which provided that "[i]t is an offence for a man knowingly to live wholly or in part on the earnings of prostitution."

Tan, a prostitute, would, for payment, subject men to "humiliating and perverted sexual treatment"[258] in a flat she had leased from Greaves. Greaves used other premises for similar purposes. The issue was that Greaves had been born male but had undergone sex re-assignment and was accepted socially as female. It was argued that Greaves should not be considered a man for the purpose of s.30; this submission was rejected and the parties were convicted. The appeal against conviction was similarly rejected. The Court of Appeal noted that "[a]n essential element of the offences […] was that Gloria Greaves was a man."[259] In determining that Greaves was a man the Court of Appeal stated that:

> [i]n our judgment both common sense and the desirability of certainty and consistency demand that the decision in *Corbett v Corbett* should apply for the purpose not only of marriage but also for a charge under section 30 of the Sexual Offences Act 1956 or section 5 of the Sexual Offences Act 1967.[260]

[257] *Corbett* (n 198) 105[D].
[258] *Tan* (n 257) 1053[E].
[259] ibid 1063[G].
[260] ibid 1064[B]-[C].

This was the first time the appeal to consistency was made. The Court considered the implications of adopting other factors when determining Greave's legal sex and noted that:

> [i]f the criteria were biological, there was evidence that Gloria Greaves was and had always been male. If she was judged on the social and psychological factors she was undoubtedly a woman. To decide that she is a man is inappropriate in the light of the social and psychological factors. If one defines sex biologically, the biological test is the right test to apply. In terms of gender role, emotional feelings and sexual behaviour, Gloria Greaves is female. In terms of the genital and chromosomal tests she is male.[261]

Therefore the Court acknowledged the uncertainty that could arise by adopting different means to determine Greave's legal sex and thus importantly the Court continued:

> [t]his is an uncertain area of the law *and clearly in an area of this kind the law should be certain.* When the issue of sexual identity is raised it should not be left to the jury to determine. One jury might wish to apply the biological criteria, while another jury dealing with the same defendant and with the same factors as Gloria Greaves might come to a different conclusion. In this matter, which should be a matter of law, guidance should be given by the court so that consistency will arise.[262]

Consequently Greaves was male for the purpose of the legislation and therefore her conviction was competent.

Two legal factors became apparent in *R v Tan* which were less apparent in the *Corbett* judgment: certainty and consistency. So even this early in the quest for legal recognition it is becoming apparent that law and medicine are two separate systems each with different motivations: law seeks to provide certainty and consistency whereas medicine seeks to "determine the sex in which it is best for the individual to live."[263]

So the UK courts were very reluctant to provide any legal recognition of sex re-assignment surgery because of the need for certainty and consistency in law and therefore they were not willing to depart from *Corbett* in any way consistently stating that *Corbett* reflected the law's approach to determining the sex of an individual for legal purposes. The result of UK law's refusal to recognise sex re-assignment procedures for legal purposes resulted in several applications to the ECtHR.

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[261] ibid 1056[A]-[B].
[262] ibid 1056[B]-[C] (emphasis added).
[263] *Corbett* (n 198) 100[F]-[G].

1980s and 1990s: transsexual applicants in the European Court of Human Rights

In 1986 there began a long campaign in the ECtHR brought by transsexual applicants against the UK Government.[264] These cases primarily concerned the rights of the applicants under Article 8 ECHR subsection 1 of which provides that "[e]veryone has the right to respect for his private and family life, his home and his correspondence" subject to the provisions in Article 8(2). Therefore Article 8 does not give anyone absolute rights but rather there is always a balancing act to be performed between the alleged violation and the provisions set out in Article 8(2).

In addition most of the cases also alleged violations of Article 12 which provides that "[m]en and women of marriageable age have the right to marry and to found a family, according to the national laws governing the exercise of this right." Therefore the right to marriage contained in Article 12 is also a qualified right such that it is subject to the national laws governing the right to marry which at the time, in relation to the sex of the parties, were contained in s.5(4)(e) of the Marriage (Scotland) Act 1977 and s.11(c) of the Matrimonial Causes Act 1973.

All of the cases in the ECtHR alleged that these violations resulted from the refusal of the UK Government to allow post-operative transsexuals to amend their birth certificates and to marry as members of the sex opposite to their birth sex. All of the cases brought by UK domiciled individuals during this period failed in their quest to have the sex re-assignment of the applicants recognised for legal purposes.

Despite these cases failing, one of the important aspects of this strand of case law was that it introduced new legal concepts into the equation; the ECtHR was not bound by Ormrod J's classification of the importance of sex as essential, irrelevant, or relevant but not essential and nor was it bound by the test which he established for determining one's legal sex. Rather the ECtHR introduced concepts such as the positive obligations on states in relation to the protection of individuals' Convention rights, the consensus throughout contracting states in particular matters and how this impacted on individual contracting states depending on whether the state was afforded a wide or narrow margin of appreciation. In addition the balance of rights of applicants against others became particularly important as did the right of individuals to be able to develop their personal

[264] *Rees*; *Cossey*; *X, Y & Z*; *Sheffield and Horsham* (n 15).

identity and, as will be shown in Chapter Three it was these concepts which enabled the legal recognition of transsexuals to emerge in the case of *Goodwin v United Kingdom*.[265]

The facts of the cases are as follows: in *Rees v United Kingdom*[266] Rees was a female-to-male (FTM) transsexual. He was born female in 1942 and was registered as such and named Brenda. In his early childhood he exhibited masculine behaviour. He sought treatment for transsexualism in 1970, he began hormone therapy and developed male secondary sex characteristics and began living as a man. In 1971 he changed his name. Over the following years he changed his name on all official documents to reflect his male identity. In 1974 he began surgical treatment to alter his body to appear as male and this was provided by the National Health Service (NHS). At the time of the case Rees was living fully, and was socially accepted, as male. The facts of *Cossey*[267] were very similar to those in *Rees*, apart from the fact that Caroline Cossey had been born male and transitioned to female i.e. she was a male-to-female (MTF) transsexual. *X, Y & Z v United Kingdom*[268] concerned three applicants. The first applicant was a FTM transsexual, the second applicant was a biological female with whom the first applicant was in a relationship and the third applicant was the child of the second applicant. The third applicant had been conceived by means of Artificial Insemination by Donor (AID). The first and second applicants had obtained private fertility treatment to conceive their child. As part of the process for obtaining fertility treatment the first applicant was asked to acknowledge himself as the child's father under the Human Fertilisation and Embryology Act 1990. The second applicant became pregnant in January 1992 and the child was born on 13 October 1992.The first applicant was then denied the ability to register as the child's father because he was not a biological man. The child was allowed to be registered using the first applicant's surname. In *Sheffield and Horsham v United Kingdom*[269] Sheffield and Horsham were MTF transsexuals. In each of these cases the ECtHR held that there were no violations of either Article 8 or Article 12. However, as time passed between each case the margin of those voting in favour of a violation versus those voting against narrowed. In Rees the court voted twelve to three that there was no violation of Article 8 and unanimously that there was no violation of Article 12. In *Cossey*, although the eventual outcome was the same there was one small positive aspect of the decision: the majority decreased. In *Cossey* the majority finding that there was no violation of article 8 was ten to

[265] (2002) 35 EHRR 18.
[266] *Rees* (n 15).
[267] *Cossey* (n 15).
[268] *X, Y & Z* (n 15).
[269] *Sheffield and Horsham* (n 15).

eight and in relation to the Article 12 claim the majority had decreased from a unanimous decision in *Rees* to fourteen to four. So, in the four years between the judgments there would appear to be some, albeit very small, degree of judicial movement towards recognising the rights of transsexual applicants. In *X, Y & Z v United Kingdom* it was held 14 votes to six that there was no violation of Article 8 and in *Sheffield and Horsham v United Kingdom* the margin was 11 votes to nine that there was no violation of Article 8 and 18 votes to two that there was no violation of Article 12.

The Article 8 decisions

Two issues had particular importance in the Court's determination of the *Rees* application in 1986; firstly the extent of the positive obligation owed by the state to transsexuals and secondly the width of the state's margin of appreciation in such cases. The ECtHR began by reiterating the essence of Article 8 as being concerned with the protection of individuals against arbitrary state interference.[270] However it continued that "there may in addition be positive obligations inherent in an effective respect for private life, albeit subject to the [s]tate's margin of appreciation."[271] The Court, however, was tasked with determining the existence and scope of the UK's positive obligation in this area because it was noted that "[t]he mere refusal to alter the register of births or to issue birth certificates whose contents and nature differ from those of the birth register cannot be considered as interferences."[272]

The fact of not altering birth certificates was not, therefore in the opinion of the ECtHR, *per se* a violation of Article 8. In order to amount to a violation it had to be shown that through not allowing changes to be made to the system of registration of births the UK was under a positive obligation to recognise post-operative transsexuals' sex for legal purposes which in itself was dependent upon many factors, for example the margin of appreciation and the balance of rights and interests of the applicant and others.

In relation to the margin of appreciation it was argued by the applicant that it should only apply in relation to the methods adopted by the state to facilitate transsexual legal recognition not in relation to whether or not there should be legal recognition at all.[273] The Government argued that "the whole matter depended on the balance that had to be struck

[270] *Rees* (n 15) [35].
[271] ibid.
[272] ibid [36].
[273] ibid.

between the competing interests of the individual and of society as a whole."[274] So the question remained, was there a positive obligation on the UK to recognise transsexuals and if so what was the extent and scope of the margin of appreciation. On the question of 'respect' contained in Article 8 the ECtHR related this to practice of contracting states in general saying that:

> the notion of 'respect' is not clear-cut, especially as far as those positive obligations are concerned: having regard to the diversity of practices followed and the situations obtaining in the Contracting States, the notion's requirements will vary considerably from case to case.[275]

On considering the situation throughout the contracting states the ECtHR observed a wide variation in practice and therefore determined that there was a wide margin of appreciation to be applied. This wide margin of appreciation therefore would benefit the UK Government rather than the applicant. In relation to the positive obligation owed by the UK Government to the applicant specifically, and transsexual individuals in general, the Court noted:

> [i]n determining whether or not a positive obligation exists, regard must be had to the fair balance that has to be struck between the general interests of the community and the interests of the individual, the search for which balance is inherent in the whole of the Convention. In striking this balance the aims mentioned in the second paragraph of Article 8 may be of a certain relevance, although this provision refers in terms only to 'interference' with the right protected by the first paragraph – in other words is concerned with the negative obligations flowing therefrom.[276]

The Court observed that "[t]he governing authorities in the United Kingdom are fully entitled, in the exercise of their margin of appreciation, to take account of the requirements of the situation pertaining there in determining what measures to adopt."[277] The purpose of this statement was to reiterate that at the time of the case, as there was no consensus among the contracting states regarding legal recognition of transsexuals, there was no onus on the UK to adopt any of the measures which existed in any of the other states. The Court continued:

> [w]hile the requirement of striking a fair balance […] may possibly, in the interests of persons in the applicant's situation, call for incidental adjustments to the existing

[274] ibid.
[275] ibid [37].
[276] ibid.
[277] ibid [42].

> system, it cannot give rise to any direct obligation on the United Kingdom to alter the very basis thereof.[278]

The Court considered the applicant's request in detail, particularly as it related to privacy of the individual and the concomitant effect this could have on the general public. One of the issues regarding legal recognition of sex change is the impact such a personal issue has on other people with whom the individual interacts. Not only was *Rees* seeking that the UK system of registration of births should be altered to allow individuals such as himself to change their legal sex, he was also seeking that the sex re-assignment and amendments to birth certificates should be kept secret from third parties.[279] On the issue of privacy and the interaction of transsexuals with third parties the Court stated that:

> [s]uch secrecy could not be achieved without first modifying fundamentally the present system for keeping the register of births, so as to prohibit public access to entries made before the annotation. Secrecy could also have considerable unintended results and could prejudice the purpose and function of the birth register by complicating factual issues arising in, *inter alia,* the fields of family and succession law. Furthermore no account would be taken of the position of third parties, including public authorities (e.g. the armed services) or private bodies (e.g. life insurance companies) in that they would be deprived of information which they had a legitimate interest to receive.[280]

So the issue was more complicated than merely declaring that the UK had violated the applicant's right to respect for his private life by failing to allow him to be declared legally male; in addition to the rights of the applicant the Court had to consider the rights of wider society also. The Court therefore had a particularly delicate balancing act to perform in this case and so, as can be seen from the *Rees* case, the cases in the ECtHR were wider in scope than those in the UK courts which, on the whole, were only tasked with determining whether to apply the *Corbett* test or to depart from it.

In particular the ECtHR had to consider the rights of the individual to privacy but also the rights of third parties to know with whom they were interacting in a variety of situations. The Court observed that:

> [i]n order to overcome these difficulties there would have to be detailed legislation as to the effects of the change in various contexts and as to the circumstances in which secrecy should yield to the public interest. Having regard to the wide margin

[278] ibid.
[279] ibid [43].
[280] ibid.

> of appreciation to be afforded the State in this area and to the relevance of protecting the interests of others in striking the requisite balance, the positive obligations arising from Article 8 cannot be held to extend that far.[281]

Although in *Rees* the court ultimately determined that there was no violation of Article 8 it was noted that the UK had to keep the situation under review "having regard particularly to scientific and societal developments"[282] which, history shows, the UK failed to do. When *Cossey* was decided the outcome was exactly the same as that in *Rees* and the reasoning of the court in the two cases was very similar. Again, one of the key issues was the rights of the individual to be balanced with the rights of the general public.[283] The Court considered the privacy of the individual against the wider public interest and noted, again, that complete confidentiality of the registration of births system may have negative adverse consequences.[284] The Court reiterated that, as a result of the little common ground between contracting states, there remained a wide margin of appreciation to be applied in favour of the respondent state.[285] Again, as in *Rees* the UK was admonished to keep the situation under consideration in light of social and scientific development.

In *X, Y & Z v United Kingdom* one of the decisive factors in the ECtHR's judgment was the margin of appreciation. The ECtHR noted that family life within the Article encompasses families deriving from a marital relationship but also other *de facto* families where members are not necessarily related to one another through law.[286] Due to the nature of the relationship between the three applicants it could be said that they were a *de facto* family and therefore *prima facie* enjoyed the protection of family life under Article 8. However the ECtHR reiterated that when considering the extent of the state's positive obligations under Article 8 the state enjoys a certain margin of appreciation.[287] This case was different from the previous transsexual recognition cases because the applicants did not argue that UK law breached their rights to private life by not affording the transsexual applicant legal recognition of his post-operative sex. Rather the applicants in this case sought to argue that UK law breached their family life because it did not allow the transsexual applicant to be registered as the father of the child created through AID whereas a biological male in the same situation as the transsexual applicant would have been able to legally register as the child's father. The Court noted that there was no

[281] ibid [44].
[282] ibid [47].
[283] *Cossey* (n 15) [36] – [37].
[284] ibid [38].
[285] ibid [40].
[286] *X, Y & Z* (n 15) [36].
[287] ibid [41].

European consensus regarding parental rights for transsexuals thereby strengthening the UK's margin of appreciation by showing that there was no common ground throughout the contracting states.[288] In addition the Court was once again, as in all of the previous cases, then tasked with balancing the interests of the state and other citizens in relation to having a stable coherent system of family law, albeit with the disadvantages alleged by the applicant. It was observed that the alleged legal hardships could be overcome easily; for example the father could make a will to overcome the issue of his daughter having no automatic right of inheritance,[289] in relation to immigration and nationality the daughter was a British citizen herself so would suffer no hardship.[290] In addition, there was nothing in UK law which prevented the transsexual applicant from acting as the child's father in a social sense[291] and that it was permissible under English law for the mother and father to apply for a joint residence order which would give the father rights and responsibilities in relation to his daughter.[292] When balancing the interests of the individual with the interests of the wider community, the wide margin of appreciation to be applied and as there were remedies already existing in English law to address the alleged difficulties it was determined that there was no breach of the applicant's Article 8 right to family life.

In *Sheffield and Horsham v United Kingdom* again, one of the decisive factors was the application of the margin of appreciation which, when applied resulted in a finding that there was no violation of the applicants' rights.

Article 12 decisions

In relation to the applicant's Article 12 claim the Court held that there was no violation because in their opinion "the right to marry guaranteed by Article 12 refers to the traditional marriage between persons of opposite biological sex."[293] In addition, the rights contained in Article 12 are specifically subject to the national laws which govern those rights i.e. in the instant case the Matrimonial Causes Act 1973 s.11(c). Therefore states enjoy a particularly wide margin of appreciation in relation to matrimonial law subject to the proviso that domestic laws cannot "restrict or reduce the right in such a way or to such an extent that the very essence of the right in impaired."[294] Restricting marriage to an

[288] ibid [44].
[289] ibid [48].
[290] ibid.
[291] ibid [50].
[292] ibid.
[293] *Rees* (n 15) [49].
[294] ibid [50]; for more on this see the cases of *B v United Kingdom* (2006) 42 EHRR 11; *F v Switzerland* (1988) 10 EHRR 411.

institution which can only be entered into by opposite sex couples was not, and indeed still is not,[295] an action which impairs the essence of the right to marry therefore the Court held unanimously that there was no violation of the applicant's Article 12 rights.

In relation to Cossey's Article 12 rights she claimed that she was in effect prevented from marrying anyone at all. She argued that as a woman she could not marry another woman and yet the law would not let her marry a man. The issue here is that this claim by Cossey is confused; Cossey, although looking like a woman, was not legally a woman and therefore would have been able to marry a woman: the fact that she did not want to marry a woman did not mean that the law prevented her from doing so therefore she was not prevented from marrying at all, just prevented from marrying someone she would wish to marry. The Court noted that:

> [a]s to the applicant's inability to marry a woman, this does not stem from any legal impediment and in this respect it cannot be said that the right to marry has been impaired as a consequence of the provisions of domestic law.[296]

As regards the question of whether Cossey should be able to marry a man it was noted that "the criteria adopted by English law are in this respect in conformity with the concept of marriage to which the right guaranteed by Article 12 refers"[297] therefore there was no violation of the applicant's right to marry.

The interesting thing about *Sheffield and Horsham* was that it highlighted the territorial scope of the UK's refusal to give legal recognition to a physical change of sex. In this case, a UK domiciled MTF transsexual was prohibited from marrying her male partner, although both lived in the Netherlands and Dutch law would permit the marriage. Since the applicant was domiciled in England, it was deemed that English marriage law applied to determine who she was legally permitted to marry.

So, it has been observed in the discussion of the above cases that throughout the 1980s and 1990s the ECtHR was not willing to find in favour of transsexual applicants when the cases challenged provisions in UK domestic law.

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[295] See *Schalk v Austria* (2011) 53 EHRR 20.
[296] *Cossey* (n 15) [45].
[297] ibid.

B v France[298]

Cossey and *Rees* both derived from the position of the UK Government not allowing post-operative transsexuals to alter their birth certificates to reflect their sex re-assignment operations and not allowing post-operative transsexuals to marry members of the sex opposite to their post-operative sex. At this time however, UK law did permit post-operative transsexuals to change their names on all official documentation apart from their birth certificates. Although changing one's name did not change one's legal sex it did afford some degree of privacy for the individuals involved. One very important development in the ECtHR at this time was *B v France* and, although not originating in the UK, it is important to discuss this case because it shows that the ECtHR was willing, as early as 1992, to afford rights under Article 8 to post-operative transsexuals. It was possible for the ECtHR to find in favour of the UK and against France on the same issue because of the factors which the Court used to make its determination. In *B v France* the applicant was a MTF transsexual who had undergone hormone and surgical treatment and lived as a woman. However, French law did not recognise her as female. The applicant sought that an annotation be made on her birth certificate to note that she was female. French law permitted annotations to birth certificates to reflect, for example, acknowledgment of an illegitimate child, adoption, marriage, divorce and death. Space was to be left on birth certificates for such annotations to be made. However French authorities refused to acknowledge a change of sex. In addition the French authorities refused to amend the applicant's identity papers. The applicant argued that this refusal by the French authorities resulted in her having to reveal personal information to third parties i.e. that she was born male. The ECtHR held by a majority of fifteen votes to six that there had been a violation of the applicant's Article 8 rights. In determining that the applicant's Article 8 rights had been breached the ECtHR departed from the previous decisions in *Cossey* and *Rees*. There were three particularly important factors which enabled the Court to depart from the previous decisions. Firstly the legal system in France itself allowed departure. The system in France allowed for amendments to birth certificates for a number of reasons. This meant that the system was not, as in the UK, a static system of historical record as was established in *X, Petitioner*.[299] In the UK, legislation would have had to have been passed to enable the change that *Rees* and *Cossey* required; in France the system was already sufficiently flexible to make the required amendment without undue burden being placed on the French authorities, a factor which in *Rees* and *Cossey* was determinative in

[298] *B v France* (n 15).
[299] *X, Petitioner* (n 186).

the Court deciding that their rights under Article 8 had not been violated.[300] Secondly, French authorities had refused to allow the applicant to change her forename to reflect her female identity whereas the law in the UK had allowed such a change of name. Thirdly the ECtHR considered the extent to which the applicant's private life was impacted by the fact that her birth sex was indicated on official documents. Therefore the interferences and inconveniences that the applicant was forced to endure on a daily basis reached "a sufficient degree of seriousness to be taken into account for the purposes of Article 8."[301] It was these three factors which enabled the ECtHR to distinguish *B v France* from the earlier cases of *Rees v United Kingdom* and *Cossey v United Kingdom.* However, as a result of the lack of formal precedential system in the ECtHR and the wide margin of appreciation to be afforded to contracting states in the area of transsexual legal recognition *B v France* ultimately did not affect the law in the UK nor the ECtHR's determination of subsequent cases raised by UK domiciled individuals as will be seen in the discussion of the following cases.

In addition to these cases arising in the ECtHR, other cases continued in the UK courts during this time. In January 1996 the case of *J v ST* went before the Family Division of the High Court.[302] This case concerned a marriage between a biological female and a FTM transsexual. The couple married in 1977 however the husband had been born female, had undergone a double mastectomy, received testosterone injections and used a prosthetic penis. In 1981 the wife discovered that her husband was using a prosthetic penis and "thereafter sexual intercourse only took place perhaps twice a year."[303] A number of years later, as a result of artificial insemination, the couple had two children. The wife petitioned for divorce in 1994 and, it was claimed, that it was only during the divorce proceedings that her husband's birth certificate was made available and that she discovered that her husband had been born female. Therefore on this ground rather than divorce she applied for and was granted a decree of nullity. In relation to financial provision the wife argued that the husband should be barred from making a claim on public policy grounds. The Family Division noted that the Court had discretion under s.23 and s.24 of the Matrimonial Causes Act 1973 in relation to financial and property provisions on divorce or nullity. Rather than bar the husband from making a claim the Court limited his claim to that of an

[300] As will be seen in Chapter Three the ECtHR returns to this very issue in *Goodwin v United Kingdom* (2002) 35 EHRR 18 and there dismisses the burden on the State's administrative system as no longer a determinative factor in these cases.
[301] *B v France* (n 15) [62].
[302] [1996] 2 FCR 665.
[303] ibid 665[F].

unmarried cohabitant. The case does not consider, in depth, how legal sex is determined. However, Russell LJ observed that medical evidence which provided that there may well be a psychological or brain differentiation reason for transsexualism "may indeed be correct but that will not do so far as capacity to marry is concerned in England and Wales."[304] Russell LJ observed the developments in the ECtHR jurisprudence, as discussed in depth above, and noted that these "are not binding upon me but seem, at any rate up to the present, to sustain the law in England and Wales as far as marriage is concerned when dealing with transsexuals."[305] He continued "[i]t may well be that in many respects a transsexual should be and is treated as having acquired a different gender but not so far as marriage is concerned in this country."[306] In making this claim Russell LJ is restating the *Corbett* position that marriage is a legal relationship in which the sex of the parties is an essential element of that relationship and so it was appropriate in the context of marriage to fail to recognise the post-operative sex of the individual in question. The case was then appealed to the Court of Appeal later in 1996[307] which affirmed the Family Division judgment and restated that the correct test in law was that established in *Corbett*.[308]

Whereas the ECtHR and domestic courts were reluctant to find in favour of transsexual individuals through the 1980s and 1990s it is clear that the cases concerning employment rights of transsexuals took a particularly positive path in the late 1990s as a result of further developments in EU law impacting on UK employment law.

Further developments in EU anti-discrimination law

1996 is notable as it was the year in which the ECJ delivered its judgment in what has since become one of the landmark transsexual rights cases in which it was clarified that the SDA 1975 applied to transsexuals. In *P v S and Cornwall County Council*[309] P was a MTF transsexual who was dismissed from her job when she informed her employer that she would be undergoing sex re-assignment. P raised an action against her employer based on sex discrimination. The Industrial Tribunal held that the SDA 1975 did not cover P's situation as there was no sex discrimination since P would have been treated in exactly the same way had she been born female and was seeking sex re-assignment to become male.

[304] ibid 676[D]-[E].
[305] ibid 677[B].
[306] ibid.
[307] [1998] Fam 103.
[308] ibid 146.
[309] [1996] 2 CMLR 247

One of the problems faced by the UK Industrial Tribunal was the question of whether or not the Equal Treatment Directive could apply in the present case and a preliminary ruling was sought from the ECJ on that matter. *P v S and Cornwall County Council*[310] was a fundamentally important case in the process of transsexuals achieving legal recognition of their post-operative sex because it established that equal treatment laws had to also apply to them.

The ECJ held that the general right of all citizens not to be discriminated against was a fundamental human right. Advocate General Tesauro noted that:

> [t]o tolerate such discrimination [on the grounds of sex re-assignment] would be tantamount, as regards such a person, to a failure to respect the dignity and freedom to which he or she is entitled, and which the Court has a duty to safeguard.[311]

This reinforced the rights of EU citizens to be free from discrimination and underlined the EU equal treatment policy. In terms of the scope of the Equal Treatment Directive in relation to transsexuals he noted that:

> the scope of the directive cannot be confined simply to discrimination based on the fact that a person is of one or other sex. In view of its purpose and the nature of the rights which is seeks to safe guard, the scope of the directive is also such as to apply to discrimination arising, as in this case, from the [sex re-assignment] of the person concerned.[312]

The reasoning of Advocate General Tesauro was that to dismiss someone who was undergoing sex re-assignment amounted to less favourable treatment between that person and someone of their birth sex[313] and that therefore this was contrary to the Equal Treatment Directive.[314] Therefore the legal position which determined the decision in *White*, as discussed above i.e. that the SDA 1975 did not protect transsexuals, was seriously undermined by the ECJ's decision in *P v S and Cornwall County Council*.

Following *P v S and Cornwall County Council,* in *Chessington World of Adventures Ltd v Reed*[315] Reed was a biological male who intended to undergo sex re-assignment. She informed her employer, Chessington World of Adventures, and was subsequently the

[310] ibid.
[311] ibid [22].
[312] ibid [20].
[313] ibid [21].
[314] ibid [22].
[315] [1998] ICR 97.

subject of prolonged and serious harassment from her male colleagues. Reed commenced a period of absence from work on the basis of ill-health in March 1994, and her employment was terminated in July 1994 on the grounds that she was incapable of carrying out the duties of her employment. Reed complained to the company on numerous occasions that she was being harassed by colleagues. However, these allegations were not investigated by her employers and no disciplinary action was ever taken against those accused of harassing her. Reed then married her female partner and was registered on the marriage certificate as male which was appropriate as she continued to be legally male at this time. Reed then made a complaint of sex discrimination at an industrial tribunal in October 1994. She claimed that she had been discriminated against on the basis of her sex and cited the SDA 1975 s. 1(1)(a) and 6(2)(b). The tribunal upheld her complaint and Chessington World of Adventure appealed. The basis for the appeal was that they claimed that the SDA 1975 did not apply where the complainant relied upon less favourable treatment following notice of intention to undergo sex re-assignment. In a landmark ruling for transsexual employment rights the appeal was dismissed. The case established that there was no need for a male/female comparator when considering the issue of discrimination on the grounds of sex re-assignment. The tribunal had correctly ascertained that discrimination on the grounds of sex re-assignment amounted to discrimination on the grounds of a person's sex and therefore the SDA 1975 could apply to those individuals who sought to undergo sex re-assignment or who were undergoing sex re-assignment. The Employment Appeal Tribunal (EAT) held that the correct interpretation of s.1(1)(a) of the SDA 1975, in line with the Equal Treatment Directive, was that the Act applied not only to those people who suffered discrimination based on the fact of their sex but it also applied to those individuals who were undergoing sex re-assignment.[316]

As a result of the clarification of the role of EU equal treatment law in protecting transsexuals from employment discrimination in *P v S and Cornwall County Council* and *Chessington World of Adventures v Reed* the Sex Discrimination (Gender Reassignment) Regulations 1999 were passed. These regulations amended the SDA 1975 by inserting s.2A, which provided that transsexuals were protected from discrimination in the

[316] Although the SDA 1975 did then protect individuals who were undergoing or who had intended to undergo sex change it has been highlighted by the Equality and Human Rights Commission that the protection offered by the SDA 1975 was inadequate as it did not protect individuals who did not intend to, were not or had not undergone sex change (M Mitchell and C Howarth *Trans Research Review* (Equality and Human Rights Commission Research Report 27, 2009, 4.) i.e. it did not protect those individuals who identified as transgender, those individuals who were unable to obtain a diagnosis of GID or those individuals who may have obtained a diagnosis but who determined not to undergo sex change; the protections offered under the SDA only applied to a very specific narrowly defined group of individuals.

workplace and in relation to vocational training. Despite these changes, the employment discrimination cases which followed were of mixed success.[317] Arguably though, these cases were not determined using the *Corbett* test but rather on the basis of EU equal treatment laws. In addition to this the *Corbett* test, had it been applied, may not have been as determinative as it had been in the family law cases because of how the employment relationships would have been classified in Ormrod J's classifications of the importance of sex in legal relationships: essential, irrelevant or as relevant but not essential. It is argued therefore that the success in employment law cases is as a result of two factors: EU law prohibiting discrimination and the fact that sex was rarely considered to be an essential element of the employment contract.[318] So, to some extent, progress was being made in relation to legal recognition of post-operative transsexuals' sex but this recognition was piecemeal and derived from different sources of law and thereby began to create inconsistency for transsexuals before UK law; in family law situations the individuals' post-operative sex was not recognised whereas in employment law protection against discrimination began at a pre-operative stage when the individual expressed an intention to undergo sex re-assignment.

Bellinger v Bellinger in the Court of Appeal

The issue of transsexual legal recognition before the UK courts reached its climax in the case of *Bellinger v Bellinger*. This section will mention the Family Division[319] decision and then discuss the Court of Appeal judgment[320] outlining the facts of the case, the majority opinion and also the dissenting opinion of Thorpe LJ. It is important to outline Thorpe LJ's dissenting opinion as, although a departure from the accepted legal position, his judgment was in fact progressive as it challenged the *Corbett* ruling that sex is fixed at birth and that psychological factors play a very limited role in determining one's legal sex and in so doing Thorpe LJ paved the way for a different model of legal sex determination to evolve and his dissenting judgment indicated the way in which the law would develop over the coming few years.

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[317] *Bavin v NHS Trust Pension Agency* [1999] ICR 1192; *Ashton v Chief Constable of West Mercia* [2001] ICR 67; *Chief Constable of West Yorkshire Police v A* [2002] ICR 552; *Chief Constable of West Yorkshire Police v A* [2002] EWCA Civ 1584; [2003] 1 CMLR 25.

[318] Although please note the decision in *White* discussed above where the sex of the applicant was considered a genuine occupational qualification under domestic law thereby making sex an essential element of the employment contract.

[319] Family Division: [2002] 3 FCR 733.

[320] [2001] EWCA Civ 1141; [2002] Fam 150.

The Bellinger Facts

Elizabeth Bellinger was born on 7 September 1946 and registered as male. However, it was argued throughout the initial petition and subsequent appeals that she had always felt herself to be female. At the age of twenty-one she married a woman however the relationship broke down and the couple divorced in 1971. Following the divorce Elizabeth began living and dressing as a woman and underwent sex re-assignment surgery which was complete by 1981. On 2 May 1981 Elizabeth married Michael Bellinger. Elizabeth was not asked, nor did she provide, any information regarding her sex at the time of the marriage. Since the date of the marriage Elizabeth and Michael continued to live together as husband and wife notwithstanding that Elizabeth was registered as male. She raised a petition on 16 November 1998, with the support of her husband, the respondent, seeking a declaration that her marriage to Michael was valid from the date of the ceremony and was subsisting. In the Family Division, Elizabeth argued that at the time of her marriage she was female[321] and that *Corbett* "was wrongly decided or should be reconsidered in light of changed social conditions and improved medical knowledge."[322]

On 2 November 2000 the petition was refused by the Family Division and it was deemed that Elizabeth remained legally male therefore the marriage was not valid. Although Johnson J in the Family Division recognised that social attitudes to transsexuals had progressed since the *Corbett* judgment and that there was some merit in the argument that identity as male or female may be linked to one's brain development it was not possible to move away from the *Corbett* criteria. [323]

So Johnston J reaffirmed the *Corbett* biological criteria for legal sex determination which meant that the marriage between Elizabeth and Michael was void as both parties were legally male.

On 26 November 2000 Elizabeth appealed the decision of Johnston J to the Court of Appeal on the basis that he:

> had erred in concluding that the criteria in Corbett v Corbett […] were still determinants of legal sex despite clear evidence that the test was no longer valid or appropriate and failed to give effect to the Matrimonial Causes Act 1973 in a way

[321] *Bellinger* (n 320) 733[e].
[322] ibid 733[f].
[323] ibid 747[c]-[d].

> that was compatible with European Convention rights in breach of articles 3 and 8.[324]

Laura Cox, QC and Ashley Bayston for the petitioner argued that definitions for 'male' and 'female' in s.11(c) of the Matrimonial Causes Act 1973 are not given in the legislation and that consequently the meaning in the 1973 statute has been interpreted following the judgment of Ormrod J in *Corbett*[325] as meaning the biological sex of an individual rather than the psychological gender identity of the individual. However, counsel for the petitioner also argued that the reasoning on which the *Corbett* decision was reached "no longer adequately reflect the state of society and science in the 21st century."[326] It was argued that:

> [t]he terms "male" and "female" in section 11(c) of the 1973 Act are deliberately left undefined to enable courts to interpret them in the light of societal development. The Court should therefore not just have regard to sex in the biological and anatomical sense but to gender in the broader sense, including culturally and socially specific expectations of behaviour and attitude, an important part of which is self-recognition.[327]

Therefore, counsel for the petitioner was seeking to rely on the science which will was outlined in Chapter One which outlines the importance of brain sex and the psychological aspects of one's identity as male or female to argue that "male" and "female" in the marriage legislation were not fixed concepts but rather open to interpretation based on developments in medical science and knowledge. Therefore it was argued:

> [i]n the past 30 years medical knowledge and understanding have developed to show that psychological and hormonal factors should be included as additional important criteria in the determination of a person's sex. It is now known that sexual differentiation occurs in several stages. Transsexualism or gender dysphoria occurs where sex differentiation in the brain does not match the previous physiological development and, since sex differentiation is not complete in the brain until the age of two or three, it is impossible to identify gender at birth.[328]

Counsel for the Attorney General argued that the *Corbett* test remained valid law and that "surgical and other treatments do not change a person's sex."[329] It was also argued that:

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[324] *Bellinger* (n 321) 151[H]-152[A]. Please note that Article 3 ECHR protects indivudals from torture, inhuman and degrading treatment.
[325] *Corbett* (n 198).
[326] *Bellinger* (n 321) 152[D].
[327] ibid 152[D]-[E].
[328] ibid 152[F]-[G].
[329] ibid 153[G].

> [t]here is insufficient evidence to justify the conclusion that the sex of the brain is the determinative factor; nor is it currently possible to ascertain the sex of the brain during a person's life. There have been no developments, either of jurisprudence or medical science, to justify or require a different approach being taken by the courts other than the biological determinants.[330]

So the question before the Court of Appeal was whether or not Elizabeth Bellinger could be said to be "female" for the purpose of s.11(c) of the Matrimonial Causes Act 1973; the consequence of the answer to the former question determining the validity of her marriage to Michael Bellinger.

The Bellinger Judgment

The judgment was delivered by Dame Butler-Sloss and Walker LJ who stated that behind the bare facts of the case:

> lies a human problem, which deeply affects a small minority of the population. In considering the difficult medical and legal issues facing this court […] we are very much aware of the plight of those who, like the petitioner, are locked into the medical condition of transsexualism.[331]

It was reiterated that the petitioner had been correctly assigned the male sex at birth and that she was not intersexed.[332] After discussing the *Corbett* judgment Dame Butler-Sloss and Walker LJ turned to the argument made by Ms Cox, counsel for Elizabeth Bellinger, that "male" and "female" are not defined in legislation so as to enable a dynamic interpretation of these terms as society changes. The Court, in determining how to interpret the Matrimonial Causes Act 1973 s.11(c), noted that it had to apply the *Corbett* criteria.[333] Dame Butler-Sloss and Walker LJ noted that:

> [i]t is clear that the three criteria relied upon by Ormrod, J in *Corbett's* case […] remain the only basis upon which to decide upon the gender of a child at birth. […] Other than in the case of a person who is inter-sexed, the biological criteria point at that stage conclusively to a decision whether the child is male or female. At birth therefore the *Corbett* criteria remain valid today.[334]

Therefore the appeal was dismissed and the marriage between the Bellingers was void; although Elizabeth had altered her body to appear as female, had been accepted socially as

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[330] ibid 153[G]-[H].
[331] *Bellinger* (n 321) [2].
[332] ibid [4].
[333] ibid [43].
[334] ibid [97].

female and identified as female because her birth sex was male as per the *Corbett* criteria outlined by Ormrod, J in 1971 she was, for all legal purposes, male.

Thorpe LJ's Dissenting opinion

Although the appeal was dismissed and therefore Thorpe LJ's dissenting opinion is of no legal consequence it is important to consider the reasons for his dissent as, as will be shown in more detail in Chapter Three, one of the main thrusts of his argument, the importance of psychological factors in determining legal status, became hugely important in the ECtHR judgment in *Goodwin v United Kingdom*[335] one year later.

Thorpe LJ was sceptical that the judgment of Ormrod J in *Corbett* should still stand some 30 years after it was first handed down. In reaching his dissenting opinion Thorpe LJ considered in depth the judgment of Johnson J in the Family Division.[336] Johnson J had decided that, based on medical evidence, the *Corbett* criteria of gonads, chromosomes and genitalia were "the only criteria for determining the gender of an individual."[337] Thorpe LJ argued that much of Johnson J's decision was based on "his erroneous citation of Professor Green"[338], one of the medical experts in the case who in fact had stated in evidence that the *Corbett* criteria were "too reductionist" in contemporary times for the purpose of determining one's gender.[339] According to Thorpe LJ the decision of Johnson J in the Family Division was fundamentally flawed and "his ultimate conclusion that the medical opinion that guided Ormrod J remained unchanged might be said to erode the validity of the conclusion."[340] However, rather than undermine Johnson J's judgment Thorpe LJ sought to question the validity of the *Corbett* judgment as relevant in present times. He stated:

> [i]n my opinion the key to this appeal lies not so much in a scrutiny of his judgment as in a fresh appraisal of the extent to which the passage of 30 years requires the revision of the propositions of law, of medical science and of social policy upon which Ormrod J founded his judgment in Corbett's case.[341]

So Thorpe LJ was concerned with how medical science and social policy ought to influence the development of law in this area. His judgment, although dissenting, is

[335] (2002) 35 EHRR 18.
[336] *Bellinger* (n 320).
[337] *Bellinger* (n 321) [112].
[338] ibid.
[339] ibid.
[340] ibid.
[341] ibid [113].

therefore not only hugely interesting but also progressive in that he sought to find a means of reforming the law while mindful of the role of the courts in relation to the legislature. Thorpe LJ provided a detailed analysis of the state of medical science in 2001 regarding the aetiology of transsexualism and noted that there was a growing trend to consider the importance of psychological factors as well as brain differentiation.[342] On consideration of the evidence of experts in the field of gender dysphoria Thorpe LJ reached the conclusion that "medical opinion no longer accepts the three *Corbett* factors for the determination of sex"[343] and that the situation is much more indeterminate than the *Corbett* judgment would suggest.[344] It should be noted that medical opinion at the time of *Corbett* was not quite as Thorpe LJ implies in this statement. As was shown in Chapter One, and as shown above in the discussion of *Corbett*, medical opinion in the 1970s was such that it was acknowledged that sex determination was based on much more than the three criteria established by Ormrod J in *Corbett.*

The judgment of Thorpe LJ therefore raises a number of themes surrounding divergence of opinion within the medical and scientific communities regarding the aetiology of transsexualism. Thorpe LJ reached the same conclusion in *Bellinger* in the Court of Appeal as was reached in Chapter One of this thesis: that the causes of transsexualism are unknown but may include a number of factors which encompass the biological, physiological and psychological.

