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The legal rights and wrongs of puberty blocking in England

Hannah Hirst*

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By analysing the recent ruling reached by the High Court in R (Bell and Another) v Tavistock and Portman NHS Foundation Trust *and consequent amendments to NHS England's Service Specification regulating pubertal blocking, this article considers the impact of the decision on children's rights in three areas: health, capacity, and involvement. It argues that the court's narrow approach to defining health led the judges to focus on the biological outcomes of puberty blockers and overlook the psychosocial consequences of withholding or delaying treatment. In the context of capacity, the* Bell *judgment impacts the rights of gender diverse youth by employing age markers and disregarding parental consent. It also groups together hormone treatments as one medical pathway and hinders an individual's right to confidential advice and treatment. In view of this, the article proposes that young capacities should be nurtured by adults, through clear dialogue and lengthy instruction. It examines these issues through a children's rights lens, and particularly in light of the UN Convention on the Rights of the Child 1989. In doing so, the article highlights the importance of involving young individuals in decisions about puberty blocking, given the internal and individualised nature of gender variance, transition, and patients' needs. The article adopts Laura Lundy's Model of Child Participation to illustrate the wider implications court interference has for patient involvement. Overall, this article proposes that children's rights should be central to decision making about gender diverse people's access to puberty blockers.*

Introduction

Although the right of non-cis adults[1] to medically transition has been addressed and analysed in queer and feminist scholarship,[2] the right of young individuals[3] has attracted little scholarly attention. This is surprising given the increasing number of referrals to the Gender Identity Development Service (GIDS) in recent years,[4] and reports describing the hurdles gender diverse youth must overcome to access puberty blockers.[5]

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* PhD student, University of Liverpool, School of Law and Social Justice. I would like to thank Marie Fox, Helen Stalford, Amber Pugh, and the journal's anonymous reviewers for their comments on earlier drafts of this paper.

1 This article employs the terms 'gender variant', 'gender diverse', and 'non-cis' to reflect instances when a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex assigned at birth.

2 See, for example, R Pearce, *Understanding Trans Health Discourse, Power and Possibility* (Policy Press, 2018), S Hines, *Transforming Gender Transgender Practices of Identity Intimacy and Care* (Policy Press, 2007), and S Whittle, *Respect and Equality: Transsexual and Transgender Rights* (Routledge, 2002).

3 This article refers to people aged 17 and under as 'young people' and 'young individuals', rather than 'children'.

4 The Gender Identity Development Service, 'Referrals to GIDS, financial years 2015–16 to 2019–20', available at: www.gids.nhs.uk/number-referrals, last accessed 20 May 2021.

5 Care Quality Commission, 'Tavistock and Portman NHS Foundation Trust Gender Identity Services Inspection Report' (2021), available at: www.cqc.org.uk/news/releases/care-quality-commission-demands-improved-waiting-times-tavistockportman-nhs, last accessed 20 May 2021, and www.thetimes.co.uk/article/it-feels-like-conversion-therapy-for-gay-childrensay-clinicians-pvsckdvq2, last accessed 20 May 2021.

Until December 2020, pubertal blocking in England was regulated by a clinical commissioning policy published by NHS England and applied by clinicians employed by the Tavistock and Portman Foundation Trust.[1] Subsequent to the High Court's ruling in *R (Bell and Another) v Tavistock and Portman NHS Foundation Trust*,[2] this policy has been amended to specify that young patients under sixteen should not be referred to paediatric endocrinologists for puberty blockers (PBs) without a 'best interests' order from the court.[3] The policy also states that patients aged sixteen and seventeen must obtain a court order in instances where there is a parental dispute regarding treatment or clinical doubt about the patient's best interests.[4] This article argues that the High Court's decision, and the subsequent modifications to GIDS policy, will significantly impede young people's access to medical transition and consequently delay or prevent treatment. This raises serious concerns about the welfare of approximately 3,000 patients annually,[5] as it constitutes a breach of their rights and reflects a distorted interpretation of *Gillick* competence.[6]

In what is one of the most significant decisions relating to young people's capacity to consent to treatment since the landmark ruling in *Gillick*,[7] it is particularly noteworthy that children's rights, and their direct experiences or views, barely feature in the judgment. Notably, in *R (Williamson) v Secretary of State for Education and Employment*,[8] Baroness Hale drew the court's attention to their disregard for children's rights:

> 'This is, and always has been, a case about children, their rights and the rights of their parents and teachers. Yet there has been no one here or in the courts below to speak on behalf of the children. The battle has been fought on ground selected by the adults.'[9]

These words are equally applicable to the legal proceedings in *Bell v Tavistock*.[10] As a medical intervention, PBs are exclusively used by young people under the age of eighteen, to relieve psychosocial suffering, carve a sense of self, and forge ownership over their body.[11] Blockers are innately tied to pubertal growth, a period of human development that only occurs during adolescence, which is intrinsic to the protection and preservation of a young person's gender identity.[12] Yet the discourse of children's rights was absent in *Bell*.[13] Adult voices and views dominated both the proceedings and the judgment. In their ruling, the judges eschewed the language of rights, focusing instead on the physical effects of PBs and young people's inability to consent to treatment according to

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[1] NHS England, 'Standard Contract for Gender Identity Development Service for Children and Adolescents' (2017): https://www.england.nhs.uk/wp-content/uploads/2017/04/gender-development-service-children-adolescents.pdf, last accessed 21 May 2021 and NHS England, 'Clinical Commissioning Policy: Prescribing of Cross-Sex Hormones as part of the Gender Identity Development Service for Children and Adolescents' (2016): https://www.england.nhs.uk/wp-content/ uploads/2018/07/Prescribing-of-cross-sex-hormones-as-part-of-the-gender-identity-development-service-for-children-andadolesce.pdf, last accessed 20 May 2021.

[2] [2020] EWHC 3274 (Admin), [2021] PTSR 593.

[3] NHS England, 'Amendments to Service Specification for Gender Identity Development Service for Children and Adolescents' (2020): https://www.england.nhs.uk/wp-content/uploads/2020/12/Amendment-to-Gender-IdentityDevelopment-Service-Specification-for-Children-and-Adolescents.pdf, last accessed 20 May 2021.

[4] Ibid, at 18.

[5] In 2019–2020, 2,728 children were referred to GIDS in the UK. Above n 4.

[6] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.

[7] Ibid.

[8] [2005] UKHL 15, [2005] 2 AC 246.

[9] Ibid, at 392.

[10] Above n 7.

[11] See, for example, J Morgan, 'Trans* health: "diversity, not pathology" ' (2015) 2(2) *The Lancet Psychiatry* 124–125.

[12] The term 'gender identity' is adopted in this article to describe a person's inherent sense of being a male, female, or an alternative gender. See, S Whittle and L Turner, ' "Sex Changes"? Paradigm Shifts in "Sex" and "Gender" Following the Gender Recognition Act' (2006) 12(1) *Sociological Research Online*: www.socresonline.org.uk/12/1/whittle.html, last accessed 20 May 2021. K O'Halloran, *Sexual Orientation, Gender Identity and International Human Rights Law Common Law Perspectives* (Routledge, 2019) and M Dru Levasseur, 'Gender Identity Defines Sex: Updating the Law to Reflect Modern Medical Science is Key to Transgender Rights' (2015) 39(4) *Vermont Law Review* 943–1004.

[13] Above n 7

the *Gillick* test.[14] In light of this, this article analyses the High Court's judgment and amendments to NHS England's Service Specification[15] regulating pubertal blocking, to consider the impact of the ruling and amendments on children's rights in three broad areas: health, capacity, and involvement.

This article argues that the court should have taken a more holistic approach to young people's health, by looking beyond the biological uncertainties of puberty blockers and acknowledging Articles 3, 6, 8 and 24 of the United Nations Convention on the Rights of the Child 1989 (CRC). It is disconcerting that Dame Victoria Sharp P, Lord Justice Lewis, and Justice Lieven interpreted Article 3 narrowly, and that empirical evidence relating to the intra-psychic and social dimensions of PBs did not inform their understanding of future best interests. The court's focus on physicality also meant that the psychosocial impacts of withholding and delaying treatment were not addressed in accordance with Articles 6 and 24 of the CRC.

Grouping together two distinct medical treatments, PBs and cross-sex hormones (CSHs), the ruling undermined an abundance of case-law emphasising that *Gillick* competency should always be assessed in a decision-specific context.[16] The judgment also downplayed research, reports, and case-law demonstrating the ineffectiveness of age makers in determining an individual's ability to make complex decisions about medical treatment. Building on this body of work, the article proposes that the puberty blocking context offers a unique opportunity for a young individual's capacity to be nurtured by adults, through clear and lengthy dialogue. It suggests that this encourages individuals to engage in action-oriented choices and become reflective decision makers, choosing to act in a manner that maintains their health. The article then examines the broader impact of the court's decision on an individual's right to confidential advice and treatment. Whilst *Bell* and NHS England's Service Specification[17] disregarded parental consent as a route to puberty blocking, the recent ruling in *AB v CD and The Tavistock and Portman Foundation Trust and University College London NHS Foundation Trust and XY*[18] held that a parent's right to consent to PBs on behalf of their child exists even when the young person is *Gillick* competent.[19] The article proposes that the role fashioned for parents in *XY*[20] should be developed into a supportive and nurturing position, which is commensurate with Article 5 of the CRC.

Finally, the article argues that the court's decision and the later revisions to GIDS policy fail to adequately recognise the views of young non-cis people and involve them in decisions about their own treatment. Whilst it is important in all medical treatment contexts that a young person is involved in decision making, it is particularly valuable in the puberty blocking context, given the internal and individualised nature of gender variance, transition and patients' needs. The article illustrates the wider implications court interference has for patient involvement through Laura Lundy's Model of Child Participation, which proposes that the fulfilment of Article 12 requires space, voice, an audience, and influence.[21]

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[14] Above n 11.
[15] NHS England, above n 6.
[16] See, for example, *Re JA (Medical Treatment: Child Diagnosed with HIV)* [2014] EWHC 1135 (Fam), [2015] 2 FLR 1030.
[17] Above n 6.
[18] [2021] EWHC 741 (Fam), 26 March 2021.
[19] Ibid, at 114.
[20] Ibid.
[21] L Lundy, ' "Voice" is not enough: Conceptualising Article 12 of the United Nations on the Rights of the Child' (2007) 33(6) *British Educational Research* 927–942.

The regulation of medical transition services for gender diverse youth in England

Although there is longstanding evidence of young people identifying as non-cis for (at least) a century,[22] health professionals paid little attention to their experiences of distress until the early 1980s.[23] In 1980 and 1990, a separate diagnosis of Gender Identity Disorder in Childhood was incorporated into the Diagnostic and Statistical Manual of Mental Disorders (DSM)[24] and the International Classification of Diseases (ICD)[25] respectively. The earliest gender identity clinic in Europe was established in 1987 by Dr Peggy Cohen-Kettenis at the University Medical Centre in Utrecht.[26] This clinic initiated the hormonal treatment of non-cis youth, allowing them to be free from suffering caused by conflict between their gender identity and sex assigned at birth.[27] Two years after this, the interventions became available to young individuals in England, when Domenico Di Ceglie established the Gender Identity Development Service (GIDS) at the Tavistock and Portman Clinic in London. GIDS supports individuals under the age of eighteen through a 'staged model of care', made up of three elements. The first involves assessment and exploration of the nature of their gender identity and, if applicable, their wishes for physical intervention.[28] The second and third stages comprise hormonal treatments, that is PBs and CSHs.[29] For over twenty years, Di Ceglie's therapeutic aims have informed clinical practice at GIDS.[30] Amongst other things, Di Ceglie's objectives encourage exploration of the mind–body relationship and challenges for gender non-conforming young people through a holistic multidisciplinary approach.[31]

Until December 2020, all three stages of medical transition at GIDS were regulated by clinical commissioning policy published by NHS England.[32] Informed by guidance developed by the World Professional Association of Transgender Health,[33] the Endocrine Society,[34] and the Royal College of Psychiatrists,[35] the policy, in two separate documents, specifies that PBs and CSHs should be prescribed to young people by clinicians working at the Tavistock and Portman Clinics. The first Service Specification outlines two separate criteria for PBs: one specifying conditions for individuals under fifteen years of age and/or in the early stage of puberty, and the other for post-pubertal persons and/or

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[22] J Gill-Peterson, *Histories of the Transgender Child* (Minnesota University Press, 2018).

