IRIS EDUCATION:
BEST PRACTICE IN TRANSGENDER HEALTH:
A WORKSHOP FOR GPs, HEALTHCARE PROVIDERS, TRANS INDIVIDUALS AND PARENTS

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EXPLORING LEGAL TOPICS THAT AFFECT TRANS INDIVIDUALS

BY STEPHEN PAGE[1]

I want to acknowledge the traditional owners. The topics I want to cover today are:

1. Relationship formation;
2. Ending relationships;
3. Domestic Violence;
4. Having children;
5. Who is shown on the birth certificate;
6. Changing identity.

1. Relationship formation

In essence, there are two types of relationships that adults can enter into:

(i) De facto relationship;

(ii) Marriage.

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De Facto relationship

There is no magic about a de facto relationship. In essence any couple can enter into one. What is a de facto relationship will vary depending on the circumstances of the couple and of the particular legislation in question as to whether that relationship is recognised.

Under the *Civil Partnerships Act 2011* (Qld) it is possible to register a relationship. This is not just limited to same sex couples. It covers the field. Someone who is trans can be in a de facto relationship and have that registered under the *Civil Partnerships Act 2011* (Qld).

Marriage

There are three types of marriage that I just want to address:

- Before the recent amendments to the *Marriage Act 1961* (Cth), the Family Court had for a number of years recognised that it was possible for a trans person to be married in an opposite sex relationship if the person identified as the opposite sex of their spouse:[2]

- Evidently, this caused difficulties with marriage celebrants who were keen to comply with the law to ensure that same sex couples did not marry. Because previous case law said that someone was immutably male or female (depending on their birth) then some celebrants were reluctant to perform the rites of marriage for these couples.

- For those who were intersex, it seemed as though they could never be married, at least on that thinking.

- No doubt some couples married when one of the parties was trans and did so overseas, out of concern of the provisions of the *Marriage Act*. If those marriages were not recognised under the *Marriage Act* before December 2017, but are now recognised, then any will that they had executed before the amendments took effect may now no longer be of effect. Those couples should update their wills immediately or they may be deemed to have died intestate (which then sets out particular fixed rules about who can inherit and in what amount).

- The welcome changes to the *Marriage Act* means that trans people can marry their intended spouse without fear of discrimination – whether their intended spouse is

[2] In *Re Kelvin (Validity of Marriage of Transsexual)* [2001] FamCA 1074.

male, female, trans or intersex. It doesn't matter. They can fall in love and marry under the *Marriage Act.*

2. Ending relationships

Whether someone is male, female, trans or intersex makes no difference as to how the relationship ends:

- A de facto relationship typically ends at separation, although there is case law from the Family Court that questions when separation occurs in particular cases. It is not always clear-cut. A property settlement or spousal maintenance application in a de facto case must be filed within 2 years of final separation.

- A marriage is only ended with divorce. In Australia we maintain no fault divorce. An application for divorce can only be brought no less than 12 months after final separation. The time limit for property settlement or spousal maintenance to be pursued in Court is different for married couples as oppose to de facto couples: it is one year from when the divorce order is made. If the parties have never divorced, then the time limit doesn't start to run.

Parenting Matters

The *Family Law Act* applies equally whether someone is straight or LGBTI.

The Family Court has set out criteria for the appointment of Independent Children's Lawyers.[3] Three of the criteria which appears to be relevant if one of the parties has transitioned or is transitioning are:

- In cases where there is an apparently intractable conflict between the parents.

- Whether sexual preferences of either or both of the parents or some other person having significant contact with the child are likely to impinge upon the child's welfare.

- Where the conduct of either or both of the parents or some other person having significant contact with the child is alleged to be antisocial to the extent that it seriously impinges on the child's welfare.

[3] *Re K* (1984) FLC92-461.

As to the sexual preferences criteria, the Court said this (remembering that it was a case decided in 1994):

> *"Disputes of this kind typically raise claims that a homosexual parent and/or their new partner is unfit by virtue of that factor alone. It is clear, however, following cases…that the nature of a party's sexual relationships is relevant to the Court's proceedings only to the extent that it affects the parenting abilities or the welfare of a child in a particular case…The particular kind of acrimony which arises in such cases, considered together with the Court's obligation to make a decision from the viewpoint of a child's best interest, may warrant the appointment of [an Independent Children's Lawyer]. This is so that the impact, if there is any, of a party or partner's sexual preference can be properly and dispassionately assessed for its relevance to the Court's enquiry into the best interest of the child."*

Cases between warring lesbian couples or gay and lesbian parents are now relatively commonplace. The concern I would suggest that the Court has now is the reaction to the other parent and the children to a parent who is transitioning or who has transitioned.

A recent case from England is illustrative of the point: *In the matter of M (Children)* [2017] EWFC 4[4].

This was a decision of the English Court of Appeal.