Advances in medical knowledge played an important role in Thorpe LJ's dissenting opinion and, as Chapter Three will show, the state of that knowledge continues to develop and our understanding of transsexualism as a medical condition continues to deepen and strengthen. So, with this in mind, Thorpe LJ stated that "a fundamental question raised by this appeal is whether this court in 2001 should approve and apply the reasoning in *Corbett's* case."[345] In answering his own question Thorpe LJ stated that there were four propositions within Ormrod J's judgment which influenced his decision in *Corbett*: firstly that biological sex is fixed at birth at the latest; secondly that marriage is a union of one man and one woman; thirdly that of the four criteria[346] for sex determination the law

[342] ibid [116].
[343] ibid.
[344] ibid.
[345] ibid [118].
[346] The four in order listed by Ormrod J in *Corbett* are: chromosomes, gonads, genitals and psychology.

should adopt the first three for the purpose of marriage law and fourthly that marriage depends on sex not gender.[347]

Taking the propositions one at a time Thorpe LJ noted that in 2001 medical knowledge was such that, although representing the expert evidence at the time of *Corbett*, the first proposition that sex is fixed at birth at the latest "30 years on, is rejected by the three experts in the present case".[348] It is simply no longer the case that medicine and science accept that sex is fixed at birth as was shown in the examination of the literature in Chapter One. In relation to the second proposition which underpinned the *Corbett* decision, that marriage is a union of one man and one woman Thorpe LJ noted that "the world that engendered those classic definitions has long since gone."[349] He acknowledged that the world had changed considerably from the time of *Lindo v Belisario*[350] in 1795 in which it was determined that marriage is a special type of union which "is a contract according to the law of nature, antecedent to civil institution".[351] In addition, the classic definition of marriage taken from the judgment of Lord Penzance in *Hyde*[352] which is taken as authority that marriage is a lifelong, heterosexual union was also challenged by Thorpe LJ who stated that "[t]he intervening 130 years have seen huge social and scientific changes"[353] which impact on marriage. So, according to Thorpe LJ marriage should be redefined "as a contract for which the parties elect but which is regulated by the state, both in its formation and in its termination by divorce, because it affects status upon which depend a variety of entitlements, benefits and obligations."[354] So, the fact that society had changed fundamentally since the time of the early definitions of marriage provided justification for Thorpe LJ to consider departing from this precedent. [355]

In relation to the fourth proposition, that marriage is dependent upon sex and not gender Thorpe LJ stated that "[t]he proposition seems to me to be now of very doubtful validity."[356] He based this pronouncement on the fact that procreative sex is now no longer considered an inherent part of marriage. In addition Ormrod J in *Corbett* refused to acknowledge the validity of sexual relations between a male and a MTF transsexual which,

[347] *Bellinger* (n 321) [124].
[348] ibid [125].
[349] ibid [128].
[350] (1795) 1 Hag Con 216.
[351] ibid 230.
[352] *Hyde* (n 215).
[353] *Bellinger* (n 321) [128].
[354] ibid [128].
[355] ibid [129].
[356] ibid [130].

according to Thorpe LJ was "at odds with the decision of this court in *SY v SY (orse W)* [1963] P 37"[357] which concerned the validity of a marriage of a man with a woman who was only able to engage in sexual intercourse following surgery to lengthen her vagina. In relation to the sexual aspect of marriage which formed an important part of Ormrod J's judgment in *Corbett* Thorpe LJ stated:

> [w]ithin any marriage there may be physical factors on either or both sides that require acknowledgement and accommodation in the sexual relationship of the parties. But that accommodation does not rob the result of its essential characteristic, namely the sexual dimension of the couple's relationship.[358]

For Thorpe LJ sexual relations were no less sexual as a result of their non-conformity to the norm. He stated that although he acknowledged that sexual relations between a couple was a "dimension of cardinal importance"[359] he "would nevertheless conclude that in cases such as the present it is sufficiently fulfilled"[360] thereby undermining Ormrod J's opinion in *Corbett* that sex between a male and a MTF transsexual could not be considered sex.

So three of the four propositions upon which Ormrod J reached his conclusion in *Corbett* had been considered, explored and repudiated by Thorpe LJ. The final proposition, actually the third upon which the *Corbett* judgment was reached, was that only the first three of the four *Corbett* criteria should be used to determine legal sex. It was this proposition which, in the opinion of Thorpe LJ, had, "the most direct bearing on the outcome of the appeal."[361] In considering this Thorpe LJ stated:

> [i]n my opinion the test that is confined to physiological factors, whilst attractive for its simplicity and apparent certainty of outcome, is manifestly incomplete. There is no logic or principle in excluding one vital component of personality, the psyche. That its admission imports the difficulties of application that may lead to less certainty of outcome is an inevitable consequence. But we should prefer complexity to superficiality in that the psychological self is the product of an extremely complex process, although not fully understood.[362]

Weighing up the analysis of the four propositions upon which the *Corbett* judgment was based Thorpe LJ stated that "the foundations of Ormrod J's judgment are no longer

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[357] ibid.
[358] ibid.
[359] ibid.
[360] ibid.
[361] ibid [132].
[362] ibid.

secure"[363] and that it "served its time well but its time has passed."[364] He stated that "Ormrod J's monumental judgment in *Corbett v Corbett* […] was undoubtedly right when given on 2 February 1970. It is only subsequent developments, both medical and social, that render it wrong in 2001."[365] Thorpe LJ was careful in his dissenting opinion to not criticise Ormrod J but he clearly noted that the *Corbett* judgment was not binding on the Court of Appeal in the present case and that, in his opinion, it ought not to be followed.[366]

As noted above the dissenting opinion of Thorpe LJ is of no legal consequence in the Court of Appeal decision in *Bellinger* however, as will be shown later in this thesis, his thoughts on the importance of the psychological aspects of identity became a fundamental part of the decision of the ECtHR in *Goodwin v United Kingdom*[367] and therefore can be considered progressive and, with hindsight, an indicator of the way in which the law would develop in the years immediately following the Court of Appeal's judgment.

The *Corbett* judgment, which was upheld by the Court of Appeal in *Bellinger,* is weak in light of contemporary knowledge on the aetiology of transsexualism, which was outlined in Chapter One, which includes an appreciation of the psychological aspects of gender identity. Had law followed the state of medical science in this respect and Thorpe LJ's judgment represented the majority opinion rather than a dissenting viewpoint the wider medical understanding of transsexualism as having a psychological element could have influenced the law much earlier than it eventually did. Had law followed medical knowledge, without accepting it as determinative of legal sex, then the medical appreciation of transsexualism in 2002 which was much wider than that in 1971 could have enabled the Court of Appeal in *Bellinger* to depart from the *Corbett* decision and develop a new means of determining the legal sex of individuals; however, as will be shown in Chapter Three when the *Bellinger* appeal in the House of Lords is discussed, such an approach by the Court of Appeal would not have been without its problems, particularly in relation to certainty of legal sex in law and consistency between judgments and indeed different areas of law – two of the factors which influenced the initial decision in *Corbett* and which were maintained as important in subsequent cases discussed above. Although Thorpe LJ's dissenting opinion could have paved the way for an acknowledgment of post-operative sex for legal purposes such a position was not to be and the majority in the Court

[363] ibid[133].
[364] ibid.
[365] ibid [155].
[366] ibid [133].
[367] *Goodwin* (n 15).

of Appeal adhered to *Corbett.* It was not until 2002 that transsexual legal recognition took a monumental leap forward in the case of *Goodwin* which formed the culmination of the human rights quest for legal recognition and, although not as transformative as it could have been, certainly provided the impetus to change UK law.

Conclusion

This chapter has shown how UK law dealt with those individuals who underwent medical procedures to modify their bodies to appear, as much as possible, to be members of the sex opposite to their birth sex. The purpose of them doing so was to ease the dysphoria which arose as a result of the medical condition, transsexualism. Clearly UK law was reluctant to provide any means of legal recognition of gender identity, insisting that one remained the sex assigned at birth despite any steps take to physically change sex. However there were some areas in which law did provide a degree of recognition to transsexuals; mostly post-operative transsexuals. In areas of law which were influenced by EC law post-operative transsexuals were provided with protection as a result of equal treatment legislation in the field of employment. This protection spread to other areas such as in the provision of goods and services. However, the dicta of Ormrod J in *Corbett* continued to reflect the law throughout the twentieth century and into the twenty-first. The impact of *Corbett* was that one's legal sex was assigned at birth based on physiological factors and any attempt to alter one's primary or secondary sex characteristics had no legal impact. This placed post-operative transsexuals in a legal limbo where socially they were accepted as members of one sex but legally were classed as the opposite. This gave rise to a number of problems for people in their day-to-day lives and indeed in terms of the legal relationships which they sought to enter into, for example marriage. As no progress was made in the domestic courts a number of applications were made to the ECtHR, beginning in the 1980s. However this strand of case law was to prove ineffectual for the transsexual applicants as the ECtHR continually held that there was no positive obligation on the UK to alter their system of birth registrations and that the approach taken by the UK was within the state's margin of appreciation. A number of factors proved detrimental to the applicants in these cases, namely the lack of European consensus on recognising transsexuals, the lack of medical consensus regarding aetiology and the abovementioned margin of appreciation. Little change was made between the 1950s and 2001 and it was only towards the end of this period that dissenting opinions, namely Judge Martens in *Cossey* and Thorpe LJ in *Bellinger* in the Court of Appeal, started to be progressive and started to raise the possibility of change in this area of the law. However this change was not forthcoming and

it was not until the cases of *Bellinger* in the House of Lords and *Goodwin* in the ECtHR that pressure was put on the Government to reform this area of law. These cases will be discussed in depth in the following chapter.

3. *Goodwin* v *United Kingdom* and its impact on UK Law: Towards Legal Recognition of Transsexuals

Introduction

The previous chapter outlined how UK law was reluctant to provide legal recognition for transsexuals in areas where an individual's sex could be considered to be an essential element of the legal relationship which the individual sought to enter. This meant that on the whole transsexuals who had changed their bodies were in legal limbo; appearing to be one sex but legally being classified as the opposite. The situation began to change in July 2002 with the European Court of Human Rights' (ECtHR) judgment in *Goodwin v United Kingdom*[368] which held that non-recognition of post-operative transsexuals was a violation of Articles 8 and 12 ECHR. The change towards recognition continued in the domestic courts. The cases of *Bellinger,*[369] *Croft v Royal Mail Group Plc,*[370] and *A v Chief Constable of West Yorkshire*[371] which were decided in April 2003, July 2003, and May 2004 respectively opened the possibility of providing legal recognition of transsexuals at different stages in the transition process. In each of these three cases there was some departure from the medical involvement and a move towards a human rights based approach which necessitated a change in UK law. This chapter will explore each of these cases in turn to show how pressure was put on the UK Government to enact legislation to give legal recognition to transsexuals and the conditions by which such legal recognition could be given as a result of these three cases.

The *Goodwin* facts

Goodwin is arguably the most important case in relation to transsexual legal recognition, other than *Corbett,*[372] as it influenced the decisions of the House of Lords in *Bellinger*, and the of the Court of Appeal in *Croft* and *A v Chief Constable of West Yorkshire.*[373] In *Goodwin* Christine Goodwin was a male-to-female (MTF) transsexual who alleged the following: sexual harassment by male work colleagues; dismissal from her previous employment because she was transsexual; that her new employer had been able to use her NI number to trace her details and discover that she was born male and that this had led to

[368] *Goodwin* (n 15).
[369] *Bellinger* (n 321).
[370] [2003] EWCA Civ 1045, [2003] ICR 1425.
[371] [2004] UKHL 21; [2005] 1 AC 51.
[372] *Corbett* (n 198).
[373] [2002] EWCA Civ 1584, [2003] 1 CMLR 25.

problems at work; that she was told that she was ineligible to receive a state pension at 60, the age at which a female at the time received her state pension; that she was materially disadvantaged in any instance where she would be required to produce her birth certificate; and she would have to continue to pay higher insurance premiums. She argued that these difficulties arose as a result of UK law which refused to allow her to obtain a new birth certificate and that this amounted to a violation of her Article 8 rights. She argued that "rapid changes, in respect of the scientific understanding of, and the social attitude towards transsexualism were taking place not only across Europe but elsewhere."[374] The implication was that the UK Government should no longer be able to rely upon their margin of appreciation to justify the continued non-recognition of transsexuals' change of sex for the purpose of UK law. In addition Goodwin alleged that non-recognition of her sex-reassignment meant that she was unable to marry a man which, she claimed, amounted to a violation of Article 12 ECHR.

In response the UK Government argued that the wide margin of appreciation ought to be maintained as "there was no generally accepted approach among the contracting states in respect of transsexuality"[375] and therefore there was no violation of Article 8. It was argued that the applicant could obtain new versions of some official documents, such as her driving licence and passport, which reflected her sex re-assignment. The UK Government contended that "a fair balance had therefore been struck between the rights of the individual and the general interest of the community."[376] In arguing this the Government clearly set out that legal recognition of transsexuals is not just about the individual himself but also about how the individual interacts with wider society. The Government was of the opinion that where transsexuals had to disclose their previous identity, for example in obtaining insurance, this was appropriate because "medical history and gender affected the calculation of premiums."[377] Accordingly, the UK's argument was that it was in the public interest that in some circumstances transsexual individuals ought to be forced to divulge their previous identity. In relation to the Article 12 claim the Government argued that states were not under any obligation to allow transsexuals "to marry a person of his or her original sex"[378] and that the Court of Appeal in *Bellinger* had recently reviewed English matrimony law and upheld the law as it existed at that time.[379] It was argued that should

[374] *Goodwin* (n 15) [63].
[375] ibid [64].
[376] ibid [70].
[377] ibid [70].
[378] ibid [96].
[379] ibid [96].

UK law change in relation to this matter then this change "should come from the United Kingdom's own courts acting within the margin of appreciation which [the ECtHR] has always afforded."[380]

The Goodwin judgment

The facts of *Goodwin* are unproblematic and reflect the earlier transsexual rights cases. However it is the reasoning of the ECtHR in this case which is fundamentally important as the judgment substantially departed from previous cases which involved UK domiciled transsexual applicants, as outlined in the previous chapter. It is the Court's reasoning in *Goodwin* which is important because it indicated a move away from the test established by Ormrod J in *Corbett* which relied solely on physiological criteria over psychological identity. The ECtHR held unanimously that there had been a violation of both of Goodwin's Articles 8 and Article 12 rights. As the most important aspect of the *Goodwin* judgment, at least for the purpose of this thesis, is how the ECtHR determined that there was a violation of Article 8 the ECtHR's determination of Goodwin's Article 12 rights will not be discussed.

The way in which the ECtHR considered Goodwin's claims that her Article 8 rights had been violated is crucially important because the reasoning of the court indicates a shift in the balance between the rights of the individual and the rights and interests of others and the state. In addition the ECtHR departed from the complex issue of medical consensus regarding aetiology which had been a focus of earlier cases before it.[381] The ECtHR did four particularly important things when reaching its conclusion that Goodwin's Article 8 rights had been violated. Firstly it gave "a greater weight to the interference with the applicants' rights than it had in earlier decisions."[382] Secondly it "abandoned the view that medical knowledge about the causes of transsexualism was a determining factor"[383]; thirdly it "replaced the factor of a European standard with respect to the legal position of transsexuals with reference to an international trend"[384] which favoured legal recognition of transsexuals and fourthly it provided a change in, what Rudolf calls, "the burden of persuasion"[385] which meant that rather than consider the consequence of current law for

[380] ibid [96].
[381] *Rees*; *Cossey*; *Sheffield and Horsham* (n 15).
[382] B Rudolf 'European Court of Human Rights: Legal Status of Postoperative Transsexuals' (2003) *International Journal of Constitutional Law* 1(4):716, 721.
[383] ibid.
[384] ibid.
[385] ibid.

the applicants and the frequency of these consequences and then ask if those consequences were disproportionate to the rights of the applicants, as was the approach in earlier cases, the Court in *Goodwin* asked whether a "concrete or substantial hardship or detriment to the public interest has been […] demonstrated as likely to flow from any change to the status of transsexuals."[386] This change in questioning of the Court meant that "it became incumbent upon the state to show an overwhelming interest in preserving the conflict […] between law and social reality"[387] for transsexuals. This reasoning therefore indicated a strong shift towards the rights of the individual and towards limited state interference in the private lives of transsexual citizens. According to Rudolf:

> [t]he underlying reason for these changes was the court's consideration that the right to personal autonomy encompassed the right to establish the details of one's own identity, including the harmonization of one's sex and self-perceived gender.[388]

So, the factor that truly impacted on the *Goodwin* decision was the developing understanding of 'personal autonomy' as an aspect of Article 8 ECHR,[389] which, as the ECtHR stated in *Goodwin,* included "the right [of individuals] to establish details of their identity as human beings."[390] It was this which "conclusively tipped the balance in favor of the applicants."[391]

The idea of personal autonomy is not new in law; however it was fairly new to the Article 8 jurisprudence at the time of *Goodwin* and it "derives its significance from its character as an emanation of human dignity."[392] The concept of human dignity as a foundation of the ECHR has been stated throughout Article 8 case law and is not a new idea and therefore its background and history will not be discussed in detail here.[393] In order to appreciate how important the *Goodwin* judgment is it is necessary to examine it in more detail as doing so will show just how fundamental this case was in relation to the quest for legal recognition.

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[386] *Goodwin* (n 15) [91].
[387] Rudolf (n 383) 721.
[388] ibid.
[389] ibid 718.
[390] *Goodwin* (n 15) [90].
[391] Rudolf (n 383) 718.
[392] ibid 719.
[393] For more general texts on the concept of human dignity under Article 8 please see: J Marshall 'A Right to Personal Autonomy at the European Court of Human Rights' (2008) *European Human Rights Law Review* 3:337-356; Marshall, J. *Personal Freedom through Human Rights Law: Autonomy, Identity and Integrity under the European Convention on Human Rights* (Martinus Nijhoff Publishers 2009) and Moreham, N.A. 'The Right to Respect for Private Life in the European Convention on Human Rights: A Re-examination' (2008) *European Human Rights Law Review* 1:44-79.

The fundamental issue in *Goodwin* was that once the ECtHR had established that the basis for the Court's determination of the case was the concept of human dignity encompassing personal autonomy this shifted the Court's focus of enquiry to the rights of the individual to develop her personal identity. The impact of *Goodwin* therefore was to severely limit the state's margin of appreciation in relation to transsexual legal recognition: it was no longer possible for the state to refuse to recognise post-operative transsexuals; the only issue remaining within the state's margin of appreciation was in determining how to provide this legal recognition.[394]

In reaching its decision that the UK violated Goodwin's Article 8 rights the ECtHR considered the following in this order: (i) the preliminary considerations, which amount to the factors which are used when interpreting any Article 8 claim; (ii) the applicant's position in relation to domestic law; (iii) the state of medical and scientific knowledge on transsexualism; (iv) the European and international consensus, or lack thereof; (v) the impact on the UK administrative system of requiring change and (vi) the balance of the rights of the individual against the state and others. As a result of the Court adopting this particular stance in analysing the *Goodwin* arguments the same structure will be adopted here.

The Preliminary Considerations

The Court began its analysis by restating that:

> the notion of "respect" as understood in Article 8 is not clear cut, especially as far as the positive obligations inherent in that concept are concerned: having regard to the diversity of practices followed and the situation obtaining in the Contracting States, the notion's requirements will vary considerably from case to case and the margin of appreciation to be accorded to the authorities may be wider than that applied in other areas under the Convention.[395]

Although the Court's reiteration of this position is not new it did prove to be crucial to the Court reaching the decision that the applicant's rights had been violated. What became important in this case was the extent of the state's margin of appreciation, the state's positive obligations towards its citizens and the obligation on the Court to continue to evolve their interpretation of the Convention rights as these three issues resulted in the Court placing the individual's interests in this case above all others. As can be seen from

[394] *Goodwin* (n 15) [93].
[395] ibid [7].

the discussion of earlier cases in the previous chapter the early transsexual rights cases failed because the balance was not in favour of the individual but rather on the state. In these cases the Court noted that there was no positive obligation on the state to recognise transsexuals[396] and that the state's margin of appreciation in relation to this was wide[397] as a result of a lack of medical and scientific consensus combined with a lack of European consensus which enabled the Court to determine that there had been no violation of Article 8.[398]

In further examining whether or not the UK was under a positive obligation in relation to transsexuals' Article 8 rights the ECtHR in *Goodwin* began by stating:

> [i]n determining whether or not a positive obligation exists, regard must also be had to the fair balance that has to be struck between the general interest of the community and the interest of the individual, the search for which balance in inherent in the whole of the Convention.[399]

It was acknowledged by the ECtHR in *Goodwin* that in the earlier cases originating in the UK:

> there was no positive obligation on the Government to alter their existing system for the registration of births by establishing a new system or type of documentation to provide proof of current civil status.[400]

The situation for *Goodwin* therefore looked bleak however this was to prove not to be the case because the ECtHR noted that it was not bound by these previous decisions. The Court stated that:

> since the Convention is first and foremost a system for the protection of human rights, the Court must have regard to the changing conditions within the respondent State and within Contracting States generally and respond […] to any evolving convergence as to the standards to be achieved.[401]

Therefore the ECtHR was laying the foundations for a departure from the previous case law concerning UK domiciled transsexuals.[402] In justifying such a departure the ECtHR

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[396] *Rees* (n 15) [42]-[44]; *Cossey* (n 15) [40]; *Sheffield and Horsham* (n 15) [61].
[397] *Rees* (n 15) [37]; *Cossey*, [40]; *Sheffield and Horsham*, [58].
[398] *Rees* (n 15) [46]; *Cossey* (n 15) [42]; *Sheffield and Horsham* (n 15) [61].
[399] *Goodwin* (n 15) [72].
[400] ibid [73].
[401] ibid [74].
[402] *Rees*, *Cossey*, *Sheffield and Horsham* and *X, Y & Z* (n 15).

stated that "[i]t is of crucial importance that the Convention is interpreted and applied in a manner which renders its rights practical and effective, not theoretical and illusory."[403] By reiterating the purpose of the Convention as protecting human rights and reinforcing the idea that the Convention is a 'living instrument' which ought to be interpreted in a manner compatible with evolving social conditions and standards the ECtHR thus paved the way for a ground-breaking decision in *Goodwin.*

The applicant's position

Once the Court had considered the extent of the state's positive obligation and the need to interpret the Convention in a manner consistent with changing social circumstances it progressed to considering the applicant's position in terms of UK law. In doing so the Court stated that "serious interference with private life can arise where the state of domestic law conflicts with an important aspect of personal identity."[404] Thus the Court was firmly placing the interests of the individual in developing personal identity above the interests of the state in maintaining the *status quo.* The Court continued:

> [t]he stress and alienation arising from a discordance between the position in society assumed by a post-operative transsexual and the status imposed by law which refuses to recognise the change of gender cannot, in the Court's view, be regarded as a minor inconvenience arising from a formality.[405]

In stating this, the interests of the individual were given primacy as the Court was swayed by the impact of interference with a fundamental aspect of oneself. In this regard the ECtHR noted that at the time of the *Goodwin* application "a conflict between social reality and law arises which places the transsexual in an anomalous position, in which he or she may experience feelings of vulnerability, humiliation and anxiety."[406] One issue which the ECtHR focused on particularly was the fact that Goodwin's medical treatment had been provided by the state. This acceptance by the UK of her medical condition and their provision of treatment in an effort to effect "as close an assimilation as possible to the gender in which the transsexual perceived that he or she properly belongs"[407] aided Goodwin's application. The ECtHR noted that it was:

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[403] *Goodwin* (n 15) [74].
[404] ibid [77].
[405] ibid.
[406] ibid.
[407] ibid [78].

> struck by the fact that nonetheless the gender re-assignment which is lawfully provided is not met with full recognition in law, which might be regarded as the final culminating step in the long and difficult process of transformation which the transsexual has undergone.[408]

And it continued:

> [w]here a State has authorised the treatment and surgery alleviating the condition of a transsexual, financed or assisted in financing the operations […] it appears illogical to refuse to recognise the legal implications of the result to which treatment leads.[409]

The Court then returned to the previous transsexual cases which had been decided in the 1980s and 1990s. In returning to these cases the Court was attempting to consider the public interest argument which had been put forward in those cases and observed that in them one fact which counted against those applicants was the "medical and scientific considerations, the state of any European and international consensus and the impact of any changes to the current birth register system."[410] In emphasising the importance of these factors in earlier cases the Court was effectively inviting a reconsideration and re-examination of them in light of 2002 knowledge and practices.

The state of medical and scientific knowledge

In revisiting these factors in *Goodwin* the ECtHR noted that "the ongoing scientific and medical debate as to the exact causes of the condition is of diminished relevance."[411] Therefore it was no longer necessary to know what definitively 'caused' transsexualism before those who had undergone sex re-assignment could be recognised in law. The fact that medical science could not pinpoint the exact aetiology of the condition, as discussed in Chapter One, was not considered to be fundamentally important to the Court's determination of Goodwin's Article 8 rights. To some extent the Court distanced itself from the medical debates ongoing at the time and stated that it was not persuaded "that the state of medical science of scientific knowledge provides any determining argument as regards the legal recognition of transsexuals."[412] One crucial observation from the Court in *Goodwin* was that in revisiting the importance of biology in relation to attributing a legal sex to an individual it was noted that:

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[408] ibid.
[409] ibid.
[410] ibid [80].
[411] ibid [81].
[412] ibid [83].

> [w]hile it […] remains the case that a transsexual cannot acquire all the biological characteristics of the assigned sex, the Court notes that with increasingly sophisticated surgery and types of hormonal treatments, the principal unchanging biological aspect of gender identity is the chromosomal element. […] It is not apparent to the Court that the chromosomal element, amongst all the others, must inevitably take on decisive significance for the purposes of legal attribution of gender identity for transsexuals.[413]

The Court was therefore distancing itself not only from its previous judgments which had relied on medical and scientific knowledge but also issued a strong challenge to the *Corbett* judgment which was based largely on the fact that one cannot change one's chromosomes. In *Goodwin* the aetiology of transsexualism was no longer deemed legally important and what was to prove more important was the growing international trend that transsexuals should be given legal recognition. In largely dismissing the state of medical and scientific knowledge as not determinative of one's legal rights the ECtHR effectively strengthened the possibility of a model of gender identity recognition emerging within the UK in the years following this decision which was not based on medical criteria. Although the Court did not directly challenge the *Corbett* decision the ECtHR did separate the issue of legal rights and medical knowledge so that one could no longer be thought of as reliant upon the other and removed any potential remaining doubt that post-operative transsexuals' right to legal recognition of their sex re-assignment was to be considered an issue of personal identity as protected by human rights law.

The European and International consensus, or lack thereof

Regarding the state of European consensus it was noted that as early as *Sheffield and Horsham v United Kingdom*[414] in 1999 there was growing consensus in the Council of Europe of providing legal recognition following sex re-assignment. However there was no clear consensus on how to provide recognition. The ECtHR in *Goodwin* noted that lack of a clear consensus in the contracting states was "hardly surprising" given the "widely diverse legal systems and traditions"[415] and the wide margin of appreciation afforded to contracting states in deciding "on the measures necessary to secure Convention rights within their jurisdictions."[416] Therefore, the ECtHR, as with the factor of medical and scientific knowledge, attached:

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[413] ibid [82].
[414] *Sheffield and Horsham* (n 15).
[415] *Goodwin* (n 15) [85].
[416] ibid.

> less importance to the lack of evidence of a common European approach to the resolution of the legal and practical problems posed, than to the clear and uncontested evidence of a continuing international trend in favour not only of increased social acceptance of transsexuals but of legal recognition of the new sexual identity of post-operative transsexuals.[417]

In largely dismissing the state of European consensus as a determinative factor the ECtHR was again in effect strengthening the rights of the individual against the state in an area of private life which could be deemed intimate to the individual. In so doing the ECtHR was giving primacy to the individual's intimate identity over the state's maintenance of the *status quo*. The means by which the ECtHR managed to achieve this in *Goodwin* will be discussed below when the *Goodwin* case is situated within the wider Article 8 jurisprudence but suffice it to say at this point the ECtHR was strongly emphasising that in some areas of one's private life the individual's sense of identity will be protected notwithstanding a lack of European consensus on the matter in question.

The impact on the state's administrative systems

So having dismissed the issue of European consensus and the state of medical and scientific knowledge on the aetiology of transsexualism, and focussing instead on the growing international trend towards providing legal recognition the ECtHR once again indicated a willingness to depart from the earlier transsexual recognition cases which had derived from the UK. The other determinative factor in the early transsexual rights case law was the impact that requiring legal recognition of post-operative transsexuals would have on the UK administrative system. This, combined with the lack of consensus which had been identified in the earlier cases, had proven to be detrimental to the early cases before the Court as discussed above. Returning to this issue in *Goodwin* the ECtHR noted that "on the basis of the material before it at this time [it did not find] that any real prospect of prejudice [to others] has been identified as likely to arise if changes were made to the current system."[418] The alleged problems identified in the Government's response were merely hypothetical.

The balance of rights

So, the four factors which were so determinative in the earlier transsexual rights cases of the 1980s and 1990s, i.e. the lack of positive obligation, the state of medical and scientific

[417] ibid.
[418] ibid [87].

knowledge, the lack of European consensus and the impact that requiring recognition would have on the state's administrative systems were dismissed by the ECtHR in *Goodwin* in 2002. The lack of positive obligation in relation to transsexual legal recognition which underpinned all of the previous case law brought by UK based transsexuals actually changed so that in 2002 in *Goodwin* it was acknowledged that there was a positive obligation on the state to enable the development of the applicant's right to private and family life. However the state of medical and scientific knowledge was dismissed as no longer determinative as was the lack of European consensus, rather the ECtHR preferred to acknowledge the growing international trend towards recognition. The ECtHR had already discussed the issue of balancing the applicant's rights and those of the wider community in relation to transsexuals in *Cossey v United Kingdom*[419] and so taking this approach was not new to the *Goodwin* case but merely a restatement of one of the guiding principles of ECHR jurisprudence: that a fair balance must be struck between the rights and interests of all. However, it became clear as the judgment progressed that the balance began to tip in favour of the applicant in *Goodwin*. The factor which allowed this to happen was the way in which human dignity and human freedom were conceived of by the Court. The Court stated:

> [u]nder Article 8 of the Convention in particular, where the notion of personal autonomy is an important principle underlying the interpretation of its guarantees, protection is given to the personal sphere of each individual, including the right to establish details of their identity as individual human beings.[420]

The Court noted that there would be difficulties for the state in changing its systems of registration of births and in relation to other areas of domestic law.[421] However the ECtHR continued that:

> [n]o concrete or substantial hardship or detriment to the public interest has indeed been demonstrated as likely to flow from any change to the status of transsexuals and, as regards other possible consequences, the court considers that society may reasonably be expected to tolerate a certain inconvenience to enable individuals to live in dignity and worth in accordance with the sexual identity chosen by them at great personal cost.[422]

[419] *Cossey* (n 15).
[420] *Goodwin* (n 15) [90].
[421] ibid [91].
[422] ibid.

Therefore there was thought to be no sufficiently strong competing public interest which would prevent transsexual applicants from receiving legal recognition of their sex re-assignment. The Court stated that:

> the respondent Government can no longer claim that the matter falls within their margin of appreciation, save as regards the appropriate means of achieving recognition of the right protected under the Convention.[423]

As noted earlier in this chapter, one of the factors which operated so decisively against UK based transsexuals was the margin of appreciation which, in relation to this strand of applications, had been accepted as being very wide in favour of the respondent states. The margin of appreciation which had been so important in the earlier cases before the ECtHR[424] was effectively reduced to almost nothing in *Goodwin*.[425]

The ECtHR's analysis in *Goodwin* of the competing interests of individual versus public interest and the balance of rights inherent in Article 8 as discussed above can be explained by how the Court had developed Article 8 jurisprudence in the years preceding *Goodwin*, in particular the extent of a state's margin of appreciation in areas of private life. The Court's analysis of the role of the margin of appreciation by the time of *Goodwin* had shifted considerably from earlier case law in this area such that it had a significant impact on the *Goodwin* judgment and, as will be shown below, this was a result of the development of concepts such as human dignity and personal autonomy which are embodied within Article 8.

This changing emphasis from the state to the individual is hugely important. Traditionally, as Kavanaugh highlights, the states' margin of appreciation has been wide where "there is no consensus by the contracting state parties on the rights in question and where the decision of the Court falls to a balancing of moral issues."[426] This wide margin was fatal to the applications of UK domiciled transsexuals as shown in Chapter Two. The issue in the previous cases had been that the lack of consensus within the medical profession regarding the aetiology of transsexualism as a medical condition and the lack of consensus between contracting states in relation to how to provide for transsexuals in domestic law meant that states were afforded a very wide margin and therefore the UK Government was not in

[423] ibid.
[424] *Rees*; *Cossey*; *Sheffield and Horsham* (n 15).
[425] *Goodwin* (n 15) [94].
[426] K A Kavanaugh 'Policing the Margins: Rights Protection and the European Court of Human Rights' (2006) *European Human Rights Law Review* 4:422-444, 427.

violation of transsexuals' Article 8 rights in the earlier cases by not providing a means of legal recognition. However, as Kavanaugh argues, the ECtHR's determination in these earlier cases was "at best, questionable."[427] The issue that rendered the determinations questionable was that at the time of these earlier cases there was in fact growing European recognition of the legal rights of transsexuals partly as a result of the European Council's Recommendation 1117 of 1989 that member states "enact provisions on transsexuals' right to change sex […] and banning discrimination against them."[428] At the time of *Rees* and *Cossey* 14 member states provided for legal recognition of transsexuals, so although there was not 100% consensus in favour of transsexuals' rights there was a growing consensus that legal recognition should be provided. However despite this, the ECtHR maintained that there was no European consensus in the case of *X, Y and Z v United Kingdom*[429] as outlined above and it was only in 2002 in the *Goodwin* case that the ECtHR, for the first time, acknowledged the growing consensus, albeit international rather than European, in favour of transsexuals' rights.[430]

In addition to this shift in the applicability of the margin of appreciation the *Goodwin* judgment is important because the Court itself began to change how it approached the determination of these types of case. Kavanaugh argues that in *Goodwin* the ECtHR "shifted away from applying a technical approach, and embraced key aspects of the arguments raised by Judge Martens some 12 years earlier in Cossey."[431] The idea of the margin of appreciation was beginning to alter slightly as early as *Cossey* albeit in dissenting judgments. In *Cossey* Judge Martens made a crucial observation which was to prove true in *Goodwin.* In *Cossey* he stated that "[s]tates do not enjoy a margin of appreciation as a matter of right, but as a matter of judicial restraint."[432] This means that the ECtHR should respect states' margins of appreciation but that this in itself does not mean that the state has a margin in relation to recognising the existence of a Convention right: the margin only applies in relation to how the state should effect that Convention right, not whether or not the right exists in the first place:[433] the same argument was

[427] ibid 429.
[428] ibid. In reference to Council of Europe Recommendation 1117 – on the condition of transsexuals. This was adopted by the Assembly on 29 September 1989.
[429] *X, Y & Z* (n 15).
[430] Kavanaugh (n 427) 432.
[431] ibid.
[432] *Cossey* (n 15) [74].
[433] Kavanaugh (n 427) 428-429.

initially raised by the applicant in *Rees v United Kingdom.*[434] Returning to Judge Marten's dissent in *Cossey* there it was stated that:

> [i]n this context there simply is not room for a margin of appreciation. That margin comes into play only when a State resolves to recognise the new sexual identity of post-operative transsexuals: then there should be room for a certain discretion as to the requirement for and the form of such recognition.[435]

So as early as *Cossey* there was an indication of how the ECtHR might develop the Article 8 jurisprudence and limit the scope of the margin of appreciation. It was not until 2002 however that this limitation would actually be realised. Nevertheless, by the time the *Goodwin* case was heard in the ECtHR although some contracting states already provided for legal recognition of (usually post-operative) transsexuals; some did not. There was, therefore, a degree of inconsistency remaining between the contracting states in relation to legal recognition of sex re-assignment: however, more states provided some degree of recognition than did not.[436] This meant that the previously wide margin of appreciation which had enabled a decision of no violation of Article 8 in *Rees, Cossey, Sheffield and Horsham,* and *X, Y and Z* had drastically narrowed as consensus was in favour of granting legal recognition to a change of sex.

The structure of the Court's decision was fundamentally important because, as was argued above, the Court altered its approach to analysing these cases and placed the emphasis on the rights of the individual. The earlier technical approach taken by the ECtHR in these cases sought to identify consensus regarding aetiology within the medical profession which, as Chapter One showed, is not possible to find. It also sought to find consensus within legal systems as to how to provide for legal recognition, if at all, and as mentioned above although there was a growing consensus in this area the fact that it was not 100% was fatal to the early applications. In addition the ECtHR had, in the earlier cases, sought to consider the impact on the UK administrative system of registration of births in relation to legal recognition of transsexuals.[437] However, as Rudolf argues, the ECtHR in *Goodwin* "no longer found these factors decisive."[438] So *Goodwin* marked a shift away from the technical formulaic approach of the Court towards broader human rights principles such as

[434] *Rees* (n 15) [36].
[435] *Cossey* (n 15) 653.
[436] Lax (n 178) 144.
[437] Rudolf (n 383) 718.
[438] ibid.

autonomy and human dignity which it is argued, was the real importance of the *Goodwin* case in relation to Article 8.[439]

Situating *Goodwin* within Article 8 jurisprudence

Marshall argued that it can now be said that Article 8 gives a justiciable right to personal identity relating to a number of areas of one's life.[440] Although the *Goodwin* judgment was a huge step forward in the emergence of transsexual rights in Europe it should not have been a surprising judgment as the ECtHR Article 8 jurisprudence was building towards such a decision through careful development of the concept of human dignity. One of the factors behind this development was articulated by Marshall who stated that:

> [a]ny interpretation of law needs to be seen in the light of the fundamental objectives of that area of law. For human rights law, the objective is to safeguard, and potentially develop, the human dignity and human freedom of everyone.[441]

The way in which the ECtHR developed Article 8 jurisprudence and the understanding of personal autonomy within Article 8 is not limited to the conception of negative rights i.e. a right not to be interfered with by the state and to choose what happens to oneself (for example, the right of a competent person to determine his own medical treatment), but rather autonomy within Article 8 is much broader than this. Marshall argues that the contemporary version of autonomy in the ECtHR's judgments:

> illustrates the importance of social conditions and relationships between human beings in creating and developing that autonomy or one's human personality: it is something which needs a social context to thrive.[442]

This then relates to the concept of positive obligations within Article 8 which was discussed above in relation to the ECtHR's determination of the *Goodwin* case. There it was noted that Article 8 includes not only negative but also positive obligations which are intended to ensure that individuals have the conditions available to enable them to exercise personal freedom and to thrive. This does not mean that individuals have absolute rights to determine their own identity and to live the lives they choose since the Article 8 rights are qualified and therefore the rights of the individual have to be balanced with the rights and interests of others. In addition the development of human dignity as a key concept which

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[439] ibid 720.
[440] Marshall 'A right to personal autonomy' (n 394) 337.
[441] J Marshall *Personal Freedom through Human Rights Law* (n 394) 13.
[442] Marshall 'A right to personal autonomy' (n 394) 338.

underpins the ECHR impacted on the development of this wider understanding of personal autonomy, as to embrace and uphold human dignity implies a move away from negative obligations of the state (from restricting the state's interference with one's private life), towards the positive obligations upon states to enable individuals to shape their own lives and their fates "in a way that [they] deem best fit [their] own personality."[443] As briefly noted above many facets of one's identity are now protected under the broad protections given by Article 8: for example rights to one's physical and social identity,[444] one's gender identity,[445] one's sexual orientation and sexual life,[446] one's name,[447] one's religious identity,[448] one's genetic heritage and early development[449]and one's cultural identity[450] among other things. However it took several decades before the ECtHR reached this position. In 1970 'privacy' as it related to Article 8 was defined by the Council of Europe Resolution as consisting of:

> the right to live one's own life with a minimum of interference. It concerns private, family and home life, physical and moral integrity, honour and reputation, avoidance of being placed in a false light, non-revelation of irrelevant and embarrassing facts, unauthorised publication of private photographs, protection from disclosure of information given or received by the individual confidentially.[451]

Slowly the ECtHR moved from this negative conception of rights towards a more enabling model of privacy.[452] Marshall argues that:

> to freely exercise their right, people need enabling conditions – including the resources to make free choices in a fully informed way. For example they need to have control over their own body and health, their sexual identity and sex life, and some would say, full knowledge of their origins and access to information about their childhood development.[453]

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[443] ibid 342.
[444] *Van Kück v Germany* (2003) 37 EHRR 51 [69]; *Pretty v United Kingdom* (2002) 35 EHRR 1 [61]; *Mikulić v Croatia* [2002] 1 FCR 720 [53].
[445] *Goodwin* (n 15) [85]; *B v France* (n 15) [63]; *I v United Kingdom* (2003) 36 EHRR 53 [57].
[446] *Smith and Grady v United Kingdom* (2000) 29 EHRR 493; *Dudgeon v United Kingdom* (1982) 4 EHRR 149; *Laskey, Jaggard and Brown v United Kingdom* (1997) 24 EHRR 39; *X and Y v Netherlands* (1986) 8 EHRR 235 [22]; *Sutherland v United Kingdom* [1997] EHRLR 117.
[447] *Burghartz v Switzerland* (1994) 18 EHRR 101; *Stjerna v Finland* (1997) 24 EHRR 195; *Űnal Takeli v Turkey* (2006) 42 EHRR 53; *Znamenskaya v Russia* (2007) 44 EHRR 15.
[448] *Leyla Sahin v Turkey* (2005) 41 EHRR 8 [104].
[449] *Gaskin v United Kingdom* (1989) 12 EHRR 36; *MG v United Kingdom* (2003) 36 EHRR 3; *Mikulić v Croatia* [2002] 1 FCR 720; *Shofman v Russia* (2007) 44 EHRR 35; *Znamenskaya v Russia* (2007) 44 EHRR 15; *Kroon v Netherlands* (1995) 19 EHRR 263*; Odievre v France* (2003) 28 EHRR 43.
[450] *Chapman v United Kingdom* (2001) 33 EHRR 18; *Connors v United Kingdom* (2005) 40 EHRR 9.
[451] Council of Europe, Conc.Ass., Twenty-first Ordinary Session (Third Part), Texts Adopted (1970).
[452] Marshall 'A Right to Personal Autonomy' (n 394) 344.
[453] ibid.