[23] S Whittle, 'The Gender Variant Child's Right to Attend School: A Guide to UK Law for the Transgender Community, Parents & Schools' (2015) *Press for Change* 1–68.

[24] American Psychiatric Association, *Diagnostic Statistical Manual of Mental Disorders* (American Psychiatric Publishing, 3rd edn, 1980).

[25] World Health Organisation, *Classification of Mental and Behavioural Disorders* (WHO, 10th edn, 1990).

[26] This clinic later relocated to the larger Amsterdam Centre of Expertise of Gender Identity Disorders in 2002.

[27] Although some young people presenting at GIDS identify as trans, others do not connect with this 'umbrella term' and adopt other labels. For more information regarding this see: D Ehrensaft, *The Gender Creative Child: Pathways for Nurturing and Supporting Children* (The Experiment New York, 2016), 1–81.

[28] See GIDS's webpage discussing puberty and physical intervention: www.gids.nhs.uk/puberty-and-physical-intervention, last accessed 20 May 2021.

[29] Ibid.

[30] D Di Ceglie, *Stranger in My Own Body: Atypical Gender Identity Development Service and Mental Health* (Routledge, 1998). Note that Di Ceglie's therapeutic aims are emphasised on GIDS's website as remaining integral to the delivery of its services: at 7.

[31] A Spiliadis, 'Towards a Gender Exploratory Model: slowing things down, opening things up and exploring identity development' (2019) (35) *Metalogos* 1–16.

[32] Above n 6.

[33] The World Professional Association for Transgender Health *Standards of Care Version 7*: www.wpath.org/publications/soc.

[34] WC Hembree et al, 'Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline (2017) 102(11) *The Journal of Clinical Endocrinology and Metabolism* 3869–3903.

[35] Royal College of Psychiatrists, 'Good practice guidelines for the assessment and treatment of adults with gender dysphoria' (2013): www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/cr181-good-practiceguidelines-for-the-assessment-and-treatment-of-adults-with-gender-dysphoria.pdf, last accessed 20 May 2021.

over the age of fifteen.[36] According to this document, a referral to the Paediatric Endocrinology Liaison Team for blockers will be considered when a patient under the age of fifteen is presenting with continuing gender dysphoria, and the intensity and distress has increased with puberty.[37] The patient must also present as relatively stable psychologically, as evaluated through clinical observation and questionnaires and have support from family/carers.[38] A referral to the Team for this age group will also be deemed necessary if there is a need to provide information about physical development in order to allay anxieties the patient and/or their family is experiencing, and to exclude the intersex or other endocrine conditions.[39] For post-pubertal patients and/or those aged fifteen or over, the document describes a more *arduous* criteria for referral to the Endocrinology Team for PBs. There must not only be a substantial history of gender incongruence, lasting more than one year, but also no ongoing major family disruption and support from one or both parent/ carers.[40] In cases where a patient's parents are separated, it must be established who has legal parental responsibility[41] and demonstrated that careful thought has been given to involving an estranged parent in the decision-making. The young person must be at least Tanner Stage 2,[42]likely to attend appointments regularly,[43] and be engaged in education and some face-to-face social interaction with peers.[44] The young patient must also be judged to have sufficient understanding of 'what the blocker will do, and how it works, to be able to give assent, or consent, to treatment'.[50] The referral request should not be linked to any intense or prolonged psychological illness on the part of the young person,[45] their sexual orientation,[46] any dissatisfaction with their body,[47] or their wish for no puberty or no gender.[48] At several points in the Service Specification, NHS England acknowledges that treatment is provided via individualised healthcare pathways,[49] to reduce the distress of patients and build their resilience across a range of domains.[50]

Difficulties implementing the Service Specification's criteria were highlighted in the 2019–2020 Internal GIDS Review conducted by the then Staff Governor, Dr David Bell.[51] A criterion common to both papers is a DSM-IV gender dysphoria diagnosis.[52] Bell's findings suggested that Tavistock doctors were misapplying this criterion by diagnosing gay, lesbian, and bisexual youth as trans.[59] This approach was also observed in interviews *The Times* conducted with five former Tavistock doctors, who described 'gay children being sent down the pathway to change gender'[53] and 'a dark joke among staff that there

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[36] NHS England, 'Standard Contract for Gender Identity Development Service for Children and Adolescents' (2017): https://www.england.nhs.uk/wp-content/uploads/2017/04/gender-development-service-children-adolescents.pdf, last accessed 21 May 2021.
[37] Ibid, at 31.
[38] Ibid.
[39] Ibid.
[40] Ibid.
[41] Ibid.
[42] Ibid.
[43] Ibid.
[44] Ibid. 50
Ibid.
[45] Ibid. Notably, the Service Specification states that this includes 'a severe eating disorder, psychotic experience, or major depression' at 31.
[46] Ibid.
[47] Ibid.
[48] Ibid.
[49] Ibid, at 9, 16, 17, 21, and 24.
[50] Ibid.
[51] L Bannerman, 'It feels like conversion therapy for gay children, say clinicians' (2019) *The Times*, available at: www.thetimes.co.uk/article/it-feels-like-conversion-therapy-for-gay-children-say-clinicians-pvsckdvq2, last accessed 20 May 2021.
[52] NHS England, above n 6. 59
Bannerman, above n 57.
[53] Ibid. 61
Ibid.

would be no gay people left'.[61] Notwithstanding the fact that no data has been published specifying Tavistock patients' sexual orientation, there are concerns that this matter is not relevant to ascertaining whether a person wishes to undergo puberty blocking and that it simply reflects young people's sexual diversity.[54] A young non-cis person may be gay, lesbian, bisexual, straight, or any other sexual orientation in the same way cisgender youth identify sexually.[55] Notably, gender diverse individuals participating in Henry Rubin[56] and Julie Nagoshi et al's[57] studies rejected any connection between gender identity and sexual orientation. Whilst the comments raised in *The Times* do not reflect the views of most practitioners working with gender diverse youth,[58] they nevertheless demonstrate one of *several* barriers individuals may experience whilst trying to access PBs and/or CSHs. A practical hurdle limiting young people's access to hormones is Tavistock's London and Leeds location, requiring adult support and resources to travel to GIDS for treatment. Other obstructions include attending an initial appointment with a General Practitioner or Child and Adolescent Mental Health Services (CAMHS), and then obtaining a referral to GIDS.[59]Research conducted by Anna Carlile describes the advice given to young trans individuals and their families by GPs and CAMHS as frustrating and contrary to parents' investigations into best practice, leading to disagreements between young individuals and their relatives.[60]Examples of this advice, shared by participants in her study, include not taking a child's thoughts of their own gender seriously and ignoring, or punishing, self-harming behaviours related to body dysphoria.[61]

Despite these hurdles and the Government's response to the Women and Equalities Committee Report on Transgender Equality (2016),[62] acknowledging 'a clear and strong case that delaying [hormone] treatment risks more harm than providing it',[63] the provision and regulation of PBs and CSHs has faced increased scrutiny in recent years. In early 2020, Liz Truss (the newly appointed Chair of the Women and Equalities Committee) outlined plans to curtail medical transition services for non-cis youth during a Parliamentary Select Committee hearing, as part of the government's upcoming response to gender policy.[64] This reform, Truss claimed, would aim to protect under eighteens from irreversible decisions relating to their gender.[73] More recently, the Quality Care Commission's inspection of the Tavistock and Portman NHS Foundation Trust rated the service as 'inadequate' and 'requiring improvement', due to improper risk assessments conducted by staff, poor record keeping, and significant variations in the clinical approaches of doctors.[65] Nonetheless, the most high profile examination of gender affirming

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[54] See, for example, M Diamond, 'Sex and Gender are Different: Sexual Identity and Gender Identity are Different' (2002) 7(3) *Clinical Child Psychology and Psychiatry* 320–334.

[55] C Keo-Meier and D Ehrensaft, *The Gender Affirmative Model: An Interdisciplinary Approach to Supporting Transgender and Gender Expansive Children* (American Psychological Association, 2018), at 10.

[56] H Rubin, *Self-made Men: Identity and Embodiment Among Transsexual Men* (Vanderbilt University Press, 2003).

[57] J Nagoshi et al, 'Deconstructing the complex perceptions of gender roles, gender identity, and sexual orientation among transgender individuals' (2012) 22(4) *Feminism & Psychology* 405–422.

[58] The Tavistock and Portman FT, 'Our response to the *Sunday Times* article on gender diverse young people and schools published on Sunday 21 January 2018' (2018), available at: https://tavistockandportman.nhs.uk/about-us/news/stories/ourresponse-sunday-times-article-gender-diverse-young-people-and-schools-published-sunday-21-january-2018/.

[59] See A Carlile et al, ' "It's like my kid came back overnight": Experiences of trans and non-binary young people and their families seeking, finding and engaging with clinical care in England' (2021) *International Journal of Transgender Health* 9–13.

[60] A Carlile, 'The experiences of transgender and non-binary children and young people and their parents in healthcare settings in England, UK: Interviews with members of a family support group' (2019) 21(1) *International Journal of Transgender Health* 16–32.

[61] Ibid.

[62] Publications Parliament UK, 'Transgender Equality Contents. Conclusions and Recommendations' (2016): available at: www.publications.parliament.uk/pa/cm201516/cmselect/cmwomeq/390/39010.htm, last accessed 20 May 2021.

[63] Ibid, para 252.

[64] A Woodcock, 'LGBT+ campaigners concerned over government plan to protect under-18s from "irreversible" gender decision' (2020), available at: www.independent.co.uk/news/uk/politics/lgbt-gender-government-liz-truss-transgenderrights-consultation-a9478901.html, last accessed 20 May 2021. 73 Ibid.

[65] Care Quality Commission, above n 5.

treatments available at Tavistock to date has been the High Court's decision in *R (Bell and Another) v Tavistock and Portman NHS Foundation Trust*.[66]

This case involved a judicial review into the lawfulness of GIDS prescribing PBs to individuals under the age of eighteen. The first, and most prominent, claimant was Kiera Bell.[67] Despite identifying as female at the time of the review, Kiera had previously been prescribed PBs and CSHs through Tavistock and acquired top surgery[68] as an adult. Kiera's motivation for issuing legal proceedings against GIDS was her belief that the processes through which she was prescribed hormones were not robust and that she should have been unable to access hormone therapy, given the understanding and maturity she possessed at the time.[69] Similar concerns were raised by the second claimant, Mrs A, who expressed worry that her autistic 15-year-old daughter may be harmed by PBs and CSHs, once she became eligible for treatment at Tavistock. Counsel for both parties, Jeremy Hyam QC and Alasdair Henderson, made three submissions regarding the lawfulness of practice at GIDS. First, that individuals under eighteen are not capable of providing consent to the administration of PBs.[70] Second, that the information provided by the defendant was misleading and an inadequate basis for informed consent.[71]Mr Hyam raised a third issue, in writing, that if any young person is prescribed PBs, then their case should be referred to the Court of Protection.[72] He also submitted that PBs 'pave the way' for CSHs,[73] and suggested that the latter treatment has irreversible consequences.[74]

An organisation known as 'Transgender Trend' acted as an Intervener in the case, providing witness statements in the proceedings.[75] They filed witness statements outlining concerns about the paucity of evidence as to the impacts and effectiveness of PBs.[85] Mr Skinner, on behalf of Transgender Trend, contended that Tavistock's delivery of PBs amounted to the deliberate provision of medical treatment, by the state, to young people, which may cause harm.[76] Thus, Skinner stated that the court should ensure that this vulnerable group are provided with the full protection of the law.[87] The parties' overall goal in pursuing these claims was to adjust NHS guidelines regulating PBs and CSHs to prevent under eighteens undergoing treatment.

