Overturning *In re Gardiner*:
Ending Transgender Discrimination in Kansas

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In *In re Estate of Gardiner*, the Kansas Supreme Court found a marriage between a man and a post-operative male-to-female transsexual woman void because of the ban against same-sex marriages in the state.\(^1\) The court reasoned, since the transsexual woman, J’Nole, was a man “in the eyes of the law,”\(^2\) to give her marriage validity would violate public policy.\(^3\) In so holding, the court ignored the substantial evidence showing the significant medical, psychological, and social transformation J’Nole had undergone.\(^4\) It also ignored the significant emotional and psychological turmoil it caused by refusing to recognize and give effect to J’Nole’s transition.

Unfortunately, the Kansas Supreme Court’s holding in *Gardiner* is not unique.\(^5\) When faced with questions about determining the legal sex of a post-operative transsexual person, courts get caught trying to define everyday notions of what constitutes “sex” and “gender,” often incorrectly interchange the terms. Many courts presume that sex/gender are naturally congruent and immutably fixed at birth. These presumptions fail to recognize and incorporate the substantial medical and psychological developments in the treatment of transgendered people. Such treatment suggests that sex and gender are not fixed, that often biological indicators of sex are incongruent with perceived or assigned gender, and that allowing transgendered individuals to transition promotes their lasting psychological well being.

As such, judicial practice ought to follow well-accepted medical doctrine and give effect to not only clinical treatment sought and surgical changes undergone by transgendered individuals, but also to their psychological and emotional transitions. Thereby, courts should legally acknowledge and validate transsexual transitions for the purpose of marriage, as these procedures irrevocably change one’s biological sex and gender identity. Such recognition and
acknowledgement in no way violates legislative intent or public policy, but rather promotes the social policy of lasting personal comfort with one’s gender.

This paper examines the medical and psychological distinctions between sex and gender, which form the basis for understanding and treating transgendered individuals. After examining the lines of cases that attempted to address sex/gender designations, this paper explains how adoption of the medical and psychological professions’ stance on the transgendered in no way violates long-standing legislative, judicial, and public policy. Rather, judicial incorporation of medical and psychological will actually promote the social policy of supporting the transgendered as they transition.

**Background**

Legal and judicial treatment of transgendered individuals is at odds with current medical and psychological practice. Though all but two states provide administrative procedures for amendments to birth certificate sex designations, many courts have held these amendments and their related surgical and therapeutic requirements are insufficient for legal recognition of transitions to the opposite sex. Modern medical and psychological practice, on the other hand, emphasize the distress and anguish that come with gender incongruity and the need to promote the psychological well being of transgendered individuals.

These two disciplines are almost speaking different languages when it comes to notions of sex, gender, and transsexual transition. Courts have not yet caught onto the significant medical and psychological distinction between “sex” and “gender.” And while some courts may at least acknowledge the magnitude of the steps needed to fully transition between sexes, judicial
treatment of transgendered individuals is not yet on par with medical and psychological treatment.

The Difference Between Sex and Gender

The highly controversial nature of gender issues has led to the use of terms “whose meanings vary over time and within and between disciplines.” This controversial variance is highlighted in the distinction between the terms “sex” and “gender.” In everyday language, “sex” implies gender distinctions (i.e., male and female), as well as sexual intimacy and related preferences. Yet, the medical and psychosocial fields generally use the term “sex” to connote genetic markers of male and female. These things include “sex chromosomes, gonads, sex hormones, and non ambiguous internal and external genitalia.” Conversely, the term “gender” is typically used to designate the socially and publicly lived role of masculine or feminine.

In the social sciences, social construction theorists argue that masculine and feminine gender distinctions such are little more than man-made categories, used to satisfy a human need for order. Yet, the medical and psychosocial fields see social and psychological factors, in their interaction with biological factors, as contributing to overall gender development. Thus, “gender” has been used in contrast with “sex” to address instances when individuals have conflicting biological indicators of sex, as well as instances when individuals develop a gender identity at odds with their biological sex indicators.