The development towards this broad understanding of privacy which encompasses personal autonomy and identity began in the late 1970s. In *Bruggemann and Scheuten v Germany*[454] which concerned availability of abortion, the ECtHR stated that respect for private life comprised:

> to a certain degree, the right to establish and to develop relationships with other human beings, especially in the emotional field, for the development and fulfilment of one's own personality.[455]

However the Court was not willing at the time, and nor have they been willing since, to give absolute precedence to the rights of the individual and reiterated the need to balance the individual's right to private life with the wider public interest and the rights of others. At the same time in *Dudgeon* the ECtHR held that Northern Irish law which made consenting homosexual activity in private between adult males, over the age of twenty-one, a criminal offence amounted to a violation of the applicant's Article 8 rights.[456] The *Dudgeon* decision was followed in the case of *Modinos v Cyprus.*[457] In relation to the right to one's sexual orientation as an aspect of private life it is clear to see that the Court was developing protections very early on.

However, the Court in *Laskey, Jaggard and Brown v United Kingdom* refused to grant absolute rights to one's chosen form of sexual expression thereby, to some degree, limiting the rights to sexual privacy under Article 8.[458] Despite this there is, to a limited extent, protection of one's sexual expression which is based on equality of individuals. Therefore the issue was not which sexual activities were being engaged in, as in *Laskey, Jaggard and Brown* but rather the legitimacy of treating homosexual and heterosexual couples differently within the domestic criminal law.

The transsexual rights case law which originated in the United Kingdom during this time was unsuccessful, as was shown in Chapter Two. The issue was that although the ECtHR had consistently reiterated that Article 8 protects against state interference and that in doing so this gave rise to positive obligations, the ECtHR had always held, until *Goodwin*, that there was no positive obligation upon the state to alter the system of birth registrations

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[454] (1981) 3 EHRR 244.
[455] ibid [57].
[456] *Dudgeon* (n 447).
[457] (1993) 16 EHRR 485. In this case the ECtHR held that the criminalisation of homosexual relations between adults under Cypriot law interfered with the applicant's Article 8 rights.
[458] *Laskey, Jaggard and Brown* (n 447).

and that the margin of appreciation was in favour of the state rather than the applicants. The Court was able to make these determinations in the early cases because the understanding of privacy comprising personal autonomy was not fully developed by this time. However by 1992 the concept of private life widened considerably in the case of *Niemietz v Germany*[459] where the Court stated:

> it would be too restrictive to limit the notion [of private life] to an 'inner circle' in which the individual may live his own personal life as he chooses and to exclude therefrom entirely the outside world not encompassed within that circle. Respect for private life must also comprise to a certain degree, the right to establish and develop relationships with human beings.[460]

So the Court was moving from a narrow interpretation of private life in the early 1970s to a much broader one by 1992. This meant though that the relationship between the state and the individual would require to be reconsidered as would the relationship between the individual and others. The right initially contained in Article 8 to be free from state interference has now morphed into a right to personal autonomy and it was this which truly impacted on the *Goodwin* decision. As shown above, the concept of human dignity as a foundation of the ECHR has been stated throughout Article 8 case law and is also not a new idea. However, the concept of personal autonomy as an issue of private life deriving from human dignity "was first recognized by the Court less than three months earlier"[461] than the *Goodwin* judgment in *Pretty v United Kingdom*.[462] In this case the ECtHR was asked to consider whether the refusal of the Director of Public Prosecutions to grant immunity from prosecution to a husband of a woman who wished to be aided to die amounted to a violation of the applicant's Convention rights. The Court held that it was not a violation of the applicant's rights.

So, as can be seen, the interpretation of Article 8 had steadily been developing and evolving to reflect basic human dignity and limited state interference in the private lives of individuals such that now, in interpreting Article 8, Moreham argues that the ECtHR judgments can be categorised into five distinct areas of "private life interest".[463] These five areas include three 'freedoms from' based rights and two 'freedoms to' type rights. According to Moreham the 'freedom from' rights include the right to freedom from

[459] (1992) 16 EHRR 97.
[460] ibid [29].
[461] Rudolf (n 383) 719.
[462] *Pretty* (n 445) [61].
[463] Moreham (n 394) 46.

interference with psychological and physical integrity,[464] the right to be free from "unwanted informational access"[465] and covers the collection, storing, publishing and disclosure of information about oneself, and the final 'freedom from' right encompasses the right to protection of one's living environment i.e. a right to be free from environmental pollution.[466] The 'freedom to' rights comprise a right to one's identity[467] including the right to have information about one's parents and early development,[468] a right to one's gender,[469] the right to retain one's name[470] and the right to one's cultural identity.[471] It is clear from the analysis of the case law that it was the development of these 'freedom to' rights by the Court which rendered the *Goodwin* judgment inevitable.

Article 8 beyond *Goodwin*

This wider interpretation of Article 8 has developed beyond *Goodwin* indicating that the Court's interpretation of Article 8 in 2002 was indeed the correct approach to take. The development of a broad right to identity and personal autonomy as aspects of Article 8 can be seen in the later Article 8 jurisprudence, for example in 2005 in *Von Hannover v Germany*[472] the ECtHR phrased the right to respect for private life as including:

> a person's physical and psychological integrity […] The guarantee afforded by Article 8 of the Convention is primarily intended to ensure the development, without [unwanted] outside interference, of the personality of each individual in his relations with other human beings. There is therefore a zone of interaction of a person with others, even in a public context, which may fall within the scope of 'private life'.[473]

In 2007 in *Tysiaç v Poland*[474] the Court again stated that the right under Article 8 to develop one's personality encompassed a right to establish and develop relationships with others and with the outside world. It also encompasses a right to moral and physical integrity. So it is clear from contemporary judicial interpretation of Article 8 that its scope is continuing to widen and it now covers almost all aspects of one's private life and

[464] ibid 49. This, according to Moreham encompasses physical assault and exposure, search, surveillance and dissemination of images.
[465] ibid 62.
[466] ibid 64.
[467] ibid 67.
[468] ibid 68.
[469] ibid 69.
[470] ibid 70.
[471] ibid.
[472] (2005) 40 EHRR 1.
[473] ibid [50].
[474] (2007) 45 EHRR 42 [107].

personal identity although a right to personal identity in terms of recognition of one's gender identity remains a long way from being an absolute and indefeasible right. As a result of the development of Article 8 by the Court from *Bruggemann and Scheuten v Germany*[475] and *Dudgeon v United Kingdom*[476] until today:

> the right to respect for one's private life, freedom from intrusion, now means the right to develop one's personality in connection with others, *the freedom to live the life of one's own choosing*.[477]

In particular, it is clear that the ECtHR's judgment of July 2002 in *Goodwin* truly marked a turning point, albeit a small one, for transsexuals domiciled in the UK and had some influence on domestic courts as the next section will show.

A v Chief Constable of West Yorkshire Police

Shortly after the *Goodwin* decision on 5 November 2002 the Court of Appeal reversed a decision of an Employment Appeal Tribunal (EAT) which had provided that the employee, a Chief Constable, had not unjustifiably discriminated against an MTF potential recruit by refusing to employ transsexuals who could not conduct intimate searches of suspects.[478] The case centred around s.54(9) of the Police and Criminal Evidence Act 1984 (PACE 1984) which provided that "[t]he constable carrying out a search shall be of the same sex as the person searched". It was argued that the potential recruit could not satisfy the requirements of this piece of legislation as she would not be in a position to search female suspects and therefore to exempt her from carrying out these searches without disclosing her transsexualism to colleagues and the public would raise certain operational difficulties. Before the employment tribunal the police force conceded that there had been discrimination on the grounds of sex under the SDA 1975 but the police argued that the discrimination was justified on the grounds of the SDA 1975 s.7(2)(b)(i) which enabled exceptions to be made on the basis of 'a genuine occupational qualification' i.e. the need to have someone who was not transsexual carry out intimate searches of suspects. It was initially argued by the police force that A had not wanted her transsexualism to be made known to colleagues and to the public and therefore excusing her from conducting searches without making her transsexualism apparent would prove difficult.

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[475] *Bruggemann* (n 455).
[476] *Dudgeon* (n 447).
[477] Marshall 'A Right to Personal Autonomy' (n 394) 345 (emphasis added).
[478] *A v Chief Constable of West Yorkshire Police* [2002] EWCA Civ 1584; [2003] 1 CMLR 25.

There was two crucial factors in the Court of Appeal's determination to overturn the decision of the EAT. Firstly that for the first time in the case history Ms A indicated that she was not averse to her transsexualism being disclosed neither to her work colleagues nor to the public where necessary.[479] The second crucial factor was that the Court of Appeal followed the ECtHR's ruling in *Goodwin* rather than determine the case based on EU anti-discrimination provisions.[480] Kennedy LJ noted that:

> [i]n light of *Goodwin* it is no longer possible, in the context of employment, to regard the appellant as being anything other than female, except perhaps in circumstances where, as was said in *Goodwin,* there are "…significant factors of public interest to weigh against the interests of the individual applicant in obtaining legal recognition of her gender re-assignment."[481]

Kennedy LJ noted that had *Goodwin* been decided before the EAT delivered its judgment in the instant case the decision of the EAT could very well have been different.[482] Kennedy LJ stated that:

> [i]f when dealing with the appellant's application for employment the Chief Constable was bound to treat her as female, then it was not open to him to discriminate against her on the basis that she was transsexual, and no possibility of invoking s.7 [SDA 1975] could arise.

Kennedy LJ stated that "in the light of *Goodwin* it is now clear that the respondent's attempt to invoke s.7 of the 1975 Act cannot succeed."[483] Buxton LJ's decision further explains how the Court of Appeal reached this decision based on *Goodwin.* He stated that:

> [i]t is important to be clear that *Goodwin* decides that it will be a breach of Art. 8, in cases "where there are no significant factors of public interest to weigh against the interest of this individual applicant in obtaining legal recognition of her gender re-assignment", to refuse to recognise that re-assigned gender.[484]

He continued:

> [a]ccordingly, in any case to which the Human Rights Act 1998 [the HRA] applies, it will in future be necessary to consider whether a failure or refusal to treat a post-operative transsexual as being of the reassigned gender involves a breach of Art.8.

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[479] ibid [32].
[480] ibid [33].
[481] ibid [27].
[482] ibid.
[483] ibid [29].
[484] ibid [41].

> Since the application of Art.8 is case specific, and does not confer absolute rights, the court will have to consider in every case whether the subject's interest in achieving respect and recognition for her gender re-assignment is outweighed by countervailing considerations of the public interest.[485]

So once again the idea of the interests of the individual being weighed against the interests of the public at large was raised in interpreting the scope and protections of Article 8 and how Article 8 applies in specific cases. It is worth noting that *Goodwin* did not provide that transsexuals had to be given legal recognition in all areas of the law or for all purposes, only that it was no longer within the state's margin of appreciation to continue to deny legal recognition to post-operative transsexuals; the manner in which this recognition was to be given and for what legal purposes, remained within the state's margin of appreciation. What the Court of Appeal did in this appeal was to take the issue of sex discrimination in employment into the realm of human rights law rather than consider it under EU law. Buxton, LJ noted that it would have been possible for the Court to have considered this case under EU law but that it was not necessary to do so.[486] The Court of Appeal's decision was subsequently upheld by the House of Lords.[487] However, although the Lords upheld the Court of Appeal decision the Lords reached their determination based on different factors than the Court of Appeal. The Lords based their determination of EC law and held that the Equal Treatment Directive applied such that domestic law and the impact of *Goodwin* was not important. The Lords therefore placed EC anti-discrimination law above the impact that *Goodwin* could have and held that the respondent had been discriminated against. This is an important case, but perhaps not as important as it could have been. The Lords' decision in this appeal was handed down just over a month after the Gender Recognition Act 2004 (GRA 2004) came into force[488] and, although the Lords could not use the GRA 2004 to make their determination as it had no retrospective effect, the Lords' decision reinforced that there are multiple ways of obtaining legal recognition of one's gender identity in UK law; either via the GRA 2004 or by means of EC anti-discrimination law and other provisions which provide recognition in certain situations. The Lords' decision extended the anti-discrimination provisions contained in EC law. It should be remembered from the previous chapter that in *White*[489] the employee was not able to be given protection under EC law as being male was considered a genuine

[485] ibid.
[486] ibid [42]-[44].
[487] [2004] UKHL 21; [2005] 1 AC 51.
[488] The GRA 2004 will be discussed in detail in Chapter Four.
[489] *White* (n 252).

occupational qualification. What the decision in this case does is challenge the idea of when one is male or female for the purpose of such provisions.[490]

Croft v Royal Mail Group Plc.

The impact of *Goodwin*, which applied ECHR jurisprudence, and other EU law based cases can be seen in the progress of *Croft v Royal Mail Group Plc. (formerly Consignia Plc.)* through the UK court system, although the *Goodwin* case was not, in *Croft*, helpful because a significant weakness of *Goodwin* as it applied to transsexuals was highlighted by the *Croft* case as will be discussed below. In September 2002 the EAT in *Croft v Royal Mail Group Plc. (formerly Consignia Plc.)*[491] held that a male employee who had been diagnosed with gender dysphoria and who began treatment which included starting the feminisation process and dressing as a woman at work, in accordance with the medically necessitated Real Life Experience, a process by which the patient's eligibility and readiness for sex re-assignment procedures is assessed by his or her supposed success or failure at living as a member of the opposite sex in all areas of life for a two year period,[492] had not been discriminated against by her employer refusing to allow her to use the female facilities during this time. As part of living as a woman Croft requested to use the female toilets but was informed that she would have to use the disabled toilets instead thereby leading her to become absent from work and later resign as a result of stress and depression. The EAT held on 30 September 2002 that she had not been discriminated against. It was held that as the employee was legally male and alternative facilities had been made available then to prevent her from using female facilities was not discriminatory because other male employees were not permitted to use the female facilities.[493] The EAT relied upon the Court of Appeal's decision in *Bellinger*[494] to reinforce that under English law Croft remained legally male. In considering the *Goodwin* judgment the EAT noted that the case would not impede Croft or assist her as *Goodwin* concerned post-operative transsexuals and Ms Croft was pre-operative. The decision of the EAT in *Croft* therefore established a significant limitation of the *Goodwin* judgment: that it only applied to post-operative transsexuals.

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[490] This will be returned to in Chapter Six.
[491] [2002] IRLR 851.
[492] Please note that NHS Scotland requires individuals to undertake a real life experience of only 12 months as a result of the recent NHS Scotland Gender Reassignment Protocol.
[493] *Croft* (n 492).
[494] *Bellinger* (n 321).

Croft was appealed to the Court of Appeal which, in July 2003, held that Ms Croft had not been discriminated against by her employers because the moment at which she should cease to be treated as male and begin to be treated as female had not arrived therefore she was not treated any differently from any other male employee.[495] Pill LJ observed in *Croft* that although the SDA 1975, as amended, protected transsexuals at all stages of sex re-assignment where they were under medical supervision it:

> does not follow that all such persons are entitled immediately to be treated as members of the sex to which they aspire. Nor does it follow that, until the final stage is reached, they can necessarily be required, in relation to lavatories, to behave as if they were not undergoing [sex re-assignment].[496]

During the transition from one sex to the other there had to be a period of time available to employers to make separate arrangements for such employees until it could be said that the employee had reached the stage at which he or she was to be treated as a member of the opposite sex; in this case, as the applicant was merely beginning the real life experience which precedes the provision of medical treatment it could not be said that she had reached the stage at which she should be treated as female for all purposes. So *Croft* is clear in that UK law provided that transsexual individuals could not be discriminated against on the basis of their transsexualism but also that this did not mean that the law obliged that they be treated as members of the opposite sex until they reached a point on their transition whereby it became appropriate to treat them as such. This meant that actually the law was no more clear than it was before *Goodwin*: some transsexuals (post-operative) would get protection in some areas of law but others (pre-operative) likely would not.

Goodwin was therefore being used to ensure that only post-operative transsexuals were protected from discrimination; this is a serious limitation of the *Goodwin* case for transsexuals in general. So, although the *Goodwin* judgment was a huge step forward in relation to transsexual rights it was not without its limitations and the question then for UK law was at which stage in the transition process should an individual be recognised as a member of the opposite sex and be protected as such. *Croft* was clear that only those who had reached a certain stage in the transition process would be protected. In a sense post-operative in this context, as highlighted by *Croft,* had to be taken to mean post-operative as far as possible. This raises issues for individuals who cannot undergo, or who choose not to undergo, medical procedures. This is a particular issue in relation to genital surgery for

[495] [2003] EWCA Civ 1045; [2003] ICR 1425.
[496] ibid [42].

female-to-male (FTM) transsexuals which is not always desired by the individuals because of the relatively less developed nature of the genital surgery available for FTMs than MTFs and the potential for a negative outcome. In addition not all individuals are medically suited to surgery and/or hormones. The Court of Appeal in *Croft* noted that s.82 of the SDA 1975 ensured that those undergoing sex re-assignment could not be discriminated against but it did not ensure that all transsexuals were entitled to be treated as members of the sex to which they aspired; legal protection increased as the individual progressed along the sex re-assignment process and as Ms Croft was merely beginning the process her legal protection was limited. So the Court of Appeal decision in *Croft*, relying on the ECtHR decision in *Goodwin*, placed strong limitations on when transsexual individuals would be protected by domestic law; the bar was set very high. So, the force of the *Goodwin* judgment was clear but it was not without limitation and *Goodwin*, although transformative for post-operative transsexuals, was merely a stepping stone in the overall quest for transsexual legal recognition.

Bellinger v Bellinger in the House of Lords

As was noted above, no progress was made in the UK following the *Goodwin* judgment. It is arguable that no reform would have been forthcoming in this area of law had it not been for the House of Lords decision in *Bellinger v Bellinger*.[497] The facts of *Bellinger* were outlined in Chapter Two when the Court of Appeal judgment was discussed so will not be repeated here. Suffice it to say the decision of the Court of Appeal[498] that the marriage between Elizabeth Bellinger, an MTF transsexual, and her husband was not a valid marriage under s.11(c) of the Matrimonial Causes Act 1973 (MCA 1973) as the parties were not male and female was appealed to the House of Lords. On appeal to the House of Lords Elizabeth Bellinger once again sought that the terms 'male' and 'female' in the s.11(c) be interpreted in such a manner as to include post-operative transsexuals. Should the interpretation sought not be forthcoming the applicant also sought that a declaration of incompatibility under s.4 of the HRA 1998 be issued.

The judgment of the House of Lords was unanimous in denying the first point of the appeal by restating that 'male' and 'female' in the legislation could not be interpreted as including post-operative transsexuals. However it was also unanimous in accepting the need to issue a declaration of incompatibility between MCA 1973 s.11(c) and the ECHR. The

[497] [2003] UKHL 21; [2003] 2 AC 467.
[498] *Bellinger* (n 187).

importance of the *Goodwin* judgment, although changing nothing in itself, comes in the impact that it had on the House of Lords' decision in the *Bellinger* appeal to issue the declaration of incompatibility. For the purpose of completeness the reasons why s.11(c) could not be interpreted to include post-operative transsexuals will be discussed in addition to the decision to declare the section incompatible with ECHR jurisprudence.

The House of Lords was faced with the decision whether to apply the *Corbett* judgment regarding sex determination for the purposes of marriage law or to depart from it. As noted in *Corbett* and indeed in subsequent cases marriage is one of the legal relationships in which the sex of the parties is an essential element of that legal relationship. *Goodwin* had held only the year before however that not allowing post-operative transsexuals to marry in their post-operative sex violated their Article 12 rights. So the question before the Lords was whether to recognise the *Goodwin* judgment and depart from previous case law by forcing an interpretation of s.11(c) to include post-operative transsexuals or to uphold previous UK court judgments which denied marriage to this group of individuals. If the Lords applied *Corbett,* which by this point had a long legacy in relation to sex for the purpose of marriage as shown in the previous chapter, then the Bellinger's marriage would be void *ab initio*: if they reinterpreted s.11(c) in the manner sought post-operative transsexuals would be able to have existing marriages recognised by the law and be able to enter into marriage as members of their post-operative sex but would still be without legal recognition overall which would place them in an anomalous position in relation to UK law: being recognised for some but not all legal purposes. In addition the problem would be in determining at what stage the law should provide legal recognition to the individual's re-assigned sex, as was the discussion in *Croft* as outlined in the previous chapter.

In relation to the reinterpretation of s.11(c) the petitioner argued that the purely biological criteria used by Ormrod J in *Corbett* should no longer be applicable as it ignored the psychological aspects of gender identity: a factor which, it was observed by Thorpe LJ in his dissenting Court of Appeal judgment[499] and by the ECtHR in *Goodwin*,[500] as being relevant to the development of one's gender identity and ought to be relevant to the legal test determining one's sex. The petitioner argued that as 'male' and 'female' were not defined in statute, and because societal attitudes had changed, the Court ought to take a broad interpretation of the terms rather than the narrow interpretation taken by previous

[499] ibid 185[C]-[D].
[500] *Goodwin* (n 15) [82].

courts tasked with determining whether post-operative transsexuals are encompassed by the terms of the legislation. The petitioner argued that in determining the meaning of 'male' and 'female' "[t]he court should not be bound by the classification of gender at the time of birth but should look at the reality of the situation at the time of the marriage."[501] She sought to base her argument on the fact that society had changed since *Corbett* and there was now a much greater understanding of the factors which determine one's sex. The petitioner contended that it was:

> clear from the Hansard records of the parliamentary debates that it was Parliament's intention […] that "male" and "female" should be left undefined and would be capable of bearing meanings other than those ascribed to them in the *Corbett* case, and that a person's sex would be a question of fact to be determined in light of evolving medical evidence and opinion.[502]

There was a possibility that the House of Lords in *Bellinger* might take an approach to s.11(c) which would allow for the marriage between Elizabeth and Jeffrey Bellinger to be declared valid. All the House of Lords had to do was to recognise that Elizabeth was female. The petitioner argued:

> [i]f, in addition to self-identity, the petitioner has female physical characteristics it must be said that she is female. Post-operative [sex re-assignment] patients are indistinguishable from members of the sex to which they have changed.[503]

Elizabeth Bellinger identified as female, she had altered her body to appear female, and all that she could not alter was her genetic make-up. Counsel for the petitioner argued that for the law to treat Elizabeth Bellinger as not female because of her chromosomes and her genetics and gonads at birth and to ignore her psychological gender identity and post-operative presentation was unfair and unjust.

Lord Nicholls' judgment is the most comprehensive of the five judgments and in it he begins by considering how one determines the sex of an individual, reiterating the *Corbett* test he stated:

> [t]he indicia of human sex or gender (for present purposes the two terms are interchangeable) can be listed, in no particular order, as follows: (1) Chromosomes: XY patterns in males, XX in females. (2) Gonads: testes in males, ovaries in

[501] *Bellinger* (n 498).
[502] ibid 469[F].
[503] ibid 469[H].

> females. (3) Internal sex organs other than gonads: for instance sperm ducts in males, uterus in females. (4) External genitalia. (5) Hormonal patterns and secondary sex characteristics, such as facial hair and body shape.[504]

He also added to the list non-biological indicia such as "[s]tyle of upbringing and living"[505] and "[s]elf-perception".[506] In relation to the self-perception criterion he noted, following some medical and scientific opinion, as outlined in Chapter One, that "[s]ome medical research has suggested that this factor is not exclusively psychological. Rather it is associated with biological differentiation within the brain."[507] As such he was claiming that self-perception is not an arbitrary choice of the individual, a 'whim', but rather is it something which is driven largely by physiological factors even if this sexed differentiation in the brain is not manifest in terms of other biological and physiological characteristics of the individual. Lord Nicholls' judgment is mindful of the state of medical and scientific knowledge on sexed differentiation in humans. He reiterates that largely there is no problem when determining the sex of individuals: for the most part individuals' self-perception and physical appearance are congruent. However he noted that "nature does not draw straight lines."[508] This leads him on to considering those whose sex is more difficult to determine: intersex individuals and transsexuals. After outlining the treatment available for transsexuals, he began his discussion of the state of the law as it was then in England and restated the *Corbett* test.[509] Although he acknowledged that *Corbett* reflected the law in England at that time he was mindful of the fact that the *Corbett* judgment had "attracted much criticism, from the medical profession and elsewhere."[510] Some of the medical criticism was mentioned in Chapter Two when discussing the *Bellinger* case in the Court of Appeal where, it will be remembered, that Professor Green stated that determining the sex of an individual using only the biological chromosomal, genital and gonadal test was too reductionist.[511] Lord Nicholl then considered the decision of the trial judge, Johnston J and the Court of Appeal judgment noting that the law was clear and that *Corbett* had to apply in determining Elizabeth Bellinger's sex for the purpose of MCA 1973 s.11(c).[512] One important question which was asked by Lord Nicholls, a question

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[504] ibid [5].
[505] ibid.
[506] ibid.
[507] ibid.
[508] ibid [6].
[509] ibid [11].
[510] ibid [13].
[511] *Bellinger* (n 187) [34].
[512] *Bellinger* (n 498) [17]-[18].

which ran through the judgment of the House of Lords in *Bellinger* was the issue of when to determine that a change of sex had occurred. He asked:

> [a]t what point would it be consistent with public policy to recognise that a person should be treated for all purposes, including marriage, as a person of the opposite sex to that which he or she was correctly assigned at birth? This is a question for Parliament, not the courts.[513]

It would appear that Lord Nicholls was sympathetic to the plight of Elizabeth Bellinger and her husband. He noted that the ECtHR "has taken the view that the sands of time have run out"[514] and that "[t]he United Kingdom's margin of appreciation no longer extends to declining to give legal recognition to all cases of [sex re-assignment]."[515] It was further noted that the impact of the *Goodwin* judgment was that "[a] test of congruent biological factors can no longer be decisive in denying legal recognition to the change of gender of a post-operative transsexual."[516] However, despite these indications of sympathy the issue of exactly how the law should be reformed and whose responsibility it was to reform the law remained. The issue of how to provide legal recognition to transsexual individuals' gender identity was considered complex and not one with which the courts should engage. In addition to the issue of complexity of this legal task the UK Government had, between the judgment being issued in *Goodwin* and the House of Lords hearing the *Bellinger* appeal, indicated that they intended to reform the law in this area by means of introducing legislation which may have had a strong bearing on the decision of the House of Lords to decline to reinterpret s.11(c) in the manner sought by the petitioner.

In justifying the refusal to reinterpret the legislation to include post-operative transsexuals Lord Nicholls is careful to highlight the very complex legal issues involved. He stated:

> [i]n this country, as elsewhere, classification of a person as male or female has long conferred a legal status. It confers a legal status, in that legal as well as practical consequences follow from the recognition of a person as male or female. The legal consequences affect many area of life, from marriage and family law to gender-specific crimes and competitive sport. It is not surprising, therefore, that society through its laws decides what objective biological criteria should be applied when categorising a person as male or female. Individuals cannot choose for themselves whether they wish to be known or treated as male or female. Self-definition is not

[513] ibid [18].
[514] ibid [21].
[515] ibid.
[516] ibid [23].

> acceptable. That would make nonsense of the underlying biological basis of the distinction.[517]

In relation to the issue of self-perception of gender identity for legal purposes Lord Nicholls stated:

> society is now facing the question of how far it is prepared to go to alleviate the plight of the small minority of people who suffer from this medical condition. Should self-perceived gender be recognised?[518]

The issue for Lord Nicholls was that it would not be easy to recognise one's self-perceived gender for legal purposes because sex is a crucial aspect of a number of legal interactions. On exploring how self-perceived gender could be recognised for legal purposes he stated:

> the circumstances in which, and the purpose for which, [sex re-assignment] is recognised are matters of much importance. These are not easy questions. The circumstances of transsexual people vary widely. The distinction between male and female is material in widely differing contexts. The criteria appropriate for recognising self-perceived gender in one context, such as marriage, may not be appropriate in another, such as competitive sport.[519]

So Lord Nicholls was highlighting the complexity of this area of law and indicating that it was not for the courts to reform this area but rather it ought to be left to Parliament. While Lord Nicholls acknowledged the very real difficulties faced by post-operative transsexuals who were denied legal recognition, he was reluctant to afford Elizabeth Bellinger the status of female. In relation to Bellinger's first point of appeal: that the terms 'male' and 'female' in the primary legislation be interpreted to include post-operative transsexuals Lord Nicholls noted that:

> [r]ecognition of Mrs Bellinger as female for the purposes of section 11(c) of the Matrimonial Causes Act 1973 would necessitate giving the expressions "male" and "female" in that Act a novel, extended meaning: that a person may be born with one sex but later become, or become regarded as, a person of the opposite sex.[520]

[517] ibid [28].
[518] ibid [30].
[519] ibid [32].
[520] ibid [36].

To recognise Mrs Bellinger as female for the purpose of marriage law "would represent a major change in the law, having far reaching ramifications."[521] As such the issue of legal recognition of transsexuals:

> raises issues whose solution calls for extensive enquiry and the widest public consultation and discussion. Questions of social policy and administrative feasibility arise at several points, and their interaction has to be evaluated and balanced. The issues are altogether ill-suited for determination by courts and court procedures. They are pre-eminently a matter for Parliament, the more especially when the government in unequivocal terms, has already announced its intention to introduce comprehensive primary legislation on this difficult and sensitive subject.[522]

The fact that the Government had already announced intention to introduce legislation on this matter and the complex ramifications of providing legal recognition to transsexual individuals both clearly influenced Lord Nicholls' reluctance that the courts should become involved in determining legal recognition of gender identity. Although comment had been made by Nicholls that it was not an easy task for the law to determine when one had changed sex[523] it was argued by counsel for the petitioner that these considerations did not apply in the instant case because regardless of where the line between being male or female was drawn "Mrs Bellinger is on the reassigned gender side of the line."[524] However Lord Nicholls, mindful of the implications of this decision for other transsexual individuals and in other areas of law, was not convinced that changing the law in such a fundamental manner on the basis of one person's situation was "a proper, or indeed, responsible basis on which to change the law."[525] The issue for Lord Nicholls was that in effect the Court was being asked to determine when individuals could be said to have transitioned from one sex to the other for legal purposes and although Mrs Bellinger clearly had achieved this the same could not be said for all transsexuals. Had the Court determined that Mrs Bellinger was female for the purpose of marriage law then would this have meant that only post-operative transsexuals could fulfil the requirements in s.11(c) of the Matrimonial Causes Act 1973? The related question to that would be how to determine which form of body modification was required to evidence transition from one sex to the other and how should the law deal with individuals who could not medically transition or who chose not to? Lord Nicholls stated:

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[521] ibid [37].
[522] ibid [30].
[523] ibid [18].
[524] ibid [39].
[525] ibid [40].

> [t]oday the case before the House concerns Mrs Bellinger. Tomorrow's case in the High Court will relate to a transsexual person who had been able to undergo a less extensive course of surgery. The following week it will be the case of a transsexual person who has undergone hormonal treatment but who, for medical reasons, has not been able to undergo any surgery. Then there will be a transsexual person who is medically able to undergo all or part of the surgery but who does not wish to do so. By what criteria are cases such as these to be decided?[526]

Lord Nicholls also was not willing to separate recognition of sex re-assignment for the purpose of marriage from other areas of law in which individuals are treated differently because they are either male or female.[527]

Therefore in relation to the first point of Mrs Bellinger's appeal Lord Nicholls refused to recognise her as female for the purpose of the MCA 1973 s.11(c) for the reasons outlined above. In determining how legal recognition should be given he stated that "[a] change in the law as sought by Mrs Bellinger must be a matter for deliberation and decision by Parliament when the forthcoming Bill is introduced."[528]

In considering whether or not to issue the declaration of incompatibility Lord Nicholls identified that the appropriate question was whether UK law prevented post-operative transsexuals marrying thereby breaching Articles 8 and 12 ECHR. The question of whether or not the impending introduction of legislation in this area impacted on the compatibility of English law with the ECHR was considered and the Government had argued that the *Goodwin* decision had given them time to reform the law therefore there was no current incompatibility however the Lords determined that the question to be asked was whether the law as it currently stood was incompatible with the ECHR.[529] In answering this fundamental question Lord Nicholls stated that "[i]n the present case section 11(c) of the Matrimonial Causes At 1973 remains a continuing obstacle to Mr and Mrs Bellinger marrying each other."[530] So, Lord Nicolls was very clear that English law on this matter was not compatible with the rights given to citizens under the ECHR. The fact that the Government had signalled intent to reform this area of law, in the opinion of Lord

[526] ibid.
[527] ibid [42].
[528] ibid [49].
[529] D Nicol 'Gender Reassignment and the transformation of the Human Rights Act' (2004) *Law Quarterly Review* 120(Apr) 194-198.
[530] *Bellinger* (n 498) [52].

Nicholls, did not preclude the Lords from issuing a declaration of incompatibility and as such the declaration was issued.[531]

Shortly after the Lords' judgment was handed down in *Bellinger* the UK Government published the draft Gender Recognition Bill, in July 2003, which was intended to ensure compliance between UK law and ECHR jurisprudence regarding the legal recognition of transsexuals.

Conclusion

This chapter has sought to show how case law developed in the short period from 2002 through to 2005 as a result of the decision of the ECtHR in *Goodwin.* Although *Goodwin* only applied to post-operative transsexuals before the law and therefore it was not a wholly transformative judgment *per se* the reliance of the ECtHR on human rights principles established in the wider Article 8 jurisprudence and the effective dismissal of medical knowledge as a determinative factor in law meant that how the law conceived of transsexuals' rights had changed. No longer was it possible for states to deny that transsexuals had a right to legal recognition and marry but rather the margin of appreciation of states was reduced in *Goodwin* to determining how to provide for the rights of transsexuals. The particular strength of the *Goodwin* judgment lies in the way that the ECtHR was willing to extend the scope of Article 8 in relation to gender identity by subsuming it within the wider legal issue of human dignity and personal autonomy and by the willingness of the ECtHR to depart from medical and scientific knowledge as determinative of the rights of transsexuals before the law. As Chapter One showed the medical model of transsexualism and the state of medical and scientific knowledge is in constant flux and, even in 2015, some 13 years after the *Goodwin* judgment it remains impossible to state that there is consensus from the medical profession in relation to the aetiology of transsexualism. Had the ECtHR continued to rely on this lack of consensus in *Goodwin* the rights of transsexuals in the UK to legal recognition would not have been achieved. So, although *Goodwin* was a limited judgment in that it only referred to post-operative transsexuals it was transformative in that it enabled the possibility of the emergence of a model of gender identity recognition in law which is based on strong human rights principles and not reliant on the medical model of transsexualism.

[531] ibid [55].

The approach taken by the ECtHR in *Goodwin* indicated a fundamental shift in the thinking and approach of the ECtHR and, as this chapter has shown, this had a huge influence on the UK domestic courts which used *Goodwin* in the following years to determine cases based on domestic legal provisions. Although *Goodwin* did not directly change the law it led to the House of Lords in *Bellinger* issuing a declaration of incompatibility between domestic marriage law and the ECHR. This was all that the House of Lords could do in this case because it was felt by the Court in *Bellinger* that reforming the law in relation to this issue was not for the courts to determine but rather it ought to be left to Parliament to determine because reform impact on so many different areas of life and law and also it was not appropriate for courts to determine at which point a person could be considered to have changed sex Later other UK courts used *Goodwin* in the context of employment protections. The issue for UK law following *Goodwin* was that it was unclear at which point on the transition process the law had to treat a transsexual individual as a member of the opposite sex. *Goodwin* was a particularly easy case to decide as the applicant had undergone full medical transition from male to female so it was easy for the Court to acknowledge that she was female. The same is true of all of the other transsexual applicants before the ECtHR as outlined in Chapter Two, they were all post-operative transsexuals therefore they posed no problem for the law in determining whether or not they had reached this elusive point at which they could be deemed to have changed sex and therefore there was a continuing challenge for UK law.

The following chapter will examine how the law was reformed following the *Goodwin* decision and it will be noted that the UK legislature opted to take an approach which firmly reinforced the idea that transsexual identity is a result of a medical condition and in so doing gave particularly strong gatekeeper roles to medical professionals and the Gender Recognition Panel.

4. The Gender Recognition Act 2004

Introduction

The previous two chapters outlined how transsexualism emerged as a medical condition and how, when transsexual individuals underwent medical procedures to alleviate the impact that the condition had on them and then sought legal recognition of their transition, law consistently refused to acknowledge the physical changes they had undergone. As a result of the European Court of Human Rights judgment in *Goodwin v United Kingdom*[532] and the House of Lords judgment in *Bellinger v Bellinger*[533] the Gender Recognition Act 2004 (GRA 2004) was enacted; this was an attempt to provide legal recognition and protection to transsexuals across the UK. This chapter explores the GRA 2004 and outlines the main provisions in the legislation. The purpose of this chapter is to show how the UK Government chose to protect and recognise transsexuals in UK law. The chapter begins by considering how the GRA 2004 was ground-breaking when it was enacted because of the quite radical approach taken by the legislature in not requiring individuals to undergo any form of body modification prior to being able to access the protections in the legislation; in effect then legislating to ensure that it was one's gender identity which would be recognised and protected rather than one's physical body. The chapter then considers exactly how the legislation provides for legal protection and recognition through outlining the mechanism by which such is provided: the Gender Recognition Certificate (GRC). Once the GRC has been examined the chapter then explores the exceptions which are contained in the legislation to show in which situations the UK Government intended that the GRC should have no legal consequence. In doing this the chapter will, until this point, have shown how the UK Government intended to meet their human rights obligations to transsexual applicants. The chapter then explores how the GRA 2004 works particularly the process by which one obtains a GRC firstly by examining the requirement that applicants apply to a panel, the Gender Recognition Panel (GRP). As the GRP determine whether or not to grant GRCs it is important that the composition and function of this panel is examined in detail. The GRP has, as will be shown below, the ability to progress or halt an applicant's quest for legal recognition of their gender identity therefore they are crucial to the determination of whether one will obtain recognition of their gender identity. The chapter then explores the specific grounds upon which one can apply for a GRC and the

[532] *Goodwin* (n 15).
[533] [2003] UKHL 21, [2003] 2 AC 467.

criteria which have to be established before a GRC can be issued by the GRP as well as the appeals process for those who have been unsuccessful in their application.

