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Gendered Childhoods, Linear Sex Development and Unruly Temporalities

This article addresses a growing social and legal debate around healthcare provision for gender diverse children. Temporality is used as a theoretical lens to highlight how biological determinism has informed legal approaches to gender diverse children in a series of recent cases. In these cases accounts of sex and gender as temporally linear are troubled by gender diverse children whose gender does not arise 'inevitably' from their sex. The Court's reaction to this conflicts with recent shifts in healthcare which have begun to reframe the temporal pathways from childhood to adulthood away from singular towards multiple futures where gender is capable of being both 'paused' and 'reversed'. Law's commitment to 'linearity' and 'permenance' in its conceptions of the temporality of childhood are a key but emerging locus in the reinforcement of heteronormative temporalities downplaying contemporary harms to the child in favour of speculative *future* harm.

Introduction

This article takes place at an important moment in the political construction of sex and gender. There has been a growing political and social debate around the concept of 'sex-based rights' or 'gender critical' beliefs that have typically focussed on sex segregated spaces such as toilets, refuge shelters and sports facilities (Cooper 2022, Cooper and Renz 2016, Renz and Cooper 2022, Renz 2023, Cowan and Morris 2022, Butler 2021, Pearce, Erikainen and Vincent, 2020, Hines 2020, Sharpe 2020, 2016). In the context of children these debates have centred on gender diverse[1] children but have failed to centre their needs and experiences instead focussing on an abstract concept of 'ideal' childhood (Edelman 2004, Halberstam 2005, Griffiths 2021, Chau 2022). In this article we seek to reorient this discussion to better respond to the experiences of gender diverse children. In order to do so we utilise temporality as a theoretical lens to reveal how the social and political constructions of sex and gender in 'sex-based rights' arguments are underpinned by a commitment to heteronormativity, biological determinism and 'gender destinies'. Gender critical arguments are characterised by their denial of agency and autonomy to children in favour of reliance upon idealised accounts of physiological, social and psychosocial development that fall along heteronormative lines (Stock, 2021, 2022, Joyce,

[1] We are using the term 'gender diverse' in relation to children who are either questioning their gender or seeking medical interventions (such as puberty blockers and cross sex hormones) in order to change their gender. Many of these children will go on to become trans but this is term is also capable of including children who do not go on to become trans, detransition or who's gender questioning leads them to accept themselves as cisgender.

2021, Lawford-Smith 2023). These 'common sense' accounts rely upon heteronormative claims to potential future harms whilst concomitantly downplaying the very real harms that are taking place in the present (Stock, 2021, 2022, Joyce, 2021, Lawford-Smith 2023).

In this article we trace how these sex-based rights approaches resonate and are reinforced in *legal* conceptions of temporality, gender and childhood focusing on the case of *Bell v Tavistock* [2020] EWHC 3274 where the judiciary expressed concern towards the timing of puberty blockers and cross sex hormones administered to adolescents under the age of 18. Despite the Court of Appeal (CA) reversing this decision in *Bell* v *Tavistock* [2021] EWCA Civ 1363, we argue that the *reasoning* within the High Court (HC) remains live ground through which to examine law's temporal understandings of childhood and the resonance it has with sex-based rights arguments. Notably, *Bell* is significant as it marks the first moment where law has actively challenged healthcare's role in regulating sex and gender in childhood. We argue that this approach is predicated on law's continuing perpetuation of a conservative account of sex and gender within childhood. Law's selective deferral to healthcare is thus contingent upon its own heteronormative construction of sex development.

To make this point, this paper identifies four important observations arising from the case. Firstly, gender critical views and law find common ground in the construction of sex development as a linear universal process. Under such an account gender is thought to rise in a predictable and inevitable way from sex. Sex is thus the primary basis for determining gender. This temporal account of sex and gender is therefore troubled by gender diverse children whose gender does not arise 'inevitably' from their sex. The nature of this 'troubling' is deeply temporal and is demonstrated through disagreements between the medical professionals and the judgment itself. Whilst the medical professionals saw puberty blockers as a 'pause' in sex development, the judiciary were convinced by the claim grounded in sex-based rights that sex development was constant and could not be suspended. Secondly, whilst clinicians were confident that the effects of puberty blockers could be reversed the judiciary chose to understand progression onto cross-sex hormones as inevitable and thus saw the effects of puberty blockers as permanent. Thirdly, whilst medical professionals saw capacity to consent as capable of being tailored to the individual the HC departed from the decision in *Gillick* to offer an understanding of capacity that was grounded in calendar time. Finally, the Court failed to consider the contextual backdrop of this case – particularly the institutional structuring effect of the Gender Identity Development Service (GIDS) 22-26 month waiting list and its effect on the persistence rate of children moving from puberty blockers to cross-sex hormones at the age