No matter which discipline’s view one takes, the distinctions between “sex” and “gender” are important, particularly when courts are making those distinctions. Courts often mistakenly use these terms interchangeably, making it “difficult to figure out what courts are trying to reflect when deciding who is male and who is female.” For example in Corbett v. Corbett, the
foundational British case on sex/gender determination, the court suggested that if naturally occurring chromosomes, gonads, and genitals were congruent (i.e., sex), then a person’s “sex for the purposes of marriage” (i.e., gender) could be determined.¹⁹

The *Corbett* court’s implied distinction between “natural” and “unnatural” characteristics ignored the fact that supposed “natural,” or so-called “immutable” things like gonads and genitals can be changed with surgery and hormone treatment.²⁰ Furthermore, many individuals’ chromosomes are incongruent with their outward biological sex indicators (i.e., chromosomal sex disorders).²¹ Similarly, by excluding gender identity from its consideration, the *Corbett* court failed to consider whether this might also be “natural” and/or “immutable.”²²

The distinctions between “sex” and “gender” are very complex and continue to cause confusion, particularly in the judicial arena. Problems persist because many courts get caught up in considerations of traditional sex/gender distinctions and their public policy implications, often ignoring the advice of modern medical and physiological treatment. These judicial stalemates are most detrimental to transgendered individuals, who must jump through overwhelming legal hurdles in order to give effect to their medically and psychologically recognized sex/gender transitions.

*What it Means to be Transgendered*

“Gender dysphoria” is the term used in the *Diagnostic and Statistical Manual of Mental Disorders-5* to identify both congenital deviations of the reproductive system, as well as discrepancies between biological (i.e., sex) and social (i.e., gender) indicators of male and female.²³ The term generally depicts an emotional and/or cognitive discontent with assigned gender.²⁴ Notably, the previous DSM-4 used the term “gender identity disorder,” which focused
on identity as the clinical issue. The current term more accurately classifies the problem, not as an individual’s identity, but as the distress caused by the incongruence between her/his gender identity and assigned sex.

Consequently, the diagnosis includes the distress and anguish that “accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender.” This incongruence and the distress it causes are the core components of a gender dysphoria diagnosis. The disorder typically manifests as a strong desire to stop or change secondary sex characteristics (i.e., growth of facial hair or development of breasts), to be of the other gender, to be treated as the other gender, or a strong conviction that one has the typical markers of the other gender.

The term “transgender” refers to the wide-range of individuals who identify with a gender different from what they were assigned. Additionally, “transsexual” medically and psychologically denotes an individual who has sought or undergone a social, hormonal, or surgical transition between sexes/genders. Though, there is some disagreement between psychosocial professionals and transgender activists as to which term is most appropriate. The power to define one’s identity (including use of identifying terms) is a primary concern for transgendered individuals, so those unfamiliar with transgender issues should be conscious of and careful with the terms they use.

No matter where they are in the process of transition, transgendered individuals are ultimately caught in a binary system that fails to recognize their existence. Western “society only recognizes two disparate sexes,” serving what philosophers see as the human need to impose order. This gender dimorphism is particularly destructive to transgendered individuals, who must conceptualize their identity in limited, cross-gendered terms (i.e., if not male, then
This gendered dichotomy simply does not reflect reality. The host of historical, religious, and cultural examples of transgendered individuals illustrates the desperate need for current judicial practices to recognize a multi-gender model, or at the very least, allow and recognize transition between the opposite ends of the current binary model.

Treating Gender Dysphoria

Currently in its sixth edition, the Harry Benjamin International Gender Dysphoria Association’s *Standards of Care for Gender Identity Disorders* is the leading authority on the medical and psychological treatment of transgendered individuals. The principal goal of the *Standards of Care* is “to maximize overall psychological well-being and self-fulfillment” through “lasting personal comfort” with one’s sex/gender. Though the guidelines are ultimately clinical in nature, the *Standards of Care* is instructional for all professionals looking to “understand the parameters within which they may offer assistance to those with [gender dysphoric] conditions.”