Background to the GRA 2004

As was shown towards the end of the previous chapter, the UK Government was effectively forced into introducing legislation to recognise a person's change of sex by the European ECtHR in *Goodwin*[534] and by the House of Lords in *Bellinger*.[535] Therefore, it may be tempting to argue that the legislation was a rushed response to the decisions of these courts. However this would be inaccurate. As noted in Chapter Two the UK had been tasked by the ECtHR, since the 1980s, with keeping the legal position of transsexuals under review. So, in 1999, before the decisions in *Goodwin* and *Bellinger,* an Interdepartmental Working Group was established to consider how the law ought to respond to transsexual individuals. The group reported in early 2000. In considering the options available to UK Government ministers the group identified three possibilities: (i) to do nothing, (ii) to issue new birth certificates which would show the individual's "new name and possibly sex",[536] and (iii) to allow full legal recognition of one's gender.[537] The group did not consider maintaining the status quo to be a real option but rather focussed on the other two options which could provide some means of achieving legal recognition to transsexuals. On the option of issuing new birth certificates the Working Group noted that it was often possible to obtain new driving licences and passports but not birth certificates.[538] Which meant that the individual may be seen by others as a member of the opposite sex by means of hormonal and/or surgical intervention but this physical transition was not reflected in all official documents. The most important legal document, because it determined *legal* sex and therefore how the law interacts with the individual – the birth certificate, did not reflect the physical changes that the individuals had undergone. Therefore, as noted by the Working Group, this disparity between *physical* appearance and *legal* sex could "lead to embarrassment when [post-operative transsexuals] are required to produce a birth certificate, for example before taking up employment."[539] So, the options were to offer a short birth certificate which reflected change of name but with no mention of sex or to show both name and new sex. The problem with taking this approach was that it would enable the individual to have a form of their birth certificate which recognised

[534] *Goodwin* (n 15).
[535] [2003] UKHL 21, [2003] 2 AC 467.
[536] Home Office *Report of the Interdepartmental Working Group on Transsexual People* (2000) 5
[537] ibid.
[538] ibid 19.
[539] ibid.

their new name but it would not constitute a change of legal sex as "they would still for all legal purposes be of their birth sex as recorded on the full certificate."[540]

The issue of providing transsexuals with a new birth certificate was thought to not be particularly easy in that it would require primary legislation to effect.[541] Issuing a short birth certificate:

> might, in some circumstances, save transsexual people some embarrassment. But unless this carried with it recognition for some or all legal purposes it would not do much to relieve their underlying concerns.[542]

It was thought that issuing an amended short birth certificate would amount to a 'half-way house' which would provide recognition in some circumstances but not in others thereby leading to confusion and uncertainty for transsexuals and those interacting with them.[543] Therefore the Working Group explored the third option – granting full legal recognition to transsexuals. Full recognition would mean that "after fulfilling certain conditions, a transsexual person would be entitled to be treated as belonging to their acquired gender for all purposes."[544] In terms of providing legal recognition of a change of sex the Working Group was of the opinion that there would need to be a formal stage when recognition would be given and noted that this could be achieved by means of an appropriate Court order "which defined the date and process from which the applicant acquired the new gender."[545]

As noted in Chapter Two one of the arguments against altering birth certificates was that they amounted to a record of historical fact.[546] The Working Group referred to this by stating that after the Court order which would enable re-registration of the individual by the Registrar General "the transsexual person would be treated as of their acquired gender for all purposes, but *there would be no rewriting of history*".[547] It was also noted that to be granted such a Court order legislation would be required which outlined the criteria for the making of such an order.[548]

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[540] ibid.
[541] ibid.
[542] ibid.
[543] ibid.
[544] ibid.
[545] ibid 20.
[546] See page 81.
[547] Home Office (n 398) 20 (emphasis added).
[548] ibid.

Regarding the criteria needed before a Court order would be granted, the Working Group considered that there were three potential stages: firstly where the person was living in the new gender role; secondly where the individual had undergone hormone treatment and thirdly where the individual had undergone surgery.[549] The concern with the first option was although it accorded with the then practice of HM Passport Office and of the DVLA in issuing new documents when a transsexual individual had been living in the new gender role, it meant that there was a "significant chance that some people will revert to their birth gender"[550] and also that "the person concerned will [at that point] still bear most of the characteristics of their birth sex."[551] If the Court order was granted at the point of hormonal intervention then the individual's body would, by this point, "have at least some physical characteristics of the opposite gender".[552] One of the factors which seemed to be important to the Working Group was that at this stage, although the individual would retain some characteristics of birth sex, they would be "unlikely to be able to have children."[553] The likelihood of the individual reverting to birth gender at this point was also reduced.[554] In relation to waiting until after surgery before granting legal recognition it was noted that not all individuals can undergo the surgical interventions necessary. However the clear benefit of adopting this stage as the prerequisite for legal recognition was that the individual "will have clear physical attributes of the opposite gender."[555] This indicated that how a person looks was important to those making the law as was the idea that the change should be a permanent change from one sex to the other as at this stage "[t]here is a reasonable expectation that the change of gender will be permanent, although the possibility of a reversion to the birth sex cannot be ruled out."[556] What was clearly coming though in the Working Group's considerations was not only the interests of transsexual individuals but also how they interact with others: the ability to become a parent, the issue of looking like the sex which the law deems one to be and the question of reversion to birth sex. These issues will be returned to in the remaining chapters of this thesis as inherently this is a debate about how the law balances the rights of individuals with the rights of third parties.

[549] ibid.
[550] ibid.
[551] ibid.
[552] ibid.
[553] ibid.
[554] ibid.
[555] ibid.
[556] ibid.

The interests of third parties argument can be seen in relation to the pre-conditions of recognition. Firstly the Working Group considered whether or not individuals ought to be sterile prior to achieving legal recognition. At the time the Working Group was considering this the requirement for sterility was a pre-condition in 29 Council of Europe member states.[557] To ensure sterility the various laws in these states required that individuals undergo medical procedures which may not be medically necessary and which the individual may not wish to undergo. In considering whether or not to require sterility the Working Group noted the argument put forward by the transsexual community that such a requirement would be discriminatory to those who, for whatever reason, could not undergo the medical procedures required.[558] Interestingly, though, the Working Group states that:

> [t]he transsexual community's concern about discrimination has, however, to be set against the great concern which would be felt by the general public if someone who was legally a man gave birth to a child or someone who was legally a woman became the father of one.[559]

By making this statement the Working Group was once again raising the interests of third parties and the importance of public perception in relation to transsexual legal recognition. The Working Group also considered amending the laws relating to surrogacy and assisted reproduction, for example by suggesting that any stored gametes would also have to be destroyed prior to the individual obtaining legal recognition so as to avoid the situation of having a legal mother who was also that same child's biological father.[560] In order to avoid same-sex marriage the Working Group suggested ensuring that prior subsisting marriages be ended before one of the parties obtained legal recognition. To not require the ending of a marriage before legal recognition is given would, in effect, legalise same-sex marriages for a small number of people while excluding the great majority. [561]

Although the Working Group considered the various issues surrounding affording legal recognition of a change of sex and identified three possible options for the Government, it

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[557] Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Greece, Iceland, Italy, Latvia, Malta, Moldova, Montenegro, the Netherlands, Norway, Poland, Romania, San Marino, Serbia, Slovakia, Sweden, certain Swiss cantons, Turkey and Ukraine. See Council of Europe *Discrimination on grounds of sexual orientation and gender identity in Europe* 2nd Ed. (Council of Europe Publishing, 2011). Although the report listed 29 states whereby the law required an individual to be sterile prior to obtaining legal recognition of their gender identity the law in Sweden has since been reformed and it is no longer a requirement in Sweden that the applicant become sterile as has the law in Denmark which has gone several steps further and demedicalised their model of gender identity recognition altogether.

[558] Home Office (n 398) 21.

[559] ibid.

[560] ibid.

[561] Home Office *Report of the Interdepartmental Working Group on Transsexual People* (2000) 22.

did not recommend one option over any other and no progress was actually made to reform the law based on the work of this group until after the decision in *Goodwin* was handed down. The Working Group was reconvened in June 2002 as it was thought that this was the "best way to achieve comprehensive consideration of the wide range of such issues, which affect the policy responsibilities of a number of other Government departments and of the devolved administrations."[562] This reflects the opinion of Nicol, who argues that had this area of law been reformed by means of judicial decisions then it would have been piecemeal and unsatisfactory,[563] and of Lord Nicholls in *Bellinger*.[564] Reforming this area of law by means of legislation would allow for comprehensive consideration of all of the issues which would be impacted by such reform and on 13 December 2002 the UK Government announced its intention to publish such legislation to enable legal recognition of transsexuals. The legislation would give transsexual individuals the right to be legally considered a member of the sex opposite to his or her birth sex from the date at which legal recognition occurred;[565] the legislation would not have retrospective effect and therefore would not affect rights and obligations which occurred prior to legal recognition e.g. in relation to parentage.

In highlighting the process for obtaining a legal change of sex Rosie Winterton MP introduced the idea of a model of recognition which relied upon third party input, namely the medical profession, when she stated:

> [c]hanging legal identity is a serious step, with significant consequences. It is important that no-one should embark upon formal recognition in the acquired gender without convincing evidence. We will therefore propose that applications should be scrutinised by an authorising body, *given legal powers to assess medical evidence before the transsexual person is allowed to register in the new gender*. In some cases, where the person undertook [sex re-assignment] years earlier, and has lived successfully in the acquired gender, that assessment may be straightforward. In other cases, the authorising body will need to be assured that, *in addition to meeting medical criteria*, the transsexual person has lived successfully in the acquired gender for at least two years. *The medical criteria may include medical treatments to modify the person's sexual characteristics*, but the Government will not require surgery as a condition of registration in the acquired gender.[566]

[562] Department for Constitutional Affairs Transsexual People Update August 2002.
[563] Nicol (n 530).
[564] *Bellinger* (n 498).
[565] <www.dca.gov.uk/constitution/transsex/statement.htm> accessed 11 September 2013.
[566] ibid (emphasis added).

One of the issues before the UK courts in the early cases: *X, Petitioner*[567] and *Corbett v Corbett*,[568] was that birth certificates could not be altered because they were records of historical fact, a position with which the ECtHR agreed in *Rees v United Kingdom*,[569] *Cossey v United Kingdom*[570] and *Sheffield and Horsham v United Kingdom*[571] all of which were discussed in Chapter Two. To acknowledge this but also provide a means of recognition in law Winterton noted that the new law did:

> not intend history to be re-written. Original birth records will remain in existence, unamended, and will continue to be made available when needed. But the authorising body will empower the Registrar General to create a new record in relation to the transsexual person, from which a new certificate stating acquired name and gender may be drawn. This certificate will be indistinguishable from a birth certificate, in order to remedy the breaches of Article 8 identified by the European Court of Human Rights. The link between the original and the revised record will remain confidential within the Registrar General's office.[572]

In her final statement justifying the new legislation Winterton noted that the proposed legislation:

> will enable transsexual people confidently to take up those rights which have been denied to them in society - including the right to marry in their acquired gender - while preserving other obligations entered into in the original gender.[573]

The legislation was introduced in the House of Lords in 2003 and was given Royal Assent on 1 July 2004.

Ground-breaking legislation

Cowan has claimed, that the GRA 2004 "embodies what could be termed groundbreaking reform"[574] and Jeffreys described the Act as a piece of radical legislation.[575] The GRA 2004 was indeed in some senses at least ground-breaking and radical because, according to Sharpe, when it was passed it located "the UK at the forefront of global transgender law reform."[576] Whereas the UK was traditionally one of the most resistant of all EU states to

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[567] *X, Petitioner* (n 186).
[568] *Corbett* (n 198).
[569] *Rees* (n 15).
[570] *Cossey* (n 15) .
[571] *Sheffield and Horsham* (n 15).
[572] <www.dca.gov.uk/constitution/transsex/statement.htm> accessed 29 August 2013.
[573] ibid.
[574] Cowan (n 2) 247.
[575] Jeffreys (fn 1) 328.
[576] Sharpe (n 200) 37.

legislate to recognise transsexuals' change of birth sex, the GRA 2004, at the time, placed the UK in "pole position among progressive states willing to legally recognise the sex claims of transgender people."[577] The reason it was ground-breaking was that it required no body modification prior to obtaining a legal change of sex.

The GRA 2004 separates gender identity from one's physical sex by not requiring any body modifications prior to applying for legal recognition of gender identity. This places the UK as one of merely a handful[578] of European states which takes this approach. For example, of the 38[579] European states which provides legal mechanisms for individuals to change their gender on official documents 23 require that the individual first undergo compulsory sterilisation[580] and 20 require that the individual undergo surgical procedures.[581] The approach taken in the GRA 2004 recognises that not everyone is medically able to undergo such procedures nor is everyone willing to do so should they be a possibility. In addition to this though, one of the most important aspects of the GRA 2004 is that it recognises, in theory at least, that one's gender identity is not necessarily linked to how one appears to others, or indeed to how one presents oneself. What the GRA 2004 does is acknowledge that what is being recognised in law is not one's body but one's sense of self as male or female; however as will be shown in this chapter and in subsequent chapters the GRA 2004 is confused in its approach to recognising gender identity because of the specific provisions in the legislation which essentially require third party intervention which is designed to 'test' the applicant's sense of themselves as male or female and to prove that the individual seeking legal recognition is really transsexual.

The Gender Recognition Panel

The GRA 2004 works by establishing a panel, the Gender Recognition Panel (GRP), which determines applications to change the applicants' legal sex to correspond with their gender identity. According to the Joint Human Rights Committee (JHRC) the GRP is one of the

[577] ibid 33.
[578] 18 European states do not require some form of medical intervention designed to alter one's body either through compulsory sterilisation or surgery.
[579] Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Czech republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Moldova, Montenegro, Netherlands, Norway, Poland, Portugal, Romania, Russia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, Ukraine and United Kingdom.
[580] Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Czech Republic, Finland, France, Greece, Ital, Latvia, Lithuania, Luxembourg, Montenegro, Norway, Romania, Russia, Slovakia, Slovenia, Switzerland, Turkey and Ukraine.
[581] Azerbaijan, Belgium, Bosnia and Herzegovina, Bulgaria, Czech Republic, France, Greece, Italy, Latvia, Lithuania, Luxembourg, Montenegro, Norway, Poland, Romania, Slovakia, Slovenia, Switzerland, Turkey, Ukraine.

essential elements in the scheme of legal gender recognition in the UK.[582] Membership of the GRP is outlined in the GRA 2004 sch.1 paragraph 1(2) and (3) which provides that members are appointed by the Lord Chancellor and have to be either legally or medically qualified. There must be at least one medically qualified member and one legally qualified member on each panel determining applications. In relation to medical qualifications, sch.1 para 1(2)(b) provides that the medical member must be a registered medical practitioner or a registered psychologist. In relation to legal members, sch.1 para 1(3) outlines the qualifications required: "a person who has a 7 year general qualification within the meaning of section 71 of the Courts and Legal Services Act 1990,"[583] "an advocate or solicitor in Scotland of at least seven years' standing,"[584] and "a member of the Bar of Northern Ireland or solicitor of the Supreme Court of Northern Ireland of at least seven years' standing."[585] As such the GRP is in reality a medico-legal tribunal[586] which is tasked with examining the evidence to determine whether or not the applicant is entitled to a change of *legal* sex. The GRP does not base its decision on an evaluation of the applicant's physical sex but rather whether or not the individual meets the requirements in the legislation to change their legal sex.

The Gender Recognition Certificate

The GRC is the document which changes an applicant's legal sex. Section 4 provides that if the application is successful and the GRP is satisfied that the applicant meets the requirements for a GRC then the GRP *must* grant a GRC.[587] In general the panel will issue a full GRC,[588] although the possibility exists to issue an interim GRC.[589] Whether or not the applicant is granted a full or interim GRC depends on his or her marital/civil partnership status and it is important to determine the difference between full and interim GRCs because s.9(1) provides that:

> [w]here a full gender recognition certificate is issued to a person, the person's gender becomes for all purposes the acquired gender (so that if the acquired gender is the male gender, the person's sex becomes that of a man and, if it is the female gender, the person's sex becomes that of a woman.

[582] Joint Committee on Human Rights *Draft Gender Recognition Bill*, 20 November 2003 HL Paper 188-I & II, HC 1276-I & II; [52].
[583] GRA 2004 sch.1 para 1(3)(a).
[584] ibid sch.1 para 1(3)(b).
[585] ibid sch.1 para 1(3)(c).
[586] R Sandland 'Running to stand still' (2009) *Social & Legal Studies* 18(2):253-257; 255.
[587] GRA 2004 s.4(1).
[588] ibid s.4.
[589] ibid s.4(3).

It is the possession of a full GRC which allows individuals to have their gender identity recognised and for their legal status as male or female to flow from this gender identity. The difference between a full and an interim certificate is important for the individuals involved because it is only the full GRC which changes the person's legal sex. The interim certificate is of no real legal value in terms of the person's right to have his or her gender identity recognised[590] as he or she remains the sex they were registered as after birth. An applicant will be issued with a full GRC if he or she is nether married or in a civil partnership.[591] In addition the GRC will be a full certificate if the applicant is in a protected marriage and his or her spouse consents to the marriage continuing[592] or the applicant is in a protected civil partnership and the GRP has decided to issue a full gender recognition certificate to the other party to the civil partnership.[593] An interim GRC will be issued in all other circumstances.

Exceptions

Although s.9 provides that once an individual has a full GRC his legal sex is the sex opposite to the one registered on birth there are some exceptions to this rule contained in the legislation itself. Section 12 provides that a GRC does not affect parenthood status of the applicant. For example if a male-to-female (MTF) transsexual fathers children prior to obtaining a GRC she[594] will remain the child's father notwithstanding that she is now legally female and if a Female-to-Male (FTM) transsexual is the mother of a child prior to obtaining a GRC then he will remain the child's mother notwithstanding that he is now legally male. Section 15 makes provision in relation to succession and states that "[t]he fact that a person's gender has become the acquired gender under this Act does not affect the disposal or devolution of property under a will or other instrument made before the appointed day."[595] Therefore if a parent of an older female child and a younger male child made provision in his or her will to leave everything to their firstborn son and the female child then obtained a GRC he would not be entitled to claim the estate as firstborn son. Section 16 provides exceptions in relation to peerages *etc.* The impact of s.16 is that the GRC "does not affect the descent of any peerage or dignity or title of honour."[596] In the

[590] However it does enable the marriage or civil partnership to be terminated.
[591] GRA 2004 s.4(2)(a) in England and Wales and s.4(1A) in Scotland.
[592] ibid s.4(2)(b).
[593] ibid s.4(2)(c).
[594] It is appropriate to use female pronouns in this context because the applicant, although being born and registered as male, now has a female legal identity to correspond with her female psychological gender identity.
[595] GRA 2004 s.15.
[596] ibid s.16(a).

Act as enacted s.19 provided for exemptions in relation to sport. Section 19 enabled sporting bodies regulating gender-affected sports[597] to prohibit or restrict the participation of those in receipt of a GRC[598] where such prohibition on restriction was "necessary to secure (a) fair competition,[599] or (b) the safety of competitors."[600] Section 19 was repealed by the Equality Act 2010 Sch. 27(1) para. 1. The sport exception in the GRA 2004 s.19 was replaced by a similar exception in s.195 of the Equality Act 2010.[601] Section 20 of the GRA 2004 provides exceptions for gender-specific offences.

So the premise behind the legislation is quite straight-forward: an individual who identifies as a member of the sex opposite to his or her birth sex can apply for a certificate which, subject to certain very specific exceptions, will legally change his or her legal sex for all purposes. However, the process of obtaining a GRC is complex and technical and not all individuals who identify as transsexual will obtain the certificate and consequent legal recognition as the remainder of this chapter will explore. The GRA 2004 places very strict boundaries around who is able to obtain a GRC and consequently who is able to benefit from the rights and protections contained in the legislation therefore it is important that the process of applying for a GRC is examined.

Making an application for a GRC

Those seeking legal recognition must satisfy a number of conditions contained in the legislation.[602] The GRA 2004 s.1 provides that a person aged 18 or over may apply to the GRP for a GRC. This provision is potentially problematic in itself as it means that there is an age based restriction on applying for a GRC. However, notwithstanding the minimum age requirement, the Act has been utilised successfully by a considerable number of individuals. Data on applications has been kept since financial year 2004/05 and so it is possible to provide a detailed picture of how many applications have been considered, how

[597] Gender-affected sport was defined in s.19(4): "[a] sport is a gender-affected sport if the physical strength, stamina or physique of average persons of one gender would put them at a disadvantage to an average person of the other gender as competitors in events involving the sport.
[598] GRA 2004 s.19(1).
[599] ibid s.19(2)(a).
[600] ibid s.19(2)(b).
[601] For a discussion of s.19 as enacted see D McArdle 'Swallows and Amazons, or the sporting exception to the gender recognition act' (2008) *Social & Legal Studies* 17(1):39-57; P Charlish 'Gender Recognition Act 2004: Transsexuals in Sport – A Level Playing Field?' (2005) *International Sports Law Review* 5(2):38-42.
[602] A N Sharpe 'Gender recognition in the UK: a great leap forward' (2009) *Social & Legal Studies* 18(2):241-245, 243.

many were successful and how many have been refused.[603] This data is presented in table 1 below:

Table 1: applications dealt with by the Gender Recognition Panel, since inception

Time Period	Applications Received	Outcome of Application Dealt with				
		Total applications dealt with	Full GRC granted	Interim GRC granted	Refused	Application withdrawn
2004/05	395	0	0	0	0	0
2005/06	991	1253	1181	33	21	18
2006/07	690	588	532	22	23	11
2007/08	293	448	392	24	27	5
2008/09	278	274	241	25	8	0
2009/10	286	273	239	16	15	3
2010/11	303	317	260	17	28	12
2011/12	320	308	264	11	23	10
2012/13	301	278	237	9	15	17
2013/14	311	371	318	16	20	17

There is no information available for the outcomes of applications in financial year 2004/05 in the table above because the Act was not yet in force and therefore no applications were determined in that financial year, although they were able to be commenced. Other than a rise in applications in financial years 2005/06 and 2006/07 the number of applications received each year has remained relatively steady. The rise in applications in 2005/06 and 2006/07 can be explained by the fact that these were the first few years that the Act was in force and therefore there would have been a spike in applications in these years as individuals took advantage of the new opportunity to apply for legal recognition. So, as can be seen from table 1 above, the Act has enabled a substantial amount of people to seek legal recognition of their gender identity.

Applications for a GRC are based on one of two criteria: either "living in the other gender"[604] or "having changed gender under the law of a country or territory outside the

[603] Please note that the most recent data available is until the end of financial year 2013/14.
[604] GRA 2004 s.1(1)(a).

United Kingdom"[605] The two types of application are called the standard track application which corresponds to s.1(1)(a) and the overseas track application which corresponds to s.1(1)(b). The list of approved countries or territories can be found in the Gender Recognition (Approved Countries and Territories) Order 2011.

In relation to the type of application being made the majority, as would be expected, are of the standard track type.[606] These two types of application were in addition to the temporary fast-track procedure for individuals who had transitioned several years before the legislation came into force. The purpose of the fast-track procedure was to enable those post-operative transsexuals such as those outlined in the previous chapter to bypass the normal legal requirements in the legislation and obtain legal recognition on the basis that they had physically transitioned from one sex to the other. Such individuals would presumably be able to meet the other criteria in the legislation which is outlined below without the need to provide the level of evidence required by the legislation.

It should be remembered that each of these applications relates to an individual seeking legal recognition of his or her gender identity. Therefore it is important to know how many of the applications are successful and how many fail. If the information in Table 1 above is analysed it can be shown that of the 4,110 applications which were dealt with by the GRP between the first quarter of financial year 2005/06 (Q1 2005/06) and the end of Q4 2013/14), 3,664 applications resulted in a full GRC being granted (89.15%), 173 resulted in an interim GRC being granted (4.21%), 180 applications were refused (4.38%) and 93 applications (2.26%) were withdrawn by the applicants. If this is broken down further it can be seen that the numbers of full GRCs being granted has dropped since the Act first came into force. In addition the percentage of applications resulting in interim GRCs being issued has remained relatively low. The data outlined above is interesting and highlights that a significant percentage of those who apply for GRCs obtain them and therefore are given the opportunity to have their gender identity recognised and protected by UK law. However some are not successful. Despite the fact that 93.37% of applications resulted in either a full or interim GRC being issued and therefore arguably the legislation is a success it is the 4.38% of applications which were rejected that is most important for this thesis: for each rejected application there is a corresponding individual who has not been able to achieve legal recognition of his or her gender identity.

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[605] ibid s.1(1)(b).
[606] This is the type of application based on establishing that one has or has had GD *etc.*

Arguably then the legislation has mostly been a success in that it has enabled a considerable number of people to obtain legal recognition of their gender identity, however this thesis seeks not to argue that the legislation has not been a success for many individuals but rather that it could be better. Although the number of applications which are successful, i.e. result in either a full or interim GRC being issued, is high there remains the possibility within the legislation that applications will not succeed. There is also the possibility that the provisions within the legislation itself may prevent individuals from even being able to make an application thereby impacting on the ability of those individuals to have their gender identity recognised and protected in UK law. Further, these provisions may play a part in individuals withdrawing applications or being deterred from making an application in the first place, although such concerns are difficult to establish. An examination of the statistics in relation to applications alongside the relevant statutory provisions will highlight problems with the success of applications under the legislation as it currently exists. As was noted above of the 4110 applications 4.38% of applications were refused. Although this percentage is small it represents 180 real individuals who have, for whatever reason, been unable to access the protections and rights in the GRA 2004. One can surmise that those whose applications were refused failed to meet the evidentiary requirements outlined in the legislation, however it is not possible to say for certain because reasons for refusal of GRCs is not publically available. Therefore it is important to examine the specific criteria required beginning with those in s.2 of the GRA 2004.

Criteria to be satisfied before GRC can be issued

Looking at the criteria in detail, determination of the application depends on which type of application the individual is making.[607] If the applicant has applied for legal recognition of his gender identity under s.1(1)(a)[608] then s.2(1) provides that the GRP must grant the application if they are satisfied that the applicant:

> (a) has or has had gender dysphoria;
> (b) has lived in the acquired gender throughout the period of two years ending with the date on which the application is made;
> (c) intends to continue to live in the acquired gender until death; and
> (d) complies with the requirements imposed by and under section 3.

[607] To recap a s.1(1)(a) application is made on the basis of living in the other gender and a s.1(1)(b) application is made on the basis of having changed sex under the law of a country or territory outwith the United Kingdom.
[608] Living in the other gender.

If the applicant is making his or her application under s.1(1)(b)[609] then under s.2(2) the panel must grant either a full or interim certificate if satisfied:

> (a) that the country or territory under the law of which the applicant has changed gender is an approved country or territory, and[610]
> (b) that the applicant complies with the requirements imposed under section 3.[611]

If, under s.1(1) the panel is not required to grant a certificate then it must reject the application.[612] Each of these criteria need to be examined in turn to highlight how the GRA 2004 operates and to show the burden placed on the individual making the application. As noted above the majority of applications are based on s.1(1)(a) – the standard-track application, and as such it is the criteria in s.2(1)(a)-(d) that will be considered as it is in s.2(1)(a)-(d) that one of the main problems of the legislation exists; the potential for a third party to derail an individual's quest for legal recognition of their gender identity.

Has or has had Gender Dysphoria (GD)

This is contained in s.2(1)(a) which provides that an application will be determined on the basis that the applicant has or has had GD and sections 3(1) and 3(2) which provide that in support of the application the applicant must include medical reports[613] which include details of the applicant's diagnosis with GD.[614]

The issue of having or having had GD appears, at first glance, to be quite straightforward as it would seem that all the applicant is required to do is provide the reports mentioned in s.3(1)(a) and (b). However, this provision was subject to considerable debate during pre-legislative scrutiny. During debate on the Bill, in an attempt to understand the phrase 'has had GD', a probing amendment was proposed. In response to which Dr Evan Harris stated that:

> [t]he treatment for gender dysphoria is [sex re-assignment]. It is perfectly possible for people to have had gender dysphoria that has been treated and dealt with by reassignment. Legal recognition is a separate issue and follows on from that process.[615]

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[609] Having changed gender under the law of a country or territory outside the United Kingdom.
[610] GRA 2004 s.2(2)(a).
[611] ibid s.2(2)(b).
[612] ibid s.2(3).
[613] ibid s.3(1).
[614] ibid s.3(2).
[615] SC Deb (A) 9 March 2004 cols 31-76 [41].

Mr David Lammy replied also:

> the Government included the words "or has had" to cover the situation of a person who was diagnosed with gender dysphoria and has since continued through the process, as we expect people to do to live fully in their acquired gender. As the person is now living fully in the acquired gender, it may not be accurate to say that the person has gender dysphoria. The gender dysphoria has been dealt with. In order to ensure that such a person could apply for recognition, the words "or has had" were included.[616]

Those individuals, according to David Lammy "will have moved beyond the GD that they had to a new life in an acquired gender, which they have had for many years."[617] As a result of this discussion it was clear that the phrase 'or has had' was intended to apply to those who have been treated for GD and who, consequently, may no longer 'have' GD and the amendment was withdrawn. It was this section which enabled the fast-track applications to be made as it relates to historical sex reassignment undergone by the applicant.

To have GD, as required by the legislation, also appears straight-forward: those who have gender dysphoria have been provided with a mechanism to change their legal status. However this very provision, alongside the provision outlined above, highlights that perhaps the legislation is not as straight-forward as it could be. If those who have undergone medical procedures to change their bodies can be said to no longer *have* gender dysphoria but rather *have had* it then to whom does the provision *have* GD apply? Presumably this would be those individuals who cannot yet be said to no longer have GD because they have taken steps to change their bodies to align with their gender identity therefore it must be those who have not yet achieved congruence of body and gender identity for whatever reason. This then begs the question of whether or not the legislation provides for not only those who seek to align mind and body through medical procedures but also those who do not? In addition to this, as outlined in Chapter One, GD is a diagnosable medical condition. The issues raised by this provision will be explored in detail in Chapter Five. Therefore it is clear from the parliamentary debates and the final legislation that one cannot seek legal recognition of one's gender identity in the UK without first having gone through the process of obtaining a diagnosis of GD at some point at least two years before making the application for recognition, see the second criteria discussed below. What this provision does is take control from the individual as he or she

[616] ibid [41].
[617] Ibid [41]-[42].

is unable to progress with their quest to have their gender identity recognised in law which has serious consequences for how the law and other people interact with him or her. However, obtaining a diagnosis is merely the first hurdle to be overcome. Should the individual be given such a diagnosis the GRP then has to be satisfied that the individual meets the other requirements in the legislation outlined below.

Has lived in the acquired gender for two years

Section 2(1)(b) places an obligation on individuals to have lived in the acquired gender for the two years immediately preceding the application. This in itself is intended to ensure that those making applications are fully committed to living as members of the opposite sex and ensures that applications are not made on a whim. However, the question of what it means to live as a member of the acquired gender is thus raised. As this is a decision which the GRP have to reach it therefore opens up space for discretion in deciding whether or not the applicant has met this requirement as it is a judgement to be made based on what the GRP believes it means to live as either male or female. This is another point in the legislation which seems straight-forward until it is examined. How does a panel, who do not personally know the applicant, determine whether or not the applicant has lived as a member of the opposite sex and to what extent will the panel members' notions of maleness and femaleness influence their decision making? This provision will be examined in depth in the following chapter as, as with the provision on having or having had GD, this is a point at which the individual's gender identity may not be given recognition in law.

Intends to live in acquired gender until death

Section 2(1)(c) requires that the individual must intend to live in the acquired gender until death. This amounts to a permanence requirement which will be discussed in depth in the following chapter because this provision is fairly easy to satisfy but arguably is impossible to enforce and does not accord with contemporary medical approaches to gender dysphoria.

Meets the evidentiary requirements in s.3

The evidence required to support an application for a GRC is contained in s.3. The evidence required to support standard track applications and overseas track applications is

slightly different. Section 3(1) – (3) stipulate the medical evidence which has to be provided to support an application under s.1(1)(1)(a). Such an application must be supported by:

> (a) a report made by a registered medical practitioner practising in the field of gender dysphoria and a report made by another registered medical practitioner (who may, but need not, practise in that field), [618] or
> (b) a report made by a registered psychologist practising in that field and a report made by a registered medical practitioner (who may, but need not, practise in that field). [619]

Section 3(2) provides that the reports outlined above must include "details of the diagnosis of the applicant's gender dysphoria."[620] Where the applicant is planning to undergo, has undergone or is undergoing medical procedures to modify their body at the time of making the application then the medical reports have to contain details of that treatment.[621] This may seem relatively unproblematic however as the recent case of *Carpenter v Secretary of State for Justice*[622] shows it is yet another potential stumbling block for those seeking legal recognition. Section 3(4) provides that applicants must provide a statutory declaration that they meet the requirements in s.2(1)(b) and (c) i.e. that they have lived in the acquired gender for two years immediately prior to the application and that they intend to live in the acquired gender until death. In addition applicants have to provide evidence in relation to their marital status under s.3(6)(a) which will vary depending on whether or not the applicant is domiciled in England and Wales or Scotland,[623] any other information or evidence required by the Secretary of State[624] and any other information or evidence required by the GRP.[625]

For overseas track applications the applicant need only provide evidence that they have changed gender under the law of an approved country or territory[626] and meet the requirements contained in s.3(6)(a)-(c) mentioned above.

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[618] GRA 2004 s.3(1)(a).
[619] ibid s.3(1)(b).
[620] ibid s.3(2).
[621] ibid s.3(3).
[622] [2015] EWHC 464 (Admin) to be discussed in depth in Chapter Five.
[623] These are relatively unproblematic for the purpose of this thesis therefore they will not be considered further.
[624] GRA 2004 s.3(6)(b).
[625] ibid s.3(6)(c).
[626] ibid s.3(5).

When the Bill was being debated the issue of evidence was raised and given considerable coverage. The main issue was that the evidence required by s.3 had a particular function; it is intended to "establish whether a person has taken decisive steps to live fully and permanently in their acquired gender" "[627] which, because there is no requirement for body modification in the legislation, requires to be proven in a different way. Had the legislation required some form of body modification, as some other European jurisdictions do, the issue of establishing their decision to live fully and permanently in their acquired gender would have been more straightforward in some respects.[628] The issue then becomes one of how to prove someone's intention without body modification and how to legislate for this.[629] The evidentiary requirements in s.3 then are intended to ensure that only transsexuals are provided with legal recognition of gender identity i.e. only those who have been diagnosed with GD and who seek to live fully and permanently as members of the sex opposite to their birth sex and this will be discussed in depth in the following chapter.

Appeals

The GRA 2004 provides a limited mechanism for appealing against a decision of the GRP to reject the application for a GRC. Section 8 provides that an applicant may appeal to the Family Division of the High Court or to the Court of Session on a point of law only.[630] The appeal must be held in private if the applicant so requests.[631] If the appeal is successful the court must either allow the appeal and issue the certificate which was applied for[632] or allow the appeal and refer the matter back to the same or a different panel for reconsideration[633] or dismiss the appeal.[634] If the appeal is dismissed then the applicant can reapply to the panel for a GRC under s.1(1) but only after a period of six months has passed since the date of rejection.[635] In addition to the limited right of appeal of the applicant there are mechanisms within s.8 to enable the Secretary of State, an applicant's spouse or civil partner to challenge the granting of a GRC, by means of an application to the High Court or Court of Session, if they consider that the GRC was obtained by means

[627] HL Deb 18 Dec 2003 vol. 655 cc1287-326 at [1289].
[628] The issue of alternative models of recognition will be returned to in Chapter Six.
[629] Joint Committee on Human Rights *Draft Gender Recognition Bill*, 20 November 2003 HL Paper 188-I & II, HC 1276-I & II at [64].
[630] GRA 2004 s.8(1).
[631] ibid s.8(2).
[632] ibid s.8(3)(a).
[633] ibid s.8(3)(b).
[634] ibid s.8(3)(c).
[635] ibid s.8(4).

of fraud.[636] If the case has been so referred based on any of the above provisions, then the court to which it was referred must either "quash or confirm the decision to grant the application"[637] and if the decision to grant the application for GRC is quashed then it "must revoke the gender recognition certificate issued."[638]

The acceptance of medical knowledge in the Gender Recognition Bill debates

Lord Filkin, in introducing the Gender Recognition Bill during the second reading in the Lords stated that in order to be able to apply for legal recognition of one's gender identity the "person must have or have had gender dysphoria, the recognised medical condition that drives a transsexual person to live in the opposite gender."[639] The emergence of transsexualism as a medical condition as outlined in Chapter One appears to have been wholly accepted by the majority of those debating the Gender Recognition Bill in both the House of Lords and the House of Commons where, it is clear from the Hansard records, that viewing transsexualism as a medical condition was not questioned other than by a few dissenting voices.[640] Therefore the position underpinning the GRA 2004 is that transsexualism, the desire to live as a member of the opposite sex to one's birth sex, is a result of a diagnosable and treatable medical condition: gender dysphoria. During the various debates and reports there were some minor doubts raised concerning the state of medical knowledge on transsexualism: those comments opposed were mainly by Lord Tebbit and Baroness O'Cathain. Lord Tebbit noted:

> there is a controversy in the world of medicine as to whether it is a medical or psychological condition. We also know that the world of medicine changes its mind quite frequently, sometimes in a spectacular fashion as we have seen recently in the press in relation to cases of infant cot deaths, and matters of that kind.[641]

This corresponds to the discussion contained in Chapter One regarding the emergence of transsexualism as a medical condition where it was noted that at various points in history there were sometimes, and still remain, competing opinions regarding the cause of transsexualism. The Government acknowledged the debate within medicine itself regarding the aetiology of transsexualism when it was said that:

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[636] ibid s.8(5), 8(5A) or 8(5B).
[637] ibid s.8(6)(a).
[638] ibid s.8(6)(b).
[639] HoL Deb 18 Dec 2003 col 1289.
[640] Namely Lord Tebbit.
[641] HoL Deb 29 Jan 2004 col 420.

> [c]learly, there are elements of the medical profession that maintain that there is no convincing evidence of a physiological cause for transsexualism and that to recognise the new gender is to pander to psychological delusion, as has been argued in this debate.[642]

This accords with the debate outlined in Chapter One. Lord Tebbit's comment above is useful, however, because it highlights that although there is an accepted medical understanding of transsexualism, this position is subject to developing medical knowledge and opinion, as is all medical knowledge which may be revisited following subsequent development in that field. Lord Chan also addressed this when he considered the state of medical knowledge and legal rights. In referring to a discussion regarding the aetiology of transsexualism Lord Chan outlined that there was no agreed aetiology, in line with the presentation of medical knowledge presented in Chapter One. As will be shown in Chapter Three the issue of aetiology was discussed by the ECtHR in *Goodwin* where it was determined that the lack of consensus surrounding aetiology was not a material factor in deciding the case. Therefore it is clear that there does not need to be a known aetiology or indeed consensus surrounding aetiology for a condition to be accepted as a medical condition and treatment protocols developed. Lord Chan observed that it was an accepted medical condition albeit that:

> [m]ore medical research is needed into transsexual people in order to provide them with appropriate support. The Gender Recognition Bill assumes that the condition is already a discrete and clearly agreed medical condition, which is not the case.[643]

In addition it was noted that although the aetiology of transsexualism could not be conclusively determined by the medical profession this did not preclude the possibility of providing legal recognition to such individuals. As noted above the decision in *Goodwin v United Kingdom*[644] was referred to as enabling legal developments notwithstanding the that there was some uncertainty within medicine because in *Goodwin* the:

> European Court of Human Rights took the view that the continuing debate over the nature and aetiology of transsexualism should no longer stand in the way of transsexual people enjoying their human rights as others do."[645]

In the debates, Lord Carlile of Berriew largely dismissed the lack of certainty about aetiology as irrelevant. He stated:

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[642] HoL Deb 18 Dec 2003 col 1325; Grand Committee Report 13 Jan 2004 GC4.
[643] HoL Deb 18 Dec 2003 col 1308.
[644] *Goodwin* (n 15).
[645] HoL Deb 18 Dec 2003 col 1325.