In response, the Tavistock and Portman NHS Foundation Trust provided details of the procedures followed by doctors working at GIDS, including the length of required preprocedural assessment and the extensive analysis of the patients undertaken by professionals at the clinic.[77] Their counsel, Fenella Morris QC and Nicola Kohn, emphasised the amount of information given to young patients during consultations and stressed that GIDS only refer individuals under 16 years to the Paediatric

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[66] Above n 7.

[67] It should be noted that Kiera is referred to as 'Quincy' in the case title of *Bell v Tavistock*.

[68] Top surgery is a surgical procedure to remove your breast tissue (subcutaneous mastectomy). This procedure can be done for individuals looking to achieve a more masculine or flat appearing chest, or for individuals seeking a more feminine sized and shaped chest.

[69] See, A Holt, 'NHS gender clinic "should have challenged me more" over transition' (2020) BBC News, available at: www.bbc.co.uk/news/health-51676020, last accessed 20 May 2021. A Rowe, 'Case Comment: *Bell v Tavistock* [2020] EWHC 3274 (Admin), available at: www.bindmans.com/insight/updates/case-comment-bell-v-tavistock-2020-ewhc-3274admin, last accessed 20 May 2021.

[70] Above n 7, 90.

[71] Ibid.

[72] Ibid, at 91.

[73] Ibid, at 94.

[74] Ibid.

[75] Ibid, at 103. 85
Ibid.

[76] Ibid, at 104. 87
Ibid.

[77] Ibid, at 17–21. 89
Above n 11.

Endocrinology Liaison Team for pubertal blocking if they are competent, as per the standard outlined by the House of Lords in *Gillick v West Norfolk and Wisbech Area Health Authority*.[89] To verify these claims the Trust called upon Dr Polly Carmichael (Director of GIDS), Professor Gary Butler (Consultant in Paediatric Endocrinology at University College London), and Dr Nurus-Sabah Alvi (Consultant in Paediatric Endocrinology at Leeds General Infirmary and Clinical Lead for Endocrine Liaison Clinics of the GIDS, Leeds) to provide statements to the court, describing the process young people go through at GIDs.[78] It is, however, important to note that the Trust failed to provide an accurate dataset to the court. Certainly, no information was collated or presented to the judges outlining the age distribution of those treated with PBs between 2011 and 2020;[79] the proportion of young people referred to GIDS who had a diagnosis of autistic spectrum disorder;[80] or the number of patients progressing from PBs to CSHs.[81]

Upholding the claimants' submissions, three divisional court judges, including the President of the Queen's Bench Division, concluded that the administration of PBs to individuals under eighteen is experimental[82] and forms part of a treatment pathway, leading to CSH therapy and gender reassignment surgery later in life.[83] In view of this, the court stated that individuals under sixteen need to understand the implications of *both* PBs and CSHs, and retain, weigh, and understand the following pieces of information to be deemed *Gillick* competent:[84]

> '(i) the immediate consequences of the treatment in physical and psychological terms;
>
> (ii) the fact the vast majority of patients taking puberty blocking drugs proceed to taking cross-sex hormones and are, therefore, a pathway to much greater medical interventions;
>
> (ii) the relationship between taking cross-sex hormones and subsequent surgery, with the implications of such surgery;
>
> (iv) the fact that cross-sex hormones may well lead to a loss of fertility;
>
> (v) the impact of cross sex hormones on sexual function;
>
> (vi) the impact of taking this step on this treatment pathway may have on future andlife-long relationships;
>
> (vii) the unknown physical consequences of taking puberty blocking drugs, and
>
> (vii) the fact that the evidence base for this treatment is as yet highly uncertain.'[85]

As GIDS's modified Service Specification outlines,[86] it is envisaged that GIDS, in conjunction with the Leeds Teaching Hospital and University College London, will apply under the inherent jurisdiction of the High Court, Family Division, for a best interests decision to determine whether a person under sixteen can meet the aforementioned criteria.[87] Given the demanding and arduous nature of this test, and the court's doubts about the capacity of persons aged fifteen years and under 'to understand and weigh

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[78] Above n 7, 11.
[79] Ibid, 27.
[80] Ibid, 34–35.
[81] Ibid, 57–59.
[82] Above n 7, at 134, 143, 148, and 152.
[83] Ibid, at 136.
[84] Above n 11.
[85] Above n 7, at 138.
[86] Ibid.
[87] Pursuant to Part 12 of the Family Procedure Rules 2010 any person with a genuine interest in or relation to the child in question can make an application relating to the exercise of the court's inherent jurisdiction. In exercising its inherent

the long-term risks and consequences of PBs',[100] it seems highly unlikely that many individuals will satisfy this criteria and gain access to hormone therapy at GIDS.

A different approach, however, was adopted by the court regarding young people aged 16–17. Although the court confirmed section 8 of the Family Law Reform Act 1969 and section 1(2) of the Mental Capacity Act 2005, acknowledging that individuals aged 16 and over should be presumed competent to consent to surgical and medical treatment,[101] they endorsed the conclusion reached in *Re W (Children)*.[102] In this case, the Court of Appeal held that a person aged 16–17 can be protected under a court's inherent jurisdiction if treatment is deemed not to be in their best interests.[103] The judges in *Bell* did nonetheless emphasise that the courts should not adopt an intrusive jurisdiction,[104] or have a role in decisions about puberty blocking in instances where a young person has capacity and there is no dispute with parents or doctors that treatment is in their best interests.[105]

The High Court's decision, and the subsequent modification to GIDS policy,[106] will significantly impede young people's access to medical transition and consequently delay or prevent treatment, raising concerns about the rights, welfare, and access to justice of approximately 3,000 patients annually referred for treatment.[107] This adjustment comes at a time when patients at Tavistock are reported to be waiting 22–26 months on average for an initial appointment. A matter which led a fourteen-year-old boy, identified only as 'Reece', to launch legal proceedings against GIDS with the support of legal activist group The Good Law Project.[108] Others, unable to tolerate prolonged suffering caused by this delay, have begun raising funds for private treatment through Crowdfunding and Go Fund Me contributions.[109] Significant delays in cases being heard in courts of all levels are likely to compound waiting times for treatment. In April to June 2020 it took on average 29 weeks for private law cases in the High Court, Family Division, to reach a final order,[110] continuing an upward trend observed in 2016 where the number of new cases overtook the number of disposals.[111] The Lord Chief Justice's Report, published in 2020, also emphasised the impact of the Covid-19 pandemic on family justice, stating that the volume of hearings in September 2020 exceeded

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jurisdiction the court may make any order or determine any issue in respect of a child unless limited by case law or statute. This includes, inter alia, decisions about medical treatment. When making said order, the court must be satisfied that the proposed treatment is both in the child's best interests and necessary. See, for example, *Re TM (Medical Treatment)* [2013] EWHC 4103 (Fam), 136 BMLR 153.

100 Above n 7, para [151] the court stated that it would be 'highly unlikely' that a person aged thirteen years or under could consent to PBs, and 'doubtful' that anyone between the ages of fourteen and fifteen could understand and weigh the long-term risks and consequences of the intervention.

101 Above n 7, at 146.

102 [2018] EWCA Civ 664, [2018] 3 WLR 1819.

103 Ibid.

104 Above n 7, at 146.

105 Ibid, at 54.

106 NHS England, above n 8.

107 In 2019–2020, 2728 children were referred to GIDS in the UK. Above n 4.

108 B Hunter, 'Trans teen in legal action over gender clinic wait' (23 November 2020) *BBC News*, available at: www.bbc.com/news/health-55015959, last accessed 20 May 2021.

109 Gofundme, 'Be Yourself: Gender Confirmation Surgery Fundraising', available at: www.gofundme.com/c/genderconfirmation-surgery-fundraising, last accessed 20 May 2021.

110 Ministry of Justice, 'National Statistics Family Court Statistics Quarterly: April to June 2020', available at: www.gov.uk/government/statistics/family-court-statistics-quarterly-april-to-june-2020/family-court-statistics-quarterly-april-to-june-2020, last accessed 20 May 2021. 111

Ibid.

pre-Covid levels.[88] Requiring all individuals under sixteen, and some aged sixteen and seventeen, to acquire court approval prior to pubertal blocking, epitomises a systematic barrier gender variant youth must overcome to live and survive in a gender distinctive to them. The outcome of *Bell v Tavistock* can be viewed, therefore, as a step in the wrong direction for the recognition and fulfilment of gender diverse children's rights.

Are pubertal blockers 'very unusual treatment'?

A central matter that led the High Court in *Bell v Tavistock* to introduce judicial oversight of hormone therapy was the classification of PBs as a medical treatment.[113] The court outlined three reasons why blocking young people's pubertal growth should be considered 'very unusual treatment'.[89] First, that there is 'real uncertainty' over the short- and long-term consequences of PBs, and limited evidence concerning the treatment's efficacy. Second, that there is a lack of clarity over the purpose of pubertal blocking.[90] Third, that the outcome of pubertal blocking is highly complex, potentially lifelong, and life-changing in 'the most fundamental way imaginable'.[116]

Puberty blocking drugs can be understood as 'very unusual treatment', but not in the way imagined by the court. Although some medicines delay a patient's physical development in the treatment of a malfunction or disease, PBs are used in a unique way to manage a normal part of human variance[91] by facilitating self-actualisation and relief from psychosocial suffering.[92] When a non-cis person self-actualises their own gender identity,[93] it is common for them to exhibit distress that their general appearance and secondary sex characteristics do not align with their gendered experiences and self.[94] Self-actualisation often occurs through a process of self-reflection, perspective shifting, and creative explorations of gendered self-expression,[95] leading academics, such as Lisa Diamond et al, to claim that it is a 'hard-fought achievement'.[96] Blockers are a tool through which young people can carve a sense of self and forge ownership over their body during self-actualisation. The High Court's judgment touched upon this when it explained that 'the treatment goes to the heart of an individual's identity, and is thus, quite possibly, unique as a medical treatment'.[97] Given this, the purpose of puberty blocking drugs appears to be aligned with Article 8(1) of the United Nations Convention on the Rights of the Child 1989, ensuring the protection and preservation of a child's identity without lawful interference.[98] Maureen Carroll similarly postulates that restricting young people's access to hormones compromises

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[88] Judiciary of England and Wales, 'The Lord Chief Justice's Report' (2020), available at: https://www.judiciary.uk/wpcontent/uploads/2020/11/6.6901_JO_Lord_Chief_Justices_AR_2020_WEB2.pdf, last accessed 20 May 2021. 113 Above n 7, at 19.

[89] Above n 7, at 134.

[90] In particular, the court queried whether pubertal suspension provides a pause to think in a hormone-neutral state or if treatment is to limit the effects of puberty and thus the need for greater surgical and chemical intervention later. 116 Above n 7, at 134.

[91] Morgan, above n 16.

[92] See N Mladenovic et al, 'Transgender rights to gender-affirming medical treatment and change of registered sex on identity documents', available at: https://www.law.utoronto.ca/documents/reprohealth/HCS2-TransgenderHealth.pdf.

[93] A Lev, *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families* (Routledge, 2004) which highlights the trans population's active engagement with processes of self-reflection, aimed at instantiating a new sense of identity authenticity.

[94] See S Giordano, 'Lives in chiaroscuro. Should we suspend the puberty of children with Gender Identity Disorder?' (2008) 34(8) *Journal of Medical Ethics* 580–584 and S Giordano, 'Gender atypical organisation in children and adolescents: ethico-legal issues and a proposal for new guidelines' (2007) 15(3) *International Journal of Children's Rights* 365–390.

[95] I Itai, 'Self Actualisation: For Individualistic Cultures Only' (2008) 27(2) *International Journal of Humanistic Ideology* 113–139.