of 16. In our conclusion we highlight how law's temporal construction of childhood shares conceptual ground with same-sex rights approaches. By examining the heteronormative assumptions that undergird this construction of temporality we hope to offer another method of disrupting and challenging their grip on this area of law and policy.

Temporality, Childhood and Gender

Childhood as a Temporality

Time is a measurement through which we measure change or duration and is usually depicted as progression into the future while present events are continuously relegated to the past (Greenhouse 1989). In contrast, temporality refers to the way in which time is produced or constructed through institutions (Chowdhury 2020, McNeilly 2019, 2021, Grabham 2010, 2016, Harrington 2016). Under these accounts time is polyvalent and contingent upon the institution in which it is embedded and the individual who experiences it. As such bodies can be understood temporally where experiences and understandings of time are pluralistic and context dependent. Institutions, such as healthcare, the law or the family, in which bodies are continuously embedded and reliant, generate multiple modes of temporality that are crucial to the ways that bodies are understood within society (Garland and Travis 2020a).

One important temporal construction within western society is that of the 'child'. Childhood is a temporality specifically constructed within law, healthcare and other institutions. Even if we attempt to understand childhood purely in terms of duration, we immediately encounter its multiplicity. For example, in law, childhood lasts from birth until the age of full majority - 18 in the England and Wales[2] - whereas scientific literature suggests that puberty may last until mid-twenties as dopamine levels regulate (National Academies of Science et al 2019). The construction of childhood also determines the way in which that time is experienced. For example, childhood is depicted as a period where the 'child' needs protection or restraint (Herring 2019: 439; Edelman 2004) due to a lack of sufficient cognitive ability, life experience and general maturity.[3] Consequently, children are considered to lack the emotional and intellectual capacity to make informed decisions relating to various aspects of their lives.

[2] Section 105(1) Children Act 1989 defines a child as 'a person under the age of eighteen'.
[3] See also Edelman (2004) for a distinction between actual children and the concept of the child often mobilised in politics.

Adulthood is positioned as a counterpoint to childhood where we expect individuals to not only be physically mature, but able to make reasoned and informed decisions relating to all aspects of their life. While the age of adulthood may be locally or temporally situated, the progression from childhood to adulthood is culturally typically depicted as a linear pathway towards competence. This progression from childhood to adulthood is marked by greater levels of autonomy and responsibility. For example, children are criminally responsible from the age of 10;[4] have increasing capacity to consent to healthcare;[5] can take up part-time employment at 13; can join the army at 16;[6] and make contracts before they officially enter the age of adulthood. The age of consent to marriage has recently risen from sixteen to eighteen perhaps reflecting a changing understanding of capacity and childhood in law, [7] although the age of sexual consent remains 16.[8] Crucially for decisions around healthcare in the England and Wales, *Gillick* confirmed that capacity to consent is not based on a set standard of time but is assessed on a case-by-case basis of the child's increasing maturity, or 'competence,' to make decisions for themselves in some ways highlighting a medical *disavowal* of universal and linear accounts of children's development.[9] As Lord Scarman stated in *Gillick*:

> If the law should impose upon the process of "growing up" fixed limits where nature knows only a continuous process, the price would be artificiality and a lack of realism in an area where the law must be sensitive to human development and social change. (per 186A – 186C)

While the age of full majority may be deemed to officially begin after a set number of calendar years, recognition of capacity may happen at different times in different institutional spaces. In contrast, some adults are deemed to be lacking capacity and have their decision making restricted by the state or institutions. For specific decisions their best interests may be determined by others, including the courts. These adults have been described as being kept in a state of 'permanent childhood' again highlighting *childhood as a temporality* rather than as a set amount of time (Fox, Thomson and Warburton 2020).