> I say to those who feel uncomfortable about this proposed legislation that we are talking about a rights issue and a medical issue. When I started my involvement in these matters people used to ask me whether it was a psychological matter, a somatic matter, a psychosomatic matter or something else, as if one could pigeon-hole gender dysphoria as akin to measles (a physical illness) on the one hand or schizophrenia (a mental illness) on the other hand. After 20 years of research into this matter and a huge amount of reading, one cannot pigeon-hole this condition in any particular way. It is a whole person, whole body condition."[646]

However the dissenting voices, although very important, were in the minority and it was reinforced throughout the debates that this was a Bill which was intended to protect the rights of those who had been diagnosed with gender dysphoria: a treatable medical condition regardless of its aetiology, focusing instead on the fact that it was a medical condition for which there was an accepted diagnosis and treatment process which enabled those with the medical condition to alleviate their dysphoria. In fact the words 'medical condition' appear regularly in the Hansard records. Baroness Hollis of Heigham stated that transsexualism "is a medical condition whereby a person feels driven to live in the opposite gender,"[647] Lord Marlesford stated that he "like other noble Lords, have great sympathy for those who suffer from the medical condition known as gender dysphoria."[648] Lynne Jones stated that "In this country, transsexual people have suffered from discrimination and fear of being exposed to ridicule because they suffer from a medical condition."[649] There was almost no challenge to the idea that transsexualism was a medical condition within these debates. David Lammy reinforced that the Bill was based on the belief that transsexualism was a result of a medical condition when he stated:

> [t[he Bill deals specifically with people with gender dysphoria who present themselves as having acquired a new gender because they are driven to that by the medical condition surrounding gender dysphoria. Gender dysphoria is, after all, a medical condition whereby a person feels driven to live in the opposite gender. To be reminded of the original gender, to be regularly confronted by it, and to have others knowing that one suffers from that medical condition and to know that they might be talking about it is not conducive to feeling secure and it makes it very difficult to live in the acquired gender in dignity.[650]

The question of aetiology was raised in the debates and Lord Carlile of Berriew largely dismissed this as irrelevant. He stated:

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[646] ibid 1300.
[647] HoL Deb 3 Feb 2004 col 665.
[648] HoL Deb 10 Feb 2004 col 1080.
[649] HoC Deb 25 May 2004 col 1528.
[650] HoC Deb 23 Feb 2004 col 55.

> I say to those who feel uncomfortable about this proposed legislation that we are talking about a rights issue and a medical issue. When I started my involvement in these matters people used to ask me whether it was a psychological matter, a somatic matter, a psychosomatic matter or something else, as if one could pigeon-hole gender dysphoria as akin to measles (a physical illness) on the one hand or schizophrenia (a mental illness) on the other hand. After 20 years of research into this matter and a huge amount of reading, one cannot pigeon-hole this condition in any particular way. It is a whole person, whole body condition."[651]

Clearly then the accepted position was that this Bill would address the difficulties faced by a small minority of individuals who could be said to suffer as a result of gender dysphoria. Lord Goodhart stated that:

> Gender dysphoria is a condition that causes enormous distress. We believe that the Bill will go some way—by no means the whole way—towards reducing that distress and will cause no foreseeable harm.[652]

The opinion of medical experts was referred to regularly throughout the debates as a means of defeating dissenting opinion. For example it was noted several times that the Chief Medical Officer recognises transsexualism as a medical condition therefore its acceptance at such a high level of office implies that it is wholly accepted by the medical profession and that treatment is provided by the state by means of the National Health Service.[653] In addition several times it was stated that esteemed medical organisations such as the BMA, the GMC, the Royal College of General Practitioners, the Royal College of Psychiatrists and the British Psychological Society had been involved in discussion of the Bill.[654] It would appear that the mention of these organisations was an attempt to give authority to the position underpinning the Bill that the Bill was only intended to provide legal recognition to those who could be deemed to have a diagnosable medical condition and not those who merely sought to live as members of the opposite sex through some form of lifestyle choice. David Lammy noted that the desire to live as a member of the opposite sex, "is not a choice according to the way in which we understand the word; it is a driven conviction because of a medical state"[655] and that the way in which the UK would seek to legislate to protect the rights of those in this position was by means of adopting the

[651] HoL Deb 18 Dec 2003 col 1300.
[652] ibid 1313.
[653] HoC Deb 23 Feb 2004 col 60; HoL Deb 18 Dec 2003 col 1323; HoL Deb 18 Dec 2003 col 1325; HoL Deb 29 Jan 2004 col 368; HoL Deb 29 Jan 2004 col 369; Grand Committee Report 13 Jan 2004 GC4; Standing Committee A 1st sitting col 26.
[654] HoL Deb 18 Dec 2003 col 1325; Grand Committee Report 13 Jan 2004 GC4.
[655] Standing Committee A 1st sitting col 17.

accepted medical knowledge on transsexualism. David Lammy reinforced the fact that a medicalised approach to gender variance underpinned the legislation when he stated:

> the standards in the Bill to some extent mirror the Harry Benjamin standards, which are the standards of acquired practice among the medical professionals who practise in this area. Those standards require three planks: the person has begun the process of social change, of acquiring a new gender, and of dressing accordingly; they have hormone treatment and other treatments; ultimately, they have surgical treatment if it is viable.[656]

The discussion in the Hansard records, mirrors, to some extent, the focus of law in the cases concerning transsexual individuals where there has often been a tension between medical knowledge and practice, and legal rights. Although medicine has developed to such an extent the condition, GD, is well established and treatment has been developed to ease the dysphoria experienced by such individuals the law has taken a slightly different approach and determined that all that is required is a diagnosis of GD and that there is no requirement on the individual to progress with any medical treatment.

Is the GRA 2004 still ground-breaking?

Although, as noted at the beginning of this chapter the GRA 2004 was considered ground-breaking legislation when it was enacted the UK is no longer at the global forefront of transsexual legal recognition. Since the 2004 Act was enacted Argentina, Colombia, Denmark, Ireland and Malta have all passed more progressive legislation which, it will be argued in Chapter Six, are not based on the medical model of transsexualism. Each of these approaches will be discussed in detail in Chapter Six. Arguably, then, the UK means of providing legal recognition of gender identity is now already outdated and in need of reform. It is argued in this thesis that a primary reason it is in need for reform is because UK law is dependent on the medical model of transsexualism which was in existence in 2004.

Conclusion

This chapter provided an overview of the GRA 2004, the subject of examination of this thesis, and in doing so showed how one obtains legal recognition of one's gender identity in UK law. What is clear from the provisions contained in the Act is that the legislation is heavily based on a medical model of transsexualism: evidenced by the requirement for a

[656] ibid 19.

diagnosis of GD, the medico-legal nature of the GRP, and the requirement for medical evidence. It is clear from this Act that the legislature sought to devise a means of testing individuals' claim to be transsexual; the very nature of the GRA 2004 is to ensure that only those who are truly transsexual can obtain a change of legal sex and that there should be no possibility of individuals choosing to change sex otherwise. The following chapter explores how the gatekeeper role given to both the medical profession, via the requirement of a diagnosis, and the GRP, via the obligation to scrutinise applications and evidence, works in practice and outlines the consequences for those who are unable to achieve legal recognition of their gender identity under the GRA 2004.

5. Problems which arise as a result of the legislation adopting a medical model of transsexualism as its basis for legal recognition of gender

Introduction

In the quest to show that the Gender Recognition Act 2004 (GRA 2004) is flawed because it adopts a medical model of transsexualism as its foundation and therefore could be reformed to ensure a better way of providing legal recognition of one's gender identity the thesis, thus far, has examined a variety of different factors such as the emergence of transsexualism as a medical condition, the law's response to those who sought legal recognition of sex reassignment procedures and the GRA 2004 itself which showed how the medical model of transsexualism underpins the GRA 2004. This chapter examines the specific problems which arise as a result of the UK Government adopting this approach as the basis for the provision of legal rights and protections in the GRA 2004. There are three main problems with the legislation adopting this model; two of which relate to gatekeeper roles inherent within the legislative provisions and one relates to the currency of the legislation as medical knowledge surrounding transsexualism, gender identity and indeed Gender Dysphoria (GD) develops. This chapter will begin by providing an overview of why the Government took the approach it did in enacting the GRA 2004 and then it will examine all three problems caused by this approach: the gatekeeper function of the medical professionals which exists in the provision that one obtains a diagnosis of GD before being eligible to make an application to the Gender Recognition Panel (GRP); the gatekeeper role of the GRP itself which has the possibility to deny applications which, in its opinion, fail to meet the legislative requirements and thirdly the changing medical knowledge surrounding gender variance. It is argued in this chapter that each of these approaches and developments undermines the GRA 2004 as the most appropriate means of providing legal recognition of one's gender.

Why did the Government take this approach?

There was considerable debate surrounding the Gender Recognition Bill when it passed though the Lords and Commons.[657] Central to these debates were a number of themes such

[657] For details see <http:// http://hansard.millbanksystems.com/bills/gender-recognition-bill> accessed 29 October 2015.

as the need to ensure certainty regarding an individual's status in law,[658] the need to avoid same sex marriage,[659] the need to ensure the protection of rights and interests of third parties[660] *etc*. Each of these concerns is important in its own right, however for the specific purpose of this thesis it is the requirement to ensure certainty of legal sex which is the most important as it is primarily this concern which gave rise to the gatekeeper function of medical professionals and the GRP. On the requirement for certainty of sex in law the Joint Human Rights Committee (JHRC) noted that:

> [i]t is reasonable for the Government to take the view that there needs to be a degree of certainty about people's genders. Gender will affect the legal status and a variety of other rights and obligations. Certainty is also needed to protect the interests and rights of people who have dealings, either administratively or in the course of personal relationships, with the person whose acquired gender is to be recognised.[661]

Therefore certainty underpins the other concerns mentioned above i.e. avoiding same sex marriage, rights and interests of others *etc.* According to the JHRC the legislation achieves certainty in two main ways: firstly by means of having a panel determine applications and secondly by the strict statutory criteria to be taken into consideration by the panel.[662] One of the primary concerns regarding recognition of gender without the requirement to alter one's body was that it might lead to a process of legal recognition of lifestyle choice or frivolous applications.[663] However, the idea that an individual would 'flit back and forth' between male and female as a result of the non-requirement for body modification was considered to be unlikely if there was a panel because they would not issue certificates to such individuals seeking to make lifestyle changes.[664]

So the panel, and the legislative criteria of which the panel require to be satisfied, are central to the operation of the GRA 2004 and also to ensuring that individuals who apply for GRCs are truly transsexual because this allows the law to be certain as to their sex as sex within the UK remains a legally important category, although to some extent the

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[658] Joint Committee on Human Rights *Draft Gender Recognition Bill,* 20 November 2003 HL Paper 188-I & II, HC 1276-I & II [29]-[52], HL Deb 13 January 2004 vol. 657 cc 1-62GC [58]-[60], HL Deb 29 January 2004 vol 656 cc357-436 [378]-[379], SC Deb (A) 9 March 2004 cols 3-30 [15]-[22].

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[660] HL Deb 18 Dec 2003 vol. 655 cc1287-326, Joint Committee on Human Rights *Draft Gender Recognition Bill,* 20 November 2003 HL Paper 188-I & II, HC 1276-I & II [77], HL Deb 29 January 2004 vol 656 cc357-436, HC Deb 23 February 2004 vol 418 cc48-108.

[661] Joint Committee on Human Rights *Draft Gender Recognition Bill*, 20 November 2003 HL Paper 188-I & II, HC 1276-I & II [49].

[662] ibid [51].

[663] ibid [27].

[664] ibid [28].

importance of legal sex is diminishing.[665] However in attempting to ensure that the need for certainty, particularly in relation to ensuring only true transsexuals were able to change their legal sex, was met by means of a panel and strict legislative criteria the legislature has enacted a piece of legislation which has the result of placing the legal identity of transsexual individuals in the hands of third parties by creating particularly strong gatekeepers which will now be explored in depth.

Gatekeeping in the GRA 2004

Gatekeeping in the GRA 2004 occurs at two specific points in the individual's quest to have his or her gender recognised in law: at the point where the individual approaches the medical profession seeking to be diagnosed as transsexual and when he or she then applies for a GRC. This two-pronged gatekeeper approach in the GRA 2004 occurs as a result of the way in which the legislature approached the issue and ensures that only 'true' transsexuals are given legal recognition. This approach is problematic because, as discussed in the Introductory chapter to this thesis, gender identity is one's deeply held sense of being male or female and, as will be discussed below, there is no way of conclusively determining, medically, whether or not the person's self-declared gender identity is accurate other than by asking him or her and measuring their response against various criteria. So if the only way of actually determining someone else's gender identity is to ask them then why should there be a means built into to the legislation to then deny that person's self-declaration?

Gatekeeping by medical professionals: the requirement for diagnosis

The gatekeeping function of the medical professional is strong in the GRA 2004 because, as Cowan argues, "the Act firmly and statutorily anchors the transsexual person within the realm of medical expertise".[666] The medical role is reinforced in the legislation by means of sections 2 and 3 of the Act. Therefore without the support of medical professionals initially providing a diagnosis of GD and then later providing medical reports, an individual cannot obtain legal recognition of his or her gender identity.

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[665] For example in *Corbett* sex was considered an essential aspect of the legal relationship of marriage i.e. one couple only marry someone of the opposite sex. This is no longer the case as a result of the Marriage and Civil Partnership (Scotland) Act 2014 and the Marriage (Same Sex Couples) Act 2013. Indeed there is also a provision in the Human Fertilisation and Embryology Act 2008 which creates the category of legal parent which applies to the same sex partner of a woman who undergoes assisted conception so to some extent the legal concept of parentage is changing.

[666] Cowan (n 2) 248.

This approach, primarily the requirement for a diagnosis, places the applicant in the position of being dependent upon the medical professional accepting his or her narrative and measuring it against the expected narrative of what it means to be transsexual; part of which includes ensuring that the individual's narrative matches the diagnostic criteria. Therefore the medical professionals working with transsexual patients are the first judges of one's gender identity and the patient is measured against what is deemed 'normal' – normal gender identity *and* normal transsexual identity thus establishing the medical professionals as the initial gatekeepers of legal identity and this role, which is not part of their professional remit, is problematic: Whittle *et al* argue that the requirement that transsexual individuals engage with the medical profession as a means of realising their identities:

> places trans people in a position with healthcare providers which has all the hallmarks of a difficult relationship: power and control; desire and need coupled with vulnerability; pathologisation and protocol.[667]

This therefore highlights concerns over the power dynamics inherent within the doctor/patient relationship in which the individual seeking legal recognition of his or her gender identity is at the mercy of the medical professional making the required diagnosis. In addition to this concern, there is extensive literature which questions the attitudes and knowledge of medical professionals who work with transsexual patients and healthcare providers' training in relation to this medical condition.[668] All of these factors influence how the medical gatekeeper role works in practice. This in turn influences an individual's ability to fulfil the diagnostic stage and therefore, by implication, impact on his or her ability to progress to the application for legal recognition because without a diagnosis of GD the individual cannot, unless he or she changes sex in a country or territory approved by the Gender Recognition (Approved Countries and Territories) Order 2011 and subsequently makes an application for a GRC under s.1(1)(b) of the GRA 2004, even initiate an application for a GRC as he or she would not be able to provide the evidence required by s.3 to support such an application. So how does one obtain a diagnosis of GD

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[667] S Whittle, L Turner, R Combs and S Rhodes *Transgender EuroStudy: Legal Survey and Focus on the Transgender Experiences of Health Care* (IlGA Europe 2008) 13.

[668] See: P Blunden and J Dale 'Gender Dysphoria: time for positive thinking: People with issues about their gender identity are often vulnerable to the attitudes of those around them' (2009) *Mental Health Practice* 12(7):16-19; E Lombardi 'Enhancing transgender health care' (2001) *American Journal of Public Health* 91(6):869-872; L R Franzini and D L Casinelli 'Health professionals' factual knowledge and changing attitudes toward transsexuals' (1986) *Social Science & Medicine* 22(5):535-539; L Kelley, C L Chou, S L Dibble 'A Critical Intervention in Lesbian, Gay, Bisexual, and Transgender Health: Knowledge and Attitude Outcomes Among Second-Year Medical Students' (2008) *Teaching and Learning in Medicine: An International Journal* 20(3):248-253.

in the UK? To answer this the different processes in the NHS in each of the UK jurisdictions must be considered because even before one can obtain a diagnosis of GD one required to have access to those who provide the diagnosis and as the following section will highlight this is not always easy.

NHS Treatment Protocols and Guidelines

The NHS in Scotland, England, and Wales has devised various treatment protocols and guidelines which apply to transsexual patients. The creation of these protocols and guidelines can be seen as a positive commitment of the NHS to providing specialist services to transsexual individuals. This is a positive step because in 2007 the issue of transsexuals' interaction with the NHS formed part of a report compiled by Whittle *et al* which found that there was "strong evidence that access to good healthcare for trans people [was] sporadic in the UK."[669] Whittle *et al* also highlighted the fact that 25% of their respondents felt that they had been refused treatment because the medical practitioner treating them did not approve of sex re-assignment.[670] Since the publication of the Whittle *et al* report it can be argued that the care of transsexuals based in the UK has been developing for the better. Over the past few years the Department of Health (DoH) has produced a number of publications on this topic, from the detail and number of such publications, it can be seen that this is an area that the DoH takes seriously.[671] Wylie notes one of the important developments in relation to treatment of transsexuals in the UK is that "[i]n recent years there has been a move away from one national centralised specialist service for gender dysphoria in the UK to the gradual introduction and development of regional services."[672] This is important as regional care and support services can offer "greater convenience for patients and also allows for an increase in the overall number of patients being referred and seeking help for gender dysphoria."[673] There are regional centres in Leicester, Leeds, Nottingham, Sheffield, Plymouth, Northampton, Newcastle/Sunderland, Glasgow, Edinburgh and Belfast.[674] The provision of treatment in Scotland is specifically governed by the NHS Scotland Gender Reassignment Protocol, in

[669] Whittle, Turner and Al-Alami (n 12) 24.
[670] Whittle, Turner, Combs and Rhodes (n 668) 10.
[671] See for example: *Trans: A Practical Guide of the NHS* (DoH, 2008); *Reducing Health Inequalities for Lesbian, Gay, Bisexual and Trans People* (DoH, 2007); *Working with Lesbian, Gay, Bisexual and Trans (LGBT) People* (DoH 2007) *Trans People's Health* (DoH 2007); *NHS Funding Processes and Waiting Times for Adult Service-Users* (DoH 2008).
[672] K Wylie 'New Standards of Care for People with Gender Dysphoria' (2008) *Mental Health in Family Medicine* 5: 71-73, 71.
[673] ibid.
[674] ibid.

England by the Interim Gender Dysphoria Protocol & Service Guideline 2013/14 and in Wales by the Specialised Adult Gender Identity Services policy which will now be explored in detail because how the NHS in the UK deals with transsexual patients has an impact on the ability of those individuals to access the rights and protections in the legislation because of the way that the legislation was framed by requiring a diagnosis of GD as one of the main criteria to be established before an applicant can make an application for a GRC.

NHS Scotland Gender Reassignment Protocol

Under the NHS Scotland Gender Reassignment Protocol (GR Protocol) a patient may present to his or her General Practitioner (GP) who is then required to refer the patient to a Gender Identity Clinic (GIC). Alternatively, within the Scottish GR Protocol, a patient may self-refer to a GIC. The GIC then assesses the patient. The purpose of this first assessment (Assessment 1) is to determine whether or not the patient has GD. The result of Assessment 1 can be threefold: (i) that GD is diagnosed; (ii) is not diagnosed; or (iii) that a diagnosis is uncertain. If GD is not diagnosed then the patient is discharged from the care of the GIC or referred onwards for further support. If the diagnosis is uncertain then the patient is given additional support at the GIC and a later diagnosis may be obtained. If, after further support from the GIC, the patient is not diagnosed then the patient is discharged or referred onwards for further support. If during Assessment 1 a diagnosis of GD is made, or a subsequent diagnosis made following initial uncertainty, then treatment possibilities are to be discussed with the patient and an agreement is sought from the patient regarding participation in a 12 month preoperative real life experience (RLE).[675]

The NHS England Interim Gender Dysphoria Protocol & Service Guideline 2013/14

Following the publication of the NHS Scotland GR Protocol in July 2012 the NHS in England began work on an equivalent protocol specific for patients in England. The NHS England Interim Gender Dysphoria Protocol & Service Guideline was accepted by the Clinical Priorities Advisory Group on 12 July 2013 and is largely based on the Scottish GR Protocol and is intended to be read alongside the UK Intercollegiate *Good Practice*

[675] As this stage considers treatment options it will not be discussed as it is outwith the scope of this thesis which is concerned with the pre-treatment stage i.e. access to services and obtaining a diagnosis.

Guidelines for the Assessment and Treatment of Adults with Gender Dysphoria[676] (the Good Practice Guidelines) The initial stages of presenting for diagnosis within the English Protocol are largely the same as in the Scottish one however one difference exists between the Protocols in relation to the referral process: in England the patient must be referred either by a GP, psychologist, psychiatrist or sexual health service via a GP.[677] There is no mechanism for self-referral to a GIC. This makes the process of accessing GICs in England more problematic than in Scotland and is a huge potential stumbling block for English domiciled patients because as the Good Practice Guidelines state "[t]he support of a GP who is prepared to be proactive in supporting referrals for treatment and to enter into collaborative care arrangements is essential."[678] Without the support of the GP the patient in England cannot progress through the process. Once the patient in England has been referred to a GIC, by whatever means, to the specialist gender service for diagnosis the process is the same as outlined above in relation to the Scottish Protocol.

NHS Northern Ireland

Diagnosis and treatment of transsexuals in Northern Ireland is dealt with at the Brackenburn Clinic in Belfast and individuals cannot self-refer to this clinic but must rather seek a referral from their GP or mental health professional. The Brackenburn Clinic does not have their own protocol as such but rather follow the Good Practice Guidelines[679] and, as such, the support of the patient's GP is crucial to the individual being able to access the specialist services provided by the clinic.

NHS Wales Specialised Adult Gender Identity Services

Following a report in 2011 the NHS in Wales developed a policy which would outline how transsexual patients were to be diagnosed and treated; the Specialised Adult Gender Identity Services policy.[680] This policy outlines that diagnosis and treatment will be provided by the NHS in England, specifically the West London Mental Health NHS Trust GIC. However the most important aspect of the policy for the purpose of this thesis is that an individual cannot self-refer to the GIC but rather a referral has to be made by the individual's GP to a local NHS Consultant Psychiatrist who will "consider whether the

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[676] Royal College of Psychiatrists *Good Practice Guidelines for the Assessment and Treatment of Adults with Gender Dysphoria* (Royal College of Psychiatrists 2012).
[677] ibid 7.
[678] ibid 17.
[679] <www.rcpsych.ac.uk/files/pdfversion/CR181.pdf > accessed 01 September 2015.
[680] <www.wales.nhs.uk/sites3/Documents/898/Specialies%20Services%20Policy%20Gender%20Services%20CP21%20Approved%20120925.pdf > accessed 02 September 2015.

patient has a diagnosis of GD and/or whether the patient also has any other form of mental disorder."[681] However the NHS Wales policy is very open about the gatekeeper role of the medical professional in this process. Once the Consultant Psychiatrist determines that the patient is ready for further assessment and treatment he or she refers the patient to the "designated gatekeeper within their Local Health Board"[682] whose role it is "to ensure that the referring consultant psychiatrist has made a diagnosis of gender dysphoria and that the referral meets the agreed criteria."[683] There are seven Local Health Boards in Wales and each have one named clinical gatekeeper.[684] Therefore it is the gatekeeper's role to check the diagnosis and also check that the referral meets the required criteria.[685] The NHS Wales system of referral is the most complex system in the UK and the one which has the most potential to derail an individual's quest for legal recognition of his or her gender identity because it is the one with the most approval stages before the patient actually meets anyone from the GIC. Once the gatekeeper is satisfied that the Consultant Psychiatrist's diagnosis and referral are ok he or she approves the referral and then forwards it on for authorisation by the Welsh Health Specialised Services Committee (WHSSC) who will, if they authorise the referral, notify the Consultant Psychiatrist that it has been so approved and that he or she can proceed with the referral to the GIC in London.

The Protocols and guidelines discussed above are entirely focussed on providing access to medical services, access to specialist medical practitioners and ensuring best practice in terms of the diagnosis and treatment of GD patients, they are not intended to fit within the current legislation on recognition of gender identity in any way. This conflation of legal and medical has introduced the first hurdle for those seeking legal recognition of their gender identity: being referred for a diagnosis, although in Scotland as a result of the mechanism for self-referral this is not a large issue. However the requirements in the English Protocol, the Welsh policy and the approach taken in Northern Ireland for referral to a specialist may well be a significant problem for such individuals should they not be supported by their GP or other medical professional who can make such a referral. Therefore what the GRA 2004 does is establish that the medical profession are gatekeepers of recognition of gender identity and this, I argue, is a result of the way that gender identity has been conceptualised as a medical issue, as outlined in Chapter One, as the test

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[681] <http://www.wales.nhs.uk/sites3/Documents/898/Specialies%20Services%20Policy%20Gender%20Services%20CP21%20Approved%20120925.pdf> (CP 21) accessed 27 October 2015, 14.
[682] ibid.
[683] ibid.
[684] ibid 26.
[685] ibid 15.

established in the legislation is to ensure that only 'true' transsexuals obtain legal recognition of their gender identity while excluding all others…and indeed excluding some who would seek to live permanently as a member of the opposite sex but, for whatever reason, cannot satisfy the requirements in the GRA 2004.

As has been already outlined in this thesis elsewhere, and will be shown further below, gender identity is something which cannot be objectively measured or determined but rather it is the individual's deeply held belief about himself or herself. Often the individual will seek to have his or her gender identity recognised by others by means of altering his or her body to conform to how they experience their gender as male or female or they will seek to have it recognised in terms of their legal identity and status or both. Therefore how one is seen by others and classified by the law has a huge impact on that person's sense of self and mental wellbeing. The purpose of the medical approach to transsexuals is to ensure that the individual is able to take the steps necessary to achieve a sense of congruence between mind and body in whatever way is best for the patient i.e. through no physical treatment, through hormone treatment alone, or through a combination of hormone and surgical treatment; the aim is to achieve the best means of treating the patient, assuming that the patient's medical condition requires, and indeed is also suitable for, such treatment. However the medical approach to treating the patient has to be separate from the process of providing legal recognition of one's gender identity because the medical approach is about ensuring that no harm is done to the patient and so the NHS protocols and policies were never intended to form part of the process of obtaining legal recognition of gender identity. Whereas it may be appropriate to have gatekeepers in medicine to ensure that an appropriate diagnosis has been provided or funding is in place to pay for treatment such gatekeepers are not required in law and merely operate as a barrier to be overcome by the individual in their quest for recognition of their internally experienced sense of self as male or female. However, the legislature opted to enact a system which provides that medical professionals have a legal gatekeeping role by means of requiring that the individual obtain a diagnosis of GD at least two years prior to making their application for a GRC and so, although I argue that this role is unnecessary, as Chapter Six will show when alternative models of providing legal recognition of gender identity are explored, it is now necessary to show how the legal gatekeeper role of medical professionals operates in practice and the impact that this could have on applications for GRCs because in the current system there is no mechanism for an individual to assert his

or her own gender identity free from medical input and to seek to have this recognised by law and this need not be the approach taken by UK law.

Why require a diagnosis of Gender Dysphoria (GD)?

The starting point in critiquing the diagnostic requirement in the legislation is to try to understand why it is there. In justifying requiring a diagnosis Mr David Lammy stated that:

> [t]he diagnosis of a specialist is essential because a specialist will know the diagnosis criteria well, apply recognised standards of care and have experience of dealing with a range of patients—those who are certainly gender dysphoric, those who are borderline and those who are not gender dysphoric.[686]

It is clear from the statement above that the role of the medical professional is to determine whether or not the patient is suffering from GD and if so whether or not he or she can be considered transsexual i.e. to distinguish between those who have a medical condition which results in their gender identity being different from that which corresponds with their physical sex and those who merely seek to make a lifestyle decision to change their legal sex. The requirement for a diagnosis is problematic because the law provides legal rights and protections to those who can satisfy medical professionals and not to those who cannot. Due to the lack of a physiological diagnostic test for GD and transsexualism, mental health professionals have had to devise alternative means of identifying the condition which are largely derived from psychiatry. As a result of the importance placed on the diagnosis in the legislation it is crucial to explore how the diagnostic process works. The psychiatrist or psychologist must diagnose the patient during the process of what is known as the 'clinical interview'.

Obtaining a diagnosis: the Clinical Interview

In the clinical interview, the diagnosis is a differential one which is made by examining the patient's narrative against the requirements of the diagnostic criteria in the DSM 5 and ICD-10 and excluding possible alternative diagnoses. In DSM 5 the diagnostic criteria for GD in adolescents and adults is contained in code 302.85 which provides that in order to diagnose there must be "[a] marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration."[687] In addition there must be two of the following present:

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[686] SC Deb (A) 9 March 2004 cols 3-30 [26].

[687] American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* 5th Edition (American Psychiatric Association 2013); Code 302.85 A.

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics […].[688]
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender […].[689]
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.[690]
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).[691]
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).[692]
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).[693]

In addition to the above it is noted that "[t]he condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning."[694] If the individual has a comorbid disorder of sexual development e.g. congenital adrenal hyperplasia or the like then this must be coded alongside the diagnosis for GD: therefore a diagnosis of a comorbid physical condition may not necessarily, according to the DSM 5, negate a diagnosis of GD. However, it might and for that reason comorbidity and paraphilias will be examined below. The thing that distinguishes GD patients from other gender non-conforming patients is the level of distress and impairment experienced by GD patients.[695]

Within the ICD-10 "disorders of gender identity are classified as disorders of adult personality and behaviour."[696] Gender Identity Disorders are contained in diagnostic code F64 with F64.0 specifically addressing transsexualism. Within code F64.0 transsexualism is characterised by a:

> [d]esire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make one's body as congruent as possible with one's preferred sex through surgery and hormonal treatment.

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[688] ibid Code 302.85 A1.
[689] ibid Code 302.85 A2.
[690] ibid Code 302.85 A3.
[691] ibid Code 302.85 A4.
[692] ibid Code 302.85 A5.
[693] ibid Code 302.85 A6.
[694] ibid Code 302.85 B.
[695] ibid 458.
[696] J Barrett 'Diagnosis' in J Barrett (ed.) *Transsexual and Other Disorders of Gender Identity: a practical guide to management* (Radcliffe Publishing 2007) 17.

This desire must be one which is persistently present for at least two years[697] and which is "[n]ot a symptom of another mental disorder, such as schizophrenia, or associated with chromosome abnormality."[698] In addition code F.64.1 provides for a disorder labelled as 'Dual-role Transvestism' which is distinct from transsexualism and is marked by "[w]earing clothes of the opposite sex in order to experience temporarily membership of the opposite sex."[699] For a diagnosis of dual-role transvestism there must be the absence of any sexual motivation for the cross-dressing[700] and an absence of any desire to change permanently into the opposite sex.[701] This is substantially the same as the criteria contained in the in DSM 5 as outlined below.

As part of the diagnostic process physiological tests are carried out prior to, or indeed, alongside the psychological testing to determine that there is no underlying physiological cause for the dysphoria experienced by the patient.[702] These physiological and psychological tests form part of the important diagnostic process of separating the true transsexual from those who cannot be so labelled but the consequence of s.2 and s.3 of the GRA 2004 is that this diagnostic process has the potential to impact on the individual's legal rights. The medical profession is, here, concerned with differentiating between 'true' transsexuals and pseudotranssexuals – as though such a differentiation can be made. The true transsexual is someone whose gender identity occurs not as a result of any other underlying physiological or psychological medical condition or abnormality whereas the pseudotranssexual's gender identity can be attributed to an underlying factor and therefore be said to not truly be the individual's identity; the true transsexual is diagnosed and treated and can access the provisions in the GRA 2004 whereas the pseudotranssexual is refused a diagnosis, cannot obtain any form of treatment for GD and cannot access the GRA 2004 but rather he or she may be offered alternative treatment or psychological support the aim of which would be to treat their underlying 'condition'. The problem is that there is a clear possibility of mis/non-diagnosis which will then impact on the individual's ability to achieve legal rights and protections because of how the legislation was drafted.

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[697] World Health Organisation *International Statistical Classification of Diseases and Related Health Problems* 10th Revision [online version]; F64.0B.
[698] ibid F64.0C.
[699] ibid F64.1A.
[700] ibid F64.1B.
[701] ibid F64.1C.
[702] S A Speer and C Parsons 'Gatekeeping gender: some features of the use of hypothetical questions in the psychiatric assessment of transsexual patients' 2006 *Discourse and Society* 17(6):785-812, 786.

The physiological tests which are carried out alongside the clinical interview are based on the premise that gender variance occurs only as a result of an abnormality of either physiology or psychology. This medical approach is a result of the research which was carried out during the twentieth century, as was outlined in Chapter One. During the clinical interview, the psychiatrist or psychologist may work with a "standardized patient interview protocol",[703] however this is not obligatory. James Barrett, Consultant Psychiatrist at Charing Cross Gender Identity Clinic, London provides an overview of the initial diagnostic interview process.[704] He notes that generally it is useful to work through a set of predetermined questions which explore all facets of the patient's life. Generally speaking, the goal of the clinical interview is to:

> document the history of the patient's gender identity struggles from their 'first awareness', to examine their motivations for hormones and sex change, and to explore whether they have realistic expectations for the future.[705]

It is within the patient/doctor interview where the patient's narrative is interpreted and "filtered through [the doctor's] accumulated experience and matched against [the doctor's] stored memory of the transsexual phenomenon, and the diagnosis is then formulated."[706] During this stage Barrett notes that it is important to determine whether any family members are "gay, cross-dress or have a gender identity disorder"[707] because, he claims, GD/transsexualism can run in families. In addition to this, according to Barrett, if there are family members who are homosexual, transvestite or have GD/transsexualism then this may be indicative of chromosomal or hormonal abnormalities such as partial androgen insensitivity syndrome which need to be explored and ruled out before the patient is diagnosed with GD/transsexualism.

As noted above there is no definitive test; rather the decision to treat the patient is often taken based on the 'balance of probabilities' principle"[708] i.e. on the balance of all of the medical evidence from the tests carried out to identify alternative causes of the patient's gender identity, the patient's narrative and the identification of any comorbid psychiatric or paraphilic conditions the patient is probably suffering from GD rather than some other medical condition; this may be a hard test to satisfy. These comorbid and paraphilic

[703] ibid.
[704] Barrett (n 697).
[705] Speer and Parsons (n 703) 786.
[706] Bower (n 142) 1.
[707] Barrett (n 697) 11.
[708] Bower (n 142) 1.

conditions need to be explored in depth as, I would argue, it is the potential for one of these conditions to be present which is most likely to derail the quest for a diagnosis of GD and disrupt the individual's quest for legal recognition under the GRA 2004.

Comorbidity

As noted above, comorbid conditions have the potential to derail the quest for a diagnosis of GD/transsexualism. In 2003 á Campo *et al* noted that in relation to comorbidity "[t]he question arises as to what extent gender identity can be reliably distinguished from a cross-gender identification that is secondary to other psychiatric disorders."[709] It is not unheard of for a patient to claim that he or she has GD or is transsexual when in fact he or she has a comorbid psychiatric disorder or physical condition which gives rise to the transsexual gender identity. In their study á Campo *et al* examined 584 reported cases of patients exhibiting symptoms of GD/transsexualism. They reported that:

> [i]n 225 (39%) of the 584 reported cases, [GD] was regarded as the primary diagnosis. For the remaining 359 patients (61%), cross-gender confusion occurred along with other psychiatric disorders, and in 270 (75%) of these 359 cases it was interpreted as secondary to other psychiatric illnesses.[710]

In addition to the above study Hepp *et al* conducted a study in 2003 seeking to assess the correlation between GID and comorbid psychiatric conditions and found that "[l]ifetime psychiatric co-morbidity in GID patients is high, and this should be taken into account in the assessment and treatment of GID patients."[711] Although the name of the condition has changed this statement by Hepp *et al* remains true. Therefore it is crucial that those making the diagnosis make the correct diagnosis so as not to misdiagnose and then mistreat those who are not transsexual. However conversely it is crucial that those who are transsexual but who also might have a comorbid condition are diagnosed and treated. Before further exploring the issue of comorbidity it is important to determine how this term will be used in this chapter. In psychiatry there is debate about the usefulness of the term.[712] The term

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[709] J á Campo, H Nijman, H Merckelbach and C Evers 'Psychiatric comorbidity of gender identity disorders: A survey among Dutch psychiatrists' (2003) *American Journal of Psychiatry* 160:1332-1336, 1332.
[710] ibid 1333.
[711] U Hepp, B Kraemer, U Schnyder, N Miller and A Delsignore (2003) 'Psychiatric comorbidity in gender identity disorder' *Journal of Psychosomatic Research* 58:259-261.
[712] See M Aragona 'The role of comorbidity in the crisis of the current psychiatric classification system' (2009) *Philosophy, Psychiatry & Psychology* 16(1):1-11 and P Zachar 'Psychiatric comorbidity: more than a Kuhnian anomaly' (2009) *Philosophy, Psychiatry & Psychology* 16(1): 13-22.

comorbidity was reportedly used for the first time by Feinstein in 1970[713] in relation to general medicine whereby the patient was diagnosed as having two or more medical conditions existing at the same time but which may or may not be independent of each other.[714] However despite the term originating in general medicine Maj argues that it:

> has recently become very fashionable in psychiatry to indicate not only those cases in which a patient receives both a psychiatric and a general medical diagnosis […], but also those cases in which a patient receives two or more psychiatric diagnoses.[715]

Maj argues that the:

> use of the term 'comorbidity' to indicate the concomitance of two or more psychiatric diagnoses appears incorrect because in most cases it is unclear whether the concomitant diagnoses actually reflect the presence of distinct clinical entities or refer to multiple manifestations of a single clinical entity.[716]

However despite this debate on the suitability of the term, it is used in the context of diagnosing GD and therefore it will continue to be used in this chapter. Comorbidity in the context of this chapter means merely *the existence of two or more psychiatric or medical conditions*. It must be noted that in some instances the comorbidity will prohibit a diagnosis of GD and in some it will not. It depends largely on the condition which has been diagnosed alongside the GD and whether or not it can be said that the GD has been caused by the comorbid condition or merely exists alongside it. This is a judgement which is made by the medical professionals and which is based on their clinical expertise. In the 2003 study by á Campo *et al* it was noted that "[o]ne hundred twenty-nine psychiatrists specified psychiatric comorbidity for their patients with [GD]."[717] Of those psychiatric comorbidities identified, "[c]omorbid personality disorders were reported by 102 (79%) of the 129 psychiatrists, major mood disorders by 34 (26%), dissociative disorders by 34 (26%), and psychotic disorders by 31 (24%)."[718] In addition to the á Campo *et al* and Hepp *et al* studies, in 1960 Edgerton *et al* found that 71% of patients presenting for sex re-assignment surgery were considered to have a psychological disorder including neurosis, personality

[713] A R Feinstein 'The pre-therapeutic classification of co-morbidity in chronic disease' (1970) *Journal of Chronic Disease* 23:455-468.
[714] M Maj 'Psychiatric comorbidity: an artefact of current diagnostic systems?' (2005) *British Journal of Psychiatry* 186(3):182-184.
[715] ibid 182.
[716] ibid.
[717] á Campo, Nijman, Merckelbach and Evers (n 710) 1333.
[718] ibid.

disorder or psychosis.[719] Meyer *et al* found that 50% of patients presenting for surgery had a psychological disorder and a further 46.66% expressed some tendency towards psychological disorder.[720] Hoening *et al* reported that 70% of transsexuals have a coexisting psychiatric disorder.[721]

One example of GD/transsexualism presenting alongside other psychiatric conditions is delusional pseudotranssexualism which occasionally accompanies schizophrenia. Although co-existence of true transsexualism and schizophrenia is unusual, it is not entirely unknown to the medical profession.[722] Patient delusions regarding the need for sex re-assignment are, according to Borras, present in 20-25% of the schizophrenic population.[723] The problem is that the medical professionals have to ensure that the schizophrenic patient is in fact truly transsexual *as well as* schizophrenic rather than presenting as transsexual as a result of delusional pseudotranssexualism derived from schizophrenia: the primary condition in this case. It would be inappropriate to diagnose such a patient with GD because the condition is merely a manifestation of a delusion caused by another psychiatric condition. The true transsexual who is diagnosed with schizophrenia may be denied recognition of their gender identity because of the belief that the desire to change one's body is a common facet of schizophrenia which occasionally results in male patients attempting self-castration.[724] Bower argues that in schizophrenic patients:

> delusions of belonging to the other sex are mistakenly thought to occur rarely. In my experience, schizophrenic patients presenting behind a mask of gender dysphoria not uncommonly apply for surgery.[725]

Psychiatrists have to rely on their expertise and experience to diagnose such patients accurately. The issue is that á Campo *et al* determined that "[i]n about half of the cases that were reported, cross-gender confusion was regarded as an epiphenomenon of other illnesses."[726] Therefore in about half of the reported cases the transsexual identity professed by the patient was considered to be caused by a comorbid condition. This in

[719] M Edgerton, W Jacobson and E Meyer 'Surgical-psychiatric study of patients seeking plastic (cosmetic) surgery' (1960) *British Journal of Plastic Surgery* 13: 136-145, 139.
[720] E Meyer, W Jacobson, M Edgerton and A Canter 'Motivational Patterns in patients seeking elective plastic surgery' (1960) *Psychosomatic Medicine* 22(3):193-201, 194.
[721] J Hoening, J Kenna and A Youd 'Social and economic aspects of transsexualism' (1970) *British Journal of Psychiatry* 117(537):163-172.
[722] L Borras, P Huguelet and A Eytan 'Delusional "Pseudotranssexualism" in Schizophrenia' (2007) *Psychiatry* 70(2):175-179, 176.
[723] ibid.
[724] ibid 177.
[725] Bower (n 142) 7.
[726] á Campo, Nijman, Merckelbach and Evers (n 710) 1334.

itself presents difficulties for those diagnosing the patient. Although the law is concerned with providing access to rights and recognition of one's gender identity the medical profession is concerned with providing treatment and care to these individuals. Once the issue of comorbid conditions has been considered and ruled out by the diagnosing clinician then it becomes necessary to explore whether the transsexual identity is a manifestation of a paraphilia.