[96] L Diamond et al, 'Transgender Experience and Identity' in S Schwartz et al, *Handbook of Identity Theory and Research* (Springer, 2011).

[97] Above n 7, at 134.

[98] United Nations Convention on the Rights of the Child 1989, Art 8(1).

their ability to express their identity and develop their character, and that granting access facilitates that development.[99]

Another unique feature of the intervention is that every patient's treatment plan is designed specifically for them.[100] Individuals presenting at Tavistock not only differ in age, they also experience varying degrees of distress, requiring different levels of support from doctors.[101] As with other forms of medical transition, PBs are used by patients envisaging diverse results and gendered futures. This was a matter the court failed to grasp in its conclusions about the purpose of treatment:

> 'There is a lack of clarity about the purpose of treatment: in particular, whether it provides a "pause to think" in a "hormone neutral" state or is a treatment to limit the effects of puberty, and thus the need for greater surgical or chemical intervention later.'[102]

Some young people may proceed with puberty blocking for one or both of these reasons. An individual may wish to stop the distress they are experiencing because of the onset of secondary sex characteristics, while others may utilise their time in a pre-pubescent body to consider the prospect of other gender identity treatments, including CSHs and gender-reassignment surgery.[103] The length of time blockers are administered to patients also varies.[104] Simona Giordano and Søren Holm acknowledge that these factors make it impossible to disentangle the specific effects of PBs and achieve an evidence base leading to whole-ranging clinical guidance applicable to all patients in all contexts.[105]

Following Ormrod J's suggestion in *Corbett v Corbett* that 'the law should keep out of decision-making' in the context of treating trans adults,[106] the High Court's description of blockers raises questions about the role of the courts in determining the classification and purpose of medical treatments in a judicial review case. Margaret Brazier and Sara Fovargue propose that the courts should take a secondary role in defining 'proper medical treatment',[107]and that it is better determined by a healthcare professional in light of their experience, knowledge of the patient and good medical practice.[108] Although the definition of good medical practice encompasses many factors,[109] McNair J in *Bolam v Friern Hospital Management Committee*[110] emphasised that it included 'what a responsible body of medical men skilled in that particular art accepted as proper'.[111] In the paediatric medical transition context, there is a consensus in the medical community specialising in gender diverse health that the administration of PBs conforms to good medical practice.[112] A recent study conducted by the European Society of Paediatric Endocrinology in 25 gender clinics indicated that blockers are routinely administered to young

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[99] M Carroll, 'Transgender Youth, Adolescent Decisionmaking and *Roper v Simons*' (2009) *UCLA Law Review* 56, at 749.

[100] See, for example, www.tavistockandportman.nhs.uk/about-us/news/stories/referrals-gender-identity-development-servicegids-level-2018–19/, last accessed 20 May 2021.

[101] Di Ceglie, above n 35.

[102] Above n 7, at 134.

[103] Whittle, above n 28.

[104] Ibid.

[105] S Giordano and S Holm, 'Is puberty delaying treatment "experimental treatment"?' (2020) 21(2) *International Journal of Transgender Health* 118.

[106] *Corbett v Corbett (otherwise Ashley)* [1971] P 83.

[107] M Brazier and S Fovargue, 'Transforming wrong into right: what is "proper medical treatment"?' in S Fovargue and A Mollock, *The Legitimacy of Medical Treatment: What Role for the Medical Exception* (Routledge, 2015).

[108] Ibid.

[109] See, for instance: https://www.gmc-uk.org/-/media/documents/good-medical-practice—english-20200128_pdf51527435.pdf, last accessed 20 May 2021.

[110] [1957] 1 WLR 582.

[111] Ibid.

[112] See, for example, P Cohen-Kettenis et al, 'Treatment of adolescents with gender dysphoria in the Netherlands' (2011) 20(4) *Child and Adolescent Psychiatric Clinics of North America* 689–700, and MP Conn et al, 'Gonadotropin-realising hormone and its analogs' (1994) 45(1) *Annual Review of Medicine* 391–405.

individuals in Australasia, the Americas, and Europe.[113] In England, puberty blocking has been a firmly established practice at the Tavistock Clinics since the Early Intervention Study began in 2009.[114] Building on this, Giordano and Holm describe an extensive range of clinical guidelines spanning two decades,[115] to emphasise that puberty blocking has been part of standard medical practice in the UK for many years and is not 'novel' treatment.[116]

The visibility of young non-cis identities and rights

In recent years, public awareness of gender diverse youth in England has increased significantly. Widespread coverage of these people's identities has been reported in the media,[117] dramatised on television,[118] and discussed in a growing number of academic papers and books.[119] Much of this coverage, however, has failed to adequately engage with the views and lived experiences of gender diverse youth in their sex assigned at birth, and perpetuated misleading information regarding their intentions to undergo a medical transition.[120] Information concerning sexuality, mental illness, and 'LGBTQ+ indoctrination' has been published by observers opposed to young people identifying as anything other than cis.[121] Some research has sought to undermine the authenticity of young non-cis identities, by suggesting that they are a product of trans affirmative lobbying and the socio-political landscape,[148] in order to protect cis peers[122] and non-cis youth[123] from harm.

In light of the few legal provisions that exist in the UK protecting the identities of gender diverse youth, Peter Dunne argues that these individuals are 'legally invisible'.[124] This has been evident in the exclusion of under eighteens from the Gender Recognition Act 2004,[125] and in gaps in legislation protecting gender diverse youth,[126] producing what Ana-Maria Bucataru describes as 'a chain reaction of human rights infringements'.[127] Given that non-cis youth form a minority who frequently experience discrimination,

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[113] N Skordis et al, 'International Survey of Centers and Clinicians Delivering Specialist Care for Children and Adolescents with Gender Dysphoria' (2018) 90(5) *Hormone Research in Paediatrics* 326–331.

[114] www.gids.nhs.uk/our-early-intervention-study, last accessed 20 May 2021.

[115] Giordano and Holm, above n 131.

[116] Ibid.

[117] See C Pullen, *Queer Youth and Media Cultures* (Palgrave Macmillan, 2014).

[118] A well-known dramatisation of a trans youth's experience living in their biologically assigned body was 'Butterfly', which aired in 2018 on ITV.

[119] See, for example, E Horowicz, 'Transgender adolescents and genital-alignment surgery: is age restriction justified?' (2019) 14(2) *Clinical Ethics* 94–103, T Murphy, 'Adolescents and Body Modification for Gender Identity Expression' (2019) 27(4) *Medical Law Review* 623–639, P Dunne, 'Transgender Children and the Law' (2017) *Family Law* 123–124, F Ashley, 'Homophobia, Conversion Therapy, and Care Models for Trans Youth: Defending the Gender-Affirmative Approach' (2020) 17(4) *Journal of LGBT Youth* 361–383, and J Drescher and W Byne, *Treating Transgender Children and Adolescents An Interdisciplinary Discussion* (Routledge, Taylor & Francis, 2014).

[120] H Brunskell-Evans, 'The Medico-Legal "Making" of the Transgender Child' (2019) 27(4) *Medical Law Review* 640–657, and M Moore and H Brunskell-Evans, *Transgender Children and Young People Born in Your Own Body* (Cambridge Scholars Publishing, 2018) provide a good model of this narrative.

[121] Ibid. 148

Ibid.

[122] A Grossman et al, 'Parents Reactions to Transgender Youths' Gender Nonconforming Expression and Identity' (2005) 18(1) *Journal of Gay and Lesbian Social Services* 181–193.

[123] T Meadow, *Bringing up the Transgender Child: Parents, Activism and the New Gender Stories* (New York University, 2011), 11.

[124] A Sharpe et al, ' "Shifting sands": six legal views on the transgender debate' *Guardian Online* (2018): available at: www.theguardian.com/society/2018/oct/19/gender-recognition-act-reforms-six-legal-views-transgender-debate, last accessed 20 May 2021.

[125] Notably, the government excluded any responses from trans children and their families when drafting the Gender Recognition Act 2004.

[126] Young trans people have not been included in fundamental equality legislation, including the Equality Act 2010. The aforementioned Act only provides adults full legal protection from unlawful age discrimination and it does not protect young people from harassment in education if it relates to their gender reassignment.

[127] A Bucataru, 'Using the Convention on the Rights of the Child to Project the Rights of the Transgender Children and Adolescents: The Context of Education and Transition' (2016) 3(1) *Queen Mary Human Rights Review* 59–81. 155 Ibid.

prejudice, violence, and mental illness related to their gender identity, manifesting in self-harm and suicidal ideations,[155] it is startling that Articles 3, 6, 12, 24, 8, 5, and 13 of the CRC were excluded from the UK legislative agenda and neglected by the court in *Bell v Tavistock*.[128]

The High Court was handed a unique and timely opportunity in *Bell* to reject these narratives, and uphold non-cis children's rights, by recognising their identities as legitimate and worthy of affirmation through puberty blocking. This would have rendered young non-cis people's identities, and rights, visible for the first time in English legal history. All the same, the court's pathologised judgment did not include any rhetoric related to rights; focusing instead on the physical effects of PBs and young people's inability to consent to treatment according to *Gillick*.[129]

Acknowledging and prioritising a language of rights, Michael Freeman proposes, makes 'visible what has for too long been suppressed', leading 'different and new stories being heard in public',[130] and resolving what Dunne describes as 'the legal invisibility' of non-cis youth.[131] In a similar vein, Carrie Menkel-Meadow explains that 'each time we let in an excluded group, each time we listen to a new way of knowing, we learn more about the limits of our current way of seeing'.[132] For too long the rights of young non-cis people have been overlooked in discussions about puberty blocking. This exclusion may be linked to adult views and voices dominating scholarship, litigation, and clinical policy, which project paternalistic notions of health, capacity, and involvement whilst discouraging individual experiences of gender.

Looking beyond the biological outcomes and uncertainties of pubertal blocking drugs and toward Articles 3, 6 and 24 of the CRC

By focusing exclusively on *Gillick* competency,[133] the court in *Bell* overlooked surplus jurisprudence and academic commentary drawing directly on the CRC.[134] The following analysis suggests that Articles 3, 6, and 24 play a valuable role in illustrating the psychosocial impact of administering and withholding puberty blocking treatment to young non-cis people.

Article 3

A major issue undermining the court's ruling that puberty supressing drugs constitute experimental treatment was their preoccupation with the biological outcomes rather than the psychosocial outcomes of PBs.[135] Such an approach fails to understand the treatment and management of transgenderism as being multi-faceted. It has, according to Simona Giordano, three main and interrelated dimensions, an

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[128] Above n 7.

[129] Above n 11.

[130] M Freeman, 'Why It Remains Important to Take Children's Rights Seriously' (2007) 15 *International Journal of Children's Rights* 5–23.

[131] Dunne, above n 151.

[132] C Menkel-Meadow, 'Excluded Voices: New Voices in the Legal Profession Making New Voices in the Law' (1987) 42(1) *University of Miami Law Review* 29–53.

[133] Above n 11.

[134] See, for instance, *R (SG) and Others v Secretary of State for Work and Pensions* [2015] UKSC 16, [2015] 1 WLR 1449, *ZH (Tanzania) v Secretary of State for the Home Department* [2011] UKSC 4, [2011] 2 AC 166, *Re McKerr* [2004] UKHL 12, [2004] 1 WLR 807, J Doek, 'The CRC: Dynamics and Directions of Monitoring its Implementation' in A Invernizzi, *The Human Rights of Children: From Visions to Implementation* (Routledge, 2011), and V Morrow, ' "We are people too": Children's and young people's perspectives on children's rights and decision-making in England' (1999) 7(2) *International Journal of Children's Rights* 149–170.