[4] S. 50 Children and Young Persons Act 1933
[5] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 provides that children can consent to treatment where they have sufficient age and maturity. At 16, children can consent to medical treatment as if they were 18 per s.8 Family Law Reform Act 1969.
[6] With parental consent.
[7] The Marriage and Civil Partnership (Minimum Age) Act 2022 amends s. 2 Marriage Act 1949 to increase the minimum age of marriage from 16 to 18.
[8] Section 9 Sexual Offences Act provides that a child for the purposes of the criminal offence of sexual activity with a child is a person under the age of 16.
[9] At least until 16 see n.3.

Nevertheless, cultural and institutional depictions of the move from childhood to adulthood often construct it as a set, linear process of development. This characterisation fits with notions of time common to western liberal societies that are built upon notions of 'progress' (Greenhouse 1989: 1638). In these societies, time is seen as objective, neutral and, crucially, linear. Certain temporalities, such as child development, for example are thus given normative weight and characterised by society as 'natural' (Edelman 2004). The gendered nature of these normative temporalities are highlighted by Emily Grabham, for example, who draws attention to: "the supposedly 'normal' timeline of childhood, puberty, courtship, marriage, children and retirement, from which we all deviate to greater or lesser extent during our lives…." (Grabham 2014:73). In the next section we examine in greater detail the links between sex, gender and childhood.

Sex, Gender and Child Development

An important aspect of childhood in the West is the appropriate development of gender over time. In terms of the law in England and Wales, for example, the Births and Deaths Registration Act 1953 requires that sex is ascribed to children within the first 42 days of their life. Sex is recorded on birth certificates, passports and other state documentation (Cooper and Renz 2016). Other than this, at least in terms of *legislation* or even case law[10] the state has taken a relatively hands-off approach to the regulation of gender in childhood, until recently.[11] This State silence foregrounds the idea that gender is biologically determined by sex and thus there is no specific *need* to engage with gender in childhood; such an account is premised on the idea that gender arises from sex development as an inevitable, linear process.

This is not to say that gender in childhood is not regulated; rather it has fallen to other institutions and social interactions such as healthcare and education. Healthcare and, in particular, psychology has taken an active role in determining and regulating the proper development of sex and gender in childhood partly in an effort to understand and intervene where children distort either potentially or in fact the heteronormative temporal pathways to adulthood.

[10] There are next to no cases on Gender diverse children and medical treatment until *Bell v Tavistock* [2020] EWHC 3274, [2021] EWCA Civ 1363 and *AB* v *CD & Ors* [2021] EWHC 741 (Fam).

[11] The Gender Recognition Act 2004 sets out the State's regulatory framework for gender recognition of adults. Individuals may not apply for a gender recognition certificate until they are at the age 18. We return to the recent legal engagement with sex and gender in childhood below.

Within the field of psychology, appropriate gender formation has been strongly linked to timeframes. John Money, for example, insisted that "age eighteen months was the temporal limit for deciding which gender a child would be raised, since during this period gender identity and role should be stabilized…." (Meoded Danon 2018:91). Sex, plays an important part in the creation of what Timmermans et al call "gender destinies" (Timmermans et al 2019). These destinies are culturally determined *destinations* of gender based on normative sex and gender development. Importantly, such gendered destinies are constructed as an inevitable, linear, natural process that is predetermined and predestined. As Timmermans et al write in relation to intersex children:

> Gender destinies capture that gender is simultaneously natural, in the sense that the child always had a specific, innate gender awaiting discovery and constructed, in ways that render the assigned gender a project for medical and social monitoring, intervention, correction and optimisation. The term does not imply that gender is make-believe, but that for children with intersex traits gender is, quite literally, made real. The biomedical gender imaginaries combined with the idea that the child is destined for a gender provide a medical rationale that absolves clinician and parents from making the "wrong" choice." (Timmermans et al 2019:1522)

The healthcare response to these children highlights the cultural entrenchment of 'gender destinies' and medicine's role in the regulation of sex and gender – often at the expense of the autonomy and bodily integrity of these children (Garland and Travis 2023, Fox and Thomson 2017). For gender diverse children, however, healthcare has been much more grounded in patient autonomy. With strong medical oversight, it is possible for gender diverse minors to access interventions, such as the administration of gonadotropin-releasing hormone agonists (GnRHa) or 'puberty blockers' once the child has reached Tanner Stage 2.[12] These 'puberty blockers' (PBs) suppress the onset of physical developments triggered by changes in hormone levels that would otherwise occur during puberty. In England, these have been available through NHS England to children with gender dysphoria as young as 10 to pause puberty and give the child time to consider their options (NHS England 2017) while gender-affirming interventions were not available until 16 for cross-sex hormones and 18 for surgeries. Pre-*Bell,* this was in line with international guidelines (WPATH 2011) although the World Professional Association for Transgender Health has recently released Version 8 of its Standard of Care (WPATH 2020). This version introduces radical changes to the provision of gender care for minors, including the removal of age restrictions on medical interventions (WPATH 2020).