Paraphilias

The DSM-IV distinguished between what could be termed 'classic transsexualism' and non-classic transsexualism', the difference being the presence or absence of paraphilias and this stance is maintained in the DSM 5. Although GD/transsexualism is not *per se* a paraphilia, certain paraphilias may present as GD/transsexualism and, as with comorbid psychiatric conditions or comorbid physiological conditions it is important that the diagnosing clinician correctly assesses the patient's narrative because, as with comorbidity the presence of a paraphilia may or may not preclude a diagnosis of GD/transsexualism: if the transsexual identity can be said to be an epiphenomenon of the paraphilia then no diagnosis of GD/transsexualism should be given, if however the transsexual identity merely co-exists with the paraphilia then this ought not preclude a diagnosis.

The ICD-10 is silent as to paraphilias and their impact on a diagnosis of transsexualism in code F64. However subsequent diagnostic codes indicate that paraphilias may need to be considered by the diagnosing clinicians. Code F65 deals with, what are termed, disorders of sexual preference which can be identified by "[r]ecurrent intense sexual urges and fantasies involving unusual objects or activities"[727] whereby the individual acts on these urges and fantasies or is "markedly distressed by them"[728] and which have been present for at least six months.[729] Disorders of sexual preference in the ICD-10 include fetishism (including fetishistic transvestism), exhibitionism, voyeurism, paedophilia and sadomasochism. However for the purpose of this chapter it is the disorder of sexual preference labelled fetishistic transvestism which will be focussed on because it is this sexual preference which might prevent an individual being diagnosed with transsexualism. According to Arcelus and Bouman:

[727] World Health Organisation (n 139) F65G1.
[728] ibid F65G2.
[729] ibid F65G3.

> [t]he fetishistic transvestite is a man (probably never a woman) who wears female clothes as fetish objects. The clothes are sexually arousing and wearing them usually leads to masturbation.[730]

This is reflected in the ICD-10 where, in addition to the general requirements of code F65, outlined above, being present the individual will be diagnosed with fetishistic transvestism if:

> [t]he wearing of articles or clothing of the opposite sex in order to create the appearance and feeling of being a member of the opposite sex and the cross-dressing is closely associated with sexual arousal.[731]

For fetishistic transsexuals the desire to cross-dress is purely sexual and is characterised by the fact that "[o]nce orgasm occurs and sexual arousal declines, there is a strong desire to remove the clothing."[732] Therefore, if a patient describes feelings of being aroused in the clothing of the sex opposite to his birth sex then he is likely to be considered to be describing transvestic fetishism rather than GD and such a declaration is likely to lead to a denial of GD.

In addition to transvestic fetishism in the ICD-10, the diagnostic criteria in the DSM 5 provide for a condition called transvestic disorder which is very similar to fetishistic transvestism contained in ICD-10. The DSM 5 criteria defines transvestic disorder as behaviour which:

> occurs in heterosexual (or bisexual) adolescent males (rarely in females) for whom cross-dressing behaviour generates sexual excitement and causes distress and/or impairment without drawing their primary gender into question.[733]

This is considered to be, therefore, a paraphilic disorder and one of the conditions of diagnosing transvestic disorder is that it must be specified whether it is accompanied with fetishism[734] or with autogynephilia.[735] So the DSM 5 makes it clear that the patient cannot obtain a diagnosis of GD if he is exhibiting evidence of autogynaephilia, which is defined

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[730] J Arcelus and W Bouman 'Gender Identity Disorder in a Child with a Family History of Cross-Dressing' (2000) *Sexual and Relationship Therapy* 15(4):407-411, 410.
[731] World Health Organisation (n 139) F65.1B.
[732] ibid F65.1C.
[733] American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* Fifth Edition (American Psychiatric Association 2013), 458.
[734] ibid 702: defined as being sexually aroused by fabrics, materials or garments.
[735] ibid; defined as being sexually aroused by thoughts or images of self as female.

as "love of oneself as a woman"[736] and occurs when the individual imagines himself as female, resulting in sexual arousal. This paraphilia may not be as rare as first appears, Bower argues that:

> [a]dults with gender identity disorder are at times sexually aroused by their cross-dressing activity and engage in masturbation. Decades ago this occurrence almost disqualified him or her from a diagnosis of transsexualism.[737]

A number of transsexual individuals may fall within this category and as such may not receive medical intervention. Individuals who exhibit any form of paraphilic behaviour which could be deemed to have 'caused' the transsexual identity are deemed unsuitable for diagnosis, notwithstanding that the transsexual's only means of arousal may be by imagining himself as a woman and by dressing as a woman, so it is arguable that it may not be appropriate always to deny a diagnosis of GD to individuals who exhibit this form of behaviour. Blanchard and Clemmensen are highly critical of the diagnostic criteria which treat transsexualism and paraphilia as mutually exclusive, suggesting that human sexuality is more complex than conceptualised in the DSM. Blanchard and Clemmensen's study suggests that the presence of paraphilia ought not to preclude treatment for GD[738] nevertheless the diagnostic manuals make it clear that paraphilic behaviour which could be deemed to 'cause' the transsexual identity preclude a diagnosis of GD/transsexualism and therefore have the ability to deny these individuals legal recognition of their gender identity under the GRA 2004.

The interpretation of the criteria established for diagnosing a patient in the DSM-5 and the ICD-10, and therefore whether or not the patient's narrative matches the diagnostic criteria, are largely open to the discretion of the diagnosing medical professional. If, in the opinion of the psychiatrist or psychologist, the patient matches the diagnostic criteria then he or she can be diagnosed as transsexual. Therefore the diagnosing clinician has a powerful gatekeeper role to play in the process of diagnosis. This then means that the first step in the process of legal recognition, obtaining a diagnosis, is crucial but uncertain as it is based on how the individual presents himself to the diagnosing physician and how that physician interprets the individual's story in line with an expected narrative which meets the DSM 5

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[736] R Blanchard 'Early History of the Concept of Autogynephilia' (2005) *Archives of Sexual Behaviour* 34(4):439-446, 439.

[737] H Bower (2001) 'The gender identity disorder in the DSM-IV classification: a critical evaluation' *Australian and New Zealand Journal of Psychiatry* 35(1):1-8, 2.

[738] R Blanchard and L H Clemmensen (1988) 'A test of the DSM-III-R's implicit assumption that fetishistic arousal and Gender Dysphoria are mutually exclusive.' *The Journal of Sex Research* 25(3):426-432.

or ICD-10 diagnostic criteria: there is little room for individuality within the diagnostic process and therefore this is an area of concern in the resultant GRA 2004. If the medical aspect of transsexualism and the legal aspect of providing legal recognition of one's gender identity were not so connected as they are in the GRA 2004 then the issue of comorbidity and paraphilias would be less important. A model of gender identity recognition which does not rely on the medical model of transsexualism as its basis will be proposed in the following chapter. This alternative model will be called the self-declaration model and will be outlined in detail in Chapter Six. The strength of this alternative model is that it does not rely on the individual obtaining a diagnosis of GD prior to seeking legal recognition of their gender identity and therefore does not require individuals to navigate the medical diagnostic process which comes with the detailed examination of the patient's life because the assumption underlying the self-declaration model would be that the individual himself or herself is best placed to know whether they identify as male or female. The question of how the law then ensures that only true transsexuals are able to align their gender identity with their legal sex is rendered unimportant because there is no need in the self-declaration model to distinguish between those who suffer as a result of a medical condition and those who seek to make a lifestyle choice based on how they perceive themselves; this will be returned to in the following chapter where it can be explored in more detail. However, at this point because the legal approach in the UK is very much dependent upon the medical professionals 'getting it right' at this stage in the process, the issue of comorbidity and paraphilia cannot be ignored.

Problems with basing legal rights and protections on clinical decision making

Medically the requirement for diagnosis is crucial but legally it is not. Within the legislation there is no need to undergo body modifications and there is no ban on making subsequent applications should the individual's sense of self as male or female change. It would therefore appear that the legislation is confused; it has taken aspects of the medical model of transsexualism and incorporated them into the process of providing legal recognition of one's gender identity but in so doing it has created a much more difficult process than was required. The desire to ensure that subsequent applications could be made to the GRP and the fact that there is no need to undergo any form of body modification show that on the one hand the legislation was seeking to ensure that lifestyle choices regarding gender identity could not impact on legal status and this was achieved by means of adding in the role of the medical profession but on the other the legislation appears to

take a very progressive approach to gender identity by acknowledging that how one identifies and how one presents oneself to others need not correspond and may change over time.

One of the main problems with the legislation, as has been argued, is the requirement for a diagnosis which, as is clear from the discussion above, is not an easy process and there are a number of instances at which the individual may be prevented from achieving the required diagnosis: by not being referred to specialist services if living in England, Wales or Northern Ireland; by not being able to access specialist services once referred or if self-referring due to the lack of specialist services in the UK. Even assuming the patient has been able to access GICs and get an appointment with a specialist, he or she may still be prevented from obtaining the diagnosis required by the GRA 2004 because his or her narrative may not meet that which the medical professional expects to hear or he or she may be diagnosed with alternative medical conditions, psychiatric conditions or paraphilias. Each of these stages represent the point at which a third party has the legal ability to prevent an individual from being able to assert his or her identity in law because without the diagnosis an application for a GRC cannot succeed. What is interesting in this is that the way that clinical decision making of the medical professionals would be exercised was never examined by the legislature during the debate stage of the GRB; it was merely accepted throughout the debates that the medical profession was best placed to make these decisions in relation to whether or not an individual has a diagnosable medical condition. That seems like a sensible approach to take until one begins to examine the medical profession's degree of acceptance of and interaction with patients who claim to be transsexual, the knowledge and understanding of medical professionals in relation to gender identity and transsexualism, and also how medical professionals make their decisions in clinical matters. The Whittle *et al* report mentioned above covered the issue of medical professionals' interaction with transsexual patients so it is not unknown that patients feel that they are not supported or believed by their GPs when initially presenting to them as transsexual. This has an impact, particularly in England, Wales and Northern Ireland, in relation to being referred to a specialist service. In addition, although patients in Scotland are protected from this stage by being able to self-refer to a GIC the patient must first know that he or she does not need to be referred by his or her GP and also the patient must be in a position to self-refer. Given that there are only two specialist centres in Scotland, both in the central belt, which provide services for gender variant patients then this in itself presents a barrier to many individuals. The issue of non-specialist medical

professionals not understanding transsexualism is also a problem if it relates to whether or not an individual is referred on for specialist diagnosis and treatment. One of the major difficulties with the law giving such a strong gatekeeper role to the medical profession relates to the issue of clinical decision making by those medical professionals particularly where transsexualism and gender variance are not routinely covered in medical school curricula and nor is clinical decision making itself. Literature suggests that there is little time spent on teaching clinical decision making in the medical school curricula but rather these skills are learned 'on the job'.[739] This has an impact for the rights and protections of individuals seeking to have the law recognise their gender identity because there is little ability to challenge the clinical decision making of a medical professional if it relates to a clinical matter i.e. a diagnosis of a viable alternative comorbid condition which leaves the individual in a position of not being able to assert their identity in law;[740] this, I argue, is far too uncertain a foundation upon which to base legal recognition of gender identity.

Gatekeeping by the Gender Recognition Panel (GRP)

In addition to the legislation creating a strong gatekeeper role for medical professionals prior to the individual even accessing the GRA 2004, the Act also adds another gatekeeping layer by ensuring that the GRP itself has a gatekeeper role to play by giving the GRP a screening function[741] which is not clearly articulated in the legislation itself but which is evidenced by Lord Chan's statement that:

> [w]e need to be absolutely clear that the right people, who are absolutely convinced of the way forward, would be those who applied and were screened carefully by the panel in order that they may be given the certificate.[742]

It is evident then at the outset of the debates on the GRB that the role of the GRP was to act as the gatekeepers of 'true' transsexual applicants versus those seeking to change legal

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[739] D Bhugra 'Thinking Shrinks: Decision Making in Psychiatry' (2010) *International Journal of Social Psychiatry* 56(5):459-461; D M Eddy 'Variations in physician practice: the role of uncertainty' in J Dowie and A Elstein (eds) *Professional Judgement: A Reader in Clinical Decision Making* (Cambridge, Cambridge University Press, 1988) 45-60; K A Ericsson 'Deliberate practice and the acquisition and maintenance of expert performance in medicine and related domains' (2004) *Academic Medicine* 79(10):S70-S81; D Bhugra, Y Malliaris and S Gupta 'How shrinks think: decision making in psychiatry' (2010) *Australian Psychiatry* 18(5): 391-393; D Bhugra, A Easter, Y Mallaris and S Gupta 'Clinical decision making in psychiatry by psychiatrists' (2011) *Acta Psychiatrica Scandinavica* 124(5):403-411; S Carey and D J Hall 'Psychiatrist' views of evidence-based psychiatric practice' (1999) *The Psychiatrist* 23(3):159-161; J M Eisenberg 'Sociological Influences on Decision-Making by Clinicians' (1979) *Annals of Internal Medicine* 90(6):457-464.

[740] For example see *R v Cambridge District Health Authority* [1995] 25 BMLR 5.

[741] HL Deb 13 Jan 2004 col GC12 (Lord Chan).

[742] ibid.

sex on a whim. The careful screening role of the GRP was also backed by Lord Filkin who stated that the change of sex is dependent not solely upon the wishes of the applicant but on "the tests set out in the Bill being met and tested by the panel."[743] Therefore it is clear that the first hurdle to be overcome by the applicant seeking legal recognition of their gender identity is to ensure that he or she provides suitable evidence to the panel which will scrutinise the application. A fundamental misunderstanding of the reasons for seeking a GRC, and indeed mistrust, of gender dysphoria and transsexuals was evident in the Grand Committee's debate on the role of the GRP. Lord Cobbold seemed quite concerned that this Bill would enable individuals to obtain same sex marriages. He asked whether Lord Filkin was "confident that the Bill, as it stands, does not open the door to same sex marriage?"[744] After some discussion he then stated that "it seems to me that there is a possibility of fraudulent application to go through the process in order to achieve a same-sex marriage."[745]

Lord Filkin responded that, essentially, the role of the panel is to determine, by means of the tests set out in the legislation, the true transsexual from the fraudulent individual who sought to use the legislation for his or her own ends to circumvent marriage laws and other laws. Lord Filkin noted that:

> there is a possibility of fraud in most areas of public life. However, one would expect the process that the panel was going through would be designed to reduce the likelihood of that, because there has to be a diagnosis and evidence.[746]

This discussion of the role of the panel in the debates may be seen as mirroring that of the development of the role of the medical professional in medical practice in determining whether or not the patient is truly transsexual or has another reason for their behaviour and desire, as discussed in detail above. An interesting point was made by Dr Harris during the second sitting of the Standing Committee where the Committee was debating the type of membership required for the panel. He noted that it was wise that the panel not be over-medicalised but that lay members may not be the best way of achieving this. Instead he continued that:

> it would be better to say that medical members must not be too old-fashioned and consider the issue narrowly. Although I am sure that there is still some way to go, I hope that medics will not do that.[747]

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[743] HL Deb 13 Jan 2004 col GC19.
[744] ibid GC14.
[745] ibid GC19.
[746] ibid.

Therefore there was acknowledgment during the debates on the GRB that there is not always particularly great understanding of transsexualism even from within members of the medical profession. As medical members are required to sit on the GRP, there exists the possibility that panel members, through their lack of understanding of transsexualism, could deem that an individual does not meet the requirements set out in the legislation to be able to obtain a GRC. These comments would seem to be reflected in the available literature which examines medical professionals' knowledge and understanding of gender dysphoria mentioned above. As there is such strong potential for the GRP to deny an individual's application and, as concerns have been raised in this thesis about the gatekeeping role of the GRP, it is now important to explore the legislative requirements of which the GRP must be satisfied before a GRC can be issued.

The requirement to have lived for two years in acquired gender

In addition to the requirement for a diagnosis outlined above the law also requires that an individual has lived in the acquired gender for a period of two years.[748] Whether or not the person has successfully achieved this will be determined, again, by the medical professionals involved in patient care but the panel must also be satisfied by the evidence provided that the individual has achieved this. One small problem with this is that immediately upon diagnosis the individual cannot apply for legal recognition of their gender identity. However a much larger problem is how one evidences that one has lived in the acquired gender for two years; what it actually means to live in the acquired gender (where one does not have to change one's body or appear physically to be a member of the opposite sex) and the discretion available to the panel when scrutinising the individual's life over the previous two years.

During the debates on this provision Baroness Buscombe stated that she:

> should be grateful if the Minister would explain precisely what that will entail. How strictly will an individual have to abide by that requirement before they are issued with a full gender recognition certificate? For example, where there are small children involved who may not be old enough to understand the process which their father or mother is going through, would the applicant be allowed

[747] Standing Committee A col 35.
[748] GRA 2004 s.2(1)(b).

> flexibility in the extent to which they live in their acquired gender for the sake of the child?[749]

The debate was interesting because it focussed on the practicalities of living in the acquired gender for a period of two years. Baroness Buscombe asked:

> [w]ould a pre-certificate applicant be expected to change in the changing rooms of their birth or acquired gender? What evidence would be sufficient to prove that an applicant had not fulfilled the criteria of living in the acquired gender for two years?[750]

This raised the issue of the burden that the legislation was placing on the individuals and indeed the difficult task of the panel in determining whether or not the applicant could be said to have lived in the acquired gender or not. If the panel is not satisfied that the applicant has so lived then it is justified in rejecting the application. This would leave the applicant with a minimum wait of six months until he or she can reapply for a GRC,[751] although in reality the wait is likely to be longer because if the applicant cannot satisfy the panel that he or she is living in the acquired gender by the date of the initial application then he or she would be unlikely to satisfy the panel of the same requirement a mere six months later. This provision, and concomitant gatekeeper role of the GRP, highlights another aspect of how difficult it is for those seeking legal recognition in the UK. Baroness Buscombe drew attention to the practical difficulties faced by applicants during the debates when she stated:

> we need to understand to what extent these individuals are able to carry out their daily lives in a discreet way but at the same time meet the criteria required in order to satisfy the panel that they have lived according to those criteria. Much impinges upon the word "lived" in the Bill.[752]

On addressing the issues raised by Baroness Buscombe Lord Filkin reassured parliament that "[t]he criteria for recognition of gender change […] are not in a sense set by the government as a set of hurdles to be leapt over."[753] However, it would be very difficult to agree with him based on an analysis of the legislation and the complete debates as the provisions in the GRA 2004 make the criteria for recognition seem very much like hurdles to be overcome by applicants. Lord Filkin stated that one of the purposes of the criteria is

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[749] HL Deb 13 Jan 2004 col GC24.
[750] ibid.
[751] GRA 2004 s.8(4).
[752] HL Deb 13 Jan 2004 col GC25.
[753] ibid.

that it provides "evidence of the commitment to want to live in the relevant gender in the future."[754] By making this comment Lord Filkin was underlining the fact that the legislation is based on permanence and commitment to a binary model of gender whereby the individual identifies as either male or female and seeks to have that reinforced and recognised by law. He continued:

> I believe that it seems right to many—it certainly seems so to the Government—that one would certainly expect a person who was genuinely committed to wanting to live in that new gender for the rest of their life to demonstrate the reality of that by living that gender in the here and now. It is not like opting for a change of clothes; it is a matter of believing at heart that there is something incongruous in one's birth gender and wanting to bring into alignment as far as one can the totality of one's life. The matter should not be interpreted as the Government saying, "You must live this life". Transsexuals who believe passionately that they want to be fully recognised will already be in this position. They will be living their lives in the way that I have described. They will have acted in that way in the totality of their lives. All the panel is doing is checking to see that there is evidence of that. I cannot fully second-guess how exactly it will inspect that process. However, I would expect it to undertake that process seriously to check that the relevant criteria had been complied with. The test in the legislation exists for a purpose; it is not a minor issue.[755]

The two year period contained in s.2(1)(b) may seem to be arbitrary but it has such a potential impact on the applicant's ability to have his or her gender identity recognised in law that it requires to be examined in depth. The Lord Bishop of Winchester attempted to link the two year period in the GRA 2004 with the then two year period in the World Professional Association for Transgender Health's *Standards of Care*. He stated:

> [m]y understanding is that this is something to do with the Benjamin protocols or the Benjamin rules or whatever and that consultants working in this field are responsible and follow that kind of code and will themselves supervise the matter in a thoroughly responsible way.[756]

It should be noted that although at the time of the GRB debates the SOC provided that patients must live as members of the opposite sex for two years before any irreversible medical interventions could be provided. This has subsequently changed to one year in version 7 of the SOC, issued in 2011.[757] The attempt by the Lord Bishop of Winchester to

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[754] ibid.
[755] ibid.
[756] ibid col GC26.
[757] World Professional Association for Transgender Health *Standards of Care* version 7 available from <www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3926> accessed 15 June 2015.

link the legal requirement with medical practice was backed by Lord Carlile of Berriew who stated that:

> the criteria that are set out in Clause 2(1)(b) are applied in gender reassignment clinics as a prerequisite to surgical treatment. Therefore, for a change, the test in law will be similar to the medical test that is applied. Would that we had so many consistencies between the law and medicine, for example, in the law of provocation for diminished responsibility in relation to homicide. However, we do not have that consistency and the law and medicine frequently have to apply quite different criteria. In this case they will be the same and that is useful.[758]

However, not only is this a fundamentally flawed argument as law and medicine are attempting to do two completely different things in relation to transsexual individuals, it has also been undermined by the developments from within medicine, which will be outlined in depth towards the end of this chapter, which now call into question the validity of the medical model of transsexualism within the GRA 2004. The two year period in medicine was there to ensure that no irreversible medical procedures had been carried out until the patient was ready to undertake them.[759] The two year period in law does not need to be there as there are no irreversible consequences of obtaining a GRC, given that further applications may be made to change one's legal sex. The comment by the Lord Bishop of Winchester evidences a fundamental confusion regarding the separation of legal and medical approaches in relation to transsexual individuals. The provision in the GRA 2004 regarding the two years will not be examined by consultants but rather by the GRP. It may well be that the applicant will be able to provide medical evidence to support that they have lived in the acquired gender for two years but this is not something that medical professionals are obliged to provide because the RLE is now limited to one year as per the SOC but also because it only relates to those seeking to modify their bodies by means of surgery. The provisions in the SOC, regarding the RLE as noted above, are to ensure that the patient is ready for irreversible medical procedures and in no way amounts to a decision about the individual's identity as this has already been determined by means of the diagnostic process, whereas the two year provision in the GRA 2004 has the power to very much make judgment on the individual's identity. In addition to the SOC requiring a period of time before irreversible medical interventions are provided to the patient, thereby attempting to safeguard against harming the patient the SOC also exist to protect the

[758] HL Deb 13 Jan 2004 col GC26.

[759] E Coleman, W Bockting, M Botzer, P Cohen-Kettenis, G De Cuypere, J Feldman and K Zucker ' Standards of care for the health of transsexual, transgender, and gender-nonconforming people Version 7' (2012) *International Journal of Transgenderism* 13(4):165-232.

medical profession from claims of negligence which may arise from providing treatment when the patient is not ready for it. So, the attempt to collate the two year waiting period, as it existed in medicine, with a similar provision in the GRA 2004 is flawed; it was flawed in 2004 because of a misunderstanding of why the two year period existed in the SOC and it is further flawed now in 2015 because developments within medical practice, which will be discussed below, highlight problems with basing the legislation on the medical model of transsexualism.

Albeit that the two year period is flawed it remains a part of the law and therefore how the panel will determine whether or not the applicant meets the requirements of this provision needs to be examined. Sandland makes some interesting points on this requirement in s.2(1)(b). He notes that the fact that the GRA 2004 does not require body modification prior to obtaining legal recognition raises a particular problem. Sandland considers the example of an FTM transsexual who undergoes no endocrine or surgical intervention but who applies for and obtains a GRC and therefore becomes legally male. Should this person then marry a woman, as he would be legally entitled to do, this would have the outward appearance, to third parties, of a same-sex marriage as both individuals would be physically, but not legally, female which, during the debates on the Bill, the Lords and Commons were at pains to avoid.[760] However Sandland furthers this analysis by noting that the FTM transsexual who has not undergone any form of body modification retains the ability to become pregnant and to give birth to a child which as Lord Tebbit noted during the debates he could "see no better test of whether a person is female than that."[761] Lord Tebbit's statement is rendered invalid by the GRA 2004 because within the legislation there exists the possibility that a legal male could give birth to a child. The possibility, as a result of the legislation, is that the UK could see male mothers and female fathers due to the fact that legal males can carry and give birth to children and legal females can biologically father children because of there is no requirement that applicants for GRCs undergo sterilisation. The fact that the legislation allows a legal male to become pregnant and give birth to a child becomes complex but is worth exploring as it shows the absurdity of what it actually means to 'live in the acquired gender for two years'. Sandland argues that "[i]t might be objected that an FTM transsexual who continued to engage in sexual activity as a female would not satisfy the criteria for recognition."[762] Now the link between

[760] See for example SC Deb (A) 9 March 2004 cols 31-76, HL Deb 18 Dec 2003 vol. 655 cc1287-326.
[761] HL Deb 3 Feb 2004 vol. 657 col. 618.
[762] R Sandland 'Feminism and the Gender Recognition Act 2004' (2005) *Feminist Legal Studies* 13(1):43-66, 53.

the examples given by Sandland is not obvious: becoming pregnant and giving birth is not necessarily linked to engaging "in sexual activity as a female"[763] because the child may be conceived by means other than sexual activity. However, where the child is conceived by means of sexual activity then this would give rise to the scenario which Sandland identified and raises the following question: *is someone who is physically female, but who identifies as male, and who engages in heterosexual sexual intercourse with a biological male engaging in sexual intercourse as a female or as a male identified female bodied person…and indeed how would the GPR interpret this as per the requirement to live in the acquired gender for two years?* Sandland continues that where this should occur:

> [i]n particular it might be thought that such a person, even if suffering from gender dysphoria, could not be said to have "lived in the acquired gender throughout the period of two years ending with the date on which the application is made.[764]

Sandland's argument is correct because he continues that if the only evidence that one has not lived in the acquired gender for a period of two years ending with the date on which the application is made is the individual's sexual practices "then that is poor evidence".[765] He notes that gender identity and sexual orientation are not linked so if the applicant opts not to modify his or her body and uses their non-modified body to engage in sexual practices and derive sexual pleasure then this is not evidence that the individual has not lived in the acquired gender for two years. Although the transsexual individuals in all of the case law before the UK courts and the European Court of Human Rights (ECtHR) identified as heterosexual it remains the case that not all transsexual individuals so identify: transsexual sexual orientation is just as diverse as within the non-transsexual community.[766] As Sandland argues of his FTM example "[i]t is perfectly possible that an individual might self-identify as male but possess female genitalia and have sexual intercourse with a man."[767] This should not amount to evidence that the individual has not lived in the acquired gender for the appropriate amount of time prior to making the application. So, on a basic level how this requirement is evidenced when the applicant has opted not to alter his or her body remains uncertain.

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[763] ibid.
[764] ibid 54.
[765] ibid.
[766] For more on this see *inter alia*: H Devor 'Sexual orientation identities, attractions, and practices of female-to-male transsexuals' (1993) *Journal of Sex Research* 30(4):303-315; M L Chilvers and J M Bailey 'Sexual orientation of female-to-male transsexuals' (2000) *Archives of Sexual Behavior* 29(3):259-278; C T Daskalos 'Changes in the sexual orientation of six heterosexual male-to-female transsexuals' (1998) *Archives of Sexual Behavior* 27(6):605-614.
[767] Sandland (n 763) 54.

The requirement to intend to live in acquired gender until death

This requirement exists in s.2(1)(c) of the GRA 2004 and highlights the concerns some members of the Lords and Commons had with the permanence and certainty of recognising gender identity in UK law. The requirement was heavily debated during pre-legislative scrutiny of the Bill. How the GRP were to assess the intention to live permanently in the acquired gender caused an issue particularly where the individual does not change his or her body in any way. The Hansard records, however, can be useful here because although the legislation does not require any body modification it is clear from the Hansard records that Parliament intended that where body modification could be undertaken there ought to be a good reason for the individual not undertaking such procedures. Lord Filkin stated that:

> in cases where the person has not had surgery we would expect the panel not to treat that as prima facie evidence that there was doubt, but at least to question why surgery had not taken place. It might, just possibly might, have a bearing on the seriousness of the intent.[768]

It would seem clear then that where the individual has had the opportunity to undergo body modification and has not done so then he or she will find it particularly difficult to convince the panel that he or she intends to live permanently in the acquired gender.

A related issue, that of being able to 'change one's mind' following obtaining a GRC, was considered in the House of Lords where amendment 42 was proposed. This amendment would have inserted a clause into the Bill regarding those who initially received a full GRC but who then wished to revert to the gender assigned at birth. Although ultimately withdrawn this proposed amendment intended to insert a new clause which would have stated that:

> (1) [w]here a successful applicant subsequently changes his or her mind, or decides a mistake has been made, and wishes to resume his or her original birth gender, a further application must be made to the Gender Recognition Panel for the issue of a further gender recognition certificate in the resumed gender
> (2) […]
> (3) Only one reversal of an original decision made by the Panel may be permitted.[769]

[768] HL Deb 13 Jan 2004 col GC10.
[769] HL Deb 13 January 2004 vol. 657 cc 1-62GC [58].

During the debate surrounding this proposed amendment Baroness O'Cathain implied that the issue of transsexual individuals 'changing their minds' was a regular occurrence. She stated:

> [t]he problem is well documented of the many people who have gone through the process of gender recognition and who have come to the decision that they want to reverse the situation. They may do that for all sorts of reasons—because they have been badly advised; because they have come to their senses, as they would say themselves; or because they recognise that a very big mistake has been made. After all our discussions today, I suspect that the full import of what they had decided to do hit them afterwards, when they realised the implications for their extended family and all their social circle. The net result is that there are people who have wished to reverse the procedure.[770]

As noted above amendment 42 proposed that there should be a limit on the number of times a person can apply to have his or her gender identity recognised. Baroness O'Cathain stated that:

> if a gender recognition certificate has been issued and the person is no longer of the gender into which he or she was born, there must be some block on their being able to change their minds again and again, so they do not go chopping and changing at whim. I suggest that, under the amendment, we should agree that they can change, but change only once.[771]

The fear that transsexual individuals might 'chop and change at whim' relates back to the fact that there needs to be no body modification prior to obtaining a GRC and therefore people might choose to change legal sex based on a lifestyle decision and not a medical condition. Despite Baroness O'Cathain's assertions, her fears do not appear to be reflected in the literature. The majority of the literature related to this idea of 'changing one's mind' examines the feelings of post-operative individuals in relation to their sex re-assignment surgery and so therefore is not on point. However, in 1993 Pfäfflin reported that no FTM transsexuals and only 1-1.5% of MTF transsexuals reported regret following sex re-assignment.[772] In 1997 Cohen-Kettenis and van Goozen reported that no participants in their study regretted their sex re-assignment surgery either.[773] The same result was reported by Lawrence in 2003 when she found that none of the 232 participants in her study

[770] ibid [58]-[59].
[771] ibid [59].
[772] F Pfäfflin 'Regrets after sex reassignment surgery' (1993) *Journal of Psychology & Human Sexuality* 5(4):69-85.
[773] P T Cohen-Kettenis and S H M van Goozen 'Sex reassignment of adolescent transsexuals: a follow-up study' (1997) *Journal of the American Academy of Child & Adolescent Psychiatry* 36(2): 263-271.

reported overall regret and only a few patients reported occasional regret.[774] Although therefore regret following sex re-assignment surgery may exist the majority of individuals who undertake these medical procedures appear to be satisfied with the outcome and therefore clearly do not want to revert to their birth sex. These are small scale studies and only those who had modified their bodies were interviewed and therefore may not be indicative of those who had changed legal sex without changing their bodies. However, the limitations of these studies aside, they show that the majority of transsexuals are satisfied with body modification and do not seek to revert back indicating that the fear expressed during the debates about individuals choosing to chop and change gender on a whim are largely misplaced and show a misunderstanding of those who would seek to use this legislation. These proposals by Baroness O'Cathain indicate poor understanding of transsexual individuals' needs and experiences. Transsexual individuals, those covered by the legislation, desire to be seen as and accepted as members of the opposite sex and almost never 'change their minds'.

Therefore there must be a reason for the legislation adopting this requirement and, as mentioned above, the Hansard records would indicate that the intention of permanence requirement is about ensuring certainty of legal sex. However, Sandland argues that this requirement is intended to separate "the 'lifers' from the rest"[775] and he has a valid point. In 2010 Grabham[776] argued that the intention of permanence requirement in the GRA 2004:

> fits with an administrative or bureaucratic logic that prioritizes permanence and stability. Within this logic, if citizens are to 'change gender', then this transition should be final, irreversible, and sanctioned by the state through applicants meeting a number of pre-agreed criteria.[777]

For Grabham this requirement is at odds with the work of queer theorists and some feminist theorists who argue that gender is fluid[778] and so the legislation imposes on transsexual individuals requirements which are not imposed upon non-transsexual citizens which is accurate and indeed is the purpose of the legislation. However a problem with Grabham's analysis in this context is that the GRA 2004 seeks to only provide legal

[774] A A Lawrence 'Factors associated with satisfaction or regret following male-to-female sex reassignment surgery' (2003) *Archives of Sexual Behavior* 32(4):299-315.
[775] Sandland (n 763) 50.
[776] E Grabham 'Governing permanence: trans subjects, time, and the Gender Recognition Act' (2010) *Social & Legal Studies* 19:107-126.
[777] ibid 109.
[778] ibid.

recognition of gender identity which is based on a binary model of gender i.e. one is either male or female. The binary model of gender is the one inherent in UK law, and indeed I cannot identify any jurisdiction which does not base laws on a binary model of gender. It could therefore be argued that this 'bureaucratic logic, as Grabham calls it, achieves what is required by such a legal system: one can identify as they choose but if they require legal recognition of this identification then there must be a means of regulating the conditions by which this recognition will be given. Grabham continues:

> [t]he moment of recognition is a gender 'arrival', intelligible within citizenship discourse as a point of inclusion and accession, but it could also be viewed as a gender fixing. It requires trans citizens to perform (and produce) gender permanence in a way that non-trans citizens are not required to do.[779]

Grabham's concerns are valid but also difficult to reconcile with how the law operates in the UK: the GRA 2004 has a particular model of gender hidden within its supposedly emancipatory and inclusive provisions as evidenced by the permanence requirement. This permanence requirement excludes those individuals whose gender identity is not fixed and stable and seeks to ensure that only those who obtain legal recognition are those who are willing to accept gender as binary and to ascribe to that model for their lives, as Sandland states the GRA 2004 "can be read as a case study demonstrating the truism that any act of inclusion also excludes."[780] Sandland argues this point also: he states that within the legislation "it is certainly the case that an individual defined as gender dysphoric who does not intend to cross and live in an acquired gender for life falls outside the legal regime of recognition"[781] and this is becoming more problematic as the medical model develops beyond the state of understanding which existed in 2003/04. As will be shown below the medical model of transsexualism continues to develop and now the diagnosis of GD which is contained in DSM 5 allows for a much wider understanding of gender. Currently within DSM 5 it is possible to obtain a diagnosis of GD if one's experience of gender is also non-binary or fluid thereby moving considerably beyond the binary understanding of gender which underpinned DSM IV and consequently the GRA 2004.

Despite this concern the GRA 2004 actually does not prohibit individuals from making subsequent applications to the gender recognition panel to revert to their original gender. It

[779] ibid.
[780] Sandland (n 763) 45. For more on this see A Harris 'Non-binary gender concepts and the evolving legal treatment of UK transsexed individuals: a practical consideration of the possibilities of Butler' (2012) *Journal of International Women's Studies* 13(6):57-71.
[781] Sandland (n 763) 50.

is therefore possible for an individual to make an application to the GRP for a GRC which will be granted if he or she satisfies the requirements in the legislation. The individual can then make another application at a later date which would, if granted, effectively return the individual to the legal sex registered on birth. However this is not a right of reversal in any sense: the individual once again applies to the GRP on the basis that his or her gender identity is not congruent with his or her legal sex and must once again meet the requirements in the legislation regarding diagnosis and the provision of evidence i.e. they must be re-diagnosed as suffering from GD and as having lived in the other gender for two years. The GRP must also be satisfied that the applicant intends to remain in the new acquired (or in this case original) gender until death, albeit that there is no means of legally ensuring that the individual does so. It may be suggested that it would be more difficult to satisfy the GRP of the latter requirement given a change of mind after obtaining a GRC.

The requirement to provide any other evidence as required by the GRP

The GRA 2004 s.3(6) provides that the panel can request further information and evidence prior to making its determination. Cowan briefly anticipated this issue in 2009 when considering how the GRP would determine applications by those who had not undergone any body modification. [782] The idea being presented by Cowan was that those who could not, or who chose not to, undergo body modification might be thought of as less committed to living permanently as a member of the acquired gender as discussed above, and therefore would be required to provide additional evidence to the GRP. Cowan developed this argument and noted that it might well be that those who could not undergo such procedures on medical grounds may be treated more favourably by the GRP than those who chose not to change their bodies because the choice to not alter one's body "renders their transsexual status suspect."[783] She observed that those who chose not to change their body:

> could well be regarded with scepticism by the GRP because it might be thought that any 'real' and committed transsexual person, who shows that they have for two years lived in the gender opposite to that associated with their birth sex – and who signs a legal declaration that they intend to continue to do so for life – would be willing to undergo 'necessary' physical surgical changes in order to have their body properly 'match' their mind.[784]

[782] Cowan (n 2) 249.
[783] Cowan (n 2) 249.
[784] ibid.