[135] Notably, this omission mirrors much of the medical literature analysing the effects of pubertal suspension in childhood. See L Rew et al, 'Review: Puberty blockers for transgender and gender diverse youth – a critical review of the literature' (2020) *Child and Adolescent Mental Health* 1–12. In particular, at para 135 the court noted 'the condition being treated, GD, has no direct physical manifestation'.

intra-psychic dimension, a social dimension, and a physical dimension.[136] Consequently, medical evidence relating to the intra-psychic and social dimensions of the treatment, were overlooked by the court in its classification of PBs as 'experimental'.[165] This was an omission on the defendant's part, as GIDS submitted limited evidence detailing the psychosocial benefits of PBs.[137] If this medical data had been examined, the judges may have considered peer-reviewed studies, such as that of Peggy Cohen-Kettenis et al, highlighting the benefit of PBs in reducing emotional and depressive symptoms and improving psychological functioning and behaviour,[138] and Baudewijntje Kreukels et al's research emphasising an increase in harmful behaviour when blockers are not used.[139] Other papers, such as Greta Bauer et al, recognise that offering gender identity interventions to young individuals whose identities are affirmed, leads to them experiencing a significantly better quality of life.[140]

From a children's rights perspective, it is problematic that the judges in *Bell* were not presented with this research evidence and did not engage with Article 3 of the CRC in the broadest sense possible.[141] Widely considered to be the most important principle in the Convention,[142]Article 3(1) states that the best interests of the child should be a primary consideration in all actions concerning children undertaken by courts of law. Whilst the CRC is not legally enforceable in England, Baroness Hale has confirmed that the 'spirit if not the precise language of Article 3(1) had been translated into English law',[143] and Lord Kerr has emphasised that 'it remains a factor which must rank higher than any other'.[144] If the aforementioned evidence had been presented to the court, it is likely that the therapeutic nature of PBs would have been highlighted in the judgment. This is because best interests should be interpreted in the widest sense possible, incorporating not just a patient's medical interests but also their social and psychological well-being.[145]

One problematic aspect of puberty blocking is that it affects young individuals' best interests in the long-term.[146] It can, in John Eekelaar's words, be construed as an 'imaginative leap of faith',[147] as no physical test exists diagnosing gender variance and identifying the need for PBs. For Helen Stalford and Kathryn Hollingsworth, empirical evidence should play a central role in informing court decisions relating to a child's future best interests.[148] This evidence can help the court establish an overall representation of a young person's best interests in the short- and long-term. It is, however, important that a court is presented with broad-ranging data that considers all aspects of a young individual's welfare.

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[136] S Giordano, *Children with Gender Identity Disorder A Clinical, Ethical, and Legal Analysis* (Routledge, 2013). 165 Above n 7, 148.

[137] Above n 7, 53–54.

[138] P Cohen-Kettenis et al, 'Treatment of adolescents with gender dysphoria in the Netherlands' (2011) 20 *Child Adolescent Psychiatry Clinical* 689–700.

[139] B Kreukels and P Cohen-Kettenis, 'Puberty suppression in gender identity disorder: the Amsterdam experience' (2011) 7 *Nat Rev Endocrinol* 466–472.

[140] G Bauer et al, 'Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada' (2015) 15(525) *BMC Public Health* 1–15.

[141] *Re McGrath (Infants)* [1893] 1 Ch 143, at 148, and *Re G (Education: Religious Upbringing)* [2012] EWCA Civ 1233, [2013] 1 FLR 677, at 27.

[142] See, for example, M Freeman, 'The best interests of the child? Is the best interests of the child in the best interests of children?' (1997) 11 *International Journal of Law, Policy and Family* 360–388.

[143] *ZH (Tanzania) v Secretary of State for the Home Department* [2011] UKSC 4, [2011] 2 AC 166, at [24].

[144] Ibid, [46].

[145] Freeman, above n 171. Also see *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, [2014] AC 591.

[146] Erika Skougard discusses how PBs can affect people's best interests long term in E Skougard, 'The Best Interests of Transgender Children' (2011) 3 *Utah Law Review* 1161–1201.

[147] J Eekelaar, 'The Emergence of Children's Rights' (1986) 6(2) *Legal Studies* 161–182.

[148] H Stalford, K Hollingsworth and S Gilmore (eds), *Rewriting Children's Rights Judgments: From Academic Vision to New Practice* (Hart Publishing, 2017), 33–37.

Article 6

The court's focus on biological risk also meant that the psychosocial impacts of withholding or delaying pubertal blocking were not addressed by the court in its ruling. By contrast, in the Australian case of *Re Jamie*,[149] the Family Court overturned almost a decade of verdicts on the treatment of non-cis youth in determining that PBs constituted *therapeutic* treatment.[150]Evidence provided in this case by the second intervenor, the Australian Human Rights Commission, stressed that withholding hormones 'may lead to an increased likelihood of major mental disorder and behavioural difficulties including severe depression and anxiety disorders and risk of self-harm'.[151] Although the English courts have explored and emphasised the psychosocial harms of non-treatment in a range of contexts involving young people,[152] the most renowned is Lord Fraser's evaluation in *Gillick*:

> 'Unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer.'[153]

Cases, such as Jayden Lowe's, demonstrate that withholding and delaying PB treatment can lead to a person to become suicidal.[154] There was, however, little regard for this in the judgment. Jayden took his own life after being informed that the two-year delay in his treatment at GIDS was likely to be extended for another four years on being referred to the Gender Identity Service for Adults on his eighteenth birthday.[155] Notably, a study conducted by Youth Chances stated that more than one in four (27 percent) of young trans people have attempted suicide and nine in ten (89 percent) have thought about it.[156] The study also noted that 72 percent of trans youth have self-harmed at least once.[186]

Time can, therefore, be fundamental in ensuring the development and survival of gender diverse youth to the maximum extent possible.[157] A problematic procedural change imposed by the judgment in *Bell* is the lengthy task of acquiring court approval. In the context of pubertal blocking, Australian scholars report that court authorisation can take months, if not years, to acquire.[158] Court intervention will inevitability extend waiting times at GIDS,[159] thereby prolonging patients' psychosocial suffering and pubertal development.[160]

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[149] [2015] FamCA 455.

[150] Ibid, at 171.

[151] Australian Human Rights Commission, 'Summary of Argument of Australian Human Rights Commission' (AHRC, 2013), available at: https://humanrights.gov.au/sites/default/files/Submissions%20of%20AHRC%20Re%20Jamie.pdf, last accessed 20 May 2021.

[152] See, for example, *Re B (A Minor) (Wardship: Medical Treatment)* [1981] 1 WLR 1421 and *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386.

[153] Above n 11.

[154] A Savva and N Small, 'Mum's fury after transgender suicide teen sold hormones from illegal online clinic' (29 June 2019) *Cambridgeshire Live*, available at: www.cambridge-news.co.uk/news/cambridge-news/transgender-treatment-nhswebberley-jayden-16504026, last accessed 20 May 2021.

[155] Ibid.

[156] See Metro, 'Youth Chances: Integrated Report' (2016), available at: https://metrocharity.org.uk/sites/default/files/2017–04/National%20Youth%20Chances%20Intergrated%20Report%202016.pdf and Stonewall, 'Trans Key Stats', available at: https://www.stonewall.org.uk/sites/default/files/trans_stats.pdf, last accessed 20 May 2021. 186 Ibid.

[157] Ibid, 48.

[158] See, F Kelly, 'Australian children living with gender dysphoria: Does the family court have a role to play?' (2014) 91(2) *Law and Medicine* 105–120.

[159] Ibid.

[160] A 2017 report by Lucy Series et al described a significant proportion of patients dying whilst waiting for their deprivation of liberty safeguards to be resolved. See: http://sites.cardiff.ac.uk/wccop/files/2017/09/Series-Fennell-Doughty-2017Statistical-overview-of-CoP.pdf, last accessed 20 May 2021.

The context of puberty blocking also raises wider questions about law's ability to manage and navigate time.[161] Examining time as a dimension of medical law, John Harrington proposes that court procedures are too 'stretched' to allow sufficient time for wide-ranging arguments and the justification of outcomes.[162] Harrington's argument can be transposed onto future best interest determinations for gender diverse youth wishing to undergo puberty blocking, as individual cases are likely to be complex and encompass a variety of evidence and testimony. Another concern, undermining Harrington's description of the law as a 'living being' and 'ontologically equivalent to children',[193] is that legal responses to gender variant children and adolescents may be outpaced by their pubertal growth and distress. This was demonstrated in the Australian case of *Re Alex*,[163] when lengthy judicial hearings about a thirteen year old's medical transition led the claimant to require invasive surgery as an adult.[164]

Article 24

The court's narrow approach can also be constructed as privileging physical health over psychosocial wellbeing.[165] Widely accepted understandings of 'health', such as the definition given by the World Heath Organisation, propose that it is a state of complete 'physical, mental and social well-being, and not merely the absence of disease or infirmity'.[166] The United Nations Committee on the Rights of the Child has also extended this view of health to individuals under eighteen in its General Comment No 15 (2013).[167] This Comment emphasises the importance of approaching a child's right to the highest attainable standard of health (expressed in Article 24) *holistically*, as this encourages the realisation of a child's right to health within the broader framework of international human rights obligations.[168] A holistic approach to health can, as Olle Hellström considers, enable an explicitly humanistic way of relating to patients, by awakening their self-knowledge and allowing professionals to acknowledge a person's 'whole picture'.[169] Understanding the purpose of puberty blocking in this way accentuates the broader benefits of PBs in relation to Articles 6, 8, and 3 of the CRC.

Assessing a young person's capacity to consent to puberty blockers

Although Kiera Bell had been considered competent to consent to PBs aged 16, the claimants' central argument was that gender diverse youth cannot weigh up the long-term risks and consequences of treatment.[170] Accepting this claim, the judges in *Bell* cast doubt on the ability of young people to consent to puberty blocking at various points in their judgment. For example, when touching upon the information GIDS provides to its patients about PBs, the court stated:

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[161] Notably, Mitchell Travis and Fae Garland reflect upon the way in which the medical profession uses temporality to prevent threats to its power/knowledge in the context of intersex children and adolescents. See M Travis and F Garland, 'Temporal Bodies: Emergencies, Emergence, and Intersex Embodiment' in M Travis et al, *A Jurisprudence of the Body* (Palgrave, 2020).

[162] J Harrington, 'Time as a dimension of medical law' (2012) 20(4) *Medical Law Review* 491–515. 193 Ibid.

[163] (2004) FamCA 297.

[164] See K Parlett and K Weston-Scheuber, 'Consent to Treatment for Transgender and Intersex Children' (2005) 9(2) *Deakin Law Review* 375–397.

[165] Notably, the social model of disability identifies systemic hurdles, social exclusion, and derogatory attitudes to disability which make it difficult for individuals to attain their valued functions. See, for example, C Barnes, 'Understanding the Social Model of Disability. Past, present and future' in N Watson and S Vehmas, *Routledge Handbook of Disability* (Routledge, 2nd edn, 2020), and M Oliver, 'The social model of disability: thirty years on' (2013) 28(7) *Disability & Society* 1024–1026.

[166] Preamble to the Constitution of the World Health Organization (WHO) as adopted by the International Health Conference, New York, 22 July 1946. Notably, this positive understanding of health provided the foundation for the UN Committee on the Rights of the Child's General Comment No 15 (2013).

[167] UN Committee on the Rights of the Child, 'General Comment No 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (Art 24)'.

[168] Ibid, at 2.

[169] O Hellström, 'Health for Healthcare. Examples from the Clinic' (1993) 14(1) *Theoretical Medicine* 325–342.

[170] Above n 7, at 144.

> 'However much information the child is given as to long-term consequences, s/he will not be able to weigh up the implications of the treatment to a sufficient degree.'[171]

These reservations, and the eight-part competency test created specifically by the High Court for puberty blocking,[172] impacts the rights of gender diverse youth in four ways. The judgment not only indicates that age markers determine capacity, it also undermines the House of Lords' decision in *Gillick*, emphasising that capacity should be assessed in a decision-specific context.[173] The legal competency test for PBs also fails to nurture a young person's capacity and undermines their right to access confidential medical advice and treatment.