In the words of the Court:

> *"The father is transgender and left the family home in June 2015 to live as a transgender person. She now lives as a woman. Because she is transgender – and for that reason alone – the father is shunned by the North Manchester Charedi Jewish community (the community), and because she is transgender – and for that reason alone – the children face ostracism by the community if they have direct contact with her."*

Peter Jackson J characterised the practices within the community as amounting to:

> *"Unlawful discrimination against and victimisation of the father and the children because of the father's transgender status".*

[4] https://www.judiciary.gov.uk/wp-content/uploads/2017/12/in-the-matter-of-m-20171220.pdf

Peter Jackson J identified 15 arguments in favour of direct contact which he described as "formidable". He could identify only two factors that spoke against direct contact. Of the first, relating to the father's "dependability", he found that *"…if it were the only obstacle to direct contact, it could probably be overcome".* That left only one factor, which he described as *"the central question"*, namely *"the reaction of the community if the children were to have direct contact with the father".*

His Honour found:

> *"The children will suffer serious harm if they are deprived of a relationship with their father."*

He decided that there should be no direct contact. First:

> *"Having considered all the evidence, I am driven to the conclusion that there is a real risk, amounting to a probability, that these children and their mother will be rejected by the community if the children were to have face-to-face contact with their father."*

Then:

> *"I…reject the bold proposition that seeing the father would be too much for the children. Children are goodhearted and adaptable and, given sensitive support, I am sure that these children could adapt considerably to the changes in their father. The truth is that for the children to see their father would be too much for the adults."*

And then this:

> *"So, weighing up the profound consequences for the children's welfare of ordering or not ordering direct contact with their father, I have reached the unwelcome conclusion that the likelihood of the children and their mother being marginalised or excluded by the ultra-orthodox community is so real, and the consequence is so great, that this one factor, despite its many disadvantages, must prevail over many advances of contact."*

The Appeal Judges said:

> *"We suspect that many reading this will find the outcome both surprising and disturbing, thinking to themselves, and we can understand why, how can this be so, how can this be right?"*

Their Honours ultimately overturned the decision, referring the matter back for further hearing.

One Rabbi, Rabbi Andrew Oppenheimer, described charedi communities as *"warm, close-knit and supportive communities for which the teachings of Torah Judaism guide all aspects of their lives… The teachings of the Torah also highlight integrity, respect for others, peace and justice (including respect for the law of a country) and place the family and its welfare at the heart of life…Allegiance to the lifestyle…means of necessity that members have traditional values and seek to guard their children and themselves against what they regard as the dangers and excesses of modern open society."*

Rabbi Oppenheimer was clear that transgender and procedures to achieve sex change violate a number of basic principles in Torah Law, including the prohibition against castration (Leviticus 22:24) and the prohibition against wearing garments of the opposite sex (Deuteronomy 22:5).

Rabbi Oppenheimer said:

> *"Where a person decides to take action likely to be irreversible to transgender, Ultra-orthodox community members will invariably take the view that, by embarking on that course, the transgender person has breached the contract which they entered into when they married their wife to observe the Torah and to establish and bring up a family in accordance with its laws. Furthermore, members of the community will naturally wish to protect themselves and their families from any discussion of the painful issues involved, especially bearing in mind the show of position in the community from the standpoint of open society. Knowledge of transgender amongst children in the Ultra-orthodox Jewish community is almost non-existent, for the reasons mentioned above concerning their lack of access to Internet and the media. There is no known precedent in the UK of a transgender person being accepted living in an Ultra-orthodox community.*
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> *The result will be that community members will expect the family of the transgender person to limit their contact with him or her as far as possible. If the family of the transgender person nevertheless seeks, or is forced, to maintain contact with that person, they will open themselves up to very serious consequences indeed. The families around them will effectively ostracise them by not allowing their children to*

have more than the most limited contact with that family's children. The impact on the family in such circumstances in terms of socialisation will be devastating.

In considering the best interests of the children, the obvious conclusion from the discussion above is that the children of an Ultra-orthodox union cannot and should not be expected to have any direct contact with the father in such circumstances. It will no doubt be argued against this approach that it is cruel, lacking tolerance, unnecessary and denies the rights of the father. But Torah law (halacha) has the same approach to English family law in this type of situation, regarding the issues of residents and contact, that the interests of the children are paramount. In other words, the father is expected to give precedence to the needs of the children over his own needs."

In the words of the Court, Rabbi Oppenheimer's chilling explanation as to why indirect contact would not give rise to a risk of ostracism was:

"It would not enable the children to have "a living relationship"."

Peter Jackson J's response to this was brisk:

"In balancing the advantages and disadvantages of the children being allowed to see their father, I apply the law of the land. Some witnesses in these proceedings assert that gay or transgender persons have made a lifestyle choice and must take the consequences. The law, however, recognises the reality that one's true sexuality and gender are no more matters of choice than the colour of one's eyes or skin.

It has also been said that transgender is a sin. Sin is not valid legal currency. The currency of the law is the recognition, protection and balancing out of legal rights and obligations. In this case, to be recognised and respected as a transgender person is a right, as is the right to follow one's religion. Likewise, each individual is under an obligation to respect the rights of others, and above all the rights of the children."

A Rabbi Ariel Abel had a contrasting position. He emphasised the central importance of honouring one's parents within Jewish law and tradition. He said there is scarcely any circumstance in which the obligation to honour one's father does not apply. Even if the father is an outright sinner, which is not in his view a consideration in this case, the obligation persists. In relation to transgender, Rabbi Abel considered that there is a plurality of opinion and that the biblical position may be qualified. He contends that there is no valid reason why any person should plead Ultra-orthodox faith as a result to disenfranchise a person on the position of the father:

> *"There is no legitimate reason to maintain that children who are transgender – parented cannot experience in the Ultra-orthodox community a full and satisfying orthodox Jewish life, physically, spiritually, emotionally and communally."*

On the contrary, there is every reason to reunite parent and child as it is the wellbeing of the nuclear family and not the social preferences of the wider community that truly matter. He argued that the transgender issue could not be ignored and that parents' relationships with their children were inalienable.