[12] Stage 2 is characterised by the beginning of physical development. It is based on hormonal development.

These international guidelines have not yet (and may never be) adopted by NHS England. Indeed, the post-*Bell* 'Cass Review' conducted by NHS England points towards a more stringent approach to the use of puberty blockers with greater emphasis on assessment procedures and written evidence of informed consent (Cass 2022: 45).

Healthcare, at least at the time of the review, offered anapproach for gender diverse children which allowed the possibility of separating biological sex from their gendered development. The Tavistock Clinic's institutional account of sex and gender development in childhood thus appears non-linear in the context of gender diverse children partly because gender care for gender diverse children is motivated by the lived experiences of children (Garland et al 2023, 3). However, the heavy policing to authenticate gender diverse children's experiences reveals the underlying presumption of linear gendered destinies. Gender diverse children therefore must pass stringent clinical standards to receive a diagnosis of gender dysphoria as well as evidence of having *Gillick* capacity (Cave 2014), which is already recognised as being higher than that of adults given that adults are presumed to have capacity whereas children must demonstrate this (Cave 2014; Moreton 2020; Garland et al 2023).[13] Consequently, there is heightened level of scrutiny of gender diverse children to ensure that the desired gender is their 'true' gender and that children are prevented from making a 'wrong choice' (Chau 2022; Garland et al 2023). Indeed, strong concerns about 'regret' and the 'wrong choice' have fuelled socio-political debates regarding gender care (Slothouber 2020; de Vires et al 2021; Chau 2022; Garland et al 2023). Indeed, these form an important aspect of the Cass Review (2022).

The heightened scrutiny attached to gender affirming care mirrors a broader cultural rise in sex-based rights arguments and commentators. As Liz Truss stated in her capacity as Minister for Women and Equalities stated in 2020 in relation to the Gender Recognition Act, the need for:

> making sure that the under 18s are protected from decisions that they could make, that are irreversible in the future. I believe strongly that adults should have the freedom to lead their lives as they see fit, but I think it's very important that while people are still developing their decision-making capabilities that we protect them from making those irreversible decisions. (Truss 2020)

[13] Indeed, the threshold of capacity increases with the severity of decision-making thus making it difficult for children to refuse treatment.

This example highlights the way that 'sex-based rights' arguments operationalise heteronormative expectations to articulate 'harm' in such a way as to deny gender diverse children agency and autonomy. These commentators tend to position themselves as concerned "whistle blowers" (Joyce 2021: 94) focussed on ensuring the best outcomes and interests for children.[14] Helen Joyce has similarly noted that:

> All in all, gender affirmation not only locks in persistence but creates trans adults who have lost fertility and sexual function, and exposed themselves to unknown health risks, in return for passing better. And those trade-offs are being made, not by adult trans people in full awareness of the risks, but in childhood, when parents and clinicians decide to socially transition children…. (Joyce 2021: 109)

Lawford-Smith has likewise commented that "Kids who consider themselves trans are at risk of being put on a conveyor belt to a lifetime of medical dependency" (Lawford-Smith 2023: 102). Gender critical accounts take the view that most gender diverse children are going through a phase that they will grow out of over time (Joyce 2021: 96, Lawford Smith 2023). As Joyce insists "The majority of children will desist if not affirmed…." (Joyce 2022: 105). Instead of affirmation, Stock argues gender diverse children should be continually reminded of their biological sex "no matter how distressing they immediately find the information" (Stock 2022: 40). As they continue "Being reminded of their sex, which cannot be changed, is essential to informed decision-making about whether to pursue a medical pathway and thereby alter their bodies irrevocably" (Stock 2022: 40). By affirming, rather than challenging these children's gender, well-meaning parents and clinicians are 'causing' these children to be trans – and, for sex-based rights approaches, this is the explanation for the huge growth in gender diverse children trying to access healthcare and support (Joyce 2021: 93, See the Cass Review 2022 for Confirmation of this rise in England). As Lawford-Smith writes, "This medicalization doesn't *treat* trans people, it *creates* trans people" (Lawford-Smith 2023: 100). Heteronormative expectations around fertility and parenthood (Joyce 2021: 109) are used as justifications to push gender diverse children in directions which correspond with parental expectations of sex-based gender destinies. These approaches are increasingly uncritically reproduced by both law and the mainstream media focussing on 'irreversibility', 'permanence' and lack of capacity for decision making.