Gillick competency should be assessed in a decision-specific context

Grouping together two very different medical treatments, the judges in *Bell v Tavistock* held that:

> 'The evidence shows that the vast majority of children who take PBs move on to take cross-sex hormones, that Stages 1 and 2 are two stages of one clinical pathway and once on that pathway it is extremely rare for a child to get off it.'[174]

The test in *Gillick* proposes that capacity is to be assessed in a decision-specific context.[175] It follows that a young person who is not *Gillick* competent in respect of some treatments may be competent in respect of others. This was the case in *Re JA (Medical Treatment: Child Diagnosed with HIV)*,[176] when Baker J ruled that a 14-year-old boy could consent to monitoring, psychotherapy, and peer support, but not ART medication.[177] ART medication, much like CSHs, is a more complex intervention than PBs and those specified in *Re J*.

Highlighting this distinction, the Australian Family Court in *Re Jamie*[178] rejected the appellant's assertion that stages one and two of medical transition should be addressed together, and established that the irreversible nature of CSHs[179] made it 'different' and therefore subject to a separate analysis.[211] Yet, the eight-part capacity test outlined by the judges in *Bell* contained four references to CSHs.[180] They noted, for example, that young people must understand the impact of cross-sex therapy on their sexual function[213] and that the hormone may lead to a loss of fertility.[181] The test raises concerns that future capacity assessments conducted by the courts will not be sufficiently rigorous to ascertain whether an individual can consent to PBs, focusing instead on the consequences of administering CSHs and gender reassignment surgery.

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[171] Ibid.

[172] Ibid, at 53.

[173] See V Larcher and A Hutchinson, 'How should paediatricians assess Gillick competence' (2009) 95(4) *Archives of Disease in Childhood* 307–311.

[174] Above n 7, at 136.

[175] Above n 11.

[176] [2014] EWHC 1135 (Fam), [2015] 2 FLR 1030.

[177] Ibid.

[178] [2015] FamCA 455.

[179] Ibid, at 113. The irreversible event that the court was most concerned with was that hormones would cause breast growth, and if Jamie changed her mind, she would need to undergo a mastectomy to remove the breast tissue. 211 Ibid, at 111.

[180] Above n 7 at 138. 213

Ibid.

[181] Ibid.

Age does not always correlate with capacity

In the past three decades, there has been a shift in scholarship about decisional capacity away from age to considering stage theory.[182] Research indicates that the threshold of age does not determine an individual's ability to make complex decisions,[183] particularly in adolescence.[184] Adolescence is usually characterised by the onset of puberty,[185] which usually begins between the ages of 12 and 18[186] and around the same time gender variant people seek PBs from Tavistock.[187] In *R (SB) v Governors of Denbigh High School*, [188] Baroness Hale recognised that 'important physical, cognitive, and psychological developments take place during adolescence',[189] and proposed that a person's 'capacity to acquire and utilise knowledge reaches its peak efficiency'[190] from puberty to adulthood. This concurs with Priscilla Alderson and Jonathan Montgomery's research, emphasising the cognitive capacity and moral judgements of young adolescents approximates that of adults.[191] Equally, Thomas Grisso et al's literature review reported that adolescents are no less capable than their adult counterparts in providing consent.[192]

Despite this, the judgment in *Bell* not only referred to obscure neuroscientific evidence,[193] it also grouped together capacity and age:

> 'It is highly unlikely that a child aged 13 or under would be competent to give consent to the administration of puberty blockers. It is doubtful that a child aged 14 or 15 could understand and weigh the long-term risks and consequences of the administration of puberty blockers.'[194]

This position undermines an abundance of case-law and reports demonstrating the ability of people aged 13–15 to consent to complex and uncertain medical procedures. For instance, the Law Lords in *Gillick* placed no lower limit on the scope of their test, meaning that gender non-confirming people, aged 15 and under, should not be excluded from its remit.[195] In *Re A (A Child)*,[196] the High Court upheld a 13-year-old girl's 'clear and persistent'[197] wishes to terminate her pregnancy, as she understood the options open to her, the risks attached to them and their implications.[198] Similarly, in the case of Hannah Jones, aged 13, Hereford Hospital abandoned legal action that would have forced her to undergo a potentially life-saving heart transplant against her will,[199] and a fifteen-year-old in *Re P (A Minor)*[200] was allowed

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[182] J Piaget, The Origins of Intelligence in Children (Routledge and Kegan Paul Ltd, 1953). Also see *Re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11, [1991] 3 WLR 592 in which Lord Donaldson MR appeared to suggest that *Gillick* competence is a 'developmental stage'.

[183] *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386.

[184] See J Fortin, *Children's Rights and the Developing Law* (Cambridge University Press, 3rd edn, 2009), 79–106.

[185] A Daly, *Children, Autonomy and the Courts Beyond the Right to be Heard* (Koninkijke Brill, 2018), at 183.

[186] See, for instance, N Brix et al, 'Timing of puberty in boys and girls: a population-based study' (2019) 33(1) *Paediatric and Perinatal Epidemiology* 70–78.

[187] NHS England, above nn 6, 8, and GIDS, above n 33.

[188] [2006] UKHL 15, [2007] 1 AC 100.

[189] Ibid, 93.

[190] Ibid.

[191] See P Alderson and J Montgomery, *Health Care Choices Making Decisions with Children* (Emphasis, 1996).

[192] T Grisso and L Vierling, 'Minors' Consent to Treatment: A Developmental Perspective' (1978) 9 *Professional Psychology* 412.

[193] Above n 7, at 46.

[194] Above n 7, at 151.

[195] See, for example, N Jennings, 'Forward, *Gillick*: Are competent children autonomous medical decision makers? New developments in Australia' (2015) 2(2) *Journal of Law and Biosciences* 459–468.

[196] [2014] EWHC 1445 (Fam), [2014] Fam Law 1229.

[197] K Moreton, '*Gillick* reinstated: Judging Mid-Childhood Competence in Healthcare Law: *An NHS Trust v ABC & A Local Authority* [2014] EWHC 1445 (Fam)' (2014) 23(2) *Medical Law Review* 303–314.

[198] Ibid.

[199] K Moreton, 'Reflecting on "Hannah's Choice": Using the Ethics of Care to Justify Child Participation in End of Life Decision-Making' (2020) 28(1) *Medical Law Review* 124–154.

[200] [1986] 1 FLR 272.

to consent to an abortion against her parents' wishes, after demonstrating that she was mature enough to understand what abortion means physically and emotionally.[201]

Nurturing a young person's capacity to consent to puberty blocking drugs

The High Court's reservations about the ability of young people to consent to PBs was, in the context of *Gillick*, 'the easy way out'.[202] The High Court judges glossed over capacity by describing 'the difficulty of achieving informed consent in these circumstances'[236] and placing the onus on gender variant individuals to demonstrate their ability to understand puberty blocking by fulfilling an eight-part legal assessment.[237]

The court's approach in *Bell* was, however, not novel. Children's rights scholars frequently describe judges using *Gillick* to achieve outcomes they desire.[203] Lynn Hagger, for example, suggests that *Re L (Medical Treatment: Gillick Competency)*[204] illustrates the courts' willingness to interfere with what they believe to be an unwise decision[205] on behalf of an otherwise competent person.[206] Building on this, Aoife Daly recognises that capacity is often given the 'most cursory consideration' in cases involving gender variant youth and medical transition.[207]

Examining a young person's capacity to consent to PBs is not a one-way process. It involves young capacities being nurtured by adults, through clear and lengthy dialogue and assistance.[208] This is a practice frequently used in the context of vulnerable adults.[209] Indeed, the English courts and the Mental Capacity Act 2005, section 1(3) emphasise that patients should be supported in accessing information and advice through a whole spectrum of activities.[210]Scholars, including Daly, propose that adults owe a duty to young people to maximise their capacities, and suggest that their assistance and support during decision-making can benefit young people.[211] Charles Lewis et al's study highlights the value of adults teaching young individuals decision-making, as it encourages action-oriented choices[212] and helps them become reflective decision makers, who choose to act in a manner that maintains their health.[248] These viewpoints are encapsulated in the CRC Committee's General Comment No 12 (2009):

> 'The child has a right to direction and guidance, which have to compensate for the lack of knowledge, experience and understanding of the child and are restricted by his or her evolving capacities.'[213]

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[201] Note that this case was decided prior to the landmark decision in *Gillick*.

[202] M Freeman, 'Rethinking Gillick' (2005) 13(1) *International Journal of Children's Rights* 201–217. 236

Above n 7, at 143. 237 Above n 7, at 138.

[203] A Daly, 'Assessing Children's Capacity: Reconceptualising our Understanding through the UN Convention on the Rights of the Child' (2020) 28(1) *International Journal of Children's Rights* 471–499.

[204] [1998] 2 FLR 810.

[205] D Archard and M Skivenes, 'Balancing a Child's Best Interests and a Child's Views' (2009) 17(1) *The International Journal of Children's Rights* 1–21.

[206] L Hagger, *The Child As Vulnerable Patient* (Ashgate Publishing, 2009), 32.

[207] Daly, above n 238. Daly describes the Australian cases of *Re A* (1993) 16 Fam LR 715 and *Re Alex* (2004) FamCA 297.

[208] J Cashmore, 'Children's Participation in Family Law Decision-Making: Theoretical Approaches to Understanding Children's Views' (2011) 33(4) *Children and Youth Services Review* 515–520.

[209] See, for example, L Series, 'Relationships, autonomy and legal capacity: Mental capacity and support paradigms' (2015) 40 *International Journal of Law and Psychiatry* 80–91.

[210] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430 and Mental Capacity Act 2005, s 1(3).

[211] Daly, above n 238, at 168–170.

[212] C Lewis, 'Decision Making Related to Health: When Could/Should Children Act Responsibly' in G Melton et al, *Children's Competence to Consent* (Plenum Press, 1983), 77–91. 248 Ibid, at 83.

[213] United Nations Committee on the Rights of the Child, General Comment No 12 (2009), para 84.

Nurturing young people's capacity in the puberty blocking context is particularly valuable, as non-cis people possess specialist knowledge of their gender identity and first-hand experience of living in a biologically assigned body.[214] Whilst an extensive history exists describing non-cis adults drawing on self-knowledge from gendered experience to negotiate access to medical transition,[215] a recent BBC documentary titled 'DIY Trans Teens' reports young individuals employing self-knowledge to purchase PBs online through unregulated pharmaceutical companies.[216] Reliance on online pharmacies[217] and private gender clinics,[218] as well as treatment centres located in America and Thailand,[219] is common for non-cis youth struggling to acquire puberty blocking drugs at Tavistock.[220] This form of self-knowledge accords with Priscilla Alderson's research, maintaining that young patients have unique, direct, embodied knowledge of their own case and care.[221] A concern, moving forward, is that court authorisation and prolonged waiting times at GIDS will lead this group of individuals to depend more on unregulated puberty blocking. These treatment routes may jeopardise the healthy development of young individuals, by failing to provide the necessary facilitates and medical assistance required to administer and monitor puberty blocking.[222] Self-administration and the sale of PBs online are particularly concerning, given that the drug should be prescribed at the correct dose and is often injected directly into the body.[223]

Confidential medical advice and treatment

The high threshold for the capacity required to obtain puberty blocking drugs raises issues regarding GIDS patients' access to confidential care and treatment at Tavistock Clinics. This is because the legal basis for the general duty of confidence owed to patients under the age of eighteen is obscure.[224] Although the courts in England have suggested that a duty of confidence is owed to the very young,[225] and that the obligation extends to certain types of information concerning young people's health,[226] it is unclear whether a young patient deemed insufficiently mature to understand contraceptive advice or treatment is entitled to medical confidentiality.[227]

One concern is that private information about GIDS patients will be disclosed to the courts when best interest assessments are sought by Tavistock doctors. Amongst other things, this disclosure may involve

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[214] A Alberse et al, 'Self-perception of transgender clinic referred gender diverse children and adolescents' (2019) 24(2) *Clinical Child Psychology and Psychiatry* 388–401.