Rabbi Abel objected to the concept of the faith as a club from which people could be ejected, although he observed that this evidently happens. An approach of this kind, practically amounting to a belief, raises itself to the surface, usually in worse case scenarios. This is a social cultural reality, not a valid orthodox reason for separating children from parents. There is a lamentable habit of censoring. Children of divorced parents can be seated separately from other children and he had experience of this, something he described as beggaring belief. In his view, this should not be accommodated or excused in Jewish or English law. On the other hand, he had never heard of table ostracism in practice, provided that the contentious matter was treated privately within the family, and not paraded before the community. However, he accepted that ostracism for these children could very possibly happen if the situation was not managed correctly with professional help. What was needed was psychological support: religious teachers should be kept out of it.

The Rabbi accepted that the present circumstances would be a challenge to the insular North Manchester Community. He argued that when it came to matters of life and death, you have to break free and seek to work with the unfamiliar problem. He gave as an example creative arrangements that might be made to allow the father to participate in A's bar mitzvah. There are ways, and it can happen if there is a will. The issues are significant, but not insurmountable. The community is not monolithic but multifarious. It will step back if proper arrangements are made by both parents. If the situation is unregulated, the community will take the matter into its own hands. If direct contact was ordered, and the law laid down, he did not think that the community would *"go to the wire"* fighting an unwinnable battle.

Justice Peter Jackson had held:

> *"Having considered all the evidence, I am driven to the conclusion that there is a real risk, amounting to a probability, that these children and their mother would be rejected by their community if the children were to have face-to-face contact with their father. I say "driven" because I began the hearing with a strong disposition to find that a community described by Rabbi Oppenheimer as "warm, close and supportive" and living under a religious law that "highlights integrity, respect for others, justice and peace" could tolerate (albeit without approval) these children's right to and need for a relationship with their father…I have reached a welcome conclusion that the likelihood of the children and their mother being marginalised or excluding by the Ultra-orthodox community is so real, and the consequence is so great, that this one factor, despite its many disadvantages, must prevail over the many advances of contact.*
>
> *I therefore conclude with real regret, knowing the pain that it must cause, that the father's application for direct contact must be refused."*

The Court of Appeal held:

> *"The fact is, as the daily business of the Family Division so vividly demonstrates, that we live today in a world where the family takes many forms and where surrogacy, IVF, same-sex relationships, same-sex marriage and transgenderism, for example, are no longer treated as they were in even the quite recent past.*
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> *What are the characteristics of the reasonable man or woman in contemporary British society? The answer…is:*
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> > *"If the reasonable man or woman is receptive to change he or she is also broadminded, tolerant, easy-going and slow to condemn. We live, or strive to live, in a tolerant society increasingly alive to the need to guard against the tyranny which majority opinion may impose on those who, for whatever reason, comprise a small, weak, unpopular or voiceless minority. The quality under the law, human rights and the protection of minorities, particularly small minorities, have to be more than what Brennan J in the High Court of Australian once memorably described as 'the incantations of legal rhetoric'."*

…First, we must recognise that equality of opportunity is a fundamental value of our society: equality as between different communities, social groupings and creeds, and equality as between men and women, boys and girls. Secondly, we foster, encourage and facilitate aspiration: both aspiration is a virtue in itself and, to the extent that it is practicable and reasonable, the child's own aspirations…Thirdly, our objective must be to bring the child to adulthood in such a way that the child is best equipped both to decide what kind of life they want to lead – what kind of person they want to be – and to give it effect so far as practicable to their aspirations. Put shortly, our objective must be to maximise the child's opportunity in every sphere of life as they enter adulthood and the corollary of this, where the decision has been devolved to a 'judicial parent', is that the judge must be cautious about approving a regime which may have the effect of foreclosing or unduly limiting the child's ability to make such decisions in the future."

3. Domestic Violence

The Bryce Taskforce in its historic report "Not Now Not Ever"[5] noted that the law as to domestic violence applied equally to those in LGBTI relationships as those who are not.

The Taskforce stated:

"The true nature and extent of domestic violence suffered by lesbian, gay, bisexual, transgender, and intersex (LGBTI) members of the community remains largely hidden. Comparatively little data and research exists on the prevalence of domestic violence experienced by people that identify as LGBTI. While focus on this issue is growing, both in academia and in policy, there is general acknowledgement that this violence is largely under-reported, under-researched, and under-responded…the limited research that does exist suggests that LGBTI people suffer domestic violence at the same rates or perhaps even higher than those in the broader community…similar to those in the broader community, there are social, political and legal impediments for LGBTI people in seeking assistance when suffering domestic violence. However, there are a number of unique barriers in the LGBTI community,

[5] https://www.communities.qld.gov.au/resources/gateway/campaigns/end-violence/about/special-taskforce/dfv-report-vol-one.pdf – Viewed on 30 January 2018.

which are broadly reflective of wider issues of stigmatisation and marginalisation. In particular, homophobia and discrimination are identified in the research as key barriers for LGBTI victims seeking the assistance they require… A lack of awareness, education and training as to the experiences of those in the LGBTI community meant that generally service providers were not able to provide these clients with the support they required. While the study indicated that LGBTI clients were eventually able to locate appropriate services, this was generally after negative experiences with providers and substantial searching for one that met their needs. Examples of negative experiences include men unable to locate necessary services or alternative accommodation, and in some instances transgender clients being referred for sexual reorientation instead of domestic and family support.

The diversity and uniqueness of domestic violence experiences in the LGBTI community, as compared to the broader community, is a clear barrier to these victims receiving the support they require."

In their book "Speaking Out: Stopping Homophobic and Transphobic Abuse in Queensland"[6], authors Alan Berman and Shirleene Robinson noted the extraordinary abuse that LGBTI Queenslanders had received in the previous 2 years: 50% of male, 54% female, 69% of transgender male to female, 28% transgender female to male and 82% of other.