Cowan argued that in order to guarantee being granted a GRC the applicant needs to show that he or she fits with the model of gender identity and transsexualism which has been wholly medicalised as outlined in Chapter One i.e. that the desire to live as a member of the opposite sex is not a mere lifestyle choice but rather driven by "a psychological need, a medical condition, that can only be remedied by medical intervention – therapy and (usually) surgery."[785] Therefore those who depart from the accepted medicalisation of gender identity and transsexualism are likely to find it more difficult to obtain legal recognition of their gender identity: to a certain extent there is an onus placed on the applicant who has not undergone or is not planning on undergoing body modification to prove that he or she is truly transsexual and this may create a hierarchy of applicants with those who have undergone treatment placed higher than those who have not. However those who have not undergone treatment can, according to Cowan, be further categorised into those who cannot undergo treatment and those who choose not to. She noted "[i]f surgery is not involved, it is likely that only those who *cannot* rather than those who *choose not* to have surgery will be given legal recognition."[786]

Cowan's observations in 2009 that those who had not undergone nor were they planning on undergoing body modification would find it difficult to satisfy the GRP have proven accurate. The recent case of *Carpenter v Secretary of State for Justice*[787] has raised specific questions about the role of the GRP and s.3(6) of the GRA 2004. In *Carpenter* the applicant was an MTF transsexual who, on 12 May 2011, applied to the GRP for a GRC. She submitted the required medical evidence but the panel requested further information, as is their right, under s.3(6)(c). The panel sought information in relation to surgical procedures which the applicant had undergone and this information was duly provided by the surgeon who had treated the applicant. The applicant appealed against what she claimed was a refusal to grant a GRC. The Family Division of the High Court held that at no point had the GRP refused her application for a GRC.[788] The GRC was issued in November 2011. The instant case concerned an alleged violation of Articles 8 and 14 ECHR on the bases that s.3(3) of the GRA 2004 which allowed the panel to request further information was incompatible with the said rights. Section 3(3) of the GRA 2004 provides that subsection (1) is not complied with where "the applicant has undergone or is

[785] ibid.
[786] ibid.
[787] *Carpenter* (n. 623).
[788] [2012] EWHC 4421 (Fam).

undergoing treatment for the purpose of modifying sexual characteristics"[789] or "treatment for that purpose has been prescribed or planned for the applicant"[790] unless one of the medical report provides details of the treatment. It was argued that this requirement was incompatible with the applicant's Article 8 right which provides that her right to private life has to be respected. It was also argued that the requirement to provide details of treatment:

> discriminates unlawfully against the applicant and other transgender people who have undergone surgery and is incompatible with Article 14 of the European Convention [on Human Rights], in the context of Article 8.[791]

Thirdly it was argued that the requirement "discriminates unlawfully against the applicant and is thus incompatible with Article 14 in the context of Article 8."[792] This case is interesting because the applicant did not argue against any of the other aspects of the legislation such the need for a diagnosis, the requirement to have lived as a member of the acquired gender for two years or the permanence requirement. Nor was it argued that the provision of medical reports *per se* is incompatible with Article 8 ECHR but rather, as observed by Mrs Justice Thirlwall, the "attack is directed to the requirement that where medical treatment to modify sexual characteristics has been planned or undergone one of the reports must set out the details of that treatment."[793] However, rather than challenge some of the problematic aspects of the legislation such as those outlined above, the applicant argued that:

> details of treatment (in this case surgery) are irrelevant and so unnecessary because a Panel must grant a certificate where it is satisfied that the applicant has or has had gender dysphoria; has lived in the acquired gender throughout the period of two years ending with the date on which the application is made; and intends to continue to live in the acquired gender until death.[794]

Therefore the argument was that if an individual had not undergone, nor was he or she planning to undergo, medical procedures he or she would be able to obtain a GRC. However those who had undergone or were planning to undergo medical procedures had to provide additional evidence of those procedures. It was argued therefore that the requirement to provide details of treatment could not be necessary to grant the GRC and

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[789] GRA 2004 s.3(3)(a).
[790] ibid s.3(3)(b).
[791] *Carpenter* (n. 623) [13].
[792] ibid.
[793] ibid [18].
[794] ibid [19].

therefore "the requirement to provide details of the surgery is an unjustifiable interference with the applicant's Article 8 rights"[795] which is a perfectly logical argument to make based on the provisions contained in s.2 0f the GRA 2004.

Mrs Justice Thirlwall observed in *Carpenter* that proving that such an applicant met the requirements in s.2(1)(b) and (c) "is not easily done in the absence of any treatment to modify sexual characteristics but the act allows for a certificate to be granted in such a case."[796] She continued:

> [u]ndergoing or intending to undergo surgery for the purposes of modifying sexual characteristics is overwhelming evidence of the existence now or previously of gender dysphoria and of the desire of the applicant to live in the acquired gender until death. No competent, conscientious medical practitioner could produce a report on gender dysphoria (past or present) which did not refer to treatment received.[797]

Mrs Justice Thirlwall noted that the provision of medical evidence asked for by the GRP was not a choice of the applicant[798] and nor did it require the applicant to disclose a particularly sensitive medical history.[799] In relation to the argument that the GRA 2004 placed a higher burden on those who had undergone medical procedures compared with those who had not because those who had were required to provide evidence relating to those procedures Mrs Justice Thirlwall held that there was no undue burden on such applicants. She noted that:

> [u]ndergoing gender reassignment surgery is physically and psychologically intrusive. It involves long term preparation and hormone treatment and then radical surgery, the purpose of which is to change fundamentally the appearance of a person so that the physical (and psychological) characteristics are those of the acquired gender. The state does not require anyone to undergo this. What the state does require is that the second report includes the name of or a list of the procedures undergone. An applicant who has not undergone surgery is required by the panel to explain his or her reasons. It might be thought that such a requirement is at least as intrusive as the requirement for the provision of the details of treatment.[800]

[795] ibid [20].
[796] ibid [20].
[797] ibid [23].
[798] ibid [24].
[799] ibid [25].
[800] ibid [35].

Although *Carpenter* was not about the role of the panel *per se* it is clear from this case that the panel can ask for any other supporting evidence and that the applicant has to convince the panel that he or she meets the requirements in the legislation. It is not simply that the panel has a rubber-stamping role but rather that they have a gatekeeper role and can deny the individual's quest for legal recognition should the applicant not match what the panel expect to hear. So both medical professionals and the GRP have gatekeeper roles to play in relation to transsexuals achieving legal recognition of their gender identity and this is problematic as at each of these stages a third party is given the ability to determine the applicant's identity: either to confirm or to deny the individual's sense of self as male or female. However there is also another problem which needs to be explored; the way in which the medical model, upon which the GRA 2004 is founded, has developed since the legislation was enacted.

Changing medical knowledge and its impact on the GRA 2004

One of the most significant developments in the medical model of transsexualism since the GRA 2004 was passed was the revision of the DSM, which was complete in 2013, and the ongoing revision of the ICD. The IDC-11 is still in the process of being developed therefore it is not possible to state with any certainty how transsexualism will be represented within the latest version which is due in 2018. However there are interesting proposals in place in relation to the revision of the ICD. On 3 and 4 February 2013 WPATH held a discussion meeting in relation to the proposed ICD-11 criteria for transsexualism.[801] The aim of the discussion meeting was to reach consensus on the following proposals:

1. Deletion of the ICD-10 F66 categories
2. Deletion of the ICD-10 F65 category Fetishistic Transvestism
3. Renaming the ICD-10 F64.0 category Gender Incongruence (GI) rather than Transsexualism
    a. Name of the category
    b. Moving Gender Incongruence from the Mental and Behavioural Disorders chapter and alternative placement options
4. Deletion or retention of the ICD-10 F64.2 category Gender Identity Disorder of Childhood.[802]

[801] Note that, as discussed in Chapter One, the ICD has always used the title *transsexualism* to denote those who identify as members of the opposite sex whereas DSM has used a variety of different titles.
[802] G De Cuypere and G Knudson *WPATH Consensus Process Regarding Transgender and Transsexual-Related Diagnoses in ICD-11* <http://transactivists.org/icd-info/> 4 accessed 14 March 2015.

The debate preceding the publication of DSM 5 and revision of ICD-10 introduced the idea of completely removing any reference to GID from the DSM and transsexualism from the ICD i.e. depathologising the condition.[803] The issue of stigmatisation and pathologisation of transsexual individuals by means of labelling as mentally unwell within the diagnostic manuals was specifically recognised by WHO when proposing reforms to the ICD. WPATH state that:

> WHO recognizes that questions that have been raised about the gender identity disorders in ICD-10 are in part based on objections to the stigmatization that accompanies the designation of a condition as a mental disorder in many countries and cultures.[804]

The depathologisation debate continues today[805] and it may be that in the next revision of the diagnostic manuals, beyond ICD-11, that the medical condition is completely removed which would have a major impact on UK law which, as discussed in depth above, requires a diagnosis to be made before the individual can be protected by the law. Although depathologisation of the condition was not brought to fruition in the published DSM 5, and therefore transsexualism is unlikely to be removed from ICD-11, the published version of DSM 5 substantially widens the medical model which, because the GRA 2004 preceded these medical reforms, is not reflected in UK law. Due to the fact that the latest revision of ICD is not due until 2018 the remainder of this section will focus on the developments in DSM 5.

Developments in the DSM 5

As noted in Chapter One in the earlier versions of the DSM GD was labelled as GID. It is thought that changing the name to GD in DSM 5 more accurately reflects the nature of the condition i.e. the level of discomfort, or dysphoria, experienced by patients with a transsexual identity and also that removing the label of disorder "is less pathologising as it no longer implies that one's *identity* is disordered"[806] which was one of the main concerns with earlier versions of the DSM.[807]

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[803] Ault and Brzuzy (n 19); Drescher, Cohen-Kettenis and Winter (n 24); G de Cuypere, G Knudson and W Bockting 'Response of the World Professional Association for Transgender Health to the proposed DSM 5 criteria for gender incongruence' (2010) *International Journal of Transgenderism* 12(2):119-123.
[804] De Cuypere and Knudson (n 803) 4.
[805] J T Theilen 'Depathologisation of transgenderism and international human rights law' (2014) *Human Rights Law Review* 14(2): 327-342.
[806] G De Cuypere, G Knudson and W Bockting 'Response of the World Professional Association for Transgender Health to the proposed DSM 5 criteria for gender incongruence' (2010) *International Journal of Transgenderism* 12(2):119-123.
[807] A Lev (n 141).

Interestingly for the purpose of this thesis the DSM 5 has widened the scope of who can be diagnosed with GD. It is noted that the term 'experienced gender' "may include alternative gender identities beyond binary stereotypes."[808] Therefore the distress experienced by the patient "is not limited to a desire to simply be of the other gender, but may include a desire to be of an alternative gender, provided that it differs from the individual's assigned gender."[809] This is a much wider provision than in UK law as contained in the GRA 2004. Whereas the DSM 5 is open to much wider experiences and expressions of gender, UK law, with its insistence that the individual live as a member of the opposite sex for the remainder of his or her life is limiting gender experience and expression to solely male or female. This change in the DSM 5 begs the question of how far the law and medicine can be linked in relation to recognition of gender identity because medicine develops much quicker than law is reformed thus potentially rendering the law outdated. As a result of these changes in DSM 5 someone with a non-binary gender identity could conceivably meet the requirements for a diagnosis of GD but he or she would still not be able to access the provisions for recognition of his or her gender identity because of how the GRA 2004 requires one to live in the acquired gender for two years prior to making an application for a GRC and also how one has to indicate an intention to live permanently in the acquired gender until death. Therefore, medicine, through the revisions in the DSM 5, is acknowledging that dysphoria which arises as a result of gender identity and gender assigned at birth not corresponding does not necessarily mean that the individual identifies as a member of the opposite gender or even has a fixed gender identity. These developments in medicine, should law continue to rely on medicine, will prove problematic for law in the future.

Conclusion

This chapter has argued that the medical model of legal recognition with the GRA 2004 has serious implications for the individuals seeking to rely on the legislation to provide them with rights and protections. The GRA 2004 clearly places limitations on whose gender identity is to be given legal recognition. Accordingly, it does not in fact operate to protect personal choice by self-declaration of gender but rather adopts a very medical approach to legal recognition of gender identity by classifying people qualifying (or not) for recognition before the law. The GRA 2004 makes it clear that determination of identity

[808] American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* Fifth Edition (American Psychiatric Association 2013), 453.
[809] ibid.

for the purpose of legal recognition of that identity is to be conferred upon the applicant, mostly, by reference to the medical profession and a panel of doctors and lawyers.

The main problems with the legislation adopting a medical model of legal recognition is that the panel which has been established has a gatekeeper role in scrutinising applications which has the potential to result in a denial of a GRC which, in turn means that that the individual is unable to change his or her legal sex. The panel may refuse the certificate on the grounds that the applicant has failed to provide the medical, or other, evidence required. However, in addition to this the panel has a huge discretion to deny applications based on one of two provisions: that the applicant fails to meet the permanence requirement, which will be difficult to prove if he or she has chosen not to undergo medical procedures to modify his or her body; or that he or she fails to show that they have lived in the acquired gender for two years immediately preceding the application. This has problems for the individual seeking the GRC because the evidence which the panel will require to satisfy the GRP has not been clearly established nor has what it means to actually live in the acquired gender for two years. In addition I argued that the two year period, should it be deemed necessary at all to require an applicant to prove that he or she can live as a member of the opposite sex before making the application, is arbitrary and based on a misunderstanding of the two year real life experience which existed in the WPATH SOC version 6 but which has subsequently been amended to one year.

However, even preceding the determination of the panel on the points above the individual may be prevented from making an application for a GRC because the Act requires evidence in the form of a diagnosis of GD to support the application. It may well be that the law has arrived at this point and given such an important role to medical professionals because transsexuals will often seek some form of medical involvement to alter their bodies to match their gender identification. Medical professionals will therefore be asked to diagnose GD and then provide hormonal and irreversible surgical procedures to alter a person's body. However these are separate issues and should not be conflated: the issue of diagnosis is medically separated from the issue of suitability for treatment and indeed the legislation recognises this by providing that legal recognition can take place before any body modification. In addition to the separation of diagnosis and treatment in medicine it is important that the medical and legal are separated also. Although medically it may be appropriate to diagnose a patient with GD prior to providing body modifying treatment legally there is no need to have a diagnosis in place before one is able to express one's

gender identity therefore there appears to be no need for the legislation to require a diagnosis of GD at all. This chapter has argued that that stage is potentially problematic for a number of individuals because it relies on there being specialist services available for the individual to access. In addition it relies upon the expertise and knowledge of medical professionals in diagnosing what is a notoriously difficult condition to diagnose as it is based solely on interpretation of the patient's narrative and the experience of the medical professional who hears that narrative. Thus medical professionals have been established as gatekeepers within the legislation also. Establishing the gatekeeper role in this way has however meant that, in the UK, legal recognition of one's gender identity is not purely a human rights issue to be solved by a model of recognition which is based wholly on the gender self-declaration of the applicant. Rather current UK law is a consequence of basing the law on the medical model of transsexualism, as outlined in Chapter One, which then places the medical professional in the position of being able to impact on the legal recognition of one's gender identity because the law is concerned with only recognising those who are ill i.e. fit the medical model of transsexualism as of 2003/04 and ensuring that no recognition is given to those who seek to make solely a lifestyle choice about their gender.

Neither of these hurdles, the role of the panel nor requiring a diagnosis, require to be in the legislation as will be shown in Chapter Six.

6. An Alternative Model for Gender Identity Recognition in the UK

Introduction

Until this point the thesis has examined the historical background, both in terms of medical and legal developments, to the Gender Recognition Act 2004 (GRA 2004) and it has shown that by the time the legislation was being debated gender variance was firmly medicalised and pathologised as a specific medical condition: transsexualism. It was this development of the medical condition, which began in the 1800s and continued throughout the twentieth century into the twenty-first century, which resulted in the legislature adopting a medical understanding of gender variance, the medical model of transsexualism, as the foundation for the legislation. This, as was shown in Chapter Five, resulted in a strong gatekeeper role being embodied in the legislation. The result of this gatekeeper role given to third parties, such as medical professionals and the Gender Recognition Panel (GRP), was that the legislation could be said to be firmly testing applicants to ensure that only 'true' transsexuals are able to obtain legal recognition of their gender identity. However this approach has the potential to result in applications being rejected where the individual cannot meet the strict legislative or medical criteria to be classed as transsexual. One of the problems with this is that one's gender identity is not absolutely identifiable by any means other than self-identification: the only way that a third party can know whether or not an individual identifies as a member of the opposite sex, or indeed as agender, genderqueer *etc*., is through being told by that person. The problems with the legislation taking the approach that it does were outlined in detail in Chapter Five where it was shown that not only is there potential for third parties to derail applications for Gender Recognition Certificates (GRCs) but that the medical model of transsexualism which underpins the legislation itself continues to change and develop such that the one in existence in 2015 is not exactly the same as the one in 2004 when the legislation was enacted. This subtle change in the medical model, which now widens the medical understanding of Gender Dysphoria (GD) no longer fits the rest of the GRA 2004 provisions, in particular the requirement to live in the acquired gender for two years prior to making the application and that the applicants must express an intention to live in the acquired gender until death. Therefore it is the very model of transsexualism upon which the legislation is founded which undermines the legislation a mere decade after the legislation came into force and which therefore allows us to consider reforming the law. In

addition to the changes in the medical model of transsexualism there has been calls from the Council of Europe (CoE) for member states to address the issue of trans* rights more broadly, as will be discussed in detail below and which allow the UK to consider reforming the GRA 2004 in light of CoE Resolution 2048 (2015).

This chapter will explore possible reform of the legislation which, given changes in other jurisdictions in recent months, can no longer be said to be radical as it was when it was first enacted. In fact the reforms proposed in this chapter are broadly in line with the legislation itself because it is the GRA 2004 which opens the possibility of an alternative approach being taken to providing legal recognition of gender. The GRA 2004 protects one's gender identity rather than provide legal recognition to the bodily changes which one has physically undertaken. This separation of body and mind in the GRA 2004 was ground-breaking at the time, as discussed in Chapter Four, but it could also be used as a means of enabling the law to change to maintain relevancy in light of other jurisdictions' approaches and in light of changing medical knowledge on GD and gender identity.

This chapter will begin by exploring the role that law plays in gender identity recognition, once that has been established the chapter will then examine the state of play in other CoE states and compare current UK law with that of other CoE states because it is important to show the different models of legal recognition which are available. The UK is not the only CoE state to legislate based on the medical model of transsexualism but nor is this the only model upon which to base such legislation as others, such as Denmark, Ireland and Malta legislate based on a self-declaration model which is a much more human rights based model than the medical one and, as such, is the model which I argue should be used to provide legal recognition of one's gender identity in the UK. It will be argued in this chapter that the UK should reform the law to adopt a self-declaration model of gender identity recognition and the chapter will end by exploring the issues which would need to be considered when adopting such a model as the basis for the legislation.

The role of law in transsexual recognition

Bell argues that "[t]he legal system plays a central role in defining and constructing identities. Through its boundary construction, people's rights and practices are shaped, confined, and even expanded."[810] As such the law is not only crucial in ensuring that those

[810] M Bell (n 242) 1751.

whose sexual and gender identities differ from the norm are protected through legislation such as the GRA 2004 and the Equality Act 2010 but in addition there needs to be thought given to the role of the law in constructing the boundaries of these identities. Chapter Five clearly set out that the GRA 2004 only recognises gender identity which is of a binary nature and therefore the GRA 2004 clearly establishes that only those who fit the medical model of transsexualism as it was in 2004 are able to obtain legal recognition of their gender identity. However the approach taken in the GRA 2004 is somewhat at odds with that taken in the Equality Act 2010 which seeks to protect against discrimination based on gender identity and also at odds with the strand of case law which derives from EC law anti-discrimination provisions as discussed in Chapters Two and Three. Section 7 of the Equality Act 2010 ostensibly protects against discrimination on the grounds of gender reassignment which would, at first reading, appear to mean those who have undergone, are anticipating undergoing or are undergoing, gender reassignment as per s.7(1). However it is only on examination of this provision that it becomes clear that s.7 actually protects a much wider group of people. The examples given in the explanatory notes accompanying the legislation make it clear that the individual need not actually be under any medical supervision to be able to come within the protection of this provision.[811] So the provisions in the Equality Act 2010, while still requiring that individuals live as either male or female, acknowledge that the medical profession do not require to have a role in this process. The combination of the EC law anti-discrimination provisions, the Equality Act 2010 and the GRA 2004 is such that an individual may be given protection from discrimination based on his or her gender re-assignment (without being under the supervision of the medical profession, having undergone any body modification or even intending to undergo such body modification) but still not be able to have the gender identity which led to him or her living as a member of the opposite sex legally recognised by the GRA 2004, or the individual may undergo medical procedures and live as a member of the opposite sex without obtaining a GRC but still be recognised as a member of the opposite sex under EC law anti-discrimination provisions;[812] therefore the law is confused. The law has progressed since the enactment of the GRA 2004 to the extent that it can be argued that there appears to be a genuine attempt to provide for the legal recognition and protection of gender variant individual, however I am not yet convinced that the legal approach is as strong as it could be. Despite the developments in the law in the form of the GRA 2004 and the Equality Act 2010 the law "has remained stagnant in its approach to defining

[811] Explanatory Notes to the Equality Act 2010, para 43.
[812] See *Chief Constable of West Yorkshire v A* [2004] UKHL 21, [2005] 1 AC 51.

sex/gender, relying on the assumption of two discrete sexes that inherently correspond with two discrete genders."[813] The result of this rigid approach is that it has led to "negative results for transsexual individuals who do not fit neatly within the rigid legal sex/gender regime."[814] Although I am not, as of yet in this thesis, arguing that UK law adopts a non-binary conceptualisation of sex it is important that such concerns with the legal system are acknowledged and raised because I believe that such an approach may be, and perhaps ought to be, taken in the future, particularly in light of CoE Resolution 2048 (2015), discussed below. The comments and criticisms of the law adopting a binary approach to sex are important as they highlight that there are many ways of thinking about sex and gender and therefore the current legal approach is merely one possibility. Bell argues that "[o]nce it is recognized that legal system definitions carry negative implications for transsexuals, it is necessary to formulate plans for reform. This question of change is complex, however."[815] Although the question of how the law should be reformed is complex it is not an issue which should be avoided because of the impact that the law has on individual lives; therefore it is important that we have in place the best possible law.

In determining how to recognise transsexuals in law the legislature must consider the purpose and aims of the proposed legislation. What is the legislature trying to achieve, does it want to maintain the status quo, it is being forced to recognise transsexuals when it would rather not, does it want to be progressive and ground-breaking? These are all important questions to ask prior to enacting legislation and some of these issues can be seen in the Hansard debates surrounding the Gender Recognition Bill where it is clear that the Bill was proposed not out of a sense of seeking to provide a means of legally recognising gender variance but in response to the judgments in *Goodwin* and *Bellinger*: in a sense the legislation was introduced because it had to be not because the Government wanted it to be and this reluctance to introduce legislation is seen in the resultant Act which is confused. The GRA 2004 seeks to provide legal recognition of one's gender identity without any corresponding bodily changes which on the one hand is extremely progressive and radical. However, on the other hand, it then strictly limits who can apply for legal recognition of their gender identity to those who meet very limiting criteria which reinforces that the only gender identities which will be recognised in the UK are those which are binary and which meet the requirements of third parties; medical professionals and the GRP and therefore "does not allow room for changing notions and perceptions of

[813] M Bell (n 242) 1751.
[814] ibid.
[815] ibid.

sex and gender."[816] The confusion would not have arisen had the GRA 2004 required that one undergoes body modification prior to seeking legal recognition as this would, by necessity, mean that the individual had to first seek a diagnosis of transsexualism or GD/GID before obtaining the medical treatment. This would have meant that the law was merely providing recognition to those whom medicine had already classified as transsexual and had treated. However such an option was, in reality, never an option. The issue of requiring body modification was considered during pre-legislative scrutiny and for various reasons was never intended to be part of the legislation. So, the question then is to what extent does the GRA 2004 actually recognise one's gender identity or rather does it merely give recognition to diagnoses of the medical profession thereby making the individual's experienced gender less important than opinions of third parties?

UK law situated within the Council of Europe

Trans* rights have been a focus of the CoE for some time.[817] However this has not resulted in the protection of such rights in all CoE member states. Currently, as of October 2015, eight CoE member states have no provision for the legal recognition of transsexual individuals.[818] However, although this seems like a small number, when methods of recognition across the other CoE states is examined it can be seen that there is a wide variety of means on offer across the CoE and so the actual number of states which do not give adequate protection is a lot higher. For example across the CoE states legal recognition can range from full recognition[819] to merely allowing individuals to change their either their name[820] and/or change their sex on official documents:[821] the situation which existed in the UK prior to the GRA 2004 being enacted.

Of those countries which do have a procedure in place to provide for legal recognition it is not uncommon to require applicants to formally interact with the medical profession. Of the 31 states which provide for full legal recognition 28 require at least a diagnosis of

[816] ibid 1729.
[817] FRA *Being Trans in the European Union: Comparative analysis of EU LGBT survey data* (European Union 2014).
[818] Albania, Andorra, Armenia, Cyprus, Lichtenstein, Monaco, San Marino and Serbia.
[819] Austria, Azerbaijan, Belgium, Bosnia & Herzegovina, Croatia, Czech Republic, Denmark, Estonia, Finland, Germany, Greece, Iceland, Ireland, Italy, Latvia, Luxembourg, Malta, Montenegro, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, Ukraine and United Kingdom.
[820] Georgia and FYR Macedonia only allow individuals to change their name. There is no further provision in these states for any form of legal recognition.
[821] Bulgaria, France, Hungary, Lithuania, Moldova and Russia allow name change and gender change on official documents.

Gender Identity Disorder (GID)/Gender Dysphoria (GD).[822] However, some states go further and require compulsory surgery,[823] sterilisation[824] or both. Of those states which do not provide full legal recognition but merely the ability to change one's name, as in Georgia and Macedonia, or change name and gender on official documents[825] all but Moldova require medical intervention prior to being able to carry out such legalities. However all eight states require a diagnosis of GID/GD. Five of the eight states require surgical intervention[826] and six require the individual to be sterile before being able to change name and/or sex on official documents.[827] Therefore the GRA 2004 is not the worst piece of legislation in Europe in relation to trans* rights but nor is it the best and therefore there is considerable scope for improving the law, as will be argued throughout the remainder of this chapter.

A renewed focus on trans* rights from the Council of Europe

From the above discussion it is clear that trans* rights across Europe vary considerably and that it is not possible to identify a European approach or consensus in relation to this issue.[828] However, despite these differences in approaches trans* rights across Europe have come to the forefront again in 2015. On 22 April 2015 the CoE adopted Resolution 2048 (2015) which is intended to combat discrimination against trans* people in Europe. The Parliamentary Assembly, commenting on Resolution 2048 (2015) note that:

> [t]he Assembly is concerned about the violations of fundamental rights, notably the right to private life and to physical integrity, faced by transgender people when applying for legal gender recognition; relevant procedures often require sterilisation, divorce, a diagnosis of mental illness, surgical interventions and other medical treatments as preconditions. In addition, administrative burdens and additional requirements, such as a period of "life experience" in the gender of choice, make recognition procedures generally cumbersome. Furthermore, a large number of European countries have no provisions on gender recognition at all, making it impossible for transgender people to change the name and gender marker on personal identity documents and public registers.[829]

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[822] Austria, Azerbaijan, Belgium, Bosnia and Herzegovina, Croatia, Czech Republic, Estonia, Finland, Germany, Greece, Iceland, Italy, Latvia, Luxembourg, Montenegro, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, Ukraine, United Kingdom.
[823] Azerbaijan, Belgium, Bosnia and Herzegovina, Czech Republic, Greece, Italy, Latvia, Luxembourg, Montenegro, Norway, Poland, Romania, Slovakia, Slovenia, Switzerland, Turkey, Ukraine.
[824] Azerbaijan, Belgium, Bosnia and Herzegovina, Czech Republic, Finland, Greece, Italy, Latvia, Luxembourg, Montenegro, Norway, Romania, Slovakia, Slovenia, Switzerland, Turkey, Ukraine.
[825] Bulgaria, France, Hungary, Moldova, Russia.
[826] Bulgaria, France, Georgia, Lithuania, Macedonia.
[827] Bulgaria, France, Georgia, Lithuania, Russia, Macedonia.
[828] Note that this was one of the reasons why applications to the European Court of Human Rights prior to *Goodwin v United Kingdom* failed. See chapter Three for further discussion on this point.
[829] Resolution 2048 (2015) [3].

This echoes the data discussed in the above section. In relation to legal recognition of gender identity Resolution 2048 (2015) requires member states to:

> develop quick, transparent and accessible procedures, based on self-determination, for changing the name and registered sex of transgender people on birth certificates, identity cards, passports, educational certificates and other similar documents; make these procedures available for all people who seek it, irrespective of age, medical status, financial situation or current or previous detentions[830]

In addition to this general requirement Resolution 2048 (2015) implores states to do four particular things in relation to the provision of legal recognition of gender. Firstly states should:

> abolish sterilisation and other compulsory medical treatment, including a mental health diagnosis, as a necessary legal requirement to recognise a person's gender identity in laws regulating the procedure for changing a name and registered gender.[831]

States must also "remove any restrictions on the right of transgender people to remain in an existing marriage upon recognition of their gender [and] ensure that spouses or children do not suffer a loss of rights".[832] This is an important issue. Of the 39 states which provide either full or partial legal recognition 19 require that individuals divorce prior to undertaking the legal process in question.[833] In addition, although Scotland, by means of the Marriage and Civil Partnership (Scotland) Act 2014, and England and Wales, by means of the Marriage (Same Sex Couples) Act 2013, have abolished the requirement to divorce it still remains in Northern Ireland. The issue of requiring individuals to divorce prior to being able to obtain legal recognition of their gender identity has been considered in cases arising from the United Kingdom[834] and from Finland.[835] In 2006 in *R and F v United Kingdom*[836] the ECtHR held that it was not a violation of applicants' Article 8 or 12 rights for a state to require divorce prior to one party being able to obtain legal recognition of his or her gender identity. Again in 2014 in the case of *Hämäläinen v Finland*[837] it was once again held that such a provision requiring divorce was not a violation of the applicants'

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[830] ibid [6.2.1].
[831] ibid [6.2.2].
[832] ibid [6.2.3].
[833] Azerbaijan, Bosnia, Bulgaria, Czech Republic, Finland, France, Greece, Hungary, Italy, Latvia, Lithuania, Macedonia, Moldova, Montenegro, Poland, Russia, Slovakia, Turkey, Ukraine .
[834] *R & F v United Kingdom* App no 35748/05 (ECtHR 28 November 2006).
[835] *Hämäläinen v Finland* App no 37359/09 (ECtHR, 16 July 2014).
[836] *R & F* (n 835).
[837] *Hämäläinen* (n 836).

Article 8 or 12 rights. Therefore CoE Resolution 2048 (2015) goes further than the ECtHR has been willing to go in recent years and this aspect of the Resolution has largely been met by the UK by means of the reform of marriage law in 2013 and 2014. At the time of the enactment of the GRA 2004 the reason for this provision would seem to have been the need, at least in 2003/04 anyway, to maintain marriage as an opposite sex union. Tirohl and Bowers claim "[t]he argument for ending such marriages is possibly that they would be same-sex relationships and that this would be incompatible with current UK law."[838] Tirohl and Bowers' comments are reflected in the parliamentary debates which surrounded the progress of the GRB through the Houses of Commons and Lords in 2003/04 in which the worry of a number of parliamentarians was that the legislation would enable same-sex marriage in some instances.[839] It would then appear that the provision to end a marriage or civil partnership prior to a full GRC being given is a clear restatement of the heterosexual nature of marriage at the time. As a result of the changes in marriage law in the UK (other than in Northern Ireland) there is no longer any need for this provision and the reform of the GRA 2004 which derived from the Marriage (Same Sex Couples) Act 2013 and the Marriage and Civil Partnership (Scotland) Act 2014 is welcome not only as it meets the requirements of Resolution 2048 (2015) but because it enables those in stable long term relationships to maintain those legal relationships while one or both seeks legal recognition of their gender identity. If the GRA 2004 is to be reformed to ensure protection of applicants' Article 8 rights then it would be worth considering how the GRA 2004 interacts with civil partnership law as this remains one area in which there is limited protection of the rights of the individuals and arguably the Civil Partnership Act 2004 would require to be amended to enable opposite sex civil partnerships, however a further discussion of this is outwith the scope of this thesis.

In addition to the above requirement on removing the obligation to divorce Resolution 2048 (2015) provides that states must "consider including a third gender option in identity documents for those who seek it."[840] This provision goes further than the issues being explored in this thesis. However, in light of the discussion in Chapter Five surrounding the developments in the medical model of transsexualism this provision would be welcome as

[838] B Tirohl and I R Bowers 'Opposite sex – a discussion of rights under the Gender Recognition Act' (2006) *Journal of Gender Studies* 15(1):83-86; 83.
[839] HL Deb 13 January 2004 vol. 657 cc 1-62GC; *HL Deb 19 January 2004 vol 657 cc124-126WA; HL Deb 29 January 2004 vol 656 cc357-436; HL Deb 3 February 2004 vol 656 cc616-670;* HL Deb 10 February 2004 vol 656 cc146-147WA; HL Deb 11 February 2004 vol 656 cc1093-1095; HC Deb 23 February 2004 vol 418 cc48-108; SC Deb (A) 9 March 2004 cols 31-76.
[840] Resolution 2048 (2015) [6.2.4].

it would enable legal recognition of gender identity for all on the gender spectrum not merely those at the polar ends.

Another provision in Resolution 2048 (2015) is the requirement that states must "ensure that the best interests of the child are a primary consideration in all decisions concerning children."[841] This is an interesting issue and one that must be considered. If this provision is in relation to minors who seek legal recognition of their gender identity then it may prove problematic. There is currently no case law from Europe on this point however one Australian Family Court case can be used to highlight the difficult situation such young people may find themselves in. In the case of *Re Alex,*[842] Alex was a thirteen year old anatomical female who had been diagnosed with GID, as it was called at the time, and who was being cared for by the local authority. An action was raised to determine whether the local authority was competent to consent to treatment for Alex's GID. The court action centred on the following question: was the applicant, the local authority, authorised to consent to the following:

> (a) that Alex be administered a combination of oestrogen and progestogen on a continuous basis until he turned 16;
> (b) ongoing psychiatric assessment; and
> (c) that after Alex reached the age of 16, he be treated with luteinizing-hormone-releasing hormone [LHRH] analogue and testosterone administered either in oral form, by monthly injection or by six-monthly subcutaneous implant.

The problem was that, although some of these procedures could be reversed with no long term effects, the testosterone injections would produce some irreversible effects. Initially, the local authority was given permission to enrol Alex in secondary school under a male name and for the hormonal treatment to begin which would suppress puberty and female development. The applicants were at no point seeking an order that would allow Alex to undergo surgical procedures to alter his physical body before he reached 18. The case centred on whether the proposed treatment was in Alex's best interests, a concept not unknown to child and family lawyers, but one that is difficult to define.[843] The best

[841] ibid [6.2.5].
[842] [2004] Fam CA 297.
[843] For example see S Parker 'The best interests of the child - principles and problems' (1994) *International Journal of Law and the Family* 8(1):26-41; M Skivenes 'Judging the child's best interests: rational reasoning or subjective presumptions?' (2010) *Acta Sociologica* 53(4):339-353; D Archard and M Skivenes 'Balancing a child's best interests and a child's views' (2009) *International Journal of Children's Rights* 17:1–21; D Archard and M Skivenes 'Deciding best interests; general principles and the cases of Norway and the UK' (2010) *Journal of Children's Services* 5(4):43-54; K Tisdall et al 'Listening to the views of children? principles and mechanisms within the Children (Scotland) Act 1995' (2002) *Journal of Social Welfare and*

interests principle, when considering medical treatment, allows for the patient to be involved in decision making but only if the patient is deemed competent to understand the decision.[844] In addition the patient's expressed views may not necessarily be upheld by the Court. Therefore the best interests principle has the potential to severely restrict patient autonomy. The patient's ability to understand the decision they are making is determined by the medical professionals providing treatment or by a court and therefore there is a substantial degree of discretion afforded to the person judging the patient's competency. In this case Nicholson CJ found that the medical intervention was in Alex's best interest.[845] In determining Alex's competency to participate in the medical decision making process regarding himself the Court was willing to discuss Alex's self-perception and self-identity and to understand the difficulty he was in when his body did not correspond to his identity. The Australian Family Court was therefore willing to hold that a young person could be capable of participating in the decision making process regarding their treatment for GID. Therefore how this provision is, or indeed is not, included within the reformed GRA 2004 will be explored below.

It is crucial that CoE states adopt the principles in Resolution 2048 (2015). In the explanatory memorandum to the Resolution by Ms Schembri, rapporteur, it was acknowledged that "[l]egal gender recognition is for many transgender people the key to meaningful participation in society and to living in dignity, protected from discrimination."[846] Therefore the fundamental principles which must underlie reform in this area of law is personal autonomy and human dignity. However, in addition to this basis there needs to be careful consideration of the role of the medical profession. I have argued throughout this thesis that one of the main problems with the GRA 2004 is the role given to the medical profession, and indeed the GRP. The reasons for these roles in the GRA 2004 were explained in the previous chapter. However it is important to note that no longer is this a theoretical idea but rather the question of medicine in relation to legal recognition of gender identity is now gathering legal momentum as a result of Resolution 2048 (2015) as Shembri commented in the explanatory memorandum that "[a] medical and legal limbo is inscribed in all existing legislation regulating gender recognition."[847]

Family Law 24(2):385-399; L A Barnes '"Moral actors in their own right": consideration of the views of children in family proceedings' (2008) *SLT* 21, 139-142; J Eekelaar 'The interests if the child and the child's wishes: the role of dynamic self-determinism' (1994) *International Journal of Law and the Family* 8(1):42-61.

[844] Age of Legal Capacity (Scotland) Act 1991 s.2(4).

[845] *Re Alex* (n 843) [49].

[846] Explanatory Memorandum to Resolution 2048 (2015) [6.1].

[847] ibid.

Whereas this was correct at the time it is no longer correct, as will be shown below, as Malta, Denmark and to some extent Ireland now provide legal recognition without the input of medical professionals therefore precedent exists for the UK to similarly reform the law in a manner which protects the rights of applicants. Shembri notes that "[a]ll too often, the requirements for gender recognition force individuals to give up one human right to gain another"[848] for example the issue of forcing individuals to obtain a divorce or undergoing medical procedures which, it is argued, is contrary to the underlying principles of human dignity and personal autonomy and therefore contrary to the spirit of Article 8 ECHR. When the legal positions across the CoE states is examined it is clear that this is the case across the region; only one state, Malta, protects the rights of citizens fully as will be shown below.

In relation to the way in which law ought to provide legal recognition of gender identity the Parliamentary Assembly noted that:

> [a] number of Council of Europe member States have recently reformed their legislation on legal gender recognition or are in the process of doing so. Some regulations are based on the principle of self-determination and do not require long and complex procedures or the involvement of medical practitioners or psychiatrists […] [t]he Assembly welcomes, in this context, the emergence of a right to gender identity, first enshrined in the legislation of Malta, which gives every individual the right to recognition of their gender identity and the right to be treated and identified according to it.[849]

Therefore it is clear that gender self-determination, or self-declaration as I have called it in this thesis, is of fundamental importance for the CoE. Within such a model there would be no role for the medical profession or for a panel such as the GRP. This would mean that legal requirements such as "diagnosis of mental disorder, medical treatment and invasive surgery, mandatory psychiatric institutionalisation, assessment of time lived in new gender identity and being single or divorced"[850] no longer have a role to play in determining whether or not the individual's sense of self is accurate and therefore worthy of recognition in law and this ought to be welcomed because "[s]uch requirements violate a person's dignity, physical integrity, right to form a family and to be free from degrading and inhuman treatment."[851]

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[848] ibid [6.2].
[849] Resolution 2048 (2015) [4]-[5].
[850] Explanatory Memorandum to Resolution 2048 (2015) para [6.2].
[851] ibid.