[215] See J Meyerowitz, *How Sex Changed: A History of Transsexuality in the United States* (Harvard University Press, 2002).

[216] G Owen, 'New BBC Three Documentary "DIY Trans Teens" reveals how children buy sex-change drugs' (*Mail Online*, 2021), available at: www.dailymail.co.uk/news/article-9180377/New-BBC-Three-documentary-DIY-Trans-Teens-revealschildren-buy-sex-change-drugs.html, last accessed 20 May 2021.

[217] C Roberts and C Cronshow, 'New Puberty; Trans: Children, Pharmaceuticals and Politics' in E Johnson, *Gendering Drugs* (Palgrave Macmillan, 2017).

[218] K Lyons, 'UK doctor prescribing cross-sex hormones to children as young as 12', *Guardian* (2016): www.theguardian.com/society/2016/jul/11/transgender-nhs-doctor-prescribing-sex-hormones-children-uk, last accessed 20 May 2021.

[219] D Cohen and H Barnes, 'Transgender treatment: Puberty blockers study under investigation' (BBC News, 2019), available at: www.bbc.co.uk/news/health-49036145, last accessed 20 May 2021.

[220] S Shield, 'The Doctor Won't See You Now: Rights of Transgender Adolescents to Sex Reassignment Treatment' (2007) 31 *New York University Review* 361–433.

[221] P Alderson, *Children's Consent to Surgery* (Open University Press, 1993).

[222] Shield, above n 256.

[223] J Olson and R Garofalo, 'The Preipubertal Gender-Dysphoric Child: Puberty Suppression and Treatment Paradigms' (2014) 43(6) *Paediatric Annals* 132–137 and R Clemons et al, 'Long-term effectiveness of depot gonadotropin-releasing hormone analogue in the treatment of children with central precocious puberty' (1993) 147(6) *The American Journal of Diseases in Children* 653–657.

[224] In *Re C (A Minor) (Wardship: Medical Treatment) (No 2)* [1990] Fam 39, [1989] 3 WLR 252 and *Re Z (A Minor) (Identification: Restrictions on Publication)* [1997] Fam 1, [1996] 2 WLR 88.

[225] *Venables v News Group Newspapers Ltd* [2001] EWHC 32 (QB), [2001] Fam 430.

[226] Ibid.

[227] It is noteworthy that the cases of *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 and *R (Axon) v Secretary of State for Health* [2006] EWHC 37 (Admin), [2006] QB 539 held that competent children have a right to confidential care and treatment, although it remains unclear whether this right extends to incompetent minors.

information relating to young patients' medical records, sexuality, tanner stage, psychosocial distress, and gender diverse behaviour.[228] Given the sensitive nature of this information, it is surprising that there was little mention or consideration of confidentiality for gender diverse youths in the High Court's judgment. Research demonstrates that patients may be discouraged from seeking treatment if their confidentiality is not guaranteed to be respected,[229] and that people aged between 13–21 years consider privacy to be the most important factor when seeking professional advice on personal matters, including sex and relationships.[230] Breaches of confidentiality may also lead young individuals wishing to undergo pubertal blocking to consider unregulated puberty blocking.

Another issue concerning confidentiality is that court consent may disrupt trusting relationships established between Tavistock doctors and young patients. Documents published by GIDS indicate that discussions relating to gender identity and medical transition, held between doctors and young patients, can often be delicate,[231] and that a long period of time is often required for confidence to be established between professional and patient.[232] Jacques Tamin refers to this in general terms, by describing a doctor's confidential role as 'fundamental in facilitating and building this relationship of trust'.[233] It is, therefore, likely that the prospect of legal proceedings will deter young patients from disclosing information that they wish to keep private about their gender identity, preventing doctors from assessing their best interests and needs. This may especially be the case if a young individual's parents, family or peers are not accepting of their gender identity or desire to transition,[234] and where a person recognises that the risk of transphobic abuse increases when a young gender variant person's history is revealed.[235]

Parents as key holders to puberty blocking

In the past, the law governing young people's capacity to consent to medical treatment has been demonstrated through the analogy of a key unlocking a door.[236] Drawing on this, Margaret Brazier and Caroline Bridge describe a key holder as an adult patient of full capacity.[237] In the case of patients aged fifteen and under who have achieved *Gillick* competency, they refer to three key holders: the child, the court, and a person with parental responsibility.[238] Amongst other things, this 'concurrent right to consent'[239] has been employed in cases concerning the circumcision[240] and vaccination[241] of young individuals.

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[228] See S Strickland, 'To treat of not to treat: legal responds to transgender people' conference paper, Association of Family and Conciliation Courts 51st Annual Conference 2014, available at: www.familycourt.gov.au/wps/wcm/connect/af23685e3f1e-4295-a8b4-d0458cd96ec0/Speech-Strickland-Transgender+Young.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE-af23685e-3f1e-4295-a8b4-d0458cd96ec0-lNSbDkf, last accessed 20 May 2021.

[229] C Jones, 'The utilitarian argument for medical confidentiality: a pilot study of patients' views' (2003) 29 *Medical Ethics* 348–352.

[230] Ibid.

[231] See, for example, http://flipbooks.leedsth.nhs.uk/LN004504.pdf.

[232] Ibid.

[233] J Tamin, 'The doctor–patient relationship, confidentiality and consent in occupational medicine: Ethics and ethical guidance' (2015), available at: https://www.research.manchester.ac.uk/portal/files/54581682/FULL_TEXT.PDF, last accessed 20 May 2021.

[234] See *Re Imogen (No 6)* [2020] FamCA 761.

[235] Meadow, above n 150.

[236] *Re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11, [1991] 3 WLR 592, at 22. Notably, Lord Donaldson later revoked this description on consent. See E Smaranda Olarinde, '*Gillick v West Norfolk and Wisbech AHA*: The Right of Adolescents to Make Medical Decisions and the Many Shades of Grey' (2016) 54 *Journal of Law, Policy and Globalization* 13–20.

[237] M Brazier and C Bridge, 'Coercion or caring: analysing adolescent autonomy' (1996) 16(1) *Legal Studies* 84–109.

[238] Ibid.

[239] *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64.

[240] *Re J (Specific Issue Orders: Child's Religious Upbringing and Circumcision)* [2000] 1 FLR 571 and *Re S (Specific Issue Order: Religion: Circumcision)* [2004] EWHC 1282 (Fam), [2005] 1 FLR 236.

[241] *F v F (MMR Vaccine)* [2013] EWHC 2683 (Fam), [2014] 1 FLR 1328.

Although one of the claimants in *Bell v Tavistock*, Mrs A, described concerns about puberty blocking from the perspective of a parent,[242] neither the claimants in proceedings, nor the court in the judgment, sufficiently considered parents as key holders.[243] In both the judgment and the subsequent order,[244] Sharp, Lewis, and Lieven JJ explained that it was not necessary to consider parental consent when reaching their conclusions since GIDS explained that it:

> 'Has never administered, nor can it conceive of any situation where it would be appropriate to administer blockers on a patient without their consent.'[245]

This position concurs with NHS England's Service Specification, which states that patients under fifteen must obtain support from family/carers,[246] and post-pubertal people and/or aged fifteen and over must receive support from one or both parents/carers.[247]

Whilst it will always remain optimal for a young individual to be involved in their own care and provide consent to treatment themselves,[248] it was surprising that the court in *Bell* did not consider parental consent as an alternate route for Tavistock patients accessing blockers, given the judges' reservations about young people's ability to consent to PBs,[249] the high threshold capacity assessment,[250] and their calls for individuals under sixteen, as well as some people aged 16 and 17, to apply for best interest orders.[287] This concern was, however, recently addressed by the High Court in *AB and CD and The Tavistock and Portman Foundation Trust and University College London NHS Foundation Trust and XY*,[251] when Mrs Justice Lieven DBE held that:

> 'A parent's right to consent to treatment on behalf of their child continues even when the child is *Gillick* competent to make the decision, save where the parents are seeking to override the decision of the child.'[289]

The *XY*[252] judgment is a welcome development in the case-law post-*Bell*. It will provide a proportion of patients, presenting at GIDS, the opportunity to undergo puberty blocking – a prospect that would have been unachievable under the Service Specification.

The role created for parents in *XY* should be developed to be commensurate with Article 5 of the CRC, which directs State Parties to respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community to provide appropriate *direction* in the exercise of the child's rights.[291] Parents should take up a supportive and neutering role, assisting their child with accessing and understanding information about puberty blocking, whilst explaining how

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[242] Above n 7, 89.

[243] Ibid, 47.

[244] *Order by Lord Justice Lewis and Mrs Justice Lieven in the matter of an application for Judicial Review Quincy Bell Mrs A v The Tavistock and Portman NHS Trust* (2020), available at: https://mermaidsuk.org.uk/wp-content/uploads/2020/12/ 3044050-Order-by-Lord-Justice-Lewis-and-Mrs-Justice-Lieven-01-12-20.pdf.

[245] Above n 7, at 47

[246] Above n 6. This criteria required parental consent to be sought and attained, and that informed consent be demonstrated by the young person prior to the administration of PBs.

[247] Notably, the Service Specification states that 'work must have been done to develop the parents' understanding of PBs and its potential advantages and disadvantages'.

[248] See, for example, V Lacher, 'Consent, competence, and confidentiality' (2005) 330 (7487) *British Medical Journal* 353–356.

[249] Above n 7, at 151.

[250] Ibid, at 138. 287

Ibid, at 54.

[251] Above n 23. 289

Ibid, 114.

[252] Ibid. 291

Ibid.

treatment will impact their life. From the perspective of a trans man, Evan Urquhart recognises that parental objection to gender diversity can result in long-term harm to parent–child relationships and proposes that parents' beliefs and actions should manifest acceptance, possibility, and self-actualisation:

> 'Parents can let their child know they will be just as loved whether they're a boy, a girl, or neither of those two. Instead of obsessing about the risks of a wrong medical choice, they can help their child understand the risks and benefits of every option, slowing them down if necessary but all the while guiding them toward well-informed decisions.'[253]

Parental direction should, however, be carried out in a manner consistent with the evolving capacities of the young person and have regard to guidance given by young individuals.[254] Shelia Varadan acknowledges that the term 'evolving capacities' has an *enabling* function, informing parents how to provide guidance and direction to their children.[255] This function is touched upon in the Committee on the Rights of the Child's General Comment No 7 (2005), which proposes that Article 5 should be understood as 'a positive and enabling process, supporting the maturation, autonomy, and self-expression of the child'[256] and urging parents to 'take account of a child's interests and wishes as well as the child's capacities for autonomous decision-making and comprehension of her or his best interests'.[257]

Nevertheless, concerns remain about those who are not able to obtain support from an adult with parental responsibility.[258] Without this key holder, a person under the age of eighteen will be unable to unlock the door to consent and undergo puberty blocking, as the Service Specification states that young patients *must* have support from parent(s).[259] It is estimated that around half of the non-cis population are 'keyless',[260] and thus unable to be considered suitable for PBs. Arguably, this group are at a greater disadvantage to young non-cis individuals who obtain support from a parent(s), because they have no adult monitoring their physical and psychosocial health at home, nor a parent helping them travel to medical appointments.

Involving young people in decisions about delaying their puberty blocking

There are concerns about young non-cis people's involvement in the litigation thus far and in future best interest applications. Their lack of involvement is perhaps best exemplified by the fact that the proceedings in *Bell v Tavistock* were brought by two adults who succeeded in transposing their own beliefs and experiences of paediatric medical transition onto gender identity services for people aged seventeen and under. Whilst witness testimony was provided by one young person, named 'S',[261] adult voices and views dominated proceedings and the judgment handed down by the High Court. S, aged 13

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[253] E Urquhart, 'My Parents Still Struggle to Know Me After I Transitioned Late' *The Atlantic* (4 July 2018): available at: https://www.theatlantic.com/family/archive/2018/07/transition-parents/564008/, last accessed 20 May 2021.