Abuse that had occurred within the last 2 years by sexuality: 56% lesbian, 49% gay, 48% bisexual and 72% other.

This accords with anecdotal evidence that trans people are amongst the most marginalised in the country and that domestic violence rates for trans people are considerably higher than those within same sex relationships let alone the broader community.

As the Bryce report says so poignantly:

"In October 2014, Queensland was shocked by the death of transgender woman Mayang Prasetyo, who was murdered, and her body subsequently mutilated, by her male partner. He later killed himself after being confronted by the police. This murder remains a devastating reminder of the existence in reality of domestic

[6] (2010) Australian Academic Press

violence for LGBTI people, and the barriers we face as a community in addressing it. It is critical that the wider community continues to seek out, hear and respond to the voices and experiences of those in our LGBTI community who experience domestic violence, to ensure their stories are not lost."

4. Having children

For transgender people this can be particularly problematic. Section 45A of the *Anti-Discrimination Act 1991* (Qld) which prohibits discrimination in the provision of goods and services does not apply to the provision of assisted reproductive technology services if the discrimination is on the basis of a relationship status or sexuality. Sexuality is irrelevant but relationship status may be a basis – under that section – to discriminate. Sexuality is defined in the dictionary of the Act as meaning *"heterosexuality, homosexuality or bisexuality"*. Evidently Parliament didn't think of transgender or inter-sex people. Relationship status is defined in the dictionary as meaning:

"Where the person is –

(a) Single; or

(b) Marriage; or

(c) Married to another person, but living separately and apart from the other person; or

(d) Divorced; or

(e) Widowed; or

(f) A de facto partner; or

(g) A civil partner.

Although this legislation remains on the books, it is clear that, if tested, any such discrimination would be unlawful. This is because of Federal legislation namely the *Sex Discrimination Act 1984* (Cth). Section 5B provides that a person discriminates against another on the ground of the other's gender identity if, by reason of:

"(a) the aggrieved person's gender identity; or

(b) a characteristic that appertains generally to persons who have the same gender identity as the aggrieved person;

(c) a characteristic that is generally imputed to persons who have the same gender identity as the aggrieved person;

the discriminator treats the aggrieved person less favourably than, in circumstances that are the same or not materially different, the discriminator treats or treat a person who has a different gender identity."

Section 22 of the *Sex Discrimination Act* makes it unlawful for a person who provides goods and services or makes facilities available to discriminate against another on the ground of the other person's sex, sexual orientation, gender identity, inter-sex status, marital or relationship status, pregnancy or potential pregnancy or breastfeeding.

Last year I wrote to my then local member the Hon Grace Grace MP seeking the repeal of section 45A, but no action has yet been taken.

Assuming that a transman becomes pregnant, when he gives birth under Queensland law he will be the mother. Parenting presumptions will apply to determine who the other parent is, whether under the *Status of Children Act 1978* (Qld) or the *Family Law Act 1975* (Cth). However, there is some argument that in giving birth the transman may not be recognised as the mother.

The *Status of Children Act* is divided into three broad divisions when it comes to children born through ART:

- A married woman with husband's consent;
- A woman with female partner's consent;
- Other married women and unmarried women.

The principle of our law as to who is a parent has been to search for who is the father. Since the time of the Emperor Justinian in the 7^{th} century, the underlying principle is that the mother is always certain, because she gives birth:

"Mater semper certa est."

The rise of IVF and ART generally has proven a challenge to parentage presumptions. The law has not yet begun to tackle with transmen giving birth.

Thankfully there is currently a review being undertaken concerning births, deaths and marriages and trans people. I would suggest that the parentage presumptions are unlikely to change quickly but the title of who is named on the birth certificate may change a little sooner.

An example of the problem is contained under section 60H(1) of the *Family Law Act 1975* (Cth). Section 60H(1) provides:

"(1) If:

(a) a child is born to a woman as a result of the carrying out of an artificial conception procedure while the woman was married to, or a de facto partner of, another person (the ***other intended parent*** *); and*

(b) either:

(i) the woman and the other intended parent consented to the carrying out of the procedure, and any other person who provided genetic material used in the procedure consented to the use of the material in an artificial conception procedure; or

(ii) under a prescribed law of the Commonwealth or of a State or Territory, the child is a child of the woman and of the other intended parent;

then, whether or not the child is biologically a child of the woman and of the other intended parent, for the purposes of this Act:

(c) the child is the child of the woman and of the other intended parent; and

(d) if a person other than the woman and the other intended parent provided genetic material--the child is not the child of that person.

(2) If:

(a) a child is born to a woman as a result of the carrying out of an artificial conception procedure; and

(b) under a prescribed law of the Commonwealth or of a State or Territory, the child is a child of the woman;

then, whether or not the child is biologically a child of the woman, the child is her child for the purposes of this Act.

(3) If:

(a) a child is born to a woman as a result of the carrying out of an artificial conception procedure; and

(b) under a prescribed law of the Commonwealth or of a State or Territory, the child is a child of a man;

then, whether or not the child is biologically a child of the man, the child is his child for the purposes of this Act.

(5) For the purposes of subsection (1), a person is to be presumed to have consented to an artificial conception procedure being carried out unless it is proved, on the balance of probabilities, that the person did not consent.

(6) In this section:

*"**this Act**" includes:*

(a) the standard Rules of Court; and
(b) the related Federal Circuit Court Rules."

You will see that a requirement is that a child is born to a woman and there is an alternate test as to who are the parents either by virtue of consent or under a prescribed law. Certain provisions of the *Status of Children Act 1975* (Qld) are prescribed.