[14] This rhetoric is similar to that which Edleman (2004) identified as an abstracted ideal used to shut down political debate and decentre the voices of real children.

Legal Engagement With Sex/Gender

As aforementioned, at least until *Bell* v *Tavistock*, Law has not engaged with the regulation of sex/gender in childhood other than the requirement to record sex as part of birth registration process.[15] Unlike the adult context,[16] England and Wales has no statutory framework regulating gender in childhood and prior to *Bell*, there had been no case law relating to a child's ability to consent to hormonal interventions for gender dysphoria.[17]

Until recently, law has thus aligned with the medical approach to sex and gender in childhood. However, in the context of gender diverse children, a recent judicial review case of *Bell v Tavistock* heard in the High Court [2020] EWHC 3274 and the Court of Appeal [2021] EWCA Civ 1363 has seen, for the first time, law challenging the legitimacy of healthcare and its emphasis on gender affirming care. Such a challenge represents an important turning point in the jurisdictional construction of healthcare for gender diverse children as an issue of medical discretion to one that requires legal oversight (Garland and Travis 2020b; Garland et al 2023). In the absence of prior legal engagement, *Bell* thus provides important insight into the way in which law conceives gender and childhood. The next section sets out the proceedings in *Bell* before considering the way in which temporality and biological determinism has featured in judicial decision-making. Significantly, the High Court (HC) issued a declaration setting out a high bar for what would be required for informed consent in these circumstances. In doing so, the Court suggested that it would be highly unlikely that gender diverse children would be able to consent to the administration of puberty blockers and thus treatment could only proceed with court authorisation. While this decision has since been overturned by the Court of Appeal (CA), we argue that the reasoning in the HC remains live ground in which to examine law's temporal understandings of childhood and the resonance it has with sex-based rights arguments. Importantly, we contend that law's breakaway from medicine in the context of gender care for minors represents an attempt to reaffirm conservative heteronormative norms and tighten the policing of sex and gender within childhood. *Bell v Tavistock*

[15] See n.11 above. Although note there has been historic recognition of intersex within law. See Sharpe (2009) and Garland and Travis (2023).
[16] The Gender Recognition Act 2004 provides a statutory framework for individuals over 18 who wish to affirm their gender.
[17] The only case that had really considered gender was Re J (A Minor) [2016] EWHC 2430 (Fam). This case was not about consent, but rather dealt with childcare arrangements involving a parent who forced her son to live as a girl.

Bell v *Tavistock* was a judicial review that arose in relation to the aforementioned prescription of 'puberty blockers' to persons under the age of 18 who experience gender dysphoria by the Tavistock and Portman NHS Foundation Trust, through its Gender Identity Development Service (GIDS).[18] The applicants, a former patient of Tavistock who had since begun 'detransitioning' and a mother of a child with GD who had recently been referred to the Tavistock Clinic, were seeking a declaration that prescribing puberty-blockers to children under 18 was "unlawful as they lacked competence to give valid consent" (per 3). Therefore, the principal question in this case was whether children could achieve *Gillick* competence with regards to the administering of PBs. The Court was concerned that in both theory and practice children as young as 10 had been prescribed puberty blockers.[19] For the medical practitioners involved, informed consent, was of course, paramount to these interventions. The judicial review revolved around two key areas. Firstly, and perhaps more abstractly, can children give consent to these types of medical interventions and secondly, in practice, were *these* children given sufficient information to provide informed consent to these *particular* interventions; namely PBs. The claimants had alleged that "the information given to those under 18 by the defendant is misleading and insufficient to ensure such children or young persons are able to give informed consent. They further contend that the absence of procedural safeguards, and the inadequacy of the information provided, results in an infringement of the rights of such children…." (per 7).