[254] Ibid.

[255] S Varadan, 'The Principle of Evolving Capacities under the UN Convention on the Rights of the Child' (2019) 27 *International Journal of Children's Rights* 306–338.

[256] UN Committee on the Rights of the Child, General Comment No 7 (2005), para 17.

[257] Ibid.

[258] S Dubin et al, 'Medically assisted gender affirmation: when children and parents disagree' (2019) 46(5) *Medical Ethics* 295–299.

[259] Ibid, n 6.

[260] In B Seibel et al, 'The Impact of the Parental Support on Risk Factors in the Process of Gender Affirmation on Transgender and Gender Diverse People' (2018) 12(9) *Frontiers in Psychology* 1–9, study 29% of the sample answered that their parents did not support their non-cis status, and 20% answered that their parents supported their status a little. Similarly, half of the respondents in The Metro's 'Young Chances Study' stated that they have not told their parents that they are trans. See, Metro, 'Youth Chances: Integrated Report' (2016). Available at: https://metrocharity.org.uk/sites/default/files/ 2017–04/National%20Youth%20Chances%20Intergrated%20Report%202016.pdf, last accessed 20 May 2021.

[261] Above n 7, at 87.

years, is described in *Bell* as a patient currently awaiting treatment at GIDS.[262] With the assistance of his parents, S decided that a two-year wait for PBs was too lengthy and sought private treatment through Gender GP.[263] In an order following *Bell*, Lewis J and Lieven J stated that S's testimony meant that 'the voice of the child, and this particular child, was heard'.[264] It is surprising that the judges found S's testimony to be sufficient, given there are around 3,000 young people referred to GIDS annually,[265] each with their own unique set of needs[266] and views about puberty blocking.[267]Since the decision in *Bell v Tavistock* concerned a matter exclusively affecting non-cis youth, a larger proportion of this group should have been called upon to articulate and express their own wishes directly to the court. This action would have been commensurate with what Baroness Hale described in *Re D (A Child) (Abduction: Rights of Custody)*[268] as 'a growing understanding of the importance of listening to children involved in children's cases',[269] as well as her recognition that:

> 'It is the child more than anyone else who will have to live with what the Court decides. They are quite capable of being moral actors in their own right, just as the adults may have to do what the Courts decide whether they like it or not, so may the child.'[270]

It is also problematic that Mrs A's concerns were based upon her child's treatment at Tavistock, and yet the views and voice of this person were overlooked. Along with other young patients, testimony from this individual could have illustrated their lived experience of gender nonconformity and treatment at GIDS. In *Re Alex*,[271] for example, evidence submitted to the court on behalf of Alex demonstrated his severe bodily distress and eagerness for stage one and two of medical transition to commence.[272]

The outcome of *Bell* and revisions to GIDS policy have eroded the involvement of under sixteens in decisions about their pubertal blocking. When PBs were regulated by NHS England's Service Specification, young patient involvement was at the centre of decision making. Indeed, one of the stated objectives of the Service is to 'promote the development of autonomy'.[312] Whilst it is important in all medical treatment contexts that young patients are involved in decisions regarding their own care in a meaningful way, it is vital that those presenting at Tavistock are involved because involvement identifies a non-cis person's individual needs.

Domenico Di Ceglie illustrates the diverse needs of non-cis youth by describing Ai Weiei's installation of seeds at the Tate Modern in London:

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[262] Ibid.

[263] Notably, the GP involved in treating S was removed from the professional register and now operates from outside the United Kingdom. See: www.thetimes.co.uk/article/online-clinic-ignores-ruling-on-puberty-blockers-q8mjwsn38, last accessed 20 May 2021.

[264] Above n 280, ground 9.

[265] Ibid, n 4.

[266] See, S Price Minter, 'Supporting Transgender Children: New Legal, Social, and Medical Approaches' (2012) 59(3) *Journal of Homosexuality* 422–433.

[267] Some young gender diverse people share wide ranging views regarding PBs on online discussion sites, such as Gender Spectrum, The Trevor Project, The Tribe, and Trans Lifeline.

[268] [2006] UKHL 51, [2007] 1 AC 619.

[269] Ibid, at 57.

[270] Ibid.

[271] Above n 194.

[272] See F Bell, 'Children with Gender Dysphoria and the Jurisdiction of the Family Court' (2015) 38(2) *University of New South Wales Law Journal* 426–450. 312 Above n 6, at 12.

> 'This extensive mass of seeds (120 million) seen at a distance looks uniform and undifferentiated, but as one looks a bit more closely, the individuality of each seed becomes more and more evident. There are no two seeds which are the same.'[273]

The variety of seeds is comparable to young gender diverse people; all presenting differently within the same category, but not as part of a stereotype.[274] This diversity extends to the needs of young patients, which Edmund Horowicz describes as complex and requiring robust and individualised assessment.[275] Patient involvement is an effective approach to ensuring patient needs and requests for additional support from services, such as CAMHS, are recognised.[276]This purpose of involvement in this context closely aligns with the Committee on the Rights of the Child's General Comment No 12 (2009),[277] highlighting a complementary role between Articles 12 and 3:

> 'One establishes the objective of achieving the best interests of the child and the other provides the methodology for reaching the goal of hearing either the child or the children. In fact, there can be no correct application of Article 3 if the components of Article 12 are not respected. Likewise, Article 3 reinforces the functionality of Article 12, facilitating the essential role of children in all decisions affecting their lives.'[278]

Children's rights researchers, including Daly, emphasise the benefit of autonomy to young people's well-being.[279] Similarly, a wealth of research demonstrates that patient involvement improves young people's self-esteem,[280] emotional functioning,[281] and life satisfaction.[282]

Although there are many frameworks theorising involvement,[283] Laura Lundy's Model of Child Participation is perhaps the most renowned and useful in demonstrating the wider implications court interference has for patient involvement.[284] Lundy's model proposes that the fulfilment of Article 12 requires space, voice, an audience, and influence.[285] That is, young people have the space to express their views; their voice is enabled; they have an audience for their views; and their views have influence.[286] There are concerns that the court environment does not provide sufficient space for involving Tavistock patients. This space should be, as Lundy notes, safe and inclusive, so that a young person may express themself freely.[287] Nevertheless, information concerning an individual's gender identity can be deeply personal and cause distress when shared openly in a public setting, such as a court. The model, along with Article 13 of the CRC, suggests that young individuals should be given appropriate information to facilitate the expression of their views. The court did not, however, consider

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[273] D Di Ceglie, 'The use of metaphors in understanding atypical gender identity development and its psychosocial impact' (2018) 44 (1) *Child Psychotherapy* 24.

[274] Ibid.

[275] E Horowicz, 'Rethinking "need" for clinical support in transgender and gender-non confirming children without clinical classification: Learning from "the paper I almost wrote" ' (2020) *Bioethics* 1–9.

[276] Alderson and Montgomery, above n 224.

[277] The UN Committee on the Rights of the Child, General Comment No 127 (2009), para 74.

[278] Ibid.

[279] Daly, above n 218, at 131–135.

[280] E Deci and R Ryan, 'Human Autonomy: The Basis for True Self-Esteem' in M Kerris, *Efficacy, Agency and Self-Esteem* (Plenum Press, 1995).

[281] Y Hasebe et al, 'Parental Control of the Personal Domain and Adolescent Symptom of Psychopathology: A Cross-National Study in the United States' (2004) 75 *Child Development* 815.

[282] I Butler et al, *Children and Decision Making* (Jessica Kingsley Publishers, 2005), 75.

[283] See, for example, R Hart, 'Children's Participation in Planning and Design' in C Weinstein and T David, *Spaces for Children* (Springer Boston, 1997), J Roche, *Youth in Society: Contemporary Theory, Policy and Practice* (Sage Publications, 2nd edn, 2004), and N Thomas, 'Towards a Theory of Children's Participation' (2007) 15(2) *International Journal of Children's Rights* 199–218.

[284] Lundy, above n 26.

[285] Ibid.

[286] Ibid.

[287] Ibid.

what information about PBs would be made available to Tavistock patients during judicial proceedings, or how it would be delivered to them in a comprehensible way. Scholars including Gill Brooks,[288] Linda Milnes et al,[289] and Priscilla Alderson and Jonathan Montgomery,[290] offer practical frameworks for information sharing with young patients in health care settings. Alderson and Montgomery's model, in particular, proposes that patients should receive information regarding their condition, the purpose, anticipated benefits, and nature of the treatment, and the risks involved which may cause the patient harm and inconvenience. The judges' lack of experience in gender identity and treating gender variance, along with the little regard for young people's views in the capacity assessment set out in *Bell*, raises questions about the court as an appropriate forum for determining young people's access to such gender affirming treatments. Moving forward, there are concerns that young people's views will not be taken seriously, or acted upon, during court proceedings. Importantly, the High Court's capacity evaluation does not refer to the views of non-cis persons at any point. There is also no consideration for how the courts will proceed with feedback explaining the reasons for the outcome of future best interest orders, excluding non-cis youth from decisions about puberty blocking altogether.

Conclusion

The High Court's decision in *Bell v Tavistock* and the consequent amendments to GIDS Service Specification limits young people's access to PBs and CSHs. It is now necessary for every young person under the age of 16 to acquire court approval prior to puberty blocking. Individuals aged 16–17 are also required to obtain an order from the High Court if Tavistock doctors are uncertain about their best interests. The dominance of adult views and voices in *Bell* left little regard for non-cis children's rights. This disregard was perhaps best characterised by the fact only one young Tavistock patient shared their experiences of puberty blocking during proceedings. The visibility of these rights in the judgment is disconcerting, since puberty blocking is a medical treatment used exclusively by individuals under eighteen to carve out a sense of identity and maintain their health. The role of the High Court in classifying PBs as 'experimental'[291] and 'very unusual treatment'[292] is also questionable. Blockers have been an established part of medical practice at GIDS, and other gender clinics, for over a decade. The court's narrow interpretation of health meant that the High Court's judgment failed to consider the implications of treatment and non-treatment on Articles 3, 6 and 24 of the CRC. Categorising PBs and CSHs as a medical pathway undermines the House of Lords' direction in *Gillick*,[293] which states that young people's capacity must be assessed in a decision-specific context. Similarly, classifying capacity by reference to age overlooks an abundance of research, reports, and case-law demonstrating the ability of individuals aged 13–15 to consent to complex and uncertain medical procedures. Glossing over capacity, the judges detailed young people's mental inabilities and overlooked methods to nurture a person's ability to consent to puberty blocking drugs. The ruling in *Bell v Tavistock*, as well as the amendments to GIDS policy, is likely to impact Tavistock patients' right to confidential advice and treatment. Breaches of confidence can result in young people accessing blockers through unregulated services, risking their health and development. Another means of accessing PBs was barred when the court refused to consider parents consenting to their child's puberty blocking. Although it remains optimal for an individual to consent to their own treatment, Article 5 of the CRC may provide a role for parents in the wake of in *AB and CD and The Tavistock and Portman Foundation Trust and University*

[288] G Brooks, 'Children's competency to consent: A framework for practice' (2000) 12(5) *Paediatric Nursing* 31–35.
[289] L Milnes et al, 'Developing an intervention to promote young people's participation in asthma review consultations with practice nurses' (2012) 69(1) *Leading Global Research* 91–101.
[290] Alderson and Montgomery, above n 224.
[291] Above n 7, at 134, 143, 148, and 152.
[292] Ibid.
[293] Above n 11.

College London NHS Foundation Trust and XY.[294] Above all, non-cis youth should be involved in decisions about their own puberty blocking. Given the changes to the way in which PBs are regulated, it is unclear how young patients will be meaningfully involved in future best interests orders. Patient involvement, in this context, can ensure that a person's needs are identified. Looking ahead, there is optimism that the Court of Appeal will consider the impact of the High Court's ruling in *Bell* on children's rights, specifically in the context of health, capacity, and involvement.

[294] Above n 23.