The *Standards of Care* begins with a clinical threshold, which is passed when an individual’s concerns about their gender identity become so pervasive as to interfere with her/his normal development and life course. Once an individual meets the criteria for gender dysphoria specified in the *Diagnostic and Statistical Manual of Mental Disorders-5*, s/he is then formally diagnosed as gender dysphoric and can begin therapeutic treatment. The therapeutic approach to transgendered patients generally consists of three phases, including “a real-life experience in
the desired [gender], hormone [therapy for] the desired [sex], and surgery to change the genitalia and other sex characteristics.  

Ethical medical and psychological treatment of a transgendered patient requires regular psychotherapy throughout transition. In so doing, psychological professionals must constantly evaluate a patient’s eligibility and readiness for each stage of the transition process. A guided and monitored transition ensures the overall psychological well being of a transgendered patient, giving effect to the desired outcomes sought by the Standards of Care (i.e., lasting personal comfort with one’s sex/gender). Thus, the eligibility and readiness requirements are quite extraordinary for both partially reversible interventions like hormone therapy, as well as for completely irreversible interventions like genital surgery.

In order to be eligible to begin hormone therapy, a patient must 1) be eighteen years of age, 2) demonstrate knowledge of the medical and social benefits and risks of hormone therapy, and either 3) live for at least three months of documented real-life experience as the desired sex/gender, or 4) participate in a period of psychotherapy determined by the mental health professional (typically a three-month minimum). To find a patient ready for hormone therapy, a mental health professional must observe 1) the patient’s positive progress towards consolidating their gender identity through their real-life experience, 2) the patient’s satisfactory control of other identified problems to improve or stabilize their mental health, and 3) the likelihood that the patient will administer their hormone therapy responsibly.

Likewise, in order to be eligible for sex-reassignment or genital surgery, a patient must 1) be eighteen years of age, 2) undergo typically twelve months of hormone therapy, 3) live successfully for twelve months in a full-time real-life experience as the desired sex/gender, 4) participate regularly in psychotherapy, 5) demonstrate knowledge of the cost, required
hospitalization, likely complications, and rehabilitation requirements of surgery, and 6) be aware of competent surgeons.\textsuperscript{53} To find a patient ready for genital or other sex-reassignment surgery, a mental health professional must observe both the patient’s progress towards consolidating her/his gender identity, as well as the patient’s progress in dealing with the interpersonal issues which should result in a “significantly better state of mental health.”\textsuperscript{54}

These eligibility and readiness requirements are substantial because of the medical and social risks associated with gender transition.\textsuperscript{55} Furthermore, many medical and psychological professionals have observed, “that not all persons with [gender dysphoria] need or want” all forms of gender transition.\textsuperscript{56} Some patients undergoing treatment spontaneously change their transition aspirations, while others accommodate their gender identities without any medical or psychological intervention.\textsuperscript{57} Consequently, the requirements to undergo partially and wholly irreversible interventions are given substantial weight to ensure appropriate treatment and transition for qualified patients.

Due to the significant adaptive disadvantages to patients, gender dysphoria does qualify as a mental disorder.\textsuperscript{58} However, the \textit{Standards of Care} is careful to note that this is not a license to stigmatize patients or deprive them of their civil rights.\textsuperscript{59} Rather, a diagnosis of gender dysphoria is important for offering relief to the patient and for “guiding research to provide more effective future treatments.”\textsuperscript{60} These treatments, as well as any clinical departures from the \textit{Standards of Care}’s minimum requirements, should and are be well documented so that “the short and long term results can be retrieved to help the field evolve.”\textsuperscript{61}

This evolution is not limited to the medical and psychological fields. As the \textit{Standards of Care} was meant to guide \textit{all} professionals in their work with transgendered individuals, so too should advancements in understanding concerning the transgendered be applied to \textit{all} arenas
where the transgendered seek assistance. Nowhere is this evolution more critically needed than in the judicial arena.