What if the person who gave birth identifies as a man? If someone can identify as being a man under the *Marriage Act* and the *Family Law Act* (as was seen in *Re Kevin*[7] is that same person also a woman under section 60H?

Justice Chisolm in that case said:

> *"Kevin is a person of a kind often referred to in the literature as a transsexual. It is useful to distinguish this term from other concepts with which it is sometimes confused. In this judgment I will generally use "transsexual" to mean a person who has some or all of the physical or biological characteristics of one sex, but who experiences himself or herself of being of the opposite sex, and has undergone hormonal and surgical treatments to change some of the physical characteristics in order to confirm more closely to the opposite sex.*
>
> *The word poses some problem. The word "transsexual" may suggest a sexual* ***transition****, a passing from one sex to the other. While that may reflect the physical changes associated with surgery or hormone treatment, it does not convey the fact that transsexual say that they have always experienced themselves as belonging to the other sex, before as well as after the hormonal surgical procedure…*
>
> *Further, I am conscious that using the word "transsexual" as a noun may tend to have a dehumanising effect. In recent years we attempt to remove such effects by a more careful use of language, for example by referring to "people with handicaps" rather than "the handicapped". Such usages are sometimes mocked as "political correctness", but I think they represent an honourable and civilised attempt to use language that reflects the essential humanity of the people being described. However no suitable alternative is evident, and the word is used in the applicants' submissions, so I will adopt it, although I attempt to minimise its use.*
>
> *A transsexual is not the same as a homosexual. A homosexual is one who is attracted sexually to members of the same sex. Similarly a transsexual is not the same as a transvestite. A transvestite is someone who dresses in the clothes of the other sex. A transsexual might or might not be a homosexual…*

[7] *In Re Kevin (Validity of Marriage of Transsexual)* [2001] FamCA1074

In these proceedings, I must determine that Kevin is either a man or a woman for the purpose of the marriage law."

Surrogacy

For surrogacy to occur in Queensland there needs to be a medical or social need for the surrogacy arrangement. Section 14 of the *Surrogacy Act 2010* (Qld) provides:

"(1) For an application for a parentage order —

(a) if there is 1 intended parent under the surrogacy arrangement—there is a medical or social need for the surrogacy arrangement if the intended parent is a man or an eligible woman; or

(b) if there are 2 intended parents under the surrogacy arrangement—there is a medical or social need for the surrogacy arrangement if the intended parents are —

(i) a man and an eligible woman; or

(ii) 2 men; or

(iii) 2 eligible women.

(2) An

"eligible woman" *is a woman who —*

(a) is unable to conceive; or

(b) if able to conceive —

(i) is likely to be unable, on medical grounds, either to carry a pregnancy or to give birth; or

(ii) either —

(A) is unlikely to survive a pregnancy or birth; or

(B) is likely to have her health significantly affected by a pregnancy or birth; or

(iii) is likely to conceive —

(A) a child affected by a genetic condition or disorder, the cause of which is attributable to the woman; or

(B) a child who is unlikely to survive a pregnancy or birth; or

(C) a child whose health is likely to be significantly affected by a pregnancy or birth."

I am not aware of any domestic surrogacy arrangement in which one or both of the intended parents was a trans person has concluded. About 2 years ago, I acted for the surrogate and her husband in a proposed surrogacy arrangement where the intended parents were a transwoman and a man. It was a New South Wales arrangement. The provisions of the New South Wales *Surrogacy Act* are essentially the same as those of the Queensland Act on this point. If the transwoman were considered to be a man by the Court under section 14, then only a social need is required. Self-evidently, the transwoman if considered to be a woman by the Court, is someone who would have been unable to conceive and therefore would have been an eligible woman within the meaning of section 14.

5. Who is shown on the birth certificate

The practice of the Registrar of Births, Deaths and Marriages, consistent with the *Status of Children Act 1978* (Qld) is to register the person who gave birth as the mother and the other parent either as father or parent. In the case of a gay couple through surrogacy, both would be described as parents. When lesbian couples have had a child they have been described as "mother" and "other parent".

There is greater flexibility with these processes interstate than in Queensland. It would be good if there were greater flexibility here. It seems unnecessarily proscriptive.

6. Changing identity on birth certificates

The first comment that needs to be made is that each of the States and Territories (and for that matter overseas jurisdictions) regulate their own birth register. Therefore it may be necessary for the alteration of a birth register that the person has to do it in the place in which they were born. This can be problematic. Recently I saw a transgender client who lives in Queensland. My client was born in Papua New Guinea and is unable to change the birth register as to the gender marker and, I suspect, their name.

Change of name of adults

There is a fairly straightforward procedure under the *Births, Deaths and Marriages Registration Act* 2003 (Qld) for the change of names. In essence there is a form to be filled out and followed through with. After the new birth certificate has issued, it is then necessary to ensure that any Australian passport is altered.

Of course if a person has multiple citizenships, it may not be possible to alter a foreign passport, so that under the Australian passport he may be recognised as George but under the foreign passport she is recognised as Martha.

Change of child's name

There are four ways in which a child's name may be altered:

(1) By an order of a Court under the *Family Law Act 1975* (Cth);

(2) By an order of a Court in adoption proceedings under the *Adoption Act 2009* (Qld);

(3) By an order of the Court in surrogacy proceedings under the *Surrogacy Act 2010* (Qld);

(4) Following the procedures under the *Births, Deaths and Marriages Registration Act 2003* (Qld).