The Judges considered an array of evidence around the effects of puberty blockers, their links to cross-sex hormones and the paucity of research around their effectiveness. The case also discussed whether the experimental nature of puberty blockers and the lack of evidence as to their long-term effects prevented children from being able to give informed consent. The Court ultimately decided that:

> A child under 16 may only consent to the use of medication intended to suppress puberty where he or she is competent to understand the nature of the treatment. That includes an understanding of the immediate and long-term consequences of the treatment, the limited evidence available as to its efficacy or purpose, the fact that the vast majority of patients proceed to the use of cross-sex hormones, and its potential life changing consequences for a child. There will be enormous difficulties in a child under 16 understanding and weighing

[18] National Health Service Commissioning Board (NHS England) were an interested party in the case although they were not represented, nor did they appear in court. University College London Hospitals NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust and Transgender Trend Ltd all acted as interveners in the case.
[19] While PBs could be prescribed to children as young as 12 per NHS England. NHS standard contract for gender identity development service for children and adolescents: schedule 2—the services. The NHS pre-*Bell* also allowed PBs to be prescribed to children under 12 as long as they had *Gillick* competence and were in Tanner Stage 2 of puberty.

> up this information and deciding whether to consent to the use of puberty blocking medication. 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. (per 151) ….

Alongside this declaration, it issued the following guidance, that:

> In respect of young persons aged 16 and over, the legal position is that there is a presumption that they have the ability to consent to medical treatment. Given the long-term consequences of the clinical interventions at issue in this case, and given that the treatment is as yet innovative and experimental, we recognise that clinicians may well regard these as cases where the authorisation of the court should be sought prior to commencing the clinical treatment. (per 153)

A key concern for the Court in *Bell* was the link between PBs and the administration of Cross-Sex Hormones (CSH). The Court determined that given that nearly all children who were prescribed PBs went on to have CSH, children who were prescribed PBs also had to understand the risks that CSH posed to factors such as fertility and sexual functioning. Accordingly, the Court held that GIDS are under an obligation to discuss not only the effects of PBs but also the effects of CSH due to the statistical likelihood that the former will lead to the latter. There was some discussion in the judgment devoted to whether the psychological consequences of delayed puberty could be described as reversible but in terms of the physical effects it was agreed that PBs are reversible. CSH's however, are not and so the high persistence of individuals from PB's to CSH's led the judiciary to require a higher standard of competence than might otherwise have been the case – in fact the Court suggested that children may never reach *Gillick* competence in regard to these factors. While the conclusion suggests that children under the age of 16 can consent to the use of puberty blockers, the standard for assessing *Gillick* competence is high. Moreover, the Court recommended that the decision to prescribe PBs requires Court authorisation and accordingly, GIDS suspended all referrals for puberty blockers until a Court order is acquired (NHS England 2020). Moreover, those children already taking puberty blockers were to be reviewed pending a judicial best interests assessment. The use of puberty blockers was reinstated in March 2021 following the decision in *AB v CD*. These changes have meant that the process of prescribing PBs became more difficult for those under 16s. This is an important point given the time sensitive nature of the interventions and the long waiting list that already existed to be referred to GIDS (at the time it was over two years).

On Appeal, the CA reviewed the HC's decision and found that its declaration had placed an improper restriction on *Gillick*. Rather than making a declaration that stated the law, the HC had "turned expressions of judicial opinion into a statement of law itself. In addition, [the

declaration] states facts as law which are both controversial and capable of change." (per 80) Consequently, the CA overturned the HC's declaration and guidance given that the HC's findings relating to PBs and CSHs amounted to a factfinding exercise it was not equipped to do, stating that "… these judicial review proceedings did not provide a forum for the resolution of contested issues of fact, causation and clinical judgement." (per 64 – 65). In doing so, the CA reaffirmed *Gillick* and set out that the HC's guidance had been wrong "to generalise about the capability of persons of different ages to understand what is necessary for them to be competent to consent to the administration of puberty blockers." (per 85). Decisions relating to the provision of puberty blockers remained a clinical rather than judicial matter. However, NHS England, following recommendations from the Cass Review established a new external body - the 'Multi Professional Review Group' - which was charged with ensuring "that procedures for assessment and for informed consent had been properly followed" (Cass 2022: 45).