*The History of Litigating Sex and Gender*

“How to determine a post-operative transsexual’s legal sex for the purposes of marriage” is a question courts across the country have attempted to answer, with varying results. To reach its determination on the question in *In re Estate of Gardiner (Gardiner II)*, the Kansas Supreme Court examined nine state and three federal cases that sought to address the same or a similar issue. The two most dispositive cases for the court were *Littleton v. Prange* from the Texas Court of Appeals and *M. T. v. J. T.* from the Superior Court of New Jersey. In *Gardiner II*, the Kansas Supreme Court chose to follow the shortsighted rule in *Littleton* rather than the inclusive rule in *M.T.*, to the detriment of fully transitioned transgendered individuals in Kansas.

In *Littleton v. Prange*, a postoperative male-to-female transsexual, Christie, brought a wrongful death action in her capacity as the deceased’s spouse. The district court granted summary judgment against her because “a man cannot be the surviving spouse of another man.” On appeal, the court looked to other jurisdictions because neither the Texas legislature nor courts had established guidelines for determining a post-operative transgendered person’s sex. However, the Texas legislature had enacted Texas Health and Safety Code § 191.028, which allows for amendments to sex designations on birth certificates, if satisfactory evidence proves them to be inaccurate.

Though the legislative intent of § 191.028 was unclear and did not mention transsexuals, Christie was able to successfully amend her birth certificate to reflect her new gender identity. Yet, the court declined to recognize the amendment, preferring instead to
leave it to the legislature to determine when and what guidelines would be created to determine the legal import of gender dysphoric treatment and sex-reassignment surgery. Though, with passing remarks about Christie being “created” male, the court made known its attitude towards sex/gender transitions.

However, the Texas court did concede that it would have been “intellectually possible… to write a protocol for recognizing transsexuals as having successfully changed their sex.” Though the court felt that it lacked authority to do so, the recognition that it could have created such a protocol suggests that the court may have recognized the precedential value inherent in standardized medical and psychological gender dysphoric treatments. Certainly, the court’s repeated acknowledgement of a transgendered person’s sincere belief that s/he is the opposite sex/gender indicates that this court could have recognized Christie’s transition, notwithstanding legislative silence as to the effect of that transition.

Conversely, when the Superior Court of New Jersey faced a similar issue in *M.T. v. J.T.*, the holding reflected and recognized the significant medical and psychological transformation of sex/gender transition. In *M.T. v. J.T.*, a post-operative male-to-female transsexual, M.T., filed a complaint for support and maintenance after separating from her husband, J.T.. In his defense, J.T. asserted that his marriage to M.T. was void because M.T. was a male. Both the trial and appellate courts disagreed with J.T.’s position, preferring instead to give effect to the significant medical and psychological transition undergone by M.T., which J.T. was aware of and helped pay for.

The New Jersey court considered *Corbett v. Corbett*, noting that like the Texas court, the English court subscribed to the opinion that biological sex is fixed at birth and cannot be changed by medical or surgical means. The court also took note of Corbett's prescribed chromosomal,
gonadal, and genital tests, which the New Jersey court felt inappropriately attached marriage to only biological sex. Rather, the court focused on the extensive medical testimony provided, which emphasized the coalescence of M.T.’s physical (i.e., sex) and psychological (i.e., gender) selves. In light of this evidence, the court felt that dual tests of anatomy and gender more appropriately address the effect of transition for transgendered individuals. Therefore, the court reasoned, "if the anatomical or genital features of a genuine transsexual are made to conform to the person's gender, psyche or psychological sex, then identity by sex must be governed by the congruence of these standards.”