As to the last procedure, this can be done by both parents by filling out a form. In the alternative, one may do so if they are the only parent shown on the child's birth certificate or the other parent is dead or a Magistrates Court approves the change of name: section 17.

The child's change of name cannot occur if the child is 12 or older unless the Registrar is satisfied that the child consents to the change of name or is unable to understand the meaning and implications of the change of name or the Magistrates Court has approved the change of name: section 18. Although not stated in the statute, it is clear that if a Court orders the change of name through an adoption, surrogacy or family law process, that that will be sufficient and the consent of the child is not required.

Change of gender

Section 22 of the *Births, Deaths and Marriages Registration Act 2003* (Qld) provides:

> *"The reassignment of a person's sex after sexual reassignment surgery may be noted in the person's entry in the register of births or adopted children register only if the person is not married."*

The requirement to be unmarried is regressive and has been rightly criticised.

When Rod Welford was Attorney General, I managed to obtain a ruling from him that the section did not apply to a person living overseas who was married overseas (but had been born in Queensland) – and thereby enable my client to change the gender marker on the birth register from M to F.

Reassignment of sex for adults

The process is:

(1) The appropriate form has to be filled out.

(2) The form is accompanied either by a recognition certificate or statutory declarations by two doctors verifying that the person the subject of the application has undergone sexual reassignment surgery.

(3) If the person has former names different from the name that is registered at birth – documents evidencing those names.

(4) If the person was married, either evidence of the death of the person's last husband or wife or a document evidencing the dissolution of marriage.

(5) Prescribed identification documents.

The statutory declaration of each doctor must include the following:

- The full name and residential address of the doctor.
- A statement of the doctor is:
    - registered under the Health Practitioner Regulation National Law as a medical practitioner; or
    - a registered medical practitioner of the country in which the doctor is registered;
    - the doctor's Medicare provider number if applicable;
    - the date the doctor physically examined, or performed the sexual reassignment surgery on, the person who had the sexual reassignment surgery;
    - a statement that the doctor has verified the person's identity.

Sexual reassignment surgery is defined in the dictionary to the Act as meaning:

> *"A surgical procedure involving the alteration of a person's reproductive organs carried out:*
>
> *(a) to help the person to be considered a member of the opposite sex; or*
>
> *(b) to correct or eliminate ambiguities about the sex of the person."*

On the reading of the definition it would appear that, in the language of *Re Kelvin*, this would be stage 3 treatment, not just one or two, i.e. that there was in fact surgery not just hormonal treatment undertaken. The definition of *"surgical"* in the Macquarie Dictionary[8] defines it as:

(1) relating to or involving surgery: a surgical procedure;

(2) used in surgery: surgical instruments.

The definition of *surgery* in the Macquarie is:

(1) The art, practice, or work of treating diseases, injuries or deformities by manual operation or instrumental appliances.

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[8] Concise Dictionary Third Edition.

(2) The branch of medicine concerned with such treatment.

(3) Treatment, operations, etc, performed by a surgeon.

(4) A room or place for surgical operations.

(5) The consulting room of a medical practitioner, dentist, or the like.

The concept in my view involved an operation, not merely hormonal treatment.

The Queensland requirements have been criticised (even by the UN Human Rights Committee) for their narrow, proscriptive manner, inconsistent with the lives of trans people and inconsistent with international human rights law.

Reassignment of a child's sex

This may occur in one of two ways.

(1) The finding of a Court under the *Family Law Act 1975*; or

(2) In accordance with the procedures under the *Births, Deaths and Marriages Registration Act*.

The latter can be done by both the child's parents or the child's guardians. One of the child's parents can undertake the procedure under the Act if:

- The other parent is dead;
- The other parent's whereabouts are unknown;
- The other parent refuses to sign the application;
- The other parent is, for another justifiable reason, unable to apply; or
- The Magistrates Court orders the reassignment: section 23(2).

Does Norrie apply in Queensland?

The High Court in *NSW Registrar of Births, Deaths and Marriages v. Norrie* [2014] HCA 11 determined that the New South Wales Registrar has power to register the change of sex to *"non-specific"*.

As Chief Justice French and Justices Hayne, Kiefel, Bell and Keane stated:

> *"Not all human beings can be classified by sex as either male or female."*

The Court noted that the New South Wales Act expressly recognised that person's sex may be ambiguous and that it recognised that a person's sex may be sufficiently important to the individual concerned to warrant that person undergoing a sex affirmation procedure to assist that person *"to be considered to be a member of the opposite sex"*. The Court noted that the objects of the New South Wales Act include *"the recording of changes of sex"*. The Queensland Act in section 3 includes as its objects *"changes of name and reassignments of sex"*.

The Court said that the New South Wales Act required the Registrar to maintain a register of registrable events and that a change of sex is a registrable event. The Queensland Act requires the Registrar to register a registrable event other than an adoption or a change of parentage under a parentage order or discharge order: section 41. Unlike the New South Wales Act, sex reassignment appears not to be a registrable event. The definition of *registrable event* in the schedule to the Queensland Act means:

"(a) a birth, death, marriage or change of name; or

(b) an adoption under the Adoption Act 2009; or

(c) a change of parentage under a parentage order; or

(d) another event for which the Registrar is required, under another Act, to record in a register."

Norrie sought for her sex to be registered under the New South Wales Act as non-specific. Her application was accompanied by statutory declarations from two medical practitioners.