Although the CA's decision was a welcomed reversal of the HC,[20] it is evident that the CA has not been able to fully reverse the impact of the HC's reasoning in a broader sense – and nor, arguably, did it intend to. Indeed, throughout the judgement, the CA wished to make "no comment on the comparisons that were drawn" (per 82) or the conclusions on the evidence reached by the HC. As Garland et al note, the CA did not engage with any attempt to reinforce the rights of gender diverse children, but actively showed empathy with the HC, stating the HC's approach was driven by "the very best of intentions" (per 94). Accordingly, Garland et al note that the CA's decision to restore *Gillick* "reflects adherence to judicial precedent rather than any commitment to ensure that the rights of individual gender diverse children are protected" (Garland et al 2023, XX). However, while the CA's decision does importantly strike down the decision and assumptions made by the HC, we argue that there remain pertinent 'live' issues as to why the HC's reasoning necessitates critical examination. Most immediately, the HC's judgement directly affected and continues to affect the provision of youth care in terms of restricting access and worsening delays: as of May 2022, waiting times for a first appointment at GIDS post-referral were 152 weeks (up from 95 weeks in 2021) with up to a

[20] See e.g. Good Law Project, 'We've won: Bell v Tavistock Judgment quashed by Court of Appeal' Good Law Project (17 September 2022) <https://goodlawproject.org/update/weve-won-bell-v-tavistock/#:~:text=We%E2%80%99ve%20won%3A%20Bell%20v%20Tavistock%20Judgment%20quashed%20by,in%20Bell%20v%20Tavistock%20by%20the%20Divisional%20Court> and Mermaids, 'Mermaids statement on the Bell v Tavistock Appeal' (17 September 2021).

three year wait for treatment to begin.[21] Inevitably, increased waiting time is likely to exacerbate the psychological distress experienced by those young persons who are referred to GIDS.[22] These time pressures have been consistently highlighted in the Cass Review with recommendations made to create a number of 'reigonal hubs' to enable more timely referrals and interventions (Cass 2022: 20).

Mermaids, Gendered Intelligence and the *LGBT Foundation* conducted an online survey into the effects of *Bell* v *Tavistock*, and found that *Bell* had negatively impacted mental health and education experiences; had caused many to seek gender affirming care in less safe spaces; and increased experiences of transphobia (Barras and Carlile 2022). Consequently, its 2022 Report describes *Bell* as casting "a long shadow over access to gender affirming care in the UK" (Barras and Carlile 2022). Beyond this, the HC's reasoning post-CA continues to have socio-political purchase in the public discourse around trans health and gender care for children and adolescents. The protective narrative adopted by the Court, which sits counter to a protecting children's rights narrative (Dimopoulous 2021; Garland et al 2023), has continued to gain traction and heated debates over the gender care of minors has even threatened devolution in the UK (Garland et al 2023).[23] Moreover, internationally, there are references made to the HC's judgement where there are steps taken to limit access to youth affirming care.[24] There seems to be both media and legal appetite for the type of 'sex-based rights' reasoning demonstrated by the HC.

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[21] *AA-Ors* v *NHS Commissioning Board* [2023] EWHC 43 (Admin) at [32]. This is in stark comparison to the statutory duty set out under reg. 45(3) of the NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 to ensure that 92% of NHS patients were treated within 18 weeks. This case sought to challenge these waiting times for being unlawful and discriminatory, yet the HC found that this was not the case. Nevertheless, leave for appeal has been granted and thus we await the decision at the CA.

[22] See J. Thornton, 'Court upholds Gillick competence in puberty blockers case' (2021) 398 *The Lancet*. 1205-1205-1206. Also see P. Strauss et al 'Perspectives of trans and gender diverse young people accessing primary care and gender-affirming medical services: Findings from Trans Pathways' (2022) 23(3) *International Journal of Transgender Health*. 295-307.

[23] Scotland's Gender Recognition Reform (Scotland) Bill (SP Bill 13) proposed, among other things to lower the age at which someone could get a gender recognition certificate from 18 to 16. Additionally, it had proposed the removal of medical evidence from this process of gender recognition. In response, the UK Government controversially for the first time ever enacted s. 35 Scotland Act 1996 to prevent the Bill from going to Royal Assent. This political move is now subject to a judicial review and a ruling awaits.

[