Like Littleton, M.T. v. J.T. presented a matter of first impression for the New Jersey courts. Also as in Littleton, the plaintiff has successfully amended her birth certificate to reflect her desired sex/gender. Yet, the court in M.T. did not find it necessary to delve into the sufficiency of that amendment, particularly as it related to the intent behind legislation permitting such amendments. Instead, the court took the change to M.T.’s birth certificate at face value and chose to recognize the transformative physical and psychological effects of undergoing medical transition. "Such recognition," the court stated, "will promote the individual's quest for inner peace and personal happiness, while in no way disserving any societal interest, principle of public order or precept of morality.”

The Kansas Court of Appeals found the holding in M.T. dispositive when deciding Gardiner I. Considering Littleton, the Gardiner I court felt the reasoning in that case to be a "rigid and simplistic approach" to the complexity that is sex/gender reassignment. As in M.T., the Gardiner I court felt it best to examine all aspects of sexual identification (from internal and external morphological sex, to assigned biological sex and gender), rather than just assuming that sex is immutable from birth. Furthermore, the court made sure to note that any listed criteria
for determining sex/gender should not preclude "the consideration of other criteria as science advances," recognizing the evolutionary necessity of legal doctrine on this issue.

Unfortunately, the Kansas Supreme Court subscribed to the shortsighted reasoning in Littleton, leaving it to the legislature to determine the public policy concerning transsexual transition. As in Texas, the Kansas legislature had limited marriage to unions between a man and a woman in K.S.A. 23-101 (Supp. 2001). Because the legislative history was silent as to the whether or how the limitation affected marriage between two parties if one is a post-operative transsexual, the court reasoned that the legislature specifically intended to exclude them. “If the legislature intended to include transsexuals,” the court said, “it could have been a simple matter to have done so.

Even so, as in Littleton, the court incorporated its attitude towards transsexual transition, noting, “the transsexual still ‘inhabits ... a male body in all aspects other than what the physicians have supplied.’” To reach this conclusion, the court examined the everyday definitions of “‘sex,’ ‘male,’ and ‘female,’” reasoning that these words simply…

…do not encompass transsexuals. The plain, ordinary meaning of ‘persons of the opposite sex’ contemplates a biological man and a biological woman and not persons who are experiencing gender dysphoria. A male-to-female post-operative transsexual does not fit the definition of a female. The male organs have been removed, but the ability to “produce ova and bear offspring” does not and never did exist. There is no womb, cervix, or ovaries, nor is there any change in his chromosomes.

The court’s harsh words completely exclude transgendered individuals not only from marriage and its related benefits, but from seemingly from all the benefits of social and psychological gender transition. The court’s focus on bearing offspring as the true test of womanhood ignores, at the very least, the fact that there is more to being a woman than having children. To be sure, no male-to-female transsexual woman would ever expect to be able to bear
children, and yet many still transition. Most probably transition to give effect to their life-long desire for personal happiness and comfort with their sex/gender.\textsuperscript{100}

The more recent cases that have grappled with this issue continue to fall into the same divergent lines of reasoning represented in \textit{Littleton} and \textit{M.T}. For example, in \textit{Kantaras v. Kantaras}, the Florida Court of Appeals stated that until the legislature “amends the marriage statutes to clarify the marital rights of a postoperative transsexual person,” the court could not recognize the marriage of a post-operative transsexual man.\textsuperscript{101} There, the court chose to focus on the petitioner’s sex at the time of birth, rather than give effect to the psychological, medical, and administrative changes he had undergone.\textsuperscript{102} Conversely, in \textit{Radtke v. Miscellaneous Drivers & Helpers Union Local No. 638 Health, Welfare, Eye & Dental Fund}, the court chose to focus on and give effect to these substantial efforts at transformation.\textsuperscript{103}