The Court noted four points in respect of the equivalent of our section 23:

> *"First, a sex affirmation procedure is defined by reference to its purpose, not its outcome. Section 32DA(1)(c) does not refer to a "successful" sex affirmation procedure.*
>
> *Secondly, the function of the Registrar is principally that of recording in the Register information provided by members of the community. Section 32DB makes express provision for the verification of an aspect of the information to be provided. Further, section 32DC(1) confers the limited and specific decision-making power on the Registrar. While the Registrar may require such particulars "relating to the change*

of sex as may be prescribed by the regulations", neither the Act nor the regulations suggest that the Registrar's function extends to the making of any moral or social judgments; its setting does not extend to the resolution of medical questions or the formation of a view about the outcome of a sex affirmation procedure.

Thirdly, section 32DA is headed "Application to Register Change of Sex"; but section 32DA(1) expressly authorises an application by a person "for the registration of the person's sex" rather than "a change of sex". Further, the modes of determination of an application under section 32DA provided by section 32DC, which involve either registration or refusal of registration of a "change of sex", are not precisely congruent with the express terms of section 32DA(1). It is tolerably clear, however, and it was not disputed, that section 32DC speaks the registration of, or refusal to register, a "person's change of sex" on the basis of a legislative assumption that this first registration in New South Wales of an applicant's sex may differ from an earlier record (made outside New South Wales) of that person's sex. On that basis an application under section 32DA for the registration of the sex of a person for the first time in New South Wales falls to be determined under section 32DC by a registration of, or a refusal to register, the person's change of sex.

Fourthly, the 1996 Amending Act, which introduced Pt 5A (but not including sections 32DA to 32DD and section 32J) into the Act, also amended the Antidiscrimination Act 1977 (NSW) by adding to that Act definitions of "recognised transgender person" (a person "the record of whose sex is altered under Part 5A of the Births, Deaths and Marriages Registration Act 1995") "transgender person" (which is defined to include a person "who, being of indeterminate sex, identifies as a member of a particular sex by living as a member of that sex"). These definitions in the 1996 Amending Act are part of the context in which Pt 5A of the Act was enacted. Accordingly, the provisions of Pt 5A are to be applied in a context of express legislative recognition of the existence of persons of "indeterminate sex"."

Ms Norrie was successful in her application.

It is unclear whether Norrie would necessarily apply in Queensland. There are slight differences in the legislation. For example, the *Anti-Discrimination Act 1991* (Qld) refers to gender identity which, in relation to a person:

"means that the person –

(a) identifies, or has identified, as a member of the opposite sex by living or seeking to live as a member of that sex; or

(b) is of indeterminate sex and seeks to live as a member of a particular sex."

There is no definition of indeterminate sex. There is no reference in the *Births, Deaths and Marriages Registration Act* to gender identity or indeterminate sex. There is only a reference to reassignment of sex.

Treatment for children

In November a specially constituted five member court of the Family Court of Australia determined the case of *Re Kelvin* [2017] FamCAFC 258[9]. It was a case arising from an application by the father concerning the administration of stage 2 medical treatment for gender dysphoria for his then 16 year old child Kelvin. In essence, the question stated for the opinion of the Full Court concerned the effect of the Full Court's decision in *Re Jamie* [2013] FamCAFC 110 and the role of the Family Court more generally in relation to stage 2 medical treatment for gender dysphoria and the determination of Gillick competence.

The Court set out in its judgment as to what was gender dysphoria, as defined in DSM-5, treatment guidelines for the care of transgender diverse children at adolescence, in accordance with the WPATH Standards of Care, Version 7 (2011) and the Endocrine Society Treatment Guidelines (2009).

At the time of the judgment it was expected that Australia's specific guidelines for the standards of care and treatment for transgender and gender diverse children at adolescence were expected to be available in September 2017. The Court went on to say:

"Best practice medical treatment for Gender Dysphoria is often following a comprehensive multidisciplinary assessment. The multidisciplinary treating team may include clinicians with the experience of the disciplines of child and adult psychiatry, paediatrics, adolescent medicine, paediatric endocrinology, clinical psychologist, gynaecology, andrology, fertility counselling and services, speech

[9] http://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/cth/FamCAFC/2017/258.html

therapy, general practice and nursing. These treating professionals need to agree on the proposed treatment plan before it can be implement. Medical treatment is only commenced after physical examination and blood tests confirm that the adolescent has entered into puberty. Best medical practice is that the adolescent and their parents/guardians must provide informed consent.

The existing Medicare legal structure for stage 1, stage 2 and stage 3 treatment in Australia requires at least one psychiatrist or a clinical psychologist to confirm a diagnosis of Gender Dysphoria in Adolescence prior to medical intervention.

Stage 1 treatment is "puberty blocking treatment" and the effects of this treatment are reversible when used for a limited time for approximately three to four years. Gonadotrophin releasing hormone analogue (GnRHa) are used for stage 1 treatment and are administered via injection with the aim of reducing the psychological distress associated with development and progression of the unwanted, irreversible changes of the adolescent's endogenous (biological) puberty. It also allows the adolescent time to mature emotionally and cognitively such that they can achieve maturity sufficient to provide informed consent for stage 2 treatment. Stage 1 treatment is ideally commenced in the early stages of puberty (known as Tanner Stage 2) which can occur from the age of approximately nine to 12 years of age.

Stage 2 Treatment or "gender affirming hormone treatment" involves the use of either estrogen to feminise the body in those who have a female gender identity or use of testosterone to masculinise the body in those who are male gender identity. This treatment is ideally commenced at an age where the adolescent is sufficient mature to be able to provide informed consent given the irreversible nature of some of the effects of estrogen and testosterone.

The irreversible physiological effects of estrogen are breast growth and decreased sperm production and partially irreversible effects are decreased testicular volume and decreased terminal hair growth. The irreversible physiological effects of testosterone are facial and body hair growth, scalp hair loss, clitoral enlargement, vaginal atrophy and deepening of voice.

