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IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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QUEEN'S BENCH DIVISION
(JUDICIAL REVIEW)

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IN THE MATTER OF AN APPLICATION BY JR111
FOR JUDICIAL REVIEW

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Karen Quinlivan QC and Mr Steven McQuitty (instructed by Phoenix Law, Solicitors) for the applicant
Tony McGleenan QC and Gordon Anthony (instructed by the Crown Solicitor's Office) for the respondent

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<u>SCOFFIELD J</u>

Introduction

[1] "*The Government's view is clear: being trans is not a mental illness. It is simply a fact of everyday life and human diversity.*" So said the Government in paragraph 2 of its July 2018 consultation paper, '*Reform of the Gender Recognition Act.*'

[2] Why then, in order to secure a gender recognition certificate under the Gender Recognition Act 2004 ('the 2004 Act'), is a transgender person still required to show, amongst other things, that they have or have had "*gender dysphoria*", defined by the Act as "*the disorder variously referred to as gender dysphoria, gender identity disorder and transsexualism*"? That is the issue with which these proceedings are concerned. More particularly, is the requirement in the 2004 Act that an applicant for such a certificate provide a diagnosis of gender dysphoria by means of specified medical evidence compatible with this applicant's Convention rights?

[3] The applicant is a transgender woman who wishes to be granted a gender recognition certificate ("GRC") under the 2004 Act but who has experienced difficulties, detailed further below, in doing so. She has been granted anonymity by order of McAlinden J in light of the sensitive and personal nature of some of the evidence relied upon in these proceedings and in recognition of the fact that an

application for a GRC, the process underlying this application for judicial review, is private (see paragraph 6(3) of Schedule 1 to, and section 22 of, the 2004 Act).

[4] The applicant was represented by Ms Quinlivan QC, who appeared with Mr McQuitty, of counsel; and the respondent was represented by Mr McGleenan QC, who appeared with Mr Anthony, of counsel. I am grateful to all counsel for their helpful written and oral submissions.

Factual background

[5] The applicant describes herself as a trans woman. In 1994 she joined an organisation established as a support network for transgender people and their families, when she had questions about her gender. Her mental health was poor at that time and she was "*most distressed*" about the feelings she was having. A friend told her about a doctor in London who was helping people with gender issues and she attended privately with this doctor, who provided her with hormone medication. The applicant describes continuing her transition from 1994 and changing her name by deed poll in 1999. She has lived as a trans woman since that time. The applicant's evidence is that since childhood, and as early as being in primary school, she knew she was "*not the right gender*." By 1994, she felt suicidal and felt forced to do something to preserve her sanity. She has "*lived with an overwhelming and persistent desire to live in/as the gender that I know is my true gender, as a woman*."

[6] Around 1996, the applicant's GP referred her to a specialist who was the lead clinician within the Gender Clinic which was, at that time, part of the Department of Psychiatry in Belfast City Hospital. The applicant says that progress at the clinic was painfully slow and that, after around five years of being assessed at the clinic, she was eventually legally prescribed hormones. Another specialist, Dr Ingram, later took over the applicant's treatment but little changed in her treatment plan.

[7] Frustrated at what she considered to be the lack of adequate progress, the applicant learned that there was a walk-in clinic in Dublin which was free; so she sought to be transferred there between 2012 and 2014, and was treated there by Professor Donal O'Shea. The applicant's evidence is that again, for a variety of reasons, progress was slow but Professor O'Shea recommended that she could have gender reassignment surgery. The applicant says that the relevant Trust in Northern Ireland refused to fund this surgery, indicating that she would have to have received treatment from, and been referred for the surgery by, the Gender Clinic in Belfast in order to qualify. The applicant discussed this with her GP and signed a consent form to return to treatment at the Brackenburn Clinic in Belfast in 2015. Further assessments occurred and she received various treatments such as hormone treatment, laser hair removal and speech therapy.

[8] More recently, the Lead Therapist at the Brackenburn Clinic has confirmed that the applicant's mental state and gender identity have been stable for a number of years. However, the applicant has nonetheless reached an impasse in terms of

gender reassignment surgery because she has not lost sufficient weight to be considered for surgery. The applicant is currently making progress in this regard and continues to work towards her goal of undergoing such surgery.

[9] As to obtaining a GRC, the applicant believes herself to fulfil all of the requirements for the grant of such a certificate, save for (what she describes as) "*the necessary paperwork which must be provided by a specialist doctor or psychologist*." The applicant says that she raised the issue of obtaining a GRC with the therapist treating her at the Brackenburn Clinic back in 2017 and that the therapist had advised the applicant that she would get a GRC eventually but not to worry at this stage, as there was a lot of work involved with it.

[10] There are two practical difficulties raised by the applicant as to her obtaining the medical evidence required in order to satisfy the statutory criteria for the issue of a GRC: (1) finding experts who can provide it; and (2) paying for the reports. As to the first of these, the applicant's evidence is that there are no specialists currently practising in Northern Ireland in the field of gender dysphoria who can provide the first specialist report required. As to the second issue, the applicant is in receipt of Employment and Support Allowance and has been in receipt of benefits for approximately 10 years. She has provided the court with some additional information as to her financial circumstances but contends, in short, that she could not afford to pay to obtain a private medical report, nor for travel and accommodation to be assessed by a specialist outside Northern Ireland. In light of the limited nature of the issue being determined at this stage (see paragraph [18] below), I need not enquire too closely into these evidential issues for the moment.

[11] However, the Belfast Health and Social Care Trust's response to correspondence from the applicant's solicitor suggests that the decision of the Gender Recognition Panel as to whether or not to grant a GRC is a legal, and not a medical, process. As a result, the Trust appears to have determined that the provision of the required specialist report (which must contain a diagnosis of gender dysphoria) is non-NHS work. The applicant was therefore advised that she would have to source her own specialist in private practice.

[12] The applicant avers to her belief that, previously, expert reports for this purpose would have been provided under the NHS and without cost to the patient. The applicant further contends that there are no specialists now practising in Northern Ireland who can provide the necessary first report, since the relevant practitioners in this field have recently retired. The Trust correspondence addressing this advises her that "*none of the practitioners in the Belfast Gender Clinic currently undertake private practice*"; and the Trust was "*not able to advise further on alternative sources.*" Furthermore, the List of Specialists in the Field of Gender Dysphoria published by HM Courts & Tribunals Service to assist applicants for a GRC to identify a specialist names three such specialists with contact details in Northern Ireland, two of whom are noted to be retired. The third, Dr Ingram, has not provided such a report for a number of years and he "*plans to have his name*

removed from the GRS expert list going forward", according to the Trust's response to pre-action correspondence.

[13] The applicant is concerned about her inability to obtain a GRC as a result of her present lack of ability to secure the necessary report confirming a diagnosis of gender dysphoria. Her birth certificate records her gender as male. She says that, for this reason, she does not keep a copy of her birth certificate and "*cannot bear to have this document around*", as it makes her feel depressed and totally ashamed. She is reluctant to disclose her birth certificate and feels anxious about the prospect of having to disclose it from time to time for various purposes. The applicant does not presently have a passport, having never left the island of Ireland and having never applied for a passport as (she avers) she did not want to disclose her birth certificate to the passport authorities or to have a passport in her old name and her assigned (rather than her acquired) gender. Obtaining a GRC and, therefore, a birth certificate with which the applicant could associate, would allow her to obtain a passport and would provide her with a further sense of assurance as to the legal recognition of her acquired gender.

[14] The applicant has a bank account and phone contract in her new, preferred name which she says, although sounding simple, was a matter of great significance to her. Generally however, she describes herself as having been "*left in limbo*" as regards full recognition of her acquired gender, which is causing her further distress, anxiety and anguish.

[15] The applicant has also provided evidence from Mr Gavin Boyd, the Policy and Advocacy Manager in the Rainbow Project (a support and advocacy organisation which promotes the health and wellbeing of LGBT people and their families and which, *inter alia*, provides a counselling and therapeutic support for transgender people through its counselling service which is funded by the Public Health Agency); and from Ms Alexa Moore of Transgender NI (a not-for-profit organisation dedicated to improving the lives of trans people in Northern Ireland, focusing, *inter alia*, on legal reform and strategic policy).

[16] Mr Boyd's evidence focuses to a large degree on what he considers to be the inadequate service provision from the Gender Identity Clinic provided by the Belfast Health and Social Care Trust. As to the issue which is being addressed in this phase of these proceedings, however, his evidence is that the present requirement for a diagnosis of a gender identity disorder before allowing a transgender person to change their legal gender "*irrationally requires transgender people to say that their understanding of their gender is caused by a mental disorder rather than a normal function of human variation.*" He also avers that the 'pathologisation' of transgender people is not only insulting but contributes to societal stigmatisation of transgender people (including transphobic violence and intimidation) and is now out of line with international best practice, including by reference to the amendment of the World Health Organisation's ICD classification, discussed further below (which has been welcomed by the United Nations' Special Rapporteur on the Right to Health and

Independent Expert on Protection against violence and discrimination based on sexual orientation and gender identity). The evidence filed by the Government Equalities Office does not take any serious issue with the contents of either the applicant's or Mr Boyd's evidence as summarised above.

The judicial review proceedings

[17] The applicant's pleaded case is against two respondents and in respect of two separate matters. First, the applicant challenges the Convention-compatibility of certain provisions of the 2004 Act, namely those provisions which require the provision of a diagnosis of gender dysphoria by means of specified medical evidence to secure a GRC. The named respondent to that aspect of her claim was initially the Department of Health in Northern Ireland (since the subject matter of these proceedings is a devolved matter); but at an early stage of the proceedings an order was made substituting the Government Equalities Office ("GEO"), the office within the United Kingdom Government responsible for the 2004 Act, as the first respondent in relation to the applicant's challenge to the legislation. Second, the applicant challenges a decision of the Trust by which it has been decided that the Trust will no longer provide specialist diagnostic reports for the purposes of applications under the 2004 Act through the NHS.

[18] As noted above, the applicant seeks to challenge the Trust's policy in respect of the non-provision on the NHS of the reports required – and, in particular, the first specialist report which is required – for her GRC application. However, in granting leave to apply for judicial review, McAlinden J stayed that element of the applicant's claim on the basis that, if her Convention challenge to the requirement to provide such reports were to succeed, the first aspect of her claim would or may be superseded. In other words, if the court held unlawful the requirement that such medical reports be provided, it would be (or may become) academic that she could not obtain them as a matter of practicality. At this stage, therefore, the court is addressing only the question of the Convention-compatibility of the requirement for the medical evidence which the applicant is required to provide. I am also addressing this as a matter of principle, since the Trust has not yet been required to file, nor has it filed, any evidence on the question of the practical accessibility of the reports which the applicant requires (the non-availability of which the applicant relies upon to ground a complaint that the exercise of her Article 8 rights is not practical and effective, as required by the Convention). Conceivably, the GEO or the Department of Health in Northern Ireland may also wish to make an evidential contribution on this further aspect of the applicant's case.

[19] The applicant challenges "*all those provisions*" within the 2004 Act "*which mandates, or operates to mandate, that a trans person applying for a [GRC] must demonstrate to the Gender Recognition Panel that they have or have had gender dysphoria in order to secure a GRC*" ('the impugned provisions'). These have been particularised as sections 2(1)(a); 3(1)-(3); 3A(5); 3B(1)-(4); 3C(5); 3D(1)-(4); 3E(6); 3F(1)-(4); and section 25(1), which I gave the applicant leave to include in an amended Order 53 statement

at the commencement of the hearing. The impugned provisions are challenged as being in breach of the applicant's rights under Article 8 ECHR and/or Article 14 ECHR (in conjunction with Article 8). An additional claim that the GEO was in breach of obligations under section 75 of the Northern Ireland Act 1998 was not pursued.

[20] As to the Convention challenge to the requirement to demonstrate gender dysphoria, there are essentially two limbs to this: first, a challenge to the requirement in principle; and, second, a challenge to the mechanism by which the requirement is to be discharged, namely the provision of the specified medical evidence. The applicant expressly does not challenge the requirement to provide information in one of the required medical reports as to the gender reassignment treatment which she has undergone or which it is planned for her to undergo, although the evidence suggests that this requirement is also contentious for many transgender people seeking a GRC.

[21] The applicant's evidence speaks to the stigma of being transgender which she has felt and experienced for many years, which she avers has caused or significantly contributed to the significant mental distress and ill health which she has suffered in her life. She says that:

> "*This stigma has been exacerbated for me by the fact that my condition is, in effect, equated in both legal and medical terms with a recognised mental disorder; namely gender dysphoria. I feel very strongly that legal recognition of my gender identity should not be contingent upon having to demonstrate to a Panel that I suffer from a mental disorder. This makes me feel that being transgender is considered by society as (only) a mental illness, as reflected in these legal requirements. It makes me feel that what I am, at the core of my being, in terms of my gender identity, is pathological and disordered. This makes me feel of less worth than other people, giving rise to stigma and related feelings of shame and distress. As the evidence before the court demonstrates, such feelings are not unique to me but, sadly are all too common for trans people in the United Kingdom and, indeed, across the world.*"

The 2004 Act

[22] By section 1(1) of the 2004 Act, a person of either gender who is aged at least 18 may make an application for a gender recognition certificate on the basis of either (a) living in the other gender, or (b) having changed gender under the law of a country or territory outside the United Kingdom. In this case, the applicant seeks a GRC on the basis of living in the female gender which, pursuant to section 1(2), is referred to as her "*acquired gender*." By section 1(3), an application for a GRC is to be determined by a Gender Recognition Panel (GRP), further provision about which is

made in Schedule 1 to the Act. Such panels generally contain both a legal member, with a relevant legal qualification, and a medical member, who is either a registered medical practitioner or a registered psychologist.

[23] Section 2 of the Act provides for the determination of applications. Section 2(1), which is relevant to the applicant's circumstances, provides as follows:

> *"In the case of an application under section 1(1)(a), the Panel must grant the application if 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."*

[24] By virtue of section 2(3), the Panel must reject an application under section 1(1) if not required by subsection (1) or (2) to grant it. Accordingly, there is no discretion on the part of the Panel, other than as to whether it is "*satisfied*" that the statutory requirements under either section 2(1) or 2(2) are met. Where it is so satisfied, it must grant the application; and where it is not so satisfied, it must refuse the application.

[25] As appears above, there are two basic statutory routes to the grant of GRC set out in section 1(1) of the 2004 Act: under section 1(1)(a) on the one hand (the route which is relevant in the present case); and under section 1(1)(b). The second route – which applies where the applicant for a GRC has already changed gender under the law of an approved country or territory outside the United Kingdom and seeks recognition of that in this country – is not directly relevant but is relied upon by the applicant in the present case for reasons which are addressed below.