In \textit{Radtke}, a post-operative male-to-female transsexual, Christine, enrolled in her husband's health care plan subsequent to their marriage.\textsuperscript{104} After finding out that she was transgendered, plan administrators terminated Christine's benefits, stating that no express basis for her marriage existed under Minnesota law.\textsuperscript{105} Even though Christine had previously undergone sexual reassignment surgery, had successfully amended her birth certificate to reflect her new status, and had secured a valid marriage license, plan administrators refused to acknowledge her judicially and administratively recognized status as female.\textsuperscript{106}

Like the courts in \textit{Gardiner I} and \textit{M.T.}, the court here recognized the many components of an individual's sex (i.e., chromosomal, anatomical, and hormonal)\textsuperscript{107} and the importance of giving legal effect to medical and psychological transitions.\textsuperscript{108} The court noted the Minnesota law that permits amendments to birth certificates, and discussed the ways amendments can be accomplished, either through court order or with a certified letter from a treating physician.\textsuperscript{109}
Thus, the court determined no Minnesota law prohibited recognition of a person's gender reassignment. In fact, the court stated "the only logical reason" to allow these type of amendments "is to permit that person to actually use the amended certificate to establish his or her legal sex for other purposes, such as obtaining a driver's license, passport, or marriage license."\textsuperscript{111}

In short, the cases that have invalidated transgendered individuals’ marriages have done so at the lack of explicit contrary instruction from their legislatures. However, each court has also included its own, shortsighted attitude about the nature of sex and gender, seeing each as immutably assigned at birth. Conversely, the cases that have upheld the marriages of transgendered individuals have recognized the full range of factors included in medical and psychological sex reassignment and given effect to transsexual transitions. These cases have done so without violating legislative intent or public policy. Rather, these cases support the policy already present in medical and psychological treatment of transgendered individuals, to support their transition and lasting comfort with their sex/gender.

**Discussion**

When faced with questions of how to determine a transsexual person’s sex for the purpose of marriage, courts should recognize and give effect to the psychological, medical, and administrative changes these individuals undergo. To do so in no way infringes upon legislative intent, as many legislatures have actually been silent on the issue of marriage and the transgendered. Such recognition also does not violate public policies against same-sex marriage, as fully transitioned individuals intend and expect to be treated as members of the opposite sex. In fact, to give effect to transsexual transition actually comports with the psychological and
medical policy of supporting transgendered individuals and promoting their lasting comfort with their sex/gender.112

_Legislative Silence_

Many, if not all of the courts that have invalidated a transsexual person’s marriage have done so under the guise of legislative intent, or the lack thereof. In _Littleton_, despite successfully amending her birth certificate per Texas Health and Safety Code § 191.028, the court felt it best the legislature decide if post-operative Christie should be recognized as a female spouse under Texas Civil Practice & Remedies Code § 71.004.113 Although Christie had met the transsexual transition requirements of one Texas statute, the court still felt that specific legislative mention of transsexuals was required for her to meet the requirements of the other.

Likewise, the court in _Gardiner II_ declined to give effect to J’Noel’s successfully amended Wisconsin birth certificate, even when its own state allows for such amendments.114 The court preferred to instead focus on the Kansas statute that limits marriage to a man and a woman,115 where the legislative intent is silent as to the effect of this limitation on the transgendered.116 According to at least one legal scholar, “the court’s interpretation of the legislative silence was strained and unpersuasive.”117

If the Kansas Supreme Court truly believed that legislative silence was indicative of legislative intent, then the court should have considered the legislative silence that followed the publication of an administrative regulation that had special relevance to the issue at hand by providing guidance on what constituted permissible modifications to Kansas birth certificates.118

In other words, the court should have taken the legislative silence following the Kansas administrative regulation allowing transgendered birth certificate amendments to mean that the legislature does not disapprove of such amendments. The court would have then been entirely
consistent with Kansas legislative intent in recognizing J’Noel’s marriage, thereby giving effect
to her medical and psychological transition.119