Towards a legal model based on gender self-declaration

Therefore, in light of the theoretical approaches to reforming gender recognition laws and the requirements of CoE Resolution 2048 (2015) which outlines the importance of gender self-declaration it is important that I outline how the law should be reformed based on the principle of gender self-declaration. As a result of reform in 2014 and 2015 only three of the European states, Denmark, Malta, and Ireland, allow for legal recognition to be given without any medical input either in the form of medical treatment such as sterilisation, hormone therapy or surgery or in the form of requiring a diagnosis. Denmark and Malta have, what could be called, absolute gender self-declaration in their laws however Ireland, does not; it has a quasi-self-declaration model where if the applicant is over the age of 18 he or she has the absolute right to self-declare his or her gender and have that recognised by law. However if he or she is over 16 but under 18 years of age then the Irish Gender Recognition Act 2015 (GRA 2015) provides that the child's parent(s) or guardian(s) must consent to the making of the application[852] and evidence is required from the child's medical practitioner[853] therefore the Irish model appears to be something of a compromise and is rather confused. Each of these approaches will be discussed in chronological order below because when Denmark enacted its legislation it was hailed as wholly progressive but it has recently been surpassed by the approach taken in Malta, however I would argue that the Irish approach ought not be followed as it is a step back from that taken by Malta.

September 2014: Denmark

The first European state to reform their law based on a gender self-declaration model was Denmark. The reform was one by making an amendment to the Danish Civil Registration System.[854] Acknowledging the reform in Danish law Shembri notes:

> [t]The new Danish regulations represent a turning point and the first time that the principle of self-determination is enacted in Europe. They make it possible to obtain legal gender recognition by requesting a new social security number. No surgical intervention or treatments such as hormone replacement therapy are requested. The law introduces a reflection period (the request needs to be confirmed six months after the original application) and a minimum age of 18.[855]

This makes the Danish law straight-forward. Individuals over the age of 18 can make a written application to have their gender identity recognised in law. Following a six month

[852] Gender Recognition Act 2015 s.12(4)(a).
[853] ibid s.12(4)(b).
[854] Motion to amend the Act on the (Danish) Civil Registration System.
[855] Explanatory Memorandum to Resolution 2048 (2015) [6.8].

reflection period the individual must confirm the application in writing.[856] The application will then be granted subject to the individual providing a written declaration that he or she bases their application on a sense of belonging to the other gender. The important aspect of the Danish law is that there are no gatekeepers, merely a period of reflection during which the individual determines for himself or herself whether the application is right for them.

April 2015: Malta

Following the 2014 Danish reform Malta reformed their law in early 2015 and went several steps further than the Danes. The Maltese Gender Identity, Gender Expression and Sex Characteristics Act (GIGESCA 2015) was passed in April 2015 and provides the mechanism by which an individual obtains legal recognition of gender identity in Maltese law. It was reported at the time that the reform of Maltese law meant that Malta became "the first European state to have gender identity in its constitution."[857] This was a huge step forward for Malta as in 2011 it was reported that despite Maltese law then requiring individuals to be sterile and undertake surgical procedures before being given any form of legal recognition of their gender identity there were no facilities in the state to facilitate such requirements.[858] This was despite rulings of the ECtHR in *L v Lithuania*[859] and *van Kück v Germany*[860] which respectively provided that states are under a positive obligation to provide means for individuals to undertake medical procedures where these were required as a prerequisite to accessing the law and that trans* health care was to be included in health insurance plans. The law in Malta was one of the most restrictive in the whole of the CoE region. Prior to the reform it was reported that to enable an individual to change his or her name required "psychotherapeutic treatment, evaluation by a qualified mental health professional, real life test, confirmation of outer appearance, hormonal treatment, sex reassignment surgery (SRS) [and] permanent infertility."[861] However the situation changed radically in 2015 when the GIGESCA 2015 was passed. The 2015 reform included gender identity as a protected ground within the Maltese constitution thus making Malta "the first country in Europe to have gender identity anchored in its highest

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[856] Motion to amend the Act on the (Danish) Civil Registration System, Art. 1.
[857] M Dalli 'Transgender Europe applauds Malta for naming gender identity' <www.maltatoday.com.mt/news/national/38027/transgender_europe_applauds_malta_for_naming_gender_identity#.VgPILJdnaYe > accessed 24 September 2015.
[858] <http://tgeu.org/sorry-no-surgeries-available-malta-continous-breach-of-human-rights/> accessed 24 September 2015.
[859] (2008) 46 EHRR 22.
[860] (2003) 37 EHRR 51.
[861] <http://tgeu.org/sorry-no-surgeries-available-malta-continous-breach-of-human-rights/> accessed 24 September 2015.

legal text."[862] According to Transgender Europe the Maltese legislation "recognizes the right of each person to their gender identity and the free development thereof" [863] and it "fulfils the Council of Europe standards of "quick, transparent and accessible" gender recognition procedures, based on self-determination."[864] The GIGESCA 2015 defines gender identity as referring to:

> each person's internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance and/or functions by medical, surgical or other means) and other expressions of gender, including name, dress, speech and mannerisms.[865]

Section 3 provides that Maltese citizens have four particular rights in relation to gender identity: (i) the right to recognition of their gender identity,[866] (ii) the right to "free development of their person according to their gender identity",[867] (iii) the right to "be treated according to their gender identity and, particularly, to be identified in that way in the documents providing their identity therein,"[868] and (iv) the right to "bodily integrity and physical autonomy."[869] Section 3(2) provides for the consequences of the recognition of one's gender identity and s.3(4) provides that:

> [t]he person shall not be required to provide proof of a surgical procedure for total or partial genital reassignment, hormonal therapies or any other psychiatric, psychological or medical treatment to make use of the right to gender identity.

All an individual is required to do to partake of the rights in this legislation is request the Director for Public Registry to change the individual's legal sex based and/or name based on their self-declaration of gender.[870] As noted it is not appropriate for the notary to then seek evidence of the person's sex as the system is based entirely on self-declaration.[871]

The Maltese approach allows minors to obtain legal recognition of their gender identity also but the requirements are slightly different than for an adult. If the person seeking legal

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[862] <http://tgeu.org/malta-douze-points-first-constitution-in-europe-to-name-gender-identity-tgeu-statement/> accessed 24 September 2015.
[863] <http://tgeu.org/malta-adopts-ground-breaking-trans-intersex-law/> accessed 24 September 2015.
[864] ibid.
[865] GIGESCA 2015 s.2.
[866] ibid s.3(1)(a).
[867] ibid s.3(1)(b).
[868] ibid s.3(1)(c).
[869] ibid s.3(1)(d).
[870] ibid s.4(1).
[871] ibid s.4(3).

recognition is under 18 then an application must be made on his or her behalf by their legal guardian or parent.[872] In deciding whether to grant legal recognition to the minor the best interest of the child[873] and his or her views are given due consideration.[874] In addition it has to be noted that parents may postpone inclusion of a gender marker on their child's birth certificate until such time as the child's gender identity is determined.[875]

The approach taken in Malta is preferable to that taken in Denmark because it does not require a period of reflection. The literature on transgender identity, as explored in Chapter One, highlights that one's gender identity is formed at a very early stage in the child's development and no psychotherapeutic, or other, interventions will change one's gender identity. Therefore if gender identity is so firmly fixed then why should an adult be required to wait six months following making an application to change legal sex to then confirm that requested change? It may well be that the six month wait in Danish law is about ensuring that individuals do not make hasty applications which are then regretted and seek to revert back to their sex assigned at birth. This, as noted above, was one of the concerns with the GRA 2004 when it was being debated in parliament. However, there are no irreversible consequences of obtaining a legal change of sex either in the GRA 2004, the Danish law or in the Maltese GIGESCA 2015 therefore, I argue that it is particularly difficult to uphold a waiting period in law and would argue that there should be no such period of reflection. Therefore the Maltese approach is preferred to the Danish one because it allows minors to obtain a change of legal sex, whereas Denmark requires that applicants be 18, and there is no waiting period. So, after deciding that reform of the GRA 2004 should follow the Maltese model it is now important to consider the most recent reforms from one of the CoE states, Ireland, to determine whether or not any more recommendations for reform can be taken from the Irish approach.

July 2015: Ireland

The Gender Recognition Act 2015 (GRA 2015) placed Ireland as the third European state to allow legal recognition of gender identity without any need for medical input, however this is only partly true, as will be seen below, and this amounts to a failing of the Irish model. Under the GRA 2015 those over the age of 18 can apply based on written self-

[872] ibid s.7(1).
[873] ibid s.7(2)(a).
[874] ibid s.7(2)(b).
[875] ibid s.7(4).

declaration of gender identity.[876] The Minister receiving the application can either issue a GRC[877] or refuse to issue a GRC.[878] As in the UK it is possible for the Minister receiving the application to request further information or evidence.[879] There is also a requirement, however, that the applicant must not be married or in a civil partnership.[880] It will be interesting to see whether this provision is amended as a result of the recent vote in Ireland to accept same-sex marriages. There are a lot of similarities between the Irish GRA 2015 and the UK GRA 2004. For example, in addition to the ability to request further information as mentioned above, there is also the requirement that the individual provide a statutory declaration that he or she intends to live "in the preferred gender for the rest of his or her life."[881] Although the Irish Act is excellent in that it removes the requirement for the medical profession to be involved (where the applicant is over 18) it retains a degree of gatekeeper functioning by means of the Minister receiving the application and the additional criteria which need to be fulfilled to support an application which is absent in the Maltese approach and for that reason the Irish approach is a step towards the reform that the UK should take but UK law should not mirror Irish law.

Another reason why Irish law is not as good as it could be is that it creates a complex situation for those aged 16 and 17. As in Malta it is possible for those under 18 to apply however the Maltese approach is to be favoured as in Ireland those aged 16 and 17 require the input of two medical professionals[882] and the consent of the child's parent or legal guardian[883] unless the parent or guardian cannot be identified, found or failed or neglected to respond to a request for consent or that consent could not be obtained because of the relationship between the parent/guardian and the child.[884] It is not possible to apply for legal recognition of one's gender identity in Ireland below the age of 16, whereas it is in Malta.

Reform in Poland

It should also be noted that on 7 August 2015 Poland enacted the Gender Marker Change Act which allows Polish people to change their legal sex. However, it has not yet been

[876] GRA 2015 s.8(2).
[877] ibid s.8(3)(a).
[878] ibid s.8(3)(b).
[879] ibid s.8(4).
[880] ibid s9(2)(b).
[881] ibid s.10(1)(f)(ii).
[882] ibid s.8(4)(b)(i)(II) and 8(4)(b)(ii).
[883] ibid s.8(4)(a).
[884] ibid s.8(5).

possible to obtain a copy of this legislation. It is understood that the law, although progressive for Poland, is not progressive in relation other legislation across the CoE region in that it required that individuals not be married and provide reports of two medical professionals to support that the applicant is of the gender identity opposite to the sex legally assigned.[885]

How to reform the GRA to adhere to a gender self-declaration model

So, based on the above discussion, and that presented throughout the preceding chapters, I am arguing that UK law requires to be reformed in light of Resolution 2048 (2015) and the problems which arise from the legislation being based on the medical model of transsexualism which existed in 2004. I argue that the model which ought to be adopted in the UK should base reform of the GRA 2004 on the approach taken in Malta; an approach based on self-declaration of gender identity which makes provision for minors to obtain legal recognition of their gender identity. I believe that this is the approach which ought to be taken because self-declaration of gender identity is the only reliable means of determining someone's gender identity therefore having legal mechanisms which rely upon third party determination of applicants' gender identity has the potential to deny recognition to those who should be given it. Reforming the GRA 2004 would be straightforward. All that is required to have a gender self-declaration model would be the removal of any third party intervention. This would mean that the GRP would be replaced by a more suitable application system which was not intended to test/scrutinise the application but rather merely 'rubber stamp' it as in Denmark and Malta. In addition any role given to the medical profession in the current legislation would need to be removed. Again the purpose of removing this role is to ensure that the individual's identity is not being tested but rather accepted. In addition the reformed law could further ensure that the individual was at the centre of the law by removing the minimum age requirement contained in s.1(1) and by removing the requirements in s.2 such as the reference to gender dysphoria,[886] the requirement for permanence[887] and the two year lived experience requirement.[888] The only reason the provisions in s.2 are in the GRA 2004 is because of how parliament accepted gender variance as a medical condition which had certain criteria

[885] <http://tgeu.org/%EF%BB%BF%EF%BB%BFpolish-parliament-makes-trans-history-trans-fuzja-media-statement/> accessed 24 September 2015.
[886] GRA 2004 s.2(1)(a).
[887] ibid s.2(1)(c).
[888] ibid s.2(1)(b).

such as a desire to live as a member of the opposite sex *etc*. The two year period in s.2 is problematic as was argued in the previous chapter because it is based on a flawed understanding of the requirements of medicine at the time, and which have since been reconsidered by the medical profession. Further s.3 could be reformed to remove any requirement for evidence that the individual has or has had gender dysphoria,[889] meets the requirements in relation to permanence and the two year experience,[890] or has changed sex in an approved country or territory.[891] The provision in s.3(5) could remain if the purpose of it was to ensure that UK law gave recognition to individuals who changed sex abroad before coming to the UK but I argue that this is not the purpose of this section. I believe that s.3(5) is concerned, again, with testing who should or should not be given recognition. If someone has legally changed sex in another jurisdiction then this ought to be recognised in UK law with no provision for UK law not to recognise it. However if someone has physically changed sex in another jurisdiction but without having that change legally recognised then it should not be for UK law to determine whether or not to recognise the procedures in that other jurisdiction but rather consider an application for legal recognition on the same basis as any other application under the reformed law i.e. that the person wishes to be recognised for legal purposes as the sex opposite to his or her sex assigned at birth. I fear that the inclusion of s.3(5) in the current legislation is connected to the medical model of transsexualism in that only countries or territories which adhere to the same medical criteria regarding transsexualism and sex re-assignment will be included in the list of approved countries or territories for the purpose of the GRA 2004 and for that reason this provision should be removed. I would also remove any reference to other evidence which may be required either by the GRP or anyone else.[892] The purpose of allowing for asking for additional evidence again returns to testing whether or not one is worthy of legal recognition and as such has no place in legislation based on gender self-declaration. Provisions in relation to marriage and civil partnership should remain as currently civil partnerships are only available to those in homosexual relationships and therefore it is necessary for one's partnership status to be declared. I am not convinced that there should be provisions in relation to one's marital status however, based on the discussion below in relation to the rights of partners in a marriage perhaps it is best to retain these provisions so that consent, or otherwise, of a spouse could be readily obtained. In addition I would abolish the two-tier recognition system which exists by means of the full and interim

[889] ibid s.3(1)-(3).
[890] ibid s.3(4).
[891] ibid s.3(5). In addition s.21 would require to be repealed if this provision was removed.
[892] For example s.3(6)(b) and (c).

GRCs. An interim GRC does not change one's legal status therefore the question is why should it exist if it does nothing to change the person's status? The interim GRC exists only as a means of terminating marriages or civil partnerships other than by through divorce/dissolution laws. Therefore I would remove the interim GRCs because there is no need to terminate a marriage if one of the parties obtains a GRC. Of course this would require consideration in relation to civil partnership laws and will be explored in more depth below. The current provisions in relation to consequences of obtaining a GRC would remain as would the other provisions not mentioned here.

Issues to be considered with the self-declaration model

Of course, the approach taken in Malta may not necessarily be the best approach for the UK therefore thought has to be given to which aspects of each approach should be adopted by the UK, and indeed should the UK go further, if possible, to ensuring full gender self-declaration in law? A return to the concerns which arose during the passing of the GRA 2004 will help to see which aspects of the current UK law should be retained and which aspects should be amended.

The need for certainty

One of the main concerns which arose in the debates preceding the GRA 2004 was that of certainty;[893] both in ensuring that one's legal sex could be certain to third parties and also that the law had to be certain that only those who ought to be given legal recognition were actually able to obtain it i.e. true transsexuals. The first concern is easy to deal with so I will start with that one. In relation to certainty of one's legal sex this is maintained in each of the approaches taken in Malta, Ireland and Denmark because in each of those states one is either male or female, there is no possibility of a third legal sex being provided. Although Resolution 2048 (2015) and the current medical understanding of gender dysphoria provide for the possibility of non-binary gender I am not arguing that such an approach should, at the moment at least, be taken by the law. At the moment the UK legal system relies upon individuals being either male or female so an approach which introduced a third identifier would be unworkable; concepts such as maternity and paternity would have to be altered, as would any remaining gender specific offences and

[893] Joint Committee on Human Rights *Draft Gender Recognition Bill,* 20 November 2003 HL Paper 188-I & II, HC 1276-I & II [29]-[52], HL Deb 13 January 2004 vol. 657 cc 1-62GC [58]-[60], HL Deb 29 January 2004 vol 656 cc357-436 [378]-[379], SC Deb (A) 9 March 2004 cols 3-30 [15]-[22].

employment law provisions which allow for different treatment of the sexes, that is not to say that these changes could not be made but I am arguing that they should not be required at the present time. Therefore, at the moment, to ensure that the legal system does not face these additional challenges the proposal would be to retain the binary approach to gender identity in the reformed Gender Recognition Act. Although I would personally welcome a non-binary approach to legal sex in the UK such a quest is one for the future. So, retaining the binary model of sex means that the other aspect of certainty for third parties can be dealt with, and relatively quickly dismissed. If certainty for third parties is such a concern then the current GRA 2004 fails to ensure that certainty can be achieved. The main way in which a third party decides upon the sex of an individual is by means of observation and measuring that individual against what he or she expects to observe; if someone appears to be male they are likely to be sexed as male by others and vice versa for females. This is, of course, an entirely unscientific approach and it also has no legal consequence. However because the GRA 2004 does not require body modification it itself gives rise to legal men who appear to others as female and legal women who appear as male. Therefore, as this situation already exists in law, it is not crucial that it be explored further here: the current law undermines this concern itself and any reform would not result in any more confusion for third parties.

The next real concern underpinning the GRA 2004 is that only those who are truly transsexual should be able to change their legal sex. The idea behind this approach is that one should not be able to 'chop and change' legal sex. The main way by which this concern was dealt in the GRA 2004 was by means of requiring the input of medical professionals. I showed in the previous chapter why this approach raised problems and so will not discuss the problems with this approach in this chapter. Suffice it to say, removing the diagnostic criteria in the GRA 2004 and removing the input of the medical professionals would not make the law any less certain. A system which provides legal recognition of gender identity without requiring a diagnosis and the input of medical professionals exists in Ireland, Malta and Denmark so there is precedent for such an approach to be taken. This may mean that non-transsexuals i.e. the wider trans* community could benefit from the rights in the reformed GRA but, in my opinion, this should be welcomed. Not all trans* people seek to abolish the categories of male and female and should someone who does not meet the medical criteria to be classified as transsexual but who still identifies as more male than female or more female than male decide that they would prefer their gender identity to be recognised in law as that opposite

to the sex assigned at birth then the question would be why should this not happen? This is really a case of flipping the question around and changing how these issues are conceived of, a bit like the approach taken by the ECtHR when determining *Goodwin v United Kingdom*,[894] as discussed in Chapter Three. Rather than starting from the perspective that gender identity follows on from one's physical sex and then assuming that gender identity which differs from sex is a result of an abnormality of psychosexual development perhaps it is better to approach the issue with a wider understanding of gender identity and experienced gender; an approach that would recognise the entire gender spectrum and recognise that gender variance is a natural part of being human. If this latter approach was taken the question for law would be *how can the law be designed in such a way as to maximise recognition of gender identity and experience* as opposed to the more restrictive *how can we ensure that the law only recognises those who meet a particular way of understanding gender identity and exclude all other gender variant individuals.* It is clear that the UK legislature sought to answer the latter question when passing the GRA 2004, and as has been pointed out throughout this thesis, such an approach resulted in problematic legislation. Therefore in reforming the GRA 2004 I would remove the need for a diagnosis of GD and the need for medical reports to support the application and, for the reasons given above, this would not make anyone's legal sex any less certain for third parties.

The requirement for permanence

Related to the need for certainty above is the need for permanence in the legislation which is based on ensuring that one cannot change one's sex too often as this would cause confusion for the legal system or for third parties. This is a problematic stance to take and this argument cannot be sustained because the GRA 2004 already allows for subsequent changes so the proposal for the reformed law would not be any different to what already exists…albeit that it would be more difficult to change back under the GRA 2004 under the proposed law which would only require another application but without the whole scrutiny of the application as currently exists. The issue of requiring an applicant to state their intention to live permanently as a member of the acquired gender in the GRA 2004 and the Irish GRA 2015 is problematic, as discussed in the previous chapter, and I am not convinced that such a provision requires being in the legislation. It was noted in Chapter Five that a major concern when debating the GRA 2004 was that if the law was not sufficiently robust individuals might revert to their birth sex. However, as noted several

[894] *Goodwin* (n 15).

times, there is nothing in the current legislation which prevents that and the reformed GRA 2004 would not make any changes to this. To remove the permanence requirement from the legislation would mean that the legislation would adhere to the current medical model of transsexualism i.e. by recognising that experienced gender is not always permanently one gender or the other. However it would not amount to legislating based on this medical model of transsexualism because there would be no means of recognising those whose gender identity is non-binary.

The concern with avoiding same-sex marriage

At the time of the debates in parliament same–sex marriage was not an option in the UK and therefore this concern was valid at the time. However with the change in law recently in England and Wales and in Scotland arguably this should no longer be a concern. What is now of more importance is the rights of those couples in civil partnerships and of those individuals in a marriage where one of the parties seeks to obtain legal recognition of his or her gender identity. Currently the GRA 2004 requires that individuals must provide "a statutory declaration as to whether or not the applicant is married [or a civil partner]"[895] and I mentioned above that this provision required consideration. Although in theory this provision should not be required I think that it ought to remain for the time being. Declarations as to marital or civil partnership status are important because if one party to the marriage or civil partnership seeks legal recognition of his or her gender identity this impacts on the other party. There are provisions within the current GRA 2004 which allow for married couples to remain married following the issuance of a GRC so long as the couple are in a protected marriage and the other party consents. There ought to remain in the reformed legislation a similar provision that if the applicant is married then the consent of his or her spouse should be obtained before a GRC is issued. However this cannot be allowed to amount to a spousal veto whereby the spouse of the applicant can derail the application for recognition therefore the current provisions in the GRA 2004 are adequate for these purposes.

Those who are in a civil partnership are in a different situation as there is no provision for heterosexual civil partnerships therefore the consent of the applicant's civil partner is irrelevant, unless of course both partners seek to change legal sex at the same time but this is a situation which I have not yet seen any evidence of having occurred and is therefore merely theoretical. The issue of rights of those in a civil partnership is difficult to address

[895] GRA 2004 s.3(6)(a)

here as to change this provision within the GRA 2004 would require a change to the Civil Partnership Act 2004 to enable civil partnerships to be entered into by homosexual couples. The CPA 2004 is currently being challenged in the English Courts and it may be in the future that civil partnerships are available to heterosexual as well as homosexual couples. If this does happen then the provisions in the GRA 2004 for civil partners should mirror those above for spouses. So the proposed amendment to the GRA 2004 would not impact on marriage or civil partnership law at all and therefore this concern of parliament is not relevant to the changes that require to be made to the GRA 2004.

The rights and interests of third parties

The issue of rights and interests of third parties was debated at length in the Gender Recognition Bill (GRB) debates. Issues such as family members and employers being able to provide evidence to the GRP, rights of children when their parents seek legal recognition, rights of third parties who may enter into a marriage with the individual seeking legal recognition etc. The current GRA 2004 addresses these issues and the proposed amendments would make no changes to the current provisions. For example the rights and interests of those in formal intimate relationships with the applicant were dealt with in the section above. In addition the law already provides prohibitions on disclosure and the proposed amendments would not impact on this. As this concern was dealt with before the current law was enacted and the proposed reforms have no impact on this issue then this is not an issue that requires any more consideration.

Concern with under 18s accessing the legislation

Is it tempting to say that the Maltese approach on this is correct, however, on closer examination I am not convinced that the UK could not go further and remove the third party from the process altogether, however this needs examining. The only discussion of this during the parliamentary debates was when Baroness Buscombe asked at what age a person can apply for a GRC to which the reply from Lord Filkin was that he was "sure she will be glad to know that no one under the age of 18 will be able to apply."[896] Therefore there was no meaningful discussion of this provision prior to its acceptance within the legislation. I think that the minimum age requirement as it currently exists in the GRA 2004, in the Danish model and in the Irish GRA 2015 is problematic because it gives no consideration to the growing capacity of the young person to be involved in decision

[896] HL Deb 18 Dec 2003 vol. 655 cc1287-326 [1322].

making in such an important area of their lives and in fact the UK and Denmark absolutely prohibits under 18s from having their gender identity recognised in law. The Irish model at least has the possibility of a young person obtaining legal recognition albeit without a full right to apply themselves and the Maltese model allows for the young person's participation in the process but that decisions will be made based on the best interest of the child.

The question therefore is to what extent should the young person be involved and actually, first, what is it the young person should be involved in? It is imperative to answer both of these questions because only then will an understanding of how to incorporate this provision into the reformed GRA be possible. Although *Re Alex* is not authoritative in the UK, the reasoning of the Court ought not to be ignored. As Barnes claims, the decision in this case "indicates that it is naïve to assume those under 16 lack the capacity to live in an acquired gender or consent to treatment for transsexuality."[897] It is this observation which is at the heart of the issue in question; although the current legislation prohibits young people from being able to have their gender identity recognised there is nothing to prevent that young person from living in the acquired gender or indeed even from taking hormones and/or having surgery. Now Barnes makes an important observation when she states that "[m]edical experts will almost certainly view prepubescent children as lacking the level of understanding required to consent to irreversible [sex re-assignment]."[898] However such decisions can be challenged on the basis that the young person does in fact understand the proposed treatment and its consequences, in which case it will be for the court to decide whether such young person has legal capacity to consent. Although the situation is that transsexual teenagers in the UK are unlikely to be provided with any permanent body modification procedures before they reach the age of 18 but there is nothing to prevent that individual from accessing diagnostic services at one of the UK Gender Identity Clinics from any age. If diagnosed with GD/transsexualism then the adolescent patient can receive endocrine therapy, particularly before he or she has begun puberty, which is intended to halt physical development and therefore ease further dysphoria experienced during puberty.[899] A diagnosis of GD/transsexualism can medically be provided to a person under

[897] L Barnes 'Transsexuality and "kidulthood": treatment and recognition' 2006 *Scots Law Times* 26:169-172: 169.
[898] ibid 172.
[899] P T Cohen-Kettenis and S H M van Goozen 'Pubertal delay as an aid in diagnosis and treatment of a transsexual adolescent' (1998) *European child and adolescent psychiatry* 7(4):246-248; P T Cohen-Kettenis, H A Delemarre-van de Waal, L G Gooren 'The treatment of adolescent transsexuals: changing insights' (2008) *The journal of sexual medicine* 5(8):1892-1897; L Gooren and H Delemarre-van de Waal 'The feasibility of endocrine interventions in juvenile transsexuals' (1996) *Journal of Psychology and Human*

the age of 18 based on the criteria contained in either of the diagnostic manuals. The minimum age provision becomes even more complicated if the individual is deemed medically competent to consent to medical procedures to alter their appearance, even simply non-invasive procedures such as taking cross-sex hormones, because such a person would be able to take steps to physically appear to be of the opposite sex but the law then prohibits legal recognition until the age of 18. In addition when one combines the minimum age requirement with the provision that the individual must have lived in the acquired gender for two years ending with the date on which the application for a GRC is made then the individual, to be able to make an application when he or she reaches 18, must have begun living as a member of the opposite sex at 16 at the latest. It is therefore argued that if the adolescent transsexual patient is diagnosed before 18 and begins living as a member of the opposite sex, with or without medical treatment, then having to wait until 18 before being able to apply for a GRC seems an unnecessary additional burden based only on the individuals age and not being capable of taking into consideration their personal circumstances and therefore this provision may not withstand ECHR challenge. This situation may lead to numerous difficulties for such young people such as "registration at school and university; production of a birth certificate for enrolment or employment; use of changing rooms and toilets"[900] all of which may give rise to a human rights based challenge under Article 8 and 14 ECHR on the basis of an individual being unable to access the provisions contained within the legislation based solely on his or her age.

As of October 2015 there have been no cases challenging the minimum age requirement. However, this provision may form the basis for human rights challenges in the near future as, Barnes argues, such an age requirement runs contrary to both the supposed aims of the Act - of increasing self-determination and respecting the private life of individuals.[901] It would have been beneficial had the debates considered this provision in more depth as one can only now speculate as to the reasons behind this provision. Given that the debates on the GRB centred around the themes of permanency and certainty it may well be that those under the age of 18 are deemed 'too risky' as they may be thought of as less certain of their identity, more likely to seek to change their legal sex based on a whim and therefore in need of more protection from their own immaturity. However, because of the lack of

Sexuality 8(4):69-74; H A Delemarre-van de Waal and P T Cohen-Kettenis 'Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects' (2006) *European Journal of Endocrinology* 155(Suppl 1):S131-S137

[900] ibid.

[901] ibid.

debate on this provision it cannot be said with any certainty that these are the reasons why the minimum age requirement was included in the legislation.

However it must not be forgotten that the GRA in its current format nor in its amended format required body modification therefore we are not asking young people to consent to medical treatment and participate in the decision making surrounding medical treatment. We are asking that young people be able to articulate their identity and request that that identity be recognised by law; there is nothing irreversible about this and therefore the test regarding capacity of the young person to be involved at this stage ought to be much weaker than that required in relation to medical treatment, It would be possible to take the Maltese model and use it as the basis for reform of UK law. Such an approach would not be unfamiliar to the UK legal system, particularly in Scotland, where young people are given the right to participate in decisions about themselves but that ultimately the court, or other official decision maker will made the decision based on the child's best interests. Such an approach in the UK could work by either removing the minimum age requirement from the GRA 2004 by rephrasing s.1(1) thus:

> (1) A person of either gender […] may make an application for a gender recognition certificate on the basis of –
> (a) living in the other gender, or
> (b) having changed gender under the law of a country or territory outside the United Kingdom.

This would be all that is required to remove the minimum age requirement and avoid any potential future ECHR based challenges from those under the age of 18. If the legislature wanted to ensure that young people were protected, in essence, from themselves then a provision could be added into the GRA 2004 which provided for under 18s. The provision in the Maltese legislation is contained in s.8 and is as follows:

> (1) The persons exercising parental authority over the minor or the tutor of the minor may file an application in the registry of the Civil Court (Voluntary Jurisdiction Section) requesting the Court to change the recorded gender and first name of the minor in order to reflect the minor's gender identity.
> (2) Where an application under sub-article (1) is made on behalf of a minor, the Court shall:
> (a) ensure that the best interests of the child as expressed in the Convention on the Rights of the Child be the paramount consideration; and
> (b) in so far as is practicable, give due weight to the views of the minor having regard to the minor's age and maturity.

There is no reason why the GRA 2004 could not be reformed by means of amending s.1(1) as noted above and also by adding a provision in relation to applications by minors such

that it mirrors GIGESCA 2015 s.8(2) above. One of the failings of GIGESCA 2015 is that it does not allow for applications to be raised by the young person himself or herself but rather requires that an application is made on behalf of the young person. I argue that this provision should not be in the amended GRA 2004 as to do so introduces another third party into the process of an individual acquiring legal recognition of their gender identity; the situation which, I argue, should be avoided. The problem then, of course, is raised in relation to how the state ensures that young people are protected from their own decisions which they may regret at a later point in time if there is no adult involvement in terms of applying for a GRC. Arguably this has already been dealt with above where discussions were made in relation to the ability to make subsequent applications for GRCs. It has to be remembered that at this point we are not discussing irreversible medical procedures, which arguably a young person could consent to if they are deemed to "understand the nature and possible consequence of the procedure or treatment."[902] Rather we are discussing an administrative procedure which can easily be changed should the person's identity change. The fact that the GRA 2004 already allows for subsequent changes undermines the argument that young people should be protected from making this decision as it is not an irreversible decision. However, it would be difficult to completely remove third party participation in relation to young people given the legal framework which exists in the UK at the moment. Under the UN Convention on the Rights of the Child Article 3 it states:

> 1. in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

This has been wholly embodied in decision making about young people in the UK. Therefore in a situation whereby a public body would be determining whether or not to issue a GRC the best interests of the child would have to be taken into consideration and so there is a strong argument for including such a provision. How this would work in reality may be different from how I would envisage it in law. In law it would be possible to mirror the GIGESCA 2015 approach but in effect this adds discretion into the process of obtaining legal recognition of one's internally experienced gender; something that cannot be definitively known by a third party. In reality if the best interests provision was to be included in the reformed GRA 2004 then it may give rise to more and more tests being developed to ensure that such a decision was in the young person's best interests and we

[902] Age of Legal Capacity (Scotland) Act 1991 s.2(4)

may end up in a situation which is similar to the one we are in now where medical professionals become involved in 'testing' the young person's expressed gender identity against medical criteria, which is a situation that should be avoided. Therefore, for this reason I argue that such a provision would be required to be included but carefully monitored. However there should be a possibility in the legislation for young people to raise applications for GRCs on their own without having to rely on their parent(s) or guardian(s).

Conclusion

This chapter has outlined possible alternative models of providing legal recognition of gender identity. It has been argued that as a result of CoE Resolution 2048 (2015) and the changing understanding of gender variance from within the medical profession that it is now the ultimate time to consider reforming the GRA 2004. If reform was to be undertaken it ought to be based on the gender self-declaration model which has been outlined throughout this chapter. Although it may be tempting to think that the gender self-declaration model cannot meet the requirements of the GRA 2004, in terms of addressing the concerns which existed when parliament initially drafted the GRA 2004, because the gender self-declaration model is so different from the medical model of transsexualism this would be inaccurate. As this chapter has shown it is possible to meet the main concerns of parliament and still take a very different approach to designing the legislation. This chapter has shown that all that would be required to fundamentally change the law to give individuals much more right to have their gender identity recognised is some minor amendments to the GRA 2004 namely removal of any role given to a third party. The proposals outlined in this chapter would secure long-term compliance with Article 8 ECHR by allowing the individual to develop his or her sense of self and to have that recognised by the state. In addition the proposals outlined in this chapter still give consideration to the need to maintain certainty in law, to ensure the rights and interests of third parties are protected where appropriate and that the minimum age requirement has been fully considered rather than merely accepted as in 2003/4. The issue with marriage and civil partnership is a bit more difficult to reconcile however it is possible. The proposals would be to ensure that those who do not wish to remain married to someone who obtains a GRC are not required to do so and thus the current law is sufficient here. It may well be though that in the next few years there will be further amendment to the GRA 2004 when civil partnership laws are examined and potentially reformed.

Conclusion

As noted in the Introduction this thesis was inspired by a number of personal friends who sought to negotiate medical involvement in the realisation of their identities before UK law. In so doing I began this thesis with the intention of exploring the exact role of the medical profession in the process of acquiring legal recognition of one's gender identity. However it quickly developed such that it ended with proposals to reform the Gender Recognition Act 2004 (GRA 2004) to adopt a model of legal recognition which is based entirely on gender self-declaration rather than on the medical understanding of transsexualism in 2003/4.

Chapter One explored the medical model of transsexualism up to the date at which the legislation was enacted and I showed how the model developed up until it was accepted by the legislature. In so doing I showed the limits of the medical model as of 2003/04 which provided very strict boundaries on who could obtain a diagnosis of GD/transsexualism and consequently who could access the GRA 2004 provisions. It was shown in Chapter One that the medical model had its roots in legislation which sought to punish those who engaged in potentially non-procreative sexual practices which led, eventually, to sexologists separating those who could be considered homosexual from those who they classed as ill and eventually, by the 1950s, labelled as transsexual. This work of sexologists created a category of individuals whom medicine then sought to research in an attempt to understand why their gender identity was not as expected: why did some women identify as men and seek to take the necessary steps to live as men and vice versa for some men? This enquiry in itself highlighted the presumptions which exist around 'normal' and 'deviant' sexuality and gender identity. The result of the work during this period was to classify transsexual individuals not as deviant but rather as exhibiting a disorder of psychosexual development: something went wrong in the development of their gender identity. As a result of these small incremental steps being taken transsexualism was fully accepted by the medical profession by the 1970s and 1980s and a whole industry was established to diagnose and treat this group of individuals. By the time the legislation was enacted in 2004 the model of transsexualism as a medical condition, the causes of which were not fully understood, was such that it became impossible to consider transsexual gender identity as anything other than a medical condition and it was this inability to reconceive of gender identity as anything other than medical which formed the basis for the GRA 2004 in its current form.

Chapter Two explored the legal consequences for individuals who identified as members of the sex opposite to the sex assigned at birth and it was shown how law refused to recognise any of the medical procedures undertaken by such individuals in an attempt to ease the dysphoria they experienced as a result of their medical condition. The chapter showed that there was no likelihood of reform of the law in the UK other than in areas which were directly influenced by EC law such as in the area of employment. It seemed then that UK domiciled transsexuals were condemned to a legal limbo of appearing to be one sex while being legally classed as the opposite.

Chapter Three explored the impact of *Goodwin v United Kingdom* where it was established that law's recognition of one's gender identity is not dependent upon the medical model of transsexualism. The ECtHR managed to establish this by means of placing transsexual legal recognition within the realm of human rights law: specifically the wide Article 8 jurisprudence which it had been developing since the 1970s. This case had a huge impact in UK Courts such that the House of Lords issued a declaration of incompatibility between UK marriage law and the ECHR. It was this that effectively forced reform of the law.

Chapter Four showed that the GRA 2004, although hailed as radical and ground-breaking, and although being a positive piece of legislation in that it does provide individuals with a means of realising their gender identity in law, is built upon a particular medical model of transsexualism which existed in medicine as of 2003/04 when the legislation was being debated in Parliament. As a result of this medical model being accepted by the legislature without question and critique the legislation requires a diagnosis of GD and also medical evidence to be provided. It was my argument throughout this thesis that law did not have to adopt that particular model of gender identity recognition in 2004 when the legislation was enacted but rather law could have taken a wholly non-medical approach to gender identity recognition based on the Article 8 jurisprudence which influenced the ECtHR in *Goodwin*.

Chapter Five explored the problems with law taking this approach and it was argued in Chapter Five that a lot of the continuing problems with the GRA 2004 which are a result of basing the law on this medical model could have been avoided had law chosen in 2004 to make this solely a human rights issue. It was also argued in Chapter Five that developments in the medical model since 2004 have undermined the GRA 2004 and therefore strengthened the argument that such a dynamic and evolving model was an inappropriate foundation for such important legal rights.

Chapter Six explored the possibility of reforming the law based on gender self-declaration, an approach taken in Denmark, Malta and Ireland. As a result of this examination it has been possible to propose reform of the GRA 2004 to adopt a more human rights based approach to legal recognition of gender identity but which still considers the concerns of parliament at the time the GRA 2004 was enacted.

What this thesis has done has been to take a piece of legislation which has had a positive impact on the lives of individuals and critique it to show that it could be better; it could be better because it has underlying assumptions about what sort of people would try to access the legislation and therefore tries to ensure that only 'true' transsexuals i.e. those who are ill, are able to legally change sex in the UK. In order to do this the legislation as it currently stands requires to adopt a means of testing applicants and thus adopts the medical model of transsexualism which requires diagnosis of GD, that one seeks to live permanently in the acquired gender, that one undergoes a two year wait between obtaining the diagnosis and making the application for recognition *etc*. This thesis has shown that there are huge problems with the law taking this approach and that it does not need to be so complicated. In proposing a new model of recognition based on gender self-declaration the approach taken in other jurisdictions, Ireland, Malta and Denmark, have been examined and the proposals for reform of UK law are based on the best aspects of each of the approaches taken in these jurisdictions. Therefore this thesis has established that a simpler approach to legal recognition can be taken in the UK, an approach which still considers the concerns of parliament at the time the GRA 2004 was enacted but which does not have the associated problems inherent in the GRA 2004. Therefore, I propose that the law ought to be reformed based on the arguments put forward in Chapter Six; an approach based on self-declaration of gender without any third party 'testing' of the applicant's professed identity.

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