[26] There are a variety of types of application which may be made under section 1(1)(a). The one which is relevant in the present case does not involve a protected marriage or civil partnership in any of the three relevant jurisdictions of the United Kingdom (such applications being governed by sections 3A to 3F of the 2004 Act). Accordingly, the present applicant must comply with the relevant requirements set out in section 3 of the Act. Subsections (1) to (3) of that section are particularly relevant in the present case and provide as follows:

> "(1) *An application under section 1(1)(a) must include either—*
>
> > (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), 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).*
>
> (2) *But subsection (1) is not complied with unless a report required by that subsection and made by—*
>
> > (a) *a registered medical practitioner, or*
> >
> > (b) *a registered psychologist,*
>
> *practising in the field of gender dysphoria includes details of the diagnosis of the applicant's gender dysphoria.*
>
> (3) *And subsection (1) is not complied with in a case where—*
>
> > (a) *the applicant has undergone or is undergoing treatment for the purpose of modifying sexual characteristics, or*
> >
> > (b) *treatment for that purpose has been prescribed or planned for the applicant,*
>
> *unless at least one of the reports required by that subsection includes details of it.*"

[27] The applicant, therefore, must provide two reports. The first must be from a registered medical practitioner or registered psychologist practising in the field of gender dysphoria, which includes details of the diagnosis of the applicant's gender dysphoria. The second must be from a registered medical practitioner who may, but need not, practise in the field of gender dysphoria. It could, for instance, be from the applicant's general practitioner. Curiously, there are no express requirements as to the substance of the second report, save that at least *one* of the reports must provide details of the treatment (if any) which the applicant has undergone, is undergoing, or has had prescribed or planned for them, for the purpose of modifying sexual characteristics.

[28] A specialist report providing a diagnosis of gender dysphoria is therefore required. What is meant by 'gender dysphoria'? That is addressed in the interpretation provision of the Act, section 25, which provides that in the 2004 Act "*"gender dysphoria" means the disorder variously referred to as gender dysphoria, gender identity disorder and transsexualism.*" At the root of this challenge is the requirement, through the combined effect of sections 1, 3 and 25, that the applicant provide medical evidence that she has or has had a "*disorder*" before she may obtain a gender recognition certificate. As I have already mentioned, the applicant objects to this on both principled and practical grounds. The current diagnostic criteria in relation to gender dysphoria are discussed below (see paragraphs [44]-[47]).

[29] By virtue of section 3(4) of the Act, an applicant under section 1(1)(a) must also provide a statutory declaration that he or she meets the conditions in section 2(1)(b) and (c), namely that they have lived in the acquired gender throughout the period of two years ending with the date on which the application is made and that they intend to continue to live in the acquired gender until death.

[30] Section 4 of the Act deals with successful applications. If a GRP grants an application under section 1(1), it must issue a gender recognition certificate to the applicant, which will be a "*full*" GRC if the applicant is neither married nor in a civil partnership: see section 4(1) and 4(1A). The more complicated provisions dealing with applications where the applicant is married or in a civil partnership, and an *interim* GRC only may issue in the first instance, are not relevant for present purposes. Section 9(1) of the Act then provides for the effect of a full GRC, in the following terms:

> "*Where 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).*"

[31] This is the effect which the applicant craves. In law, the recipient of a full GRC becomes a person of their acquired gender. Although this is subject to certain exceptions (for instance, by virtue of section 9(2), in relation to things done, or events occurring, before the certificate is issued; and, by virtue of section 9(3), in relation to a variety of other significant matters provided for in the 2004 Act itself or under other legislation), it is a major change in the status of the individual in the eyes of the law. As the Introduction to *The General Guide for all Users* of the 2004 Act published by HM Courts & Tribunals Service to assist potential applicants for a GRC (the 'General Guide') states: "*If you are granted a full GRC you will, from the date of issue, be considered in the eyes of the law to be of your acquired gender.*"

[32] In addition, under section 10, where there is a UK birth register entry in relation to a person to whom a full GRC is issued, the Secretary of State must send a copy of the certificate to the appropriate Registrar General – in this case the Registrar

General for Northern Ireland. The successful applicant for a GRC, if their birth was registered in the United Kingdom (or abroad with the British authorities), is then able to obtain a new birth certificate showing their recognised legal gender.

President's Guidance as to the required medical reports

[33] Paragraph 6(5) of Schedule 1 to the 2004 Act provides that the President of Gender Recognition Panels established by the Act may give directions about the practice and procedure of such Panels. As recorded in paragraph [13] of *Jay v Justice Secretary* [2018] EWHC 2620 (Fam); [2019] Fam 87, the only directions given under this provision are set out in '*President's Guidance No 1 – Evidential requirements for applications under section 1(1)(a) of the Gender Recognition Act 2004.*' The whole of this guidance is relevant for present purposes but paragraphs 3-6, which are in the following terms, are particularly material:

> *"3. It is the responsibility of the Panel to decide whether the applicant has satisfied all of the section 2 requirements by considering the evidence provided in support of each of the four requirements. In the case of section 2(a), the Panel must therefore examine the medical evidence provided in order to determine whether it is satisfied that the applicant has or has had the diagnosis of gender dysphoria. In order to do so the Panel requires more than a simple statement that such a diagnosis was made. The medical practitioner practising in the field who supplies the report should include details of the process followed and evidence considered over a period of time to make the diagnosis in the applicant's case. Nor is it sufficient to use the broad phrase, 'gender reassignment surgery' without indicating what surgery has been carried out. Nor should relevant treatments be omitted, such as hormone therapy. These requirements are particularly pertinent in assisting the Panel to be satisfied not only that the applicant has or has had gender dysphoria but also has lived in the acquired gender for at least 2 years and intends to live in that gender until death.*
>
> *4. On the other hand, doctors need not set out every detail which has led them to make the diagnosis. What the Panel needs is sufficient detail to satisfy itself that the diagnosis is soundly based and that the treatment received or planned is consistent with and supports that diagnosis.*
>
> *5. It would be impossible to set out precisely what should be provided in all cases. Each will have its own individual facts and the detail which might be sufficient in one case may be inadequate in another. The Panels perform a judicial function. In the ultimate analysis it is for each Panel to determine*

precisely what is required. At the same time, doctors and applicants need to know in broad terms what is expected of them and what detail is likely to satisfy a Panel. The burden upon them of providing the evidence should not be such as to deter applicants from applying in the first place or to deter doctors from supporting them.

6. The detail required should normally be no greater than can be set out in the space provided in the medical report pro forma.

Under paragraph 11 the Panel should see:

a. the diagnosis,
b. details of when and by whom the diagnosis was made,
c. the principal evidence relied on in making the diagnosis,
d. details of the non-surgical (eg hormonal) treatment to date (giving details of medications prescribed, with dates) and an indication of treatment planned, and
e. date of referral for surgery, or, if no referral, the reasons for non-referral."

[34] Paragraph 9 of the President's Guidance notes that it is not the role of the Panel to impose unnecessary or excessive evidential burdens on applicants but that the 2004 Act does place on Panels the responsibility of ensuring that the requirements of sections 2 and 3 are complied with before an application is granted.

The consideration given to amending the 2004 Act

[35] Much of the evidence before me in this case related to proposals and plans to amend the 2004 Act to make it easier for a person in the position of the applicant to obtain a GRC, including by removal of the impugned requirement to provide supporting medical reports. I summarise below the key developments in this regard from 2016 until it became clear, in September 2020, that the Government no longer intended to amend the provisions of the 2004 Act. I am conscious that, pursuant to section 6(6) of the Human Rights Act 1998 ("HRA"), the failure to introduce in Parliament a proposal for legislation or to make any primary legislation, is not a relevant 'act' for the purpose of section 6(1). Nor does the applicant mount this challenge as an attack on the failure to introduce a Bill to amend the 2004 Act. Rather, this is simply a challenge to the continuing Convention-compatibility of the Act's provisions. In assessing the challenge, however, and the respondent's justification for the continuing effect of the impugned provisions, the consideration given to revision of the Act and the reasons for its contemplated amendment provide helpful illumination of the interests which the court must balance.

The House of Commons Woman and Equalities Committee report

[36] In a report published in 2016 ('*Transgender Equality*', HC 390, published on 14 January 2016), the cross-party House of Commons Women and Equalities Committee recommended reform of the process established by the 2004 Act in line with the principles of gender self-identification. The Committee noted that, when it was enacted, the 2004 Act was considered to be "*world-leading*"; but it heard evidence that the model used in the 2004 Act was now "*outdated*" and "*in need of significant revision*", noting that more recent gender recognition legislation in other countries was now regarded as providing "*a more enlightened model.*"

[37] In particular, the Committee criticised the "*medical approach*" found in the 2004 Act. In paragraphs 36-37 of its report, the Committee recounted some of the evidence it had heard on this issue, to the effect that the continued "pathologisation" of transgender identities (treating them as a disease or disorder) causes significant offence and distress; and that some trans people had been traumatised and humiliated by the process. In paragraphs 44-45 of its report, the Committee gave the following summary and recommendation:

> "*While we recognise the importance of the Gender Recognition Act as pioneering legislation when it was passed, it is clear that the Act is now dated. The medicalised approach regarding mental-health diagnosis pathologises trans identities; as such it runs contrary to the dignity and personal autonomy of applicants.*
>
> *Within the current Parliament, the Government must bring forward proposals to update the Gender Recognition Act, in line with the principles of self-declaration that have been developed in other jurisdictions. In place of the present medicalised, quasi-judicial application process, an administrative process must be developed, centred on the wishes of the individual applicant, rather than on intensive analysis by doctors and lawyers.*"

[38] The Committee also considered treatment protocols in relation to transgender issues. It noted that homosexuality was once classified as a disease until its removal from the World Health Organisation (WHO) International Classification of Diseases (ICD) in 1992; and observed that "*attitudes in respect of gender identity are now likewise shifting.*" The Committee noted that, at the time of its report, the ICD still classified transsexualism under "*Mental and Behavioural Disorders*", although it also observed that the WHO was expected to revise the ICD. As discussed further below, that has now occurred. The Committee's expectation was that "*the 'psychopathological model' of trans identity will be 'abandoned, in favour of a model that reflects current scientific evidence and best practice.'*"

[39] There was, of course, no obligation on the part of the executive to accept the recommendations of the Women and Equalities Committee Report in full or at all.

However, as detailed further below, the report's findings and recommendation for sweeping reform of the 2004 Act provided a springboard for further consideration and, for some time, an intention on the part of government to make amendments to the process prescribed by the 2004 Act, to a greater or lesser degree.

The medical classification of gender dysphoria

[40] The Woman and Equalities Committee referred to an anticipated change in the ICD approach to the relevant diagnosis. There was indeed an amendment made in the ICD classification regime in 2018-19, on which the applicant in these proceedings strongly relies and which became relevant to further discussion of potential reform.

[41] ICD-11 is the eleventh edition of the International Statistical Classification of Diseases and Related Health Problems. It provides standardized data and vocabulary to help diagnose and monitor health problems around the world, setting out an international system of 'codes' which are used by health professionals to classify diseases and health conditions. ICD-11 was published in 2018 and approved in 2019, although it does not formally come into effect until January 2022. The changes introduced into ICD-11 in relation to transgender health are said to reflect modern understandings of sexual health and gender identity. The background to this is discussed in Mr Boyd's affidavit, filed on behalf of the applicant.

[42] In particular, ICD-11 has redefined gender identity-related health, replacing diagnostic categories like ICD-10's "*transsexualism*" and "*gender identity disorder of children*" with "*gender incongruence of adolescence and adulthood*" and "*gender incongruence of childhood*" respectively. Gender incongruence has also been moved out of the "*Mental and behavioural disorders*" chapter and into the new "*Conditions related to sexual health*" chapter. The WHO considered that the changes reflect "*evidence that trans-related and gender diverse identities are not conditions of mental ill health, and classifying them as such can cause enormous stigma*." Accordingly, the ICD has moved away from the diagnoses of gender identity disorder and transsexualism mentioned above (each of which features in the definition of gender dysphoria in the 2004 Act); and, significantly, does not view gender incongruence as a *disorder*.

[43] The description given of gender incongruence of adolescence or adulthood in ICD-11 is in the following terms:

> *"Gender Incongruence of Adolescence and Adulthood is characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual's body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis*

cannot be assigned prior the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis."

[44] In addition, gender dysphoria is also dealt with in the DSM-5. This is the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. DSM-5 was published in 2013. Previously, the relevant entry in the DSM (DSM-IV) was that of "*gender identity disorder*", which was renamed in DSM-5 to, again, remove the stigma associated with the term "*disorder.*" The introductory text to the chapter dealing with gender dysphoria in DSM-5 notes that:

> "*Gender dysphoria as a general descriptive term refers to an individual's affective/cognitive discontent with the assigned gender but is more specifically defined when used as a diagnostic category…*
>
> *Gender dysphoria refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available. The current term is more descriptive than the previous DSM-IV term gender identity disorder and focuses on dysphoria as the clinical problem, not identity per se.*"

[45] The diagnostic criteria used in DSM-5 for gender dysphoria in adolescents and adults are as follows:

> "*A. A marked incongruence between one's experienced/expressed gender and assigned gender, or at least 6 months' duration, as manifested by at least two of the following:*
>
> *1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).*
>
> *2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).*

> 3. *A strong desire for the primary and/or secondary sex characteristics of the other gender.*
>
> 4. *A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).*
>
> 5. *A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).*
>
> 6. *A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).*
>
> B. *The condition is associated with clinically significant distress or impairment in social, occupation or other important areas of functioning."*

[46] In the explanatory text dealing with the diagnostic features, DSM-5 also notes that:

> "*Individuals with gender dysphoria have a marked incongruence between the gender they have been assigned to (usually at birth, referred to as natal gender) and their experienced/expressed gender. This discrepancy is the core component of the diagnosis. There must also be evidence of distress about this incongruence.*"

[47] Although DSM-5 emphasises that incongruence is the "*core component*" of a diagnosis of gender dysphoria, there remains an emphasis on clinically significant distress or impairment which does not find similar expression in the ICD's description of gender incongruence (although gender variant behaviour and preferences alone are not a basis for assigning that diagnosis).

[48] The parties were unable to provide me with much assistance as to which of the two taxonomies was in more prevalent use in clinical practice in the United Kingdom or when and how a psychiatrist or psychologist would use one rather than the other, although previous UK authorities in this field (some of which are discussed further below) seem to place greater emphasis on the ICD classification.

The previous Government's consultation

[49] In July 2018, the Government published a consultation on reforms to the 2004 Act. The consultation document was presented to Parliament by the then Minister for Woman and Equalities, the Rt Hon Penny Mordaunt MP, and was sponsored by the LGBT Policy Team within the GEO. The consultation concerned the gender recognition system in England and Wales only, although the implications of change for the United Kingdom as a whole were also considered to some degree. In the Ministerial Foreword to the consultation document, it was noted that many of the trans respondents to the Government's LGBT survey had said that they found the present system for changing gender to be intrusive, costly, humiliating and administratively burdensome. The foreword continued:

> "*Whilst many trans people want legal recognition, too few are able to get it. In too many cases the current system prevents them from acquiring legal recognition of who they are, denying them the dignity and respect that comes with it. It often leaves trans people in the difficult situation of living in one gender, and holding Government-issued forms of identification, credit cards, driving licence and all other documents in that gender, but a birth certificate and legal status in another.*
>
> *This consultation seeks views on how the Government might make it easier for trans people to achieve legal recognition…*"

[50] One of the options which was considered was the removal of the requirement of a medical diagnosis in order to achieve legal recognition of an acquired gender. Although it was emphasised in the foreword that no firm decisions on the Government's eventual approach had been taken, the body of the consultation document made clear that the Government at that time was persuaded by the arguments that the 2004 Act required updating, including that the system was denying too many people access to the legal recognition they wanted, which was an additional burden on trans people who already faced a series of other barriers to full participation in wider society and to achieving the respect they deserved (see paragraphs 23-26 of the consultation document). In reaching this view, the Government recounted the argument that, by requiring a diagnostic report, the process set out in the 2004 Act "*perpetuates the outdated and false assumption that being trans is a mental illness.*" It also accepted that, whilst many trans people want legal recognition, too few are able to get it, stating that it believed that the number of people who have successfully applied for a GRC is lower than might be expected.

[51] The consultation specifically referred to the fact that the WHO had revised the ICD, in ICD-11, to ensure that gender incongruence – which was said to be "*another name for gender dysphoria*" – was no longer classed under 'Mental and Behavioural Disorders.' It sought views on the requirement to provide medical evidence in order to satisfy the criteria for the issue of a GRC and on the possibility of completely decoupling the medical transition process from the legal transition process (see Questions 3 and 4; and paragraphs 52-58 of the consultation document).

[52] Some additional insight into the Ministerial thinking behind the consultation can also be gleaned from a letter from the Minister of 15 June 2018 which was sent to David Liddington MP, the Chair of the Home Affairs Committee, seeking clearance to publish the consultation, which has been exhibited to the affidavit of the respondent's deponent, Mr Oliver Entwistle OBE, the Deputy Director of LGBT Policy and Operations within the GEO. In the letter, the Minister mentioned the requirement to obtain a medical diagnosis of gender dysphoria from a psychiatrist and commented (in a reference to changes made in DSM-5) that "*in 2004 this was seen as a reasonable request, but since then organisations like the American Psychiatric Association have declassified transgender identity as a mental disorder*." The Minister went on to state that:

> "*Trans people feel strongly that this process is difficult to follow, that providing intimate medical details to strangers is intrusive and that the need for a diagnosis of gender dysphoria 'pathologises' their identity, treating them as if they have a mental illness. Viewing transgender identity as a mental illness is analogous to describing homosexuality as mental illness.*"

[53] The Minister's letter again made the case that one of the impacts of the present system is that trans people are put off from applying for a GRC. Since the system had been introduced only 4,910 trans people had obtained a GRC, out of an estimated trans population of around 250,000. The Minister stated that that equated to only 2% and suggested that this public service was not working for the people it was designed to serve. (Although the number of successful applicants for a GRC has now increased, and there is some debate about the correct estimate of the transgender population, it seems clear that there has been a very low take-up rate of the GRC application process.)

Analysis of the consultation and proposed next steps

[54] The consultation was duly launched and the Government in time received 102,818 valid consultation responses. On the question of whether the requirement for a diagnosis of gender dysphoria should be reformed, 64% of respondents said that there should not be such a requirement in future. 80% of respondents were in favour of removing the requirement for a medical report which details all treatment received (a requirement not challenged in these proceedings). Although strong support for a particular proposal in a government consultation may be generated by an effective campaign of mobilisation and engagement on the part of interested advocacy groups, the applicant unsurprisingly points to the widespread support amongst consultation respondents for removal of the requirement she challenges in these proceedings.

[55] In April 2019 the GEO completed a 'Post-Consultation Equality Impact Assessment for the Gender Recognition Act 2004', which incorporated the main results of the consultation into the assessment and which allowed the government to consider the results as part of the discharge of its Public Sector Equality Duty under section 149 of the Equality Act 2010. As to the de-medicalisation of the GRC process, consistent with the figures given above, this document noted that just over a third (36%) of respondents thought that the requirement for a diagnosis of gender dysphoria should be retained, while nearly two thirds (64%) thought it should be removed. A fifth (20%) of respondents said that the requirement for a medical report detailing treatment received should be retained; while four-fifths (80%) said that that requirement should be removed.

[56] It was noted that many respondents shared the view that being trans was not a mental illness; with a much smaller group agreeing with that but considering that medical safeguards should still be in place, including some respondents thinking that this was a form of safeguard for trans people in vulnerable situations. The analysis also stated that, "*It should be noted that the relationship between requirements for medical transitioning and for legal gender recognition is a historical one. There is no reason why requirements should not change over time according to changing views*." However, some consultation respondents and a number of stakeholders had questioned whether decoupling medical and legal transition would decrease the safety of women (with single-sex and separate-sex services and prisons being the places most frequently mentioned).

[57] On 18 April 2019, GEO officials wrote to the GEO Ministers of the time in a submission entitled, 'Gender Recognition Act – Next Steps.' This submission contained a number of observations as to possible reform of the gender recognition process. In the present context, however, the following recommendation (in paragraph 9 of the submission) is particularly relevant:

> "*We would also strongly recommend that you agree to remove the medical aspects of the process; the need for diagnosis of gender dysphoria and the second medical report. These are certainly, alongside spousal consent, the most disagreed with and hated of the six elements of the current GRC application process. The concept of 'gender dysphoria' is now a very out of date notion. The World Health Organisation no longer uses the term and no longer considers 'gender incongruence' (as the WHO refers to it) a mental health disorder. Continuing to think of 'gender dysphoria' as something a psychiatrist has to diagnose in a transgender person has been compared to similar views of homosexuality in the past as a mental disorder.*"

[58] The submission recommended that the responsible Ministers consider a variety of the recommendations, including removing the requirement for a diagnosis of gender dysphoria, before a meeting to be held the following week, by which time

they would have had an opportunity to further consider the consultation responses. I was provided with no evidence as to whether that meeting occurred or what its outcome was. It may well be that this is because, in the event, what actually became of the recommendations from officials was to be considered by a newly appointed Ministerial team. In his submissions, Mr McGleenan was keen to point out that the relevant decision-making which ultimately resulted in the 2004 Act remaining unchanged was that of the present Government and that the intended approach of Ministers appointed in a previous government should be given little weight.

The present government's consideration of the consultation

[59] There followed a change of government with the announcement of the resignation of the Rt Hon Theresa May as Prime Minister in May 2019 and the subsequent taking up of office of the Rt Hon Boris Johnston as Prime Minister in July 2019. Mr Entwistle refers in his evidence to a period of Ministerial changes within Government, with the Minister for Women and Equalities changing in July 2019 and September 2019. He avers that, during this period, discussion with Ministers about how to proceed with reform of the 2004 Act remained ongoing, but no decision about changes was made. There was then a general election in the United Kingdom on 12 December 2019. Following this, Mr Entwistle's evidence as to the approach of the new government – that is to say, the current government – is as follows:

> *"[T]he new government indicated that it was not minded to dispense with the need for a medical assessment under GRA because it provides a safeguard, ensuring people do not embark unadvisedly on the process of legally changing their gender identity, but that it would actively explore the possibility of removing the term "dysphoria" from the legislation. This, in turn, gave rise to the question of which alternative term might be used and the form that any medical assessment should take. Following extensive consultation internally and with clinical experts, as well as wider decisions on the Government's legislative programme, it was decided not to pursue primary legislative reform to the gender recognition process but instead focus on other options, namely digitising the Gender Recognition Certificate application process and lowering the fee to apply for that certificate."*

[60] The respondent has provided the court in evidence with a range of documents which shed light on how this position came about. The main developments may be summarised as follows.

[61] On 3 March 2020 there was a submission from GEO officials addressed to the Secretary of State, titled '*Gender Recognition Act Reform.*' This submission set out potential options for reforming the 2004 Act and cross-referenced a range of potential options to the results of the earlier consultation exercise. The Secretary of State (the Rt Hon Elizabeth Truss MP, Secretary of State for International Trade and Minister

for Woman and Equalities since September 2019) was asked to confirm which policy option contained in the submission she would like to be included in the Government response. However, a draft statement had been prepared on the basis of 'Option A' (a GRA Reform Bill accompanied by non-legislative reforms) "*given your previous steers on this issue.*"

[62] It is clear from the content of this submission, that the Secretary of State had discussed the issue generally with "*Number 10*" (referred to hereafter as the Prime Minister's Office, although it is unclear on each occasion when 'Number 10' is mentioned with whom precisely any engagement took place). The then current lead option was to take forward reforms to the 2004 Act, accompanied by some wider non-legislative reforms. The officials understood that one of the key legislative reforms that both the Secretary of State and the Prime Minister's Office wanted to include in a Bill related to the need for medical reports and the required diagnosis of gender dysphoria. The relevant section of the submission summarised the position thus:

> "*<u>Medical reports and diagnosis of gender dysphoria</u> – You are keen to move away from the diagnosis of gender dysphoria required by the current legislation. 64% of respondents were in favour of removing the gender dysphoria diagnosis requirement. 80% of respondents were in favour of removing the requirement for a medical report which details all treatment received, as it causes delays in the application process and is seen as stigmatising. You want to retain a medical element to this process, with the continued involvement of gender specialist practitioners, in order to deter vexatious applications …*
>
> *An alternative would be to bring the medical requirement in line with the current WHO guidelines to use the term 'gender incongruence', a term already widely understood and less stigmatised, and removing the requirement for a report detailing treatment received …*"
> [underlined emphasis in original]

[63] Mr Entwistle's affidavit evidence emphasised the reference to "*Ministers' desire to retain a medical element to the system as an important safeguard.*" Nonetheless, it is clear that there was an eagerness to move away from a diagnosis of gender dysphoria being required. Options for reform taking into account the desire to retain a medical element were identified as follows:

> "*(1) Remove the need for a specific diagnosis of gender dysphoria – this has been seen as a mental illness so can be quite stigmatising – but retain the need for medical reports demonstrating that a person wants to permanently change their gender.*

> *(2) In addition to 1, change who can provide the report or increase the number of people on the list of accredited gender specialists.*"

[64] The draft oral statement and write-round letter which were prepared for the Minister were prepared on the basis of a strong preference to maintain medical checks as part of the process but to remove the requirement for a diagnosis of gender dysphoria, recognising how stigmatising this can be. The Secretary of State was also advised, in advice which appears to have remained consistent throughout her consideration of the various options, that all of the opposition parties were in favour of de-medicalising the legal process but would likely contend that the proposals did not go far enough.

[65] On 29 May 2020, there was a further submission from GEO officials to the Secretary of State, titled '*Government Response to the GRA Reform Consultation.*' This was to permit the Secretary of State to review the initial draft of the Government's consultation response, and, *inter alia*, to "*note the current progress on agreeing the policy package*"; and to confirm whether she wanted to engage with Ministers from the Department of Health and Social Care (DHSC) to pursue changing the gender dysphoria diagnosis requirement and launching a review of trans healthcare. At paragraph 7 of the submission, it is recorded that, following the advice of 3 March 2020, the Secretary of State had provided a steer that she wanted to explore options to amend the existing legislation to remove reference to the diagnosis of gender dysphoria.

[66] At paragraphs 12-13 of the submission of 29 May 2020, under the heading "*Removing references to the diagnosis of gender dysphoria*", the submission recorded as follows:

> "*It has become clear from our discussions with DHSC and the helpful insight provided by the National Adviser on LGBT Health, Dr Michael Brady, that removing the diagnosis of gender dysphoria while maintaining a medical aspect to this process would be an impractical step. For those seeking medical support to change their gender, the NHS would continue to provide a diagnosis of gender dysphoria or gender incongruence even if we removed this requirement from the GRA process.*
>
> *The view of the DHSC and NHS England officials and advisors was that such a change would create confusion and uncertainty amongst clinicians and so they do not currently support such a change…*"

[67] The Secretary of State was therefore asked whether she still wanted GEO officials to seek to change the requirement for a gender dysphoria diagnosis. If so, they would continue to engage with counterparts at DHSC; but the officials also

recommended that the Secretary of State engage directly with DHSC Ministers to secure agreement, "*otherwise we risk them blocking this element of the package which would mean that the gender dysphoria diagnosis would have to remain*." The draft response to the consultation which was provided as an annex to this submission now indicated a failure to be convinced by the arguments in favour of removing the requirement for applicants to provide medical reports demonstrating that the applicant has, or has had, gender dysphoria. The draft said, "*These are important medical checks and ensure that specialist practitioners remain involved in the GRC process*."

[68] At this point, therefore, the GEO Ministers' previous enthusiasm for removal of the requirement for a diagnosis of gender dysphoria hung in the balance, in light of concerns expressed by DHSC and the Government's National Adviser on LGBT Health ('the LGBT Health Adviser') about how practical any change would be for practitioners. These issues then appear to have been the subject of discussion between the Secretary of State and the Secretary of State for Health and Social Care (SSHSC) in a telephone call. GEO officials prepared a briefing note dated 11 June 2020 for their Minister. This note recorded that the Secretary of State was meeting the SSHSC "*to discuss our proposed changes to the gender dysphoria diagnosis*" in the 2004 Act. It further recorded that GEO's position was that a medical element to the GRC process should be maintained "*to ensure appropriate checks and support remain in place for applicants*" but that "*we are aware that gender dysphoria can be seen as a pathologising term and are keen to move away from the idea that this is a mental health condition – in line with the World Health Organisation*." GEO had been working with DHSC officials to explore options to amend the current legislation to remove any stigma in the requirement and, as a result of this work, GEO was "*proposing that we remove the reference to gender dysphoria from the GRA, and replace the term with gender incongruence*" which was the term already used in the ICD (*i.e.* ICD-11) and one with which clinicians and patients would be familiar.