Public Policy Implications: Same-Sex Marriage

The therapeutic goals for transgendered individuals are to successfully live socially and
emotionally as their new gender.120 In other words, once transitioned, a transgendered individual
wishes to be seen as and for all purposes is the opposite sex. As the court reasoned in M.T.,

If such sex reassignment surgery is successful and the postoperative
transsexual is, by virtue of medical treatment, thereby possessed of the full
capacity to function sexually as a male or female, as the case may be, we perceive
no legal barrier, cognizable social taboo, or reason grounded in public policy to
prevent that person's identification at least for purposes of marriage to the sex
finally indicated.121

The court was referring to the public policy against same-sex marriage.122 Many of the
cases dealing with transgender persons’ marriage discuss the policy considerations of same-sex
marriage. Though, the Radtke court clarified the issue not as one of same-sex marriage, but
whether transsexual transitions allow an individual’s marriage to be “recognized as an opposite-
sex marriage.”123

Distinguishing these cases from same-sex marriage highlights the drastically different
public policy implications of each. While many state legislatures have specifically stated their
policy position against same-sex marriage, hardly any have specifically addressed their policy
position on transsexual transition. In fact, many courts and administrative agencies have taken
this silence to mean that transgendered individuals may amend their birth certificates after
substantial medical and psychological treatment.124 These treatments then must be seen as
permanently changing one’s sex/gender, which for the purpose of marriage, indicates that same-
sex marriage is not an issue.
In stark contrast is courts’ apparent willingness to permit “two individuals who appeared to be of the same sex” to marry.\textsuperscript{125} Shortly after \textit{Littleton} was decided, “a post-operative male-to-female transsexual married her female partner in Texas.”\textsuperscript{126} But because her original birth certificate indicated her sex as male, “there was no legal impediment to their marriage, although both appeared to be women.”\textsuperscript{127} Because courts continue to attach marriage only to biological sex,\textsuperscript{128} they fail to recognize the importance of congruence with social gender. In essence, courts simultaneously deny access to marriage for those who may only appear to be biologically compatible (i.e., gender), while permitting marriages between the biologically though not socially compatible (i.e., sex).

This inconsistency makes a farce of public policy arguments in favor of denying the transgendered access to marriage. Because courts so often use the terms “sex” and “gender” interchangeably, they often fail to see the distinctions between them. Certainly, the public policy against same-sex marriage includes unions between those whose biological sex and social gender are incongruent. But, when one is congruent and the other is not, as in the case of the transgendered, what harmonizes the two is the significant psychological and medical treatment inherent in transsexual transition. It would then be more in line with public policy if courts gave effect to those transitions and permitted opposite-sex marriage for transitioned transsexuals.

\textit{Social Policy: Congruence with Modern Treatment}

Perhaps the most important implication for transgendered individuals is the emotional and psychological validation that comes with legal enforcement of their transition. Whether an amended birth certificate, driver’s license, or a successful opposite-sex marriage application, social and legal recognition of their transition is key to their full psychological transition.\textsuperscript{129}
Because legal recognition can be such an intricate part of transsexual transition, it is important for the legal system to be receptive to the role it plays in validating that transition. To do so will not only give important effect to transsexual transition, but it will also bring the judicial arena up to par with modern medical and psychosocial treatment.

Conclusion

The judicial veil of ignorance concerning the transgendered needs to be lifted. No longer can courts safely assume that sex and gender are permanently fixed at birth. Courts and judges must open their eyes to the vast advancements in the medical and psychological professions, which have long recognized the fluid nature of not only social gender, but of biological sex characteristics. If they do so, courts and judges will come to understand the significant emotional turmoil transgendered individuals experience, and the substantial steps they must take to transition between sexes/genders.