Stage 2 treatment for Gender Dysphoria may, but does not necessarily, cause long term infertility. For individuals who are assigned male at birth, estrogen treatment *may render the adolescent infertile over time. However, options are explored with the adolescent regarding their future ability to have biological children prior to the commencement of estrogen use including preserving their fertility using sperm preservation procedures prior to the commencement of estrogen use.*

So that it is clear, stage 2 treatment does not include stage 3 treatment which treatment involves surgical interventions. Those interventions include:

(a) chest reconstructive surgery (also known as top surgery)…;

(b) phalloplasty;

(c) hysterectomy;

(d) bilateral salpingectomy;

(e) creation of a neovagina;

(f) vaginoplasty.

Failure to provide gender affirming hormones results in the development of irreversible physical changes of one's biological sex during puberty or the development of changes that lead to the need for otherwise avoidable surgical intervention such as chest reconstruction in transgender males or facial feminisation surgery in transgender females.

The prolonged use of puberty blockers (stage 1 treatment) has long term complications for bone density (osteopenia) namely osteoporosis and bone fractures in adulthood. Best practice is to limit the time an adolescent is on puberty blockers and then commence estrogen or testosterone. Delaying stage 2 treatment for those on puberty blockers also results in psychological and social complications of going through secondary school in a pubertal state which is inconsistent with the child's peers.

The distress caused by Gender Dysphoria can lead to anxiety, depression, self-harm and attempted suicide.

Individuals with Gender Dysphoria who commence sex hormone therapy generally report improvements in psychological wellbeing. An affirmation of their gender *identity coupled with improvements in mood and anxiety levels typically results in improved social outcomes in both personal and work lives.*

For a transgender male, manifestations of increased body hair and deepening of the voice are generally considered by them as positive.

For transgender females if stage 2 is not administered another risk is linear growth beyond their expected final height.

Some patients receiving treatment for Gender Dysphoria have reported purchasing hormones over the internet or illegally obtaining hormones through prescriptions written for other people. They have also reported that estrogen and testosterone are cheap and freely available over the internet or through friends or acquaintances. Accessing hormones in this way is dangerous for several reasons including the risks of complications from blood born viruses such as Hepatitis B, Hepatitis C and HIV contractible with shared use of needles and syringes and the taking of inappropriate dosages of hormones which can be life threatening."

Kelvin had experienced all aspects of the DSM-5 diagnostic criteria for Gender Dysphoria since he was 9. In April 2014 when he was in year 8, Kelvin transitioned socially as a transgender person. Throughout 2015, Kelvin attended upon doctors for referrals for his general health and wellbeing. In April 2015, Kelvin commenced being named by his preferred name at school. In that same month he attended upon a psychologist and continued to do so for 10 sessions. In June 2015, Kelvin attended upon an endocrinologist. He attended a further appointment with his doctor in August 2016. In October 2015, Kelvin commenced attending upon an accredited counsellor mental health social worker. In July 2016, Kelvin attended upon a psychiatrist. In July and August 2016, Kelvin attended upon a psychologist.

Kelvin's history of Gender Dysphoria has resulted in significant problems with anxiety and depression including self-harming for which he has been prescribed medication. His mental health improved since taking steps towards a medical transition. Kelvin had not undergone stage 1 treatment and as a consequence has experienced female puberty which has caused him significant distress. Stage 2 treatment is necessary for his ongoing psychological health and wellbeing. Although they were separated, both Kelvin's parents supported him commencing stage 2. Kelvin was 17 and wished to commence stage 2.

The Court noted that between 2013 and 2017 it ended up with 63 cases involving applications of either stage 2 or stage 3 treatment. In 62 of those cases the outcome allowed treatment. The most common outcomes were:

(a) declaring a child Gillick competent to consent (26);

(b) finding that the child is Gillick competent to consent (22);

(c) finding Gillick competence and making a declaration (7).

In the one case where an application was dismissed the child was 17 years and 11 months at the time of the hearing. The application was not supported by evidence that would allow the Court to make a positive finding that the child was Gillick competent. In 39 of the 63 cases the date of filing of the initiating application was recorded in the judgment and on average took 26 days.

A study undertaken in 2016 found the average delay for families was 8 months from the time the process commenced until the adolescent commenced treatment. The Court costs over 12 families varied between $8,000 and $30,000.

The Royal Children's Hospital Gender Service in Victoria had since its commencement in 2003 received 710 patient referrals including 126 between 1 January and 7 August 2017. 96% of all those patients received a diagnosis of Gender Dysphoria and continued to identify as transgender or gender diverse into late adolescence. No patient who had commenced stage 2 treatment had sought to transition back to their birth assigned sex. No longitudinal study is yet available.

The Court came to the conclusion that Court approval is not required for stage 2 treatment where the child is Gillick competent.

The Court said:

> *"We think it important to emphasise that the Court in this case is concerned to examine, within the confines of the questions stated, whether there is any role for the Family Court in cases where there is no dispute between parents of a child who has been diagnosed with Gender Dysphoria, and where there is also no dispute between the parents and the medical experts who propose the child undertake treatment for that dysphoria. To paraphrase counsel for the Royal Children's Hospital, the question is why should the family of a child in one wing of the Hospital be forced to*

come to court before recommended medical treatment commences when the family of a child in another wing of the Hospital is not required to do so, in circumstances where both forms of treatment carry a significant risk of making the wrong decision as to a child's capacity to consent and with both forms of treatment the consequences of a wrong decision are particularly grave."

Stephen Page
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