[69] The Secretary of State was to ask the SSHSC whether he would support the proposed change. The briefing note also outlined that DHSC officials and the National Advisor for LGBT Health had raised concerns that there would be an unwillingness on the part of the SSHSC to progress changes that might interfere with current clinical practice. It continued:

> "*Their view is that, given that we intend to maintain a medical aspect to the GRA requirement, the process currently set out is the correct one.*
>
> *However, they acknowledge that gender incongruence is a term already known and used by the NHS. Changing the terminology used in the GRA from gender dysphoria to incongruence is largely symbolic and will not interfere with existing clinical processes. We are therefore hopeful that SOSHSC will support this change.*"

[70] No note, record or minute of the discussion between the two Secretaries of State has been provided. However, there was then a further GEO submission dated 22 June 2020, titled '*Government Response to the GRA consultation: final documents for write round clearance*', which was prepared for the Secretary of State. This noted that, following the advice of 29 May 2020, the Secretary of State wanted to amend the existing legislation to remove reference to the diagnosis of gender dysphoria and replace it with a diagnosis of gender incongruence. There had been meetings between the Secretary of State and both the SSHSC and the Lord Chancellor "*to crystallise their positions on these issues*." Then, at paragraphs 9-10, it is recorded that the SSHSC was "*hesitant to commit to replacing the reference to gender dysphoria with gender incongruence*" in the 2004 Act when the two Secretaries of State spoke; but that this had now been "*resolved… at official level*" and DHSC officials were seeking conformation of approval of the change from SSHSC that week.

[71] The 'final' draft Government response to the consultation which was attached to the 22 June 2020 submission now, again, proposed removal of the requirement for applicants to provide a diagnosis of gender dysphoria and replacing it with gender incongruence. The draft response further explained in this regard that:

> "*This diagnosis will not require the presence of distress or impairment and does not imply psychological abnormality, thereby removing the stigma associated with gender dysphoria. Importantly it will ensure the medical element to the process is maintained, with the continued involvement of gender specialist practitioners, to ensure applicants receive appropriate support and to deter unmeritorious applications.*"

[72] A further equality impact assessment was conducted to support this submission. Its summary of the position was in similar terms, at paragraph 13:

> "*We intend to remove the diagnosis of gender dysphoria, to be replaced with gender incongruence, whilst retaining the need for a medical report detailing medical interventions that have taken place (if any). This is to ensure sufficient checks and balances remain in place to dissuade frivolous applications, alongside continuing to provide the right level of medical support to transgender people going through the GRC process.*"

[73] Put shortly, by the time of the submission of 22 June 2020, GEO officials were hopeful that the SSHSC's hesitation in agreeing to the proposed change in the 2004 Act (replacing gender dysphoria with gender incongruence) would be overcome. GEO's position was that this reform should still be taken forward. Seemingly, DHSC officials were now content with the GEO officials' stance on this issue.

The final Government position

[74] Finally, there was a submission of 2 July 2020, titled '*The GRA consultation: final documents for write round clearance*' prepared for the Secretary of State by GEO officials. At paragraph 5 of this submission, it stated: "*Following our advice of 22 June, you and No 10 have agreed the following response to the GRA consultation: (i) Keep the current legislation as it stands…*". At paragraph 6 it was noted that, given that there was now no legislative change being proposed to the 2004 Act, "*it has been agreed with No 10 to use an oral statement to announce the Government's position on this, together with publication of the analysis report*."

[75] Thus, as of 22 June 2020, GEO officials, and indeed their Secretary of State, still appeared to support the removal of a requirement of a diagnosis of gender dysphoria from the legislation (in favour of a requirement of a diagnosis of gender incongruence) and appeared hopeful that the SSHSC would approve of this approach. It seems that the SSHSC had expressed some concerns about a change to the process which currently applies insofar as that might interfere with clinical practice. It is far from clear to me, however, what that interference might have been and, in particular, whether it would have been such that the medical professionals involved would not have been able to readily adapt to it. The GEO briefing note of 11 June 2020 notes that "*gender incongruence is a term already known and used by the NHS*", which was acknowledged by DHSC, and that "*changing the terminology used in the GRA from gender dysphoria to gender incongruence is largely symbolic and will not interfere with existing clinical processes.*" It was on this basis that the GEO officials were hopeful that the SSHSC would support the change.

[76] However, the key decision appears to have been taken between the Secretary of State and the Prime Minister's Office in the form of a general decision to "*keep the current legislation as it stands.*" The extent to which (if at all) the ongoing debate about amending the diagnosis required to qualify for a GRC featured in this broader decision is unclear from both the description of it in the exhibited documents and from the respondent's evidence. In short, it is unclear whether a decision was taken in principle that no change to any aspect of the existing legislation was appropriate, from which it followed that the legislation simply did not require to be amended, and would not be; or whether a decision was taken that the legislation was not going to be amended, so that changes which might otherwise have been thought to be a good idea would simply have no mechanism to be brought forward.

[77] The latter of these options appears to me to find support in Mr Entwistle's averment on behalf of the respondent in the following terms:

> "*It is my understanding that the government's decision not to change the gender dysphoria requirement was <u>primarily</u> a result of a wider decision not to move forward with <u>any</u> legislative reform on the GRA (as described in paragraph 36), as well as being informed by engagement with clinical experts (as described in paragraphs 36 and 37). Since Ministers were minded to retain some medicalised element to the system, and*

> *more broadly believed that the current system provides for people to change their legal gender if they wish, I understand that the government formed the view that it was unnecessary to reform the law at this stage."*
>
> [underlined emphasis added]

[78] It is perhaps unlikely that the Prime Minister's Office would have opposed the proposed change to the diagnosis required by the 2004 Act in substance, given that this appears from the submission of 3 March 2020 to have been a proposal previously adopted by the GEO Ministers with the support of the Prime Minister's Office (see paragraphs [61]-[63] above). Although it is possible that the Number 10 view on this issue changed – perhaps in light of the SSHSC's concerns – I read Mr Entwistle's averment above as supporting the conclusion that, whilst the issues raised by engagement with clinical experts were taken into account, they would not alone have been fatal to the proposed amendment favoured by the Secretary of State with responsibility for the GEO. The primary reason for the requirement of a gender dysphoria diagnosis remaining unchanged was "*a wider decision not to move forward with any legislative reform on the GRA.*"

[79] In any event, on 22 September 2020, the Secretary of State published a written Ministerial Statement, in terms consistent with the policy position adopted in the submission of 2 July 2020, announcing the outcome of the Government's response to the consultation on the 2004 Act. The core of the announcement for present purposes is as follows:

> *"We have looked carefully at the issues raised in the consultation, including potential changes to the Gender Recognition Act 2004.*
>
> *It is the Government's view that the balance struck in this legislation is correct, in that there are proper checks and balances in the system and also support for people who want to change their legal sex."*

Further disclosure in relation to the final policy position

[80] The opacity in the respondent's evidence surrounding the process and reasons for the change in position between the GEO submissions of 22 June and 2 July 2020 respectively gave rise to correspondence from the applicant's solicitor seeking further disclosure, in particular in relation to any role played by the Prime Minister in the adoption of the Government's ultimate policy position. A response from the Crown Solicitor's Office confirmed (a) that there was no relevant documentation relating to discussions between the Prime Minister, his office and/or officials or advisers with the GEO Ministers or their officials; but (b) there was some additional documentary evidence relating to interaction between the Secretary of State and the SSHSC or their officials, which was then disclosed.

[81] In particular, the applicant was provided with notes of meetings between GEO officials, DHSC officials and Dr Brady of 12 May 2020 and 3 June 2020; and with a briefing note from DHSC officials for their Minister in advance of the meeting with Minister Truss on 11 June 2020. As to the meeting notes involving the LGBT Health Adviser:

(a) The 12 May 2020 meeting note recorded the LGBT Health Adviser as saying that, "*Gender dysphoria is the accepted terminology (although there is a move towards using gender incongruence).*" He had not been advised by trans people that the diagnosis or label was stigmatising; but felt that the process overall was stigmatising and that the issue of stigma should be seen in that context. He further considered that it did not matter where the diagnosis was categorised (whether under mental health or sexual health): it remained a diagnosis but was not perpetuating a mental health stigma. The Adviser did not appear keen on assessing psychological readiness or 'fitness to proceed', the additions of which he considered would further medicalise the process and more intrinsically link gender recognition to medical treatment. Ultimately, he recommended "*using the terminology that is used in the medical community, and that is gender dysphoria.*" However, it is also recorded that he "*wondered how the LGBT sector would receive this; thought there would also be kick back from clinicians*" (although it is unclear precisely what it was thought might give rise to the "*kick back*").

(b) The 3 June 2020 meeting note records the LGBT Health Adviser as saying that he "*thinks that when a medical element remains part of the GRA, the most and only logical one is the gender dysphoria diagnosis.*" The DHSC officials were then going to write a submission to their Secretary of State. They thought that he "*will not want to use his role to interfere in the medical diagnosis, and also not to change the wording in legislation (just because you don't like the word).*" From DHSC's perspective, the key question was what the clinical implications of the change would be. If the 2004 Act required a medical process, then DHSC's input should be fed into that; but the officials were to explore if and when the LGBT Health Adviser could play a role in giving clinical advice to the Ministers.

[82] The 11 June 2020 briefing note informed the SSHSC that the GEO Minister was minded to remove the requirement for a gender dysphoria diagnosis from the 2004 Act. As to the DHSC view (at that stage), it contained this advice:

> "*It is our view, however, that the term gender dysphoria is internationally recognised by both the medical and transgender community, and we don't believe there is any stigma attached to its use. The National Advisor for LGBT Health at NHSEI shares this view.*"

[83] The note went on, however, to recommend that any decisions around removing the term 'gender dysphoria' from the 2004 Act should be clinician-led. Other than the input from the LGBT Health Adviser, I have seen no evidence (save for any responses which may have been provided by clinicians to the broader policy consultation) of any attempt to obtain a view from clinicians as to the ease, or otherwise, with which they could adjust to a new diagnosis requirement.

The redactions in the respondent's evidence

[84] The exhibits to Mr Entwistle's affidavit contained a large number of redactions on the grounds that the documents so disclosed were otherwise confidential and the redacted portions were either not relevant to the issues in the proceedings or, in limited cases, were subject to legal professional privilege. The nature and extent of the redactions were objected to on behalf of the applicant and, in the event, the respondent provided the Court with a bundle of the materials in un-redacted form and I was requested, by consent, to review the redactions in accordance with the process envisaged in the case of *Somerville v Scottish Ministers* [2007] UKHL 44 at paragraph [155]. Having done so, I indicated that I considered there to be force in the respondent's basic position that – given the limited nature of the applicant's challenge, to one aspect only of the machinery of the 2004 Act – it was unnecessary for the fair disposal of the proceedings for the applicant to be provided with the full contents of a range of confidential, internal government communications which addressed not only that issue but also the development of policy which was unrelated to the provisions at issue in the applicant's pleaded case.

[85] On the other hand, it seemed to me that the redactions which had been made to the exhibits were, in places, overly restrictive in terms of what was properly to be considered relevant; or where the interest in disclosing the material (both in terms of fairness and the principle of open justice), even where its relevance was more limited or indirect, could properly be considered to outweigh any interest in maintaining confidentiality. In light of the indication provided by the Court, the applicant was then provided by the respondent with a further version of the materials with some of the previous redactions 'rolled back.' For present purposes, it is perhaps simply worth noting that some of the previously redacted portions of the documents indicated that the Government was aware that there are concerns around access to healthcare services for transgender people, with a waiting time for accessing gender identity clinics of around two and a half years for a first appointment and a shortage of specialists in the field. Although a full transgender healthcare review was considered at one point, it seems that this is not presently being taken forward. Rather, in the Ministerial Statement to Parliament of 22 September 2020, the Secretary of State announced that at least three new gender clinics were to be opened that year, which should see a significant cut to waiting lists in England and Wales. This may be more relevant to the second aspect of the applicant's case (see paragraph [18] above).

The position in Scotland

[86] The 2004 Act presently applies across the United Kingdom. However, since gender recognition is a devolved matter, legislation in this area is within the competence of the Scottish Parliament. The Scottish Government launched its own, separate consultation on reform of the 2004 Act, which ran from November 2017 to March 2018. It contained the Scottish Government's initial view that Scotland should adopt a self-declaration system for legal gender recognition. In June 2019, the relevant Scottish Minister announced that a draft bill to reform the current process for obtaining a GRC would be published by the end of the year and would be introduced to the Scottish Parliament after full consultation on the precise details contained in the draft bill. A further consultation on the draft bill was published in December 2019 and the consultation period concluded in March 2020. The draft bill, amongst other proposals which would generally make it easier to obtain a GRC, proposed removing the need for applicants for a GRC to provide medical evidence, although they would still need to provide a statutory declaration that they intend to live permanently in their acquired gender.

[87] On the basis of consideration of the *AP, Garçon and Nicot* judgment (discussed below), the Scottish Government took the view in its consultation in December 2019 that, as the case-law stands at the moment, the current system for gender recognition in Scotland under the 2004 Act is compliant with the Convention; and that there is no obligation arising under the Convention to introduce a system for obtaining gender recognition based on an applicant's statutory declaration. Its proposals for change were based on its desire to keep the system in Scotland under review "*to ensure that it continues to be in line with international best practice*" (see paragraphs 2.12 to 2.14 of the consultation document).

[88] The Scottish Government's consultation paper set out its rationale for proposing reform of the 2004 Act. It proposed to retain a process which was "*a solemn and serious one that requires a lifelong declaration of intent*" but said it was "*aware that the current system has an adverse impact on people applying for gender recognition, due to the requirement for a medical diagnosis and the intrusion of having their life circumstances considered by the GRP*."

[89] The present position, however, is that the planned reforms have been put on hold. On 1 April 2020, the Minister for Parliamentary Business announced that, as a result of the impact of the Covid-19 pandemic on the Scottish Government's legislative programme, work within the Government on the reform of the 2004 Act in Scotland was being halted. A bill would not therefore be brought before the Scottish Parliament until after the very recent elections to it. Although the applicant placed considerable reliance on the direction of travel in terms of legislative reform in Scotland, and I have summarised the position there given the treatment it received in evidence and submissions in the present case, I have found little assistance from consideration of these materials, particularly because the final state of the proposals and the outcome of their consideration in the Scottish Parliament remains unknown. In any event, the mere fact that a less restrictive regime has been adopted in one

nation of the United Kingdom does not, of course, mean that a different legislative choice in another part of the United Kingdom is necessarily unlawful.

Relevant Strasbourg authority

[90] The applicant's case faces a significant hurdle in the form of the decision of the European Court of Human Rights (ECtHR) in *AP, Garçon and Nicot v France* (2017) (App Nos 79885/12, 52471/13 and 52596/13), since in that case it was held, *inter alia*, that a requirement to demonstrate the existence of a gender identity disorder in order to secure legal gender recognition was not a violation of Article 8; nor was a requirement to undergo a medical examination.

[91] The legal backdrop to the *AP, Garçon and Nicot* case is to be found in a variety of earlier decisions of the ECtHR in which the Strasbourg Court had established that Article 8 contained a right to legal recognition of one's gender identity in certain circumstances. A brief summary will suffice for present purposes.

[92] The 2004 Act was passed in response to the judgment of the ECtHR in *Goodwin v United Kingdom* [2002] 2 FLR 487. That was a claim brought by a transgender woman who had undergone gender reassignment surgery and had been permitted under domestic law to change her name but was unable to change a number of official government records which listed her as a male. 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. It considered that:

> "*The 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. 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.*"

[93] The court was particularly struck by what it considered to be the illogical positon that the State would authorise (and finance or assist in financing) gender reassignment surgery but then "*refuse to recognise the legal implications of the result to which the treatment leads.*" In a departure from its previous jurisprudence (in cases such as *Rees v United Kingdom* and *Cossey v United Kingdom*), and in recognition of changing conditions within the United Kingdom and contracting states generally, the court found that the UK 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*" (see paragraph 93 of the court's judgment). This distinction between the means of providing recognition, but not the core obligation to provide legal recognition (at least in the case of transgender persons who have undergone gender reassignment surgery), has assumed greater

significance in some of the later case-law discussed below. On the core matter before the ECtHR in *Goodwin*, however, the court continued as follows:

> "*Since 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, [the Court] reaches the conclusion that the fair balance that is inherent in the Convention now tilts decisively in favour of the applicant. There has, accordingly, been a failure to respect her right to private life in breach of Article 8 of the Convention.*"

[94] The *Goodwin* case was followed by the making of a declaration of incompatibility by the House of Lords in *Bellinger v Bellinger (Lord Chancellor intervening)* [2003] 2 AC 467 in relation to a provision of the Matrimonial Causes Act 1973 which prevented a transgender woman who had undergone gender reassignment surgery and treatment from marrying a man. The 2004 Act was introduced in order to remedy the situation. Then, in *Grant v United Kingdom* (2007) 44 EHRR 1, a case concerning the refusal of a state pension to a transgender woman who had had gender reassignment surgery and had reached the age of 60, the ECtHR found that the applicant's victim status in respect of her Article 8 claim came to an end when the 2004 Act had come into force, thereby providing the applicant with the means on a domestic level to obtain the legal recognition previously denied.

[95] More recently, in *Hämäläinen v Finland* [2015] 1 FCR 379, the applicant was a transgender woman who had undergone gender reassignment surgery and who was seeking to have her identity number changed, since it still indicated that she was male. However, she was married to a female and at that time Finnish law did not allow for same-sex marriage. The Grand Chamber considered the question from the perspective of whether respect for the applicant's private and family life entailed a positive obligation on the State to provide an effective and accessible procedure allowing the applicant to have her new gender recognised whilst remaining married. The facts of the case are different from the present case but in the course of its judgment the Grand Chamber recalled that it had held on numerous occasions that a transgender person who had undergone gender reassignment surgery may claim to be a victim of a breach of his or her Article 8 rights on account of the lack of legal recognition of his or her change of gender (relying on *Grant*, by way of example, as well as *L v Lithuania* (2008) 46 EHRR 22). The court's ultimate conclusion in that case was that the Finnish system as a whole had not been shown to be disproportionate in its effects, particularly since its case-law on Article 8 was not to be interpreted as imposing an obligation on contracting states to grant same-sex couples access to marriage.

[96] As the respondent observes, the Article 8 Strasbourg authorities discussed above involved applicants who had undergone gender reassignment surgery. In the *AP, Garçon and Nicot* case – which is perhaps the most relevant in the context of the present case – the applicants, three transgender persons seeking a legal change of

gender in France, contended that the refusal of their requests to have their gender on their birth certificates corrected, on the grounds that persons making such a request under French law had to substantiate it by demonstrating that they suffered from a gender identity disorder and that there had been a change in their appearance which was irreversible, amounted to a violation of Article 8. In addition, in one of the applicant's cases, he alleged a violation of Article 8 (read in conjunction with Article 3 of the Convention) on the basis that the amendment of his birth certificate had been made conditional on his undergoing an intrusive and degrading medical assessment.

[97] In the course of its judgment the ECtHR undertook a comparative review of the system for legal gender recognition across the Council of Europe member states (see paragraph 70). The court noted that, at that time, in April 2017, legal recognition of the gender identity of transgender persons was not possible at all in seven Council of Europe (CoE) member states – which, the applicant submits, would now be considered a breach of Article 8 if challenged in the Strasbourg Court. In 22 member states such recognition was possible but was subject to a legal requirement to undergo sterilisation. In 18 member states legal recognition was possible without a legal requirement to undergo sterilisation, with a number of states also then in the process of reviewing or intending to review the conditions for legal recognition of the identity of transgender persons. In addition, at paragraph 72 of the judgment, the court noted that a psychiatric diagnosis was among the prerequisites for legal recognition of transgender identity in 36 CoE countries (with only four having enacted legislation establishing a recognition procedure which excluded such a diagnosis). The respondent relies heavily on this authority for obvious reasons, including in order to demonstrate that there is no European consensus on the inappropriateness of requiring a psychiatric diagnosis as a condition for gender recognition.

[98] In the course of its judgment, the ECtHR made reference to a number of recommendations or resolutions adopted by the organs of the CoE relevant to the questions under consideration. For instance, it referred to the recommendation adopted on 31 March 2010 by the Committee of Ministers of the Council of Europe (CM/Rec(2010)5 on measures to combat discrimination on grounds of sexual orientation or gender identity). This recommendation stated, *inter alia,* that "*prior requirements, including changes of a physical nature, for legal recognition of the gender reassignment, should be regularly reviewed in order to remove abusive requirements*." Further resolutions of the Parliamentary Assembly of the Council of Europe called for the removal of prior obligations to undergo sterilisation or other medical procedures, such as gender reassignment surgery or hormonal therapy, as conditions for gender recognition. Finally, on 22 April 2015 the Parliamentary Assembly adopted Resolution 2048 (2015) on discrimination against transgender people in Europe. This called on member states to, among other things, abolish sterilisation and other compulsory medical treatment, *as well as a mental health diagnosis*, as a necessary legal requirement to recognise a person's gender identity in laws regulating the procedure for changing one's registered gender; and to amend

classifications of diseases used at national level, and advocate the modification of international classifications, to make sure that transgender people were not labelled as mentally ill, whilst ensuring stigma-free access to necessary medical treatment.

[99] The applicants' complaints in the *Nicot* litigation included the fact that, in order to secure gender recognition, they had to demonstrate that they suffered from a gender identity disorder and that a relevant change in their appearance was irreversible, this latter requirement meaning that they were compelled to undergo prior surgery or treatment entailing irreversible sterility. As noted at paragraph 84 of the court's judgment, the second applicant complained specifically of the fact that the first requirement, namely that individuals prove that they suffered from a gender identity disorder, infringed the dignity of the persons concerned as it assumed that they suffered from a mental disorder. That claim plainly resonates with aspects of the applicant's case in these proceedings

[100] The court had no difficulty concluding that Article 8 was engaged, recalling its case law that elements such as gender identity or identification fall within the personal sphere protected by Article 8's guarantee of respect for one's private life; and that the notion of personal autonomy was an important principle underlying the interpretation of the guarantees within Article 8. Albeit the ECtHR's judgments in this sphere had hitherto concerned legal recognition of the gender identity of transgender persons who had undergone gender reassignment surgery, the Court held that it could not be inferred from this that the issue of legal recognition of the gender identity of transgender persons who had *not* undergone such treatment, or did not wish to undergo such treatment, did not come within the scope of application of Article 8.

[101] The court considered that the applicants' complaints fell to be examined from the perspective of whether or not the respondent state had failed to comply with its positive obligation to secure to the applicants concerned the right to respect for their private lives. This resolved to the question of whether, in view of the margin of appreciation which the national authorities enjoyed, the French authorities, by making legal recognition of the applicants' gender identity subject to the conditions of which they complained, had struck a fair balance between the competing interests of the individuals concerned and of the community as a whole.

[102] In paragraph 121 of its judgment, the court noted that:

> *"In implementing the positive obligations under Article 8 the States enjoy a certain margin of appreciation. A number of factors must be taken into account when determining the breadth of that margin. Hence, where there is no consensus within the member States of the Council of Europe, either as to the relative importance of the interest at stake or as to the best means of protecting it, particularly where the case raises sensitive moral or ethical issues, the margin will be wider.*

> *There will also usually be a wide margin if the State is required to strike a balance between competing private and public interests or Convention rights. Nevertheless, where a particularly important facet of an individual's existence or identity is at stake the margin allowed to the State will be restricted…*"

[103] The significance of these issues lying within states' margin of appreciation is returned to below: see paragraphs [111]-[115].

[104] The court also noted (at paragraph 123) that "*an essential aspect of individuals' intimate identity, not to say of their existence, is central to the present applications*." This was partly because the applications concerned the individuals' gender identity, as well as the fact that the issue of sterilisation went directly to the individual's physical integrity. In light of this finding, the court concluded that the respondent state had only a narrow margin of appreciation, at least as far as the requirement for treatment was concerned. In assessing the Convention compliance of the treatment requirement, the court also referred to a trend which had been emerging in Europe in recent years towards abolishing that condition, driven by developments in the understanding of transgenderism (see paragraph 124). The court also noted that numerous European and international institutional actors involved in the promotion and defence of human rights had adopted a very clear position in favour of abolishing the sterility criterion, which they regarded as an infringement of fundamental rights.

[105] As to the French government's asserted justification of the stringent conditions required under French law for a legal gender change, the court (at paragraph 132) said that it fully accepted that "*safeguarding the principle of the inalienability of civil status, ensuring the reliability and consistency of civil-status records and, more generally, ensuring legal certainty, are in the general interest.*" Nonetheless, it noted that, at the material time, French law presented transgender persons not wishing to undergo full gender reassignment with an "*impossible dilemma*": either they underwent surgery or treatment against their wishes, thereby relinquishing full exercise of their right to respect for their physical integrity, or they waived recognition of their gender identity and hence full exercise of another aspect of their Article 8 rights. In the court's view this did not amount to a fair balance between the general interest and the individuals' rights. Accordingly, the court held that the requirement for proof of the irreversible nature of the change in their appearance imposed on the second and third applicants was a failure by the respondent state to fulfil its positive obligation to secure their right to respect their private lives under Article 8.

[106] Of course, in the United Kingdom there is no such requirement for an irreversible change in one's appearance (by means of sterilisation surgery or medical treatment entailing a very high probability of sterility) before one may obtain a GRC. That aspect of the Strasbourg Court's conclusion therefore is of limited assistance in

the present case, save for an appreciation of the legal reasoning used by the court to reach that terminus. Of more direct significance is the court's disposal of the claim made by the second applicant, who challenged the making of legal recognition of his gender identity conditional on proof that he actually suffered from a gender identity disorder. He claimed, as does the present applicant, that this amounted to labelling him as mentally ill and hence to an infringement of his dignity. In response, the French government observed that a prior diagnosis of gender identity disorder was a requirement in most countries. The applicant Garçon's stance, much like that of the present applicant, was to the effect that transgenderism is not an illness and that addressing gender identities from the perspective of a psychological disorder added to the stigmatisation of transgender persons – a position which, the ECtHR noted, was common with that adopted by many non-governmental organisations working to protect transgender rights (see paragraph 138 of the court's decision).

[107] The court observed that psychiatric diagnosis featured among the pre-requisites for legal recognition of transgender persons' gender identity in the vast majority of the 40 contracting parties which allowed such recognition, with only four of them (at least at that stage, although this may now be seven) having enacted legislation laying down a recognition procedure which excluded such a diagnosis. Significantly, the court noted that transsexualism featured in Chapter V of the WHO's ICD-10 and was categorised as a disorder, which has now changed (see paragraphs [40]-[43] above). Unlike the treatment condition, the requirement to obtain a prior psychiatric diagnosis did not directly affect the individual's physical integrity. Nonetheless, the Commissioner for Human Rights of the Council of Europe had stressed that the requirement to obtain a psychiatric diagnosis may hinder the exercise of individuals' fundamental rights.

[108] On this point, the ECtHR considered (at paragraph 140) that contracting parties retained wide discretion in deciding whether or not to lay down such a requirement. The court also noted support for the view that a diagnosis of gender dysphoria was required for the purposes of differential diagnosis so that doctors could be sure, before administering hormone treatment or performing surgery, that the patient's suffering did not stem from other causes; that is to say, the requirement for a diagnosis was of utility and important when assessing the need or appropriateness of gender reassignment treatment. Although finding aspects of the government's argument "*not wholly persuasive*", the Court nevertheless accepted that the requirement for a gender identity diagnosis was "*aimed at safeguarding the interests of the persons concerned in that it is designed in any event to ensure that they do not embark unadvisedly in the process of legally changing their identity*"; and that it promoted the interests of legal certainty relating to civil status which had been accepted as a legitimate aim pursued (albeit unjustifiably in the outcome) by the sterility requirement in French law (see paragraphs 141-142). Consequently, and "*especially in view of the wide margin of appreciation which they enjoyed*", the Court considered that the French authorities had struck a fair balance between the competing interests at stake in requiring the second applicant to show that he had suffered from a gender identity disorder (paragraphs 143-144). Significantly, the

court's reasoning proceeds on the basis that the applicant's Article 8 rights were engaged by the requirement for such a diagnosis but that his interests were outweighed in the balancing exercise, bearing in mind the wide margin of appreciation available to the national authorities.

[109] Finally, as regards the obligation to undergo a medical examination (another overlap with the case made by the applicant in the present proceedings), on the facts of the case before it the expert assessment in question had been aimed at establishing whether the first applicant's claim – that he had undergone gender reassignment surgery abroad – was accurate. It had been ordered by the judge assessing the applicant's case as part of the taking of evidence, an area in which the ECtHR allows contracting parties very considerable room for manoeuvre. In the circumstances of the *AP* case, the court concluded that, although the expert medical assessment which was ordered entailed an intimate genital examination of the applicant, the extent of the resulting interference with the exercise of his right to respect for his private life should be qualified to a significant degree. The court did not find that this requirement failed to strike a fair balance between the competing interests at stake on the facts of the case.

[110] The respondent contends that the outcome of the ECtHR's deliberation in *AP, Garçon and Nicot* demonstrates that the current system for gender recognition in the United Kingdom under the 2004 Act is compliant with the Convention. Put shortly, although the Strasbourg Court found that the requirement for irreversible appearance-altering treatment in France was Convention non-compliant, it generally reaffirmed the wide margin of appreciation open to CoE member states as to the conditions which they lay down for gender recognition, including a requirement to demonstrate a gender identity disorder and to undergo a medical examination. This is a powerful submission.

Convention scrutiny by domestic courts within the margin of appreciation

[111] The riposte on behalf of the applicant is that, where the ECtHR has left a matter to the discretion of member states in the exercise of their margin of appreciation and in the absence of a European consensus, the domestication of Convention rights in the HRA nonetheless permits and requires domestic courts to determine whether there has been a violation of those rights in the domestic context. Notably, in *R (Nicklinson) v Ministry of Justice* [2014] UKSC 38, the Supreme Court held by a majority that, in enacting section 4 of the HRA, Parliament had delegated the power to declare legislation incompatible with the Convention to the courts, even where the decision fell within the State's margin of appreciation, and the courts should not shirk from exercising that power.

[112] At paragraphs [70]-[76] of his judgment in *Nicklinson*, Lord Neuberger addressed this issue. In cases in which the Strasbourg Court had held that there was a wide margin of appreciation accorded to each state and that it was for each state to decide for itself how to accommodate Article 8 rights, Lord Bingham's observation in

the *Ullah* case that "*the duty of national courts is to keep pace with the Strasbourg jurisprudence as it evolves over time: no more…*", as well as no less, was not in point. Within the margin of appreciation, it was for national courts to decide the issues for themselves, with relatively unconstraining guidance from the Strasbourg Court, albeit bearing in mind the constitutional proprieties and such guidance from the Strasbourg jurisprudence and domestic jurisprudence as seemed appropriate. This was partly because, as Lord Hoffmann had observed in *In re G (Adoption: Unmarried Couple)* [2009] AC 173, after the enactment of the HRA Convention rights were now domestic and not international rights (see generally Lord Hoffman's judgment at paragraphs [33]-[36]).

[113] Lord Mance returned to this topic in *D v Commissioner of Police of the Metropolis*. A helpful and recent summary of the import of his contribution is found in Singh LJ's judgment in *R (Schofield) v Secretary of State for the Home Department* [2021] EWHC 902 (Admin) at paragraph [93]:

> "*In D v Commissioner of Police of the Metropolis [2018] UKSC 11; [2019] AC 196, at paras. 153-153, Lord Mance DPSC considered the principle first established by Lord Bingham in R (Ullah) v Special Adjudicator [2004] UKHL 26; [2004] 2 AC 323. Lord Mance said that those "well-known cautionary remarks" mean that the general aim of the HRA was to align domestic law with Strasbourg law. Domestic courts should not normally refuse to follow Strasbourg authority, although circumstances can arise where this is appropriate and a healthy dialogue may then ensue. Conversely, domestic courts should not, at least by way of interpretation of the Convention rights as they apply domestically, "forge ahead", without good reason. This follows not merely from Ullah but from the ordinary respect attaching to the European Court of Human Rights and the general desirability of a uniform interpretation of the Convention in all member States. At para. 153, Lord Mance continued that there are, however, cases where the English courts can and should, as a matter of domestic law, go with confidence beyond existing Strasbourg authority. If the existence or otherwise of a Convention right is unclear, then it may be appropriate for domestic courts to make up their minds whether the Convention rights should or should not be understood to embrace it. However, where the European Court of Human Rights has left a matter to a state's margin of appreciation, then domestic courts have to decide what the domestic position is, what degree of involvement or intervention by a domestic court is appropriate, and what degree of institutional respect to attach to any relevant legislative choice in the particular area.*"
> [underlined emphasis added]

[114] An illustration of such Convention scrutiny by domestic courts, in the very context with which these proceedings are concerned, is to be found in another case which poses some difficulties for the applicant: *Carpenter v Secretary of State for Justice* [2015] EWHC 464 (Admin); [2015] 1 WLR 4111. In that case the applicant, a transgender woman who had undergone gender reassignment surgery, obtained a GRC under the 2004 Act having been required, in accordance with section 3(3), to provide details to the GRP considering her application of the surgical treatment she had undergone for the purposes of modifying her sexual characteristics. She sought a declaration that, in requiring her to provide details of such treatment, section 3(3) of the Act was incompatible with her Article 8 rights and/or discriminated against her in the enjoyment of those rights contrary to Article 14 (on the ground of her 'other status' as a transgender person who had undergone gender reassignment surgery or on the ground for sex, in that applicants who had not undergone such treatment were entitled to a certificate without being required to provide such details).

[115] Thirlwall J dismissed the application. However, in doing so he held that the adequacy of the State's criteria for recognising gender was a justiciable matter. In particular, at paragraph [11] of his judgment he said that, "*Whilst the courts have given broad approval of the GRA, as has the United Nations Committee, that approval does not preclude a closer analysis of the statute which might lead to a different result.*" He noted that at the time of the passage of the 2004 Act the relevant minister had certified that it complied with the United Kingdom's obligations under the Convention, which meant that the Government had intended to comply with those obligations and understood that it had done so. Relying on the decision of Underhill LJ in *MB v Secretary of State for Work and Pensions* [2014] ICR 1129, the judge accepted (at paragraph [14]) that, whilst it was for member states to determine the conditions under which legal recognition is given to the change of gender of a person, it was not possible to stop there. The ECtHR clearly did not intend that member states should have *carte blanche*. That was clear as a matter of principle but the point was in any event made explicit by the Strasbourg Court in *Goodwin* at paragraph 103. On the substance of the case Thirlwall J held that, although the requirement to provide medical details plainly engaged Article 8 rights, where an applicant had undergone surgery (or planned to do so) that fact was highly relevant, if not central, to the application and was plainly necessary to the GRP's consideration of the criteria in section 2(1)(a)-(c) of the 2004 Act. As to the Article 14 claim, the learned judge held that since the burden in the case of all applicants was the same, namely to provide the details of treatment (whether surgical or nonsurgical), there had been no unlawful discrimination.

The proper approach for the Court

[116] What then is the proper approach for this court to take in the present challenge? Although the ECtHR has left the conditions upon which gender recognition will be granted in the United Kingdom to its national authorities, this is a case in which the Court, whilst respecting the principle of the separation of powers

and the respective institutional competences of the three branches of government, must form its own judgment as to the Convention compatibility of those arrangements as a matter of domestic law.

[117] That said, authority clearly indicates that where the legislature has enacted a statutory provision which is within the margin of appreciation accorded to member states, although it is wrong in principle for the court to "*frank the provision as a matter of course simply because it is rational*" (see Lord Neuberger at paragraph [75] of *Nicklinson*, applied by Lieven J at paragraph [49] of *R (H) v Secretary of State for Health and Social Care* [2019] EWHC 2095 (Admin)), the court will normally be "*very cautious*" about deciding that it infringes a Convention right. In this context, the court should be mindful, first, that the fact that a better scheme could have been devised does not mean that the statutory scheme lies outside the appropriate margin of judgment and, second, that the impact of the scheme as a whole should be the focus, bearing in mind that bright line rules, rather than individual discretionary decisions, can be proportionate (see Lieven J in *H* at paragraph [52], drawing on Lord Sumption's judgment in *Re Gallagher* [2019] 2 WLR 509).

[118] The parties were agreed, consistent with the Strasbourg authority discussed above, that the ultimate test is whether the impugned provisions of the 2004 Act strike a fair balance between the competing interests of the individual and the community as a whole.

[119] There was some debate before me as to whether the applicant's case involved an interference with her Article 8 rights by the State, as she submitted, or whether, as the respondent submitted, Article 8 was engaged only by means of a failure to adequately give effect to a positive obligation. I consider the respondent's approach to be the better analysis and the one which is consistent with the Strasbourg case-law, albeit this may well make little difference in the final analysis. In *Hämäläinen*, the Grand Chamber considered it better to address the case as involving the State's positive obligation to provide an effective and accessible procedure for gender recognition. However, the court also noted that the principles applicable to assessing a State's positive and negative obligations under the Convention are similar. In either case, regard must be had to the fair balance that has to be struck between the competing interests of the individual and of the community as a whole, the aims in the second paragraph of Article 8 being of a certain relevance (see paragraph 65 of *Hämäläinen*.)

Has a fair balance been struck by the impugned provisions?

Summary of the applicant's submissions

[120] The applicant's primary case in relation to the requirement for a diagnosis of gender dysphoria is simply that it is unnecessary in light of the content and import of the remaining criteria set out in section 2(1) of the 2004 Act. She draws specific attention to the requirements to provide evidence of having lived full-time in one's

acquired gender for at least two years at the date of the application and a solemn statutory declaration indicating an intention to live in the acquired gender until death. What then does a medical label – especially one which might relate to a historic diagnosis – add? Recognising that, during the Parliamentary debates on the Bill which became the 2004 Act, a Government Minister had stated that the statutory requirements were "*designed to establish whether a person has taken decisive steps to live fully and permanently in their acquired gender*", the applicant submitted that the requirements of living in one's acquired gender for two years and making the statutory declaration amply demonstrated that.

[121] There is then a more particular objection to the requirement that one must provide a diagnosis of something expressly defined as a disorder. Put simply, the applicant contends that this is an out-of-date notion and needlessly derogatory and offensive towards transgender people – a position with which, the applicant submits, the respondent has been shown to agree in its 2018 consultation and subsequent consideration of amendments to the Act. It is also interesting to note that the *General Guide*, the current version of which was produced in 2020, shies away from the definition within the 2004 Act to the effect that gender dysphoria is necessarily a "*disorder.*" Rather, the guidance merely states (at paragraph 2.4) that:

> "***Gender dysphoria*** *is a recognised medical <u>condition</u> variously described as gender identity disorder and transsexualism. It is an overwhelming <u>desire</u> to live in the opposite gender to that which a person has been registered at birth.*"
>
> [underlined emphasis added]

[122] That is to downplay the express definition of gender dysphoria in section 25(1) of the 2004 Act as "*the disorder variously referred to…*" in a number of ways; and to minimise the requirement for clinically significant distress as part of the diagnostic criteria. The applicant complains about (at least) four features of the requirement for a diagnosis of gender dysphoria:

(i) First, some plainly deserving applicants for a GRC may not have or have had a condition conforming to the definition. They might be utterly convinced that their assigned gender does not match their gender identity but suffer no distress or discomfort as a result of this; or, alternatively, such distress or discomfort as they do experience might arise not from this discrepancy but from (for example) their experience of prejudice against transgender people. In such a situation, the applicant for a GRC is faced with a dilemma of either being found not to meet the diagnostic criteria for gender dysphoria or being dishonest in their application (and seeking to persuade the relevant medical practitioner to provide what is, in essence, a false diagnosis). In short, some transgender people are not necessarily gender dysphoric. (The 2018 consultation recounted that some stakeholders suggested that this specifically

affects intersex individuals whose sex was incorrectly assigned at birth.) I might add that I do not consider on the evidence before me that this concern arises or is likely to arise in this particular applicant's case, so that, if this was the only issue raised in the applicant's challenge, I would not be persuaded that she had established victim status for the purposes of section 7 of the HRA.

(ii) Second, given that an applicant for a GRC need only show that they, at some point in the past, *had* gender dysphoria, and need not presently be suffering from that condition, the requirement lacks any significant relevance to the consideration of the applicant's circumstances at the time of the application.

(iii) Third, as discussed above, the requirement to show that one has a *disorder* is, in itself, objectionable and unjustifiable.

(iv) Fourth, the requirement to obtain a diagnosis from a specialist practitioner can be practically burdensome, inconvenient, expensive, and intrusive.

[123] Several of these contentions find support in the analysis of responses submitted to the consultation in 2018. The House of Commons Library Briefing Paper on the Gender Recognition Process (Number 08746, published on 8 January 2020) also summarises a number of these concerns, which seem to be shared by many within the transgender community, when it notes that:

> "*The current process for legal gender recognition has been criticised by some people for its medicalised approach (it is necessary to submit medical evidence with most applications). Some trans people have argued that the requirement for a diagnostic psychiatric report perpetuates the assumption, which they consider to be outdated and false, that being trans is a mental illness. Many trans people also consider the process to be overly intrusive, humiliating and administratively burdensome.*"

[124] The applicant also understandably emphasises those portions of the Government's 2018 consultation document which make clear that the Government then did not consider being trans to be a mental illness. Indeed, in paragraph 24 of Annex D to the consultation document, it was stated that, "*Irrespective of international classifications, the Government does not view gender dysphoria as a mental illness.*" Even after the change of Government in 2019, the GEO's position remained consistently in favour of removing the requirement for a diagnosis specifically of gender dysphoria (as evidenced by the submissions and briefing notes discussed at paragraphs [61]-[73] above), at least up to the very last moment, even if its initial enthusiasm for removing entirely the medical aspects of the process (which the applicant contends was entirely right and justified) had been jettisoned. In light of that position, the applicant submits that the respondent's position is contradictory and incoherent.

Summary of the respondent's submissions

[125] In its submissions, the respondent has emphasised the significance of the step of changing one's legal gender and the importance therefore of ensuring that the decision is taken in a fully informed and considered manner and with a proper basis. The requirement for medical reports serves this broad aim, Mr McGleenan submitted. Furthermore, this was both recognised and intended at the time when the 2004 Act was enacted.

[126] The respondent's deponent, Mr Entwistle, provided evidence about the development of what became the 2004 Act and exhibited a range of relevant documents, many of which were opened in the course of the hearing before me. The following points were emphasised:

(a) The Joint Committee on Human Rights (JCHR) undertook pre-legislative scrutiny of the Bill which became the 2004 Act as part of the process of consultation on the draft Bill, which involved collecting evidence and engaging with and probing the Department responsible for the Bill. Its report was published on 20 November 2003 (HL Paper 188-I and HC 1276-I). The JCHR considered a number of questions about the Bill. At that time, the term "*dysphoria*" was in common usage; and the Committee neither recommended that the term should not be used, nor that a medical element should not be used in the criteria for the issue of a GRC. The Committee noted that someone presenting with gender dysphoria would normally have careful psychological assessment in order to ensure that they were "*not in reality homosexual or transvestite rather than a gender dysphoria sufferer.*"

(b) The contemporaneous documents show that the Government considered that there needed to be *certainty* in the way in which a person's gender was treated for legal purposes, to which end there would be legal conditions for recognition of a change of gender (with Gender Recognition Panels acting as 'gatekeepers') and certificates should not be issued to "*people who are making a mere lifestyle choice.*" The JCHR accepted that the manner in which the law should be changed was a matter for the legislature, taking account of the fact that the resulting changes to laws and practices would "*inevitably have far reaching effects, with an impact on many areas of life and law, including criminal law, family law, entitlement to pensions, and sex discrimination…*" (see paragraph 21 of the JCHR Report). It concluded that the approach in the draft Bill represented a "*sensitive and sensible compromise by allowing pre-operative transsexual people to have their acquired gender recognised, with the Gender Recognition Panel providing a safeguard against premature or frivolous applications*" (see paragraph 29). In reaching this view, the Committee had heard evidence suggesting that some medical experts were sometimes unfairly sceptical about whether someone was suffering from gender dysphoria. This appears to have been considered by the Committee to be part of the safeguards

inherent in the proposed scheme to ensure that "*premature or frivolous*" applications were not made or granted.

(c) Although the JCHR recognised that some may find it demeaning to have to apply to a Panel for recognition of an acquired gender in which the applicant had been living for some years, it was accepted as appropriate for the State to regulate the acquisition of a new identity and to require an official act of recognition for a step which has legal consequences and affected a person's status. That was considered justified in order to protect the rights of others, including the family of the person whose status was changing and those who would have dealings with them in future. Ultimately, the JCHR considered the criteria proposed to represent a fair and proportionate balance between the competing interests of those involved. In doing so, they accepted the force of the Government's argument that willingness to receive treatment is very important as evidence that the applicant is suffering from gender dysphoria and intends to live permanently in the acquired gender. There was a recognised concern that the system should not "*degenerate into giving legal recognition to lifestyle changes*" (see, for instance, paragraphs 52-57 of the JCHR Report).

(d) When the Bill was introduced in the House of Lords in November 2003, the term "*gender dysphoria*" was then routinely used as the Bill passed through Parliament. In its second reading, Lord Filkin explained that the criteria – including the requirement of a diagnosis of gender dysphoria – were "*designed to establish whether a person has taken decisive steps to live fully and permanently in their acquired gender.*" Moreover, at the committee stage, Lord Carlile, in addressing concerns about whether the Bill could make it too easy for someone to change their gender, pointed out that obtaining a diagnosis of gender dysphoria can be onerous. This appears to have been concurred in by Lord Filkin for the Government, who also observed that the process would not be "*a sudden, one-consultation end decision*" but that "*a careful and thorough medical process must be gone through before a doctor, or more than one doctor, comes to the conclusion that a person experiences gender dysphoria.*" This was said to be "*absolutely right*" because "*it must not be a sudden process.*"

[127] Mr McGleenan relied on these materials to submit that the statutory requirement impugned in these proceedings had been carefully and consciously considered and inserted by Parliament for good reason; and had been properly scrutinised and considered to be Convention-compliant at the appropriate time. It operates as a barrier to applicants making ill-thought out or precipitous applications for a GRC and also against 'cheating' the process.

[128] The *General Guide* emphasises that a change of legal gender may affect aspects of the applicant's life negatively, including financially or emotionally, particularly where the applicant is married or in a civil partnership and their spouse is unhappy with the change. In addition, if a person in receipt of a full GRC wishes to revert to

their birth gender, to do so they must make a further application for a GRC and meet the requirements of the 2004 Act in the same way in which they did when making their initial application. It is a process which should only be embarked upon advisedly and with proper reflection.

[129] The Women and Equalities Committee Report noted that the Intercollegiate *Good Practice Guidance* (the Royal College of Psychiatrists' Good Practice Guidelines for the Assessment and Treatment of Adults with Gender Dysphoria (College Report CR181, October 2013)) explains that the purpose of requiring clinical opinions – at least in relation to treatment – was to ensure that there was a persistent and well-documented gender dysphoria, that the patient has capacity to make fully informed decisions and consent to treatment, and that any significant medical or mental health concerns are reasonably well controlled. Those features were also relevant to the decision to seek a life-altering change in one's gender; and there was a value in having consistency of approach across both the legal and medical aspects of transitioning.

[130] There are also concerns that a system based upon, or moving more closely towards, self-identification might create additional scope for abuse and consequent possible negative impacts, particularly on vulnerable women. Proponents of self-identification point out that taking the significant step of changing gender is unlikely to be done lightly and that, in the possible rare cases where this has been done for nefarious reasons, the correct response should be to deal with the perpetrator. However, concerns about possible abuse were a feature of many consultation responses.

Conclusion on fair balance – the requirement for a diagnosis

[131] I am satisfied that the requirement that a relevant diagnosis be provided in support of an application for a GRC was and remains within the discretionary area of judgment available to Parliament for the reasons the respondent has given and which are summarised at paragraphs [125]-[130] above. The requirement that a medical report be provided by a specialist in the relevant area is a corollary of the requirement that a diagnosis must be obtained as part of the statutory criteria for the grant of a GRC. They are two sides of the one coin. As Baker LJ explained in *Jay v Justice Secretary*, at paragraph [93], the evidential requirements in section 3 of the 2004 Act are ancillary to the statutory criteria in section 2 of the Act.

[132] In reaching this conclusion, I am mindful of the approach adopted by the ECtHR in the *AP, Garçon and Nicot* case. Beyond the Strasbourg cases dealing with applicants who have undergone reassignment surgery, the conditions under which legal gender recognition must be afforded to transgender persons is left to member states to determine, given the sensitive moral and ethical issues which this judgment entails. This is not a case where the applicant has undergone gender reassignment surgery, such as *Goodwin*; nor a case where the law requires sterilisation or invasive surgery before a legal gender change may be granted to her. There is no consensus

within Council of Europe member states as to when, in those circumstances, gender recognition must be granted. Indeed, the parties provided me with a map produced by TGEU (Transgender Europe) showing that some 31 countries in Europe and Central Asia still require a mental health diagnosis in legal gender recognition. Although a trend may be starting to emerge of moving away from such a requirement, many CoE countries still consider it an appropriate requirement. For the reasons expressed further below, I do not consider that this is an appropriate case to "*forge ahead*" of the Strasbourg jurisprudence and require recognition to be granted in the absence of a relevant specialist diagnosis.

[133] In light of the aims pursued by Parliament in requiring a diagnosis at the time of enacting the 2004 Act – which are, broadly, the same aims being pursued by the Government's more recent policy choice to retain a medical aspect to the process – I do not consider that the Act fails to strike a fair balance in this regard between the needs of the applicant (or other individuals seeking gender recognition) and the community as a whole. The materials exhibited to Mr Entwistle's affidavit demonstrate that the present Government wishes to retain a medical element to the process, with the continued involvement of gender specialist practitioners, partly in order to deter vexatious applications or abuse of the GRC process, and partly in order to provide appropriate support, advice and safeguards for applicants. In turn, this is consistent with the recognition by the ECtHR in *AP, Garçon and Nicot* that a requirement for a mental health diagnosis could be of utility and important in assessing the appropriateness of a legal change in gender identity as a means of safeguarding an applicant's own interests and in the interests of legal certainty for the community more generally.

[134] I reject the applicant's submission that the *ultimate* statutory basis for the issue of a GRC is not a diagnosis of gender dysphoria "*but rather, and more appropriately, whether the applicant is living in the other gender.*" The applicant submitted that this could be established by a Panel without the need to prove gender dysphoria and on the basis of the other criteria set out in section 2(1) of the 2004 Act. However, this is to read into the statutory language a hierarchy of criteria which finds no textual support in the Act. The requirement that an applicant have lived in their acquired gender for two years is not the "*ultimate*" criterion to be applied or "*the ultimate litmus test*", as the applicant also variously submitted. It is one of several criteria, which are independent (although inter-related) and of equal importance.

[135] I accept the respondent's submission that the legal change in a person's gender is a significant and formal change in their status with potentially far-reaching consequences for them and for others, including the State. It is not easily undone. The State is entitled, in my view, to require that an applicant for a GRC provide evidence from an appropriately qualified medical practitioner – who will not only be an expert in the field but also subject to both a duty of care to the applicant and exacting professional standards in the public interest – which sets out why the applicant is seeking a legal change of gender and provides a measure of reassurance that this has been discussed with an independent expert and reflected upon carefully

by the applicant. Although an assessment of these matters could be made by the GRP itself, the model which is adopted under the 2004 Act is designed so that the Panel generally considers applications on the papers without face-to-face engagement with an applicant: see paragraph 6(4) of Schedule 1 to the Act. In my view there is something to be said for a process which allows the in-depth discussion and analysis of the context and reason for a GRC application to occur at a time and place of the applicant's choosing, with a medical professional or professionals (whom they perhaps know and trust), rather than at an in-person hearing before the GRP.

[136] I also agree with the conclusion of Thirlwall J in *Carpenter* that the far-reaching effects of the decision to grant (or to refuse) a GRC require that the decision is made on the basis of full information in respect of each applicant (see paragraph [24] of the *Carpenter* judgment); and with the guidance issued by the President of the Gender Recognition Panels that the statutory requirement of a specialist medical report setting out a diagnosis is not only important in its own terms but will or may also assist a GRP to be satisfied in respect of the other statutory criteria (see paragraph 3 of the guidance set out at paragraph [33] above).

[137] It is emphatically not this court's role to judge whether this is the best or most appropriate way to provide for gender recognition. There may well be force in the suggestion that gender recognition is sought by individuals who know their own mind and only make such a choice with thought and commitment, demonstrated amply by a requirement to have lived in one's acquired gender for a period of two years before application. There may well be force in the LGBT Health Adviser's view that it is the need for *any* diagnosis which is viewed as stigmatising, rather than any *particular* diagnosis. There may well also be force in the suggestion that the respondent's own statistics show that there is a woefully low uptake of the GRC process by the transgender community so that, in general, the present system cannot be said to be serving well those for whose benefit it has been devised (although the precise reasons for that, and the role played in it by the requirement for a diagnosis which is challenged in this case, are matters as to which I can really only speculate). But Parliament was and is entitled, in my view, to require some additional evidence about the background to, and reasons for, an application for a GRC by way of medical evidence which addresses the basis and context for the application.

[138] The fact that the required diagnosis may be a historic one – that is to say, relating to a condition which the applicant had in the past – does not alter this analysis. The benefits of professional clinical input into the GRC application process which are summarised above are not dependent upon the diagnosis to which that input will ultimately give rise only being one which is current. Likewise, the applicant's reliance on the fact that, under the section 2(2) route, some applicants may obtain a GRC without having had to provide a medical diagnosis in support of it does not avail her. Section 2(2) applications, which appear to be comparatively rare, simply provide legal recognition in the United Kingdom of what has already been formally recognised by the law of another approved country (set out in the

Gender Recognition (Approved Countries and Territories) Order 2011, SI 2011 No 1630). The mere fact that some of those countries may have more relaxed requirements as to when gender recognition will be granted does not materially affect the ability of Parliament in Convention terms to decide for itself what the conditions for such recognition should be in this jurisdiction.

[139] Finally, I also consider that there is force in the respondent's submission that it was entitled to take into account a desire to maintain consistency of approach across the legal and medical processes for gender transition, with specialist medical input in each. I cannot accept the applicant's submission that the 2004 Act was specifically designed to fracture any such link. Although it was designed to facilitate gender recognition without an applicant having had to undergo any gender reassignment surgery or treatment, the requirement for a diagnosis and more especially the requirement that a medical member form part of the GRP demonstrates that Parliament considered it proper to have some read-across between the two processes by way of professional clinical involvement in each. That judgment, and the possible impacts of entirely de-coupling the medical from the legal transition process, are matters which are not well suited to judicial adjudication. Indeed, there is an uneasy tension at the heart of the applicant's case, namely that, on the one hand, she eschews any 'medicalisation' of the process for legal gender recognition but, on the other, contends that any necessary diagnosis (and presumably any consequent gender reassignment or gender confirming treatment) should be paid for on the NHS. This tension was also noted at the time of the Women and Equalities Committee Report, since one of the contributors to the Committee's inquiry, the Gender Identity Research and Education Society (GIRES), noted that removal altogether from the ICD (as occurred with the depathologisation of homosexuality) was not an option, since gender dysphoria frequently requires medical interventions (see paragraph 192 of the Committee's report). Inclusion of gender incongruence in the ICD was also designed to ensure transgender people's access to gender-affirming health care, as well as adequate health insurance coverage for such services. When there is plainly a medical aspect to some elements of gender transition, at least for some transgender individuals, the authorities are entitled to consider that there is some value in maintaining an element of consistency of approach across both processes.

Conclusion on fair balance – the required diagnosis

[140] However, I have reached a different conclusion on the question of what it is that the required first medical report must demonstrate. On the basis of the 2004 Act as it stands at present, it is incumbent on an applicant for a GRC to show that they have, or have had, a "*disorder.*" This requirement is imposed on them in circumstances where the Government does not now contend that a transgender person necessarily has, or has ever had, a disorder: indeed, its public-facing documents say the opposite. It is also imposed on them in circumstances where both the ICD and DSM classifications have clearly and purposefully moved away from categorising the relevant diagnoses as being of a mental disorder. The definition in

section 25(1) of the 2004 Act which requires an applicant for a GRC to prove themselves to have or have had a disorder is a legacy of the Act being drafted at a time when a different approach to these matters prevailed. It is now an unnecessary affront to the dignity of a person applying for gender recognition through the legal process set out for that purpose by Parliament.

[141] The English Court of Appeal in *R (Elan-Cane) v Home Secretary* [2020] 3 WLR 386, at [46]-[47], observed that there can be little more central to a citizen's private life than gender; and gender is one of the most important aspects of private life. This is consistent with the ECtHR's view in *AP, Garçon and Nicot* that gender is "*an essential aspect of individuals' intimate identity, not to say of their existence.*" Parliament has determined that, in the United Kingdom, transgender persons are entitled to obtain a GRC changing their gender in law to that of their acquired gender, without gender reassignment surgery, in order to respect and give effect to this aspect of their private life, bearing in mind the principle of autonomy. This system is designed to give effect to rights within the Article 8 sphere and plainly engages them, as was also held in the *Carpenter* case. There is no reason why the grant of such recognition should or must be conditional on an applicant proving that that element of their private life amounts to a disorder. Although there may be those who take that view on moral or religious grounds, crucially the respondent has not sought to stand over it. The result is that applicants for a GRC face a quandary: in order to assert their legal rights to gender recognition, they must denigrate that aspect of their identity which the 2004 Act is in principle designed to vindicate. As the development of the ICD and DSM classifications shows, that is no longer necessary. Moreover, the changes made in ICD-11 are an important factor which had not occurred, and which was not therefore considered, by the ECtHR in *AP, Garçon and Nicot*.

[142] In his judgment in *Carpenter* in February 2015, Thirlwall J said this (at paragraph [5]):

> "*Gender dysphoria occurs when a person experiences discomfort or distress as a result of the mismatch between his or her biological sex and the gender with which they identify. Until recently it was considered a psychiatric disorder. The current approach has moved away from categorising it as a disorder and towards a description of its characteristics.*"

[143] However, some six years on, the 2004 Act still expressly treats the required diagnosis as one of a disorder. The GEO's advice to Ministers was that the present approach was now "*a very out of date notion*" and, even after the change in the Ministerial team in 2019 and involvement of the Prime Minister's Office, the Government's approach was initially characterised by a keenness to move away from the required diagnosis of gender dysphoria, albeit whilst retaining a medical element to the process.

[144] The only real basis put forward by the respondent in the course of these proceedings to seek to defend retention of the present definition of gender dysphoria (as opposed to gender incongruence) as the required diagnosis, and the statutory definition of that condition as a "*disorder*", was the suggestion that medical practitioners were familiar with that diagnosis and that a change in practice may present difficulties. I do not find that at all convincing, for the following reasons:

(a) First, the report providing the diagnosis must be provided by a specialist practising in the relevant field (see section 3(1)(a)). I find it extremely difficult to accept that such specialists could not readily become familiar with any necessary change in approach which was required by an amendment of the required diagnosis in the 2004 Act.

(b) Second, it appears to me that there is good reason to believe that many such practitioners will be familiar with the relevant concepts already. There have been significant modifications to both the DSM and ICD classifications since 2004. There is no evidence before me to suggest that specialist practitioners are unable to adapt to changing terminology, concepts or diagnoses within their field of practice or that they have failed to do so in the past. In particular, ICD-11 has now been in circulation for a number of years.

(c) As discussed above (see paragraph [66]), the GEO submission of 29 May 2020 noted that those seeking medical support to change their gender would continue to receive an NHS diagnosis of gender dysphoria *or* gender incongruence. The GEO briefing note of 11 June 2020 (see paragraphs [68]-[69] above) proceeded on the basis that "*gender incongruence is a term already known and used by the NHS*" and that "*changing the terminology used in the GRA from gender dysphoria to gender incongruence is largely symbolic and will not interfere with existing clinical processes.*" This advice was given after engagement with DHSC and the LGBT Health Adviser. It clearly suggests that those practitioners involved in providing the required reports would quite easily have been able to adapt to providing a diagnosis of gender incongruence, a term already known and in use, and that it would not cause significant, much less widespread and serious, confusion.

(d) The 2018 consultation document suggested that gender incongruence was "*another name for gender dysphoria.*" Mr McGleenan in oral submissions also suggested that there was no material difference between the two. I do not consider that that properly reflects the statutory text and the relevant diagnostic classifications. Nonetheless, the GEO's view was plainly that there was significant overlap between a diagnosis of gender incongruence (albeit not classified as a disorder and not requiring the same element of distress for diagnosis) and that of gender dysphoria. The Government's analysis of the 2018 consultation responses, published in September 2020, also notes (in the analysis of answers to Question 3 in the consultation) that, "*A diagnosis of gender dysphoria or incongruence is also required in order to access NHS*

treatment…" [underlined emphasis added]. This further supports the view that gender incongruence is a term known to and used by relevant practitioners already.

(e) Although some concern was raised through DHSC and the LGBT Health Adviser, no evidence has been provided on behalf of the respondent from the Department of Health and Social Care, or from any medical practitioners, to support the suggestion that a change would create confusion or uncertainty amongst clinicians or to gainsay the GEO's assessment that it would not materially interfere with clinical practice. There is also some evidential support for the suggestion that DHSC officials' concerns about GEO's proposals to amend the required diagnosis had been resolved by mid-June 2020.

(f) I was also provided with a position statement from March 2018, entitled '*Supporting transgender and gender-diverse people*' (PS02/18), published by the Royal College of Psychiatrists, the professional medical body responsible for many of those who are likely to provide diagnoses for the purposes of GRC applications, which specifically recommended that the ICD and the DSM "*should, at the earliest opportunity, de-classify any terms they use to describe transgender as a mental health disorder*."

(g) Indeed, my reading of the documents provided by the respondent suggests that the primary concern on the part of DHSC and the LGBT Health Adviser in relation to the role of clinicians was the confusion and uncertainty which would be involved if they were to be retained as part of the GRC application process in the absence of a requirement for *any* diagnosis. That arose from a suggestion – considered but quickly jettisoned – that the clinicians may have some different role such as assessing 'fitness to proceed' with the application.

(h) In any event, it seems to me that the abandonment of the policy proposal to amend the diagnosis required by the 2004 Act was taken as much, if not more so, on the basis of a wider decision simply to leave the Act untouched than on the basis of any concern about the practicality of clinicians coping with the proposed change (see paragraph [78] above).

[145] Even if a change in the required diagnosis may be (on one view) "*symbolic*", on the evidence available to me the importance of such symbolism should not be underestimated. Words can and do matter in this context. On the other hand, I can discern no material interest on the part of the community, independent of those discussed above in support of the general requirement that some diagnosis be provided, in an applicant being required to provide a diagnosis of a disorder rather than merely a condition related to sexual health.

[146] In summary, the Government's decision to continue to require supporting medical evidence and a specific diagnosis before a Gender Recognition Panel is

obliged to grant a GRC may be viewed as part of the "*proper checks and balances*" which the State, in its judgment, is entitled to adopt and passes Convention muster; but the requirement that that diagnosis be one which is specifically and expressly defined as a "*disorder*" is not.

[147] This narrow issue is also not one on which in my view the Court is required to accord a significant degree of deference to Parliament's judgment. For a start, the Government's decision not to bring forward a legislative vehicle for reconsideration and amendment of the 2004 Act means that Parliament has not had an apt opportunity to express a clear, recent view of the appropriateness of the maintenance of the requirement for a GRC applicant to prove that they suffer from a mental disorder. This is an area where Parliament has been inactive since 2004. Moreover, the consistent advice of GEO officials was that opposition parties would prefer a more radical change to the gender recognition system, de-medicalising it further. Lord Neuberger also referred, at paragraph [112] of his judgment in *Nicklinson*, to rapid changes in moral values being a factor militating against an unduly restrictive approach to the judiciary's role on an issue falling within the margin of appreciation. In the same context, Lord Mance referred (at paragraph [164] of his judgment) to the fact that, while the legislature is there to reflect the democratic will of the majority, the judiciary is there to protect minority interests. Although these points might also be made in respect of the maintenance of the requirement for *any* diagnosis, that question (in my view) falls into a different category, on which Parliament's expressed view in the 2004 Act is entitled to much greater respect. Parliament is not to be taken as an expert on the particular diagnostic classifications involved (which have, in any event, changed to a considerable degree in the last 17 years, along with social attitudes); but is properly to be viewed as the arbiter of what safeguards should or should not be built into the process of applying for a GRC, as discussed at paragraphs [131]-[137] above.

[148] Although this is strictly beside the point, I also note that the Government's September 2020 analysis of responses to its consultation suggested that there was a substantial amount of support for the retention of a diagnosis but in a manner which made clear that gender dysphoria was not a mental illness. At page 43 of the analysis, again considering responses to Question 3, the following summary of such responses is provided:

> "***Gender dysphoria is not a mental illness, but a diagnosis should be required***. *A substantial proportion of respondents agreed with the Government and the World Health Organisation (which issues the ICD handbook, the globally used diagnostic classification standard for all clinical and research purposes), that gender dysphoria is not a mental illness. However, these respondents felt that a diagnosis was necessary prior to transitioning, and should remain part of the legal gender recognition process. Among these respondents there was a significant level of support for gender dysphoria not*

> *being pathologised, and avoiding the stigma associated with mental health problems. Many of these respondents likened it to the way that autism was previously perceived as a mental disorder when little was known about the condition."*
>
> [bold emphasis in original]

The Article 14 claim

[149] The applicant also challenges the impugned provisions of the 2004 Act on the basis of unlawful discrimination contrary to Article 14 ECHR (in conjunction with Article 8). The kernel of her contention under Article 14 is that she is entitled to establish her gender identity and enjoy that aspect of her private life in the full sense enjoyed by others but that, in requiring her to establish gender dysphoria as a condition of legal recognition, she is being treated differently from others in a manner which is unjustified.

[150] In the *Elan-Cane* case, both the High Court and Court of Appeal considered that the claimant's case based on Article 14 added little if anything to their substantive complaint under Article 8: see paragraphs [135] and [117] of the judgments of Baker J and King LJ respectively. In the latter instance, the judge referred to the conclusion of the ECtHR in the *Van Kück* case that the applicant's discrimination complaint amounted in effect to the same complaint as was made under Article 8 "*albeit seen from a different angle.*" I share that view in the present case. Indeed, in both their written and oral submissions, which were otherwise comprehensive, the applicant's representatives devoted relatively little time to the Article 14 issues. In her oral submissions, Ms Quinlivan realistically accepted that since, when considering whether a fair balance had been struck for the purposes of a failure to comply with an Article 8 positive obligation, the Court was applying the same test as it would apply (on her case) at the fourth stage of a *Bank Mellat* analysis of the justification in any difference in treatment, the applicant's reliance on Article 14 added little, if anything, to her Article 8 claim.

[151] The jurisprudence on Article 14 is complex and evolving. This judgment is not the place for any attempt to expound it further. I am confident that the applicant's Article 14 claim does not advance her case beyond her direct reliance on Article 8 but, for completeness, spell out in summary terms why that is so. I accept that being a transgender woman is an 'other status' which would warrant protection under Article 14 and that the subject matter of these proceedings is plainly within the ambit of the applicant's Article 8 rights. I am not persuaded that she is in an analogous position to her comparator, namely a non-transgender (or cisgender) woman; and, in any event, would consider the difference in treatment between the two to be objectively justified – whether one applies the manifestly without reasonable foundation or the fair balance level of scrutiny – on the basis of the aims identified in *AP, Garçon and Nicot* and of the analysis above in relation to the applicant's Article 8 claim.

How can the identified incompatibility be addressed?

[152] Section 3(1) of the Human Rights Act 1998 provides that: "*So far as it is possible to do so, primary legislation and subordinate legislation must be read and given effect in a way which is compatible with Convention rights*." It has been recognised that this places a strong interpretative obligation on the courts; but the obligation also has its limits.

[153] In an early case on the effect of the section 3 obligation, *R v A (No 2)* [2002] 1 AC 45, Lord Steyn stressed that it will sometimes be necessary under section 3 to adopt an interpretation which is linguistically strained and that this may be done not only by reading down the express language of the statute but by the implication of provisions. One reason why the interpretive obligation, and the language of the relevant statute, may be stretched so far is because a declaration of incompatibility under section 4 of the HRA is to be a measure of last resort. Such a declaration must be avoided unless it is plainly impossible to do so, for instance if a clear and express limitation on Convention rights as stated. Lord Hope, in the same case, took a more cautious approach but nonetheless recognised that the rule of construction which section 3 lays down is quite unlike any previous rule of statutory interpretation, requiring no need to identify an ambiguity or absurdity. Nonetheless, it remains only a rule of interpretation, not entitling judges to act as legislators and compelling compatibility with Convention rights to be achieved only so far as this was possible.

[154] The limitations of the section 3 interpretative obligation were returned to in the cases of *R v Lambert* [2002] 2 AC 545 and *Re S (Care Order: Implementation of Care Plan)* [2002] 2 AC 291. The section 3 obligation will not be able to be used where the Convention compatible interpretation breaches a cardinal principle of the statutory scheme in which the offending provision arises or fundamentally alters the nature of the statutory scheme.

[155] In *Ghaidan v Godin-Mendoza* [2004] 2 AC 557, the correct approach to the use of the section 3 interpretative obligation was considered again by the House of Lords. This case evinced a willingness to use the provision in a more muscular way. Lord Nicholls emphasised that section 3 has an unusual and far-reaching character and that it may require the Court to depart from the unambiguous meaning which the legislation would otherwise bear. He said that the intention of Parliament in enacting section 3 was that, to the extent bounded only by what is 'possible', the court can modify the meaning and hence the effect of legislation. In ascertaining what is possible, it is now well established that the Court can have recourse to the constitutional tools of both 'reading down' the statute and 'reading in' words to the statute; but these tools also have their limits.

[156] In the present case, I consider that the incompatibility identified in this judgment should be addressed by, at the very least, removing the reference in section 25(1) to the required diagnosis being one which was of a disorder. It might helpfully be achieved by permitting the required diagnosis under section 2(1)(a)

(and other provisions of the 2004 Act in materially similar terms) to be one of gender incongruence (which would require to be defined) or, alternatively, of gender dysphoria *or* gender incongruence. How best this might be done (subject, of course, to the question of appeal of this judgment) and whether or not removal of the identified incompatibility can be achieved consistently with the limits of the Court's function under section 3 of the HRA, and without straying into impermissible judicial legislation, is a matter on which I propose to hear the parties further. This was addressed only very briefly at the previous hearing and, obviously, in the absence of the conclusions and reasoning set out above.

Conclusion

[157] Accordingly:

(a) The applicant fails in her claim that, in principle, the general requirement for a diagnosis set out in a specialist medical report under sections 2(1)(a) and 3(1) of the 2004 Act is a breach of her Article 8 rights. Parliament's determination that an applicant for a gender recognition certificate must provide a report with specialist medical input in support of their application strikes a fair balance between her interests and those of the community having regard to the discretionary area of judgment available to Parliament on this issue and the aims which that requirement is designed to pursue.

(b) The applicant succeeds in her claim insofar as the 2004 Act imposes a requirement, through sections 2(1)(a) and 25(1), that she prove herself to be suffering or to have suffered from a "*disorder*" in order to secure a gender recognition certificate. Within the context of the scheme adopted by Parliament, that specific requirement is now unnecessary and unjustified, particularly in light of diagnostic developments. Even taking into account Parliament's discretionary area of judgment and the legitimate aims which the requirement for medical input pursues, the requirement to provide a specific diagnosis which is defined as a disorder fails to strike a fair balance between the interests of the applicant and those of the community generally.

(c) I will hear the parties further on the question of remedy as to the identified incompatibility and, in particular, whether it may properly be addressed by way of a standard declaration setting out how the impugned provisions are now to be interpreted pursuant to section 3 of the Human Rights Act 1998 or whether, alternatively, it may only properly be addressed by way of the specific remedy of a declaration of incompatibility under section 4 of that Act.

(d) I will also hear submissions on the proper way to now proceed in respect of the second limb of the applicant's case, previously stayed by order of McAlinden J, namely that, assuming the requirement for provision of a diagnosis by means of a specialist medical report is in principle justified (as I

have found), the applicant's Article 8 rights are nonetheless breached by reason of the practical difficulties she faces in obtaining such a report.