Courts should then realize that through these transitions, transgendered individuals are permanently and irrevocably changing their sex/gender. And as the medical and psychological professions have acknowledged, it is important to support and give effect to these transitions for the lasting psychological and emotional well being of transgendered individuals. Courts will also realize that, once sex/gender are irrevocably changed, the typically proffered public policies against same-sex marriage simply do not apply. Furthermore, legislative silence on the effect of laws permitting birth certificate amendments suggest that, at the very least, if legislatures wanted to adopt legislation denying such access to the transgendered, they very well could.

Though, in the absence of such explicit instruction, courts should follow the well-accepted medical and psychological doctrine and give effect to the substantial transitions
undergone by transgendered individuals. In so doing, courts should legally acknowledge and validate transsexual transitions for the purpose of marriage.

2 Strasser supra note 1 at 179.

3 Gardiner at 120.

4 Gardiner at 122.


9 DSM-5, supra note 8 at 451.

10 Id.

11 Id.

12 Id.

13 Id.


15 DSM-5, supra note 8 at 451.

16 Id.

17 Strasser, supra note 1 at n. 49.

18 Strasser, supra note 1 at 188.


20 Strasser, supra note 1 at 189, n. 62.

21 See generally Julie A. Greenberg, Defining Male and Female: Intersexuality and the Collision Between Law and Biology, 41 Ariz. L. Rev. 265 (1999).
22 *Id.* at n. 64.


24 *Id.*

25 *Id.*

26 *Id.*

27 *Id.*

28 *Id* at 453.

29 *Id* at 452.

30 *Id* at 451.

31 *Id.*


33 Feinberg, *supra* note 32 at x.


35 *Id* at n. 44.


37 *Id.*

38 Feinberg, *supra* note 32 at 61.


40 *Id.* at 13.

41 *See generally, Standards of Care, supra* note 8.

42 *Id.*

43 *Id.* at 1.

44 *Id.* at 2.


46 *Standards of Care, supra* note 8 at 2.

47 *Id.* at 3.

48 *Id.*

49 *Id.* at 7.

50 *Id.* at 13, 20.
51 Id. at 13.
52 Id. at 14.
53 Id. at 20.
54 Id.
55 Id. at 13.
56 Id. at 3.
57 Id.
58 DSM-5, supra note 8 at 451; Standards of Care, supra note 8 at 6.
59 Standards of Care, at 6.
60 Id.
61 Id. at 2.
63 Gardiner, supra note 1.
64 Id. at 137.
66 Id.
67 Many of the same cases were reviewed by the Kansas Supreme Court in Gardiner.
68 Greenberg, supra note 62 at 746.
70 Greenberg, supra note 62 at 750.
71 Littleton at 231.
72 Id.
73 Id. at 230. See also Greenberg, supra note 62 at 752-3.
74 Littleton at 231.
75 Id. at 230.
76 Id.
77 Id.
79 Id. 205.
Of the cases cited on the issue of transgendered sex/gender identification, none were from New Jersey. So, though the court did not name this issue as one of first impression, the lack of applicable case law suggests it is nonetheless.

M. T. at 205.

Id. 211.


Gardiner I at 1110.

Id.

Id.

Gardiner at 136-37.


Gardiner at 136.

Id.

Id. at 135.

Id.

See generally, Standards of Care, supra note 8; M. T. at 211.

Kantaras at 161.

Id. at 155-6


Id. at 1026.

Id. at 1027.
Id. at 1028.

Id. at 1032.

Id. (The court notes that Christine is "anatomically and hormonally female.")

Id. at 1033.

Id.

Id. at 1034.

See generally, Standards of Care, supra note 8.

Littleton at 225, 231.


Gardiner at 136.

Strasser, supra note 1 at 196.

Id.

Id. at 197.

Standards of Care, supra note 8 at 20.

M.T. at 210-11.

M. T. at 208.

Radtke at 1031.

Lambda Legal, supra note 6.

Strasser, supra note 1 at 193.

Id. at 193-94.

Id.

M.T. at 208.

Standards of Care, supra note 8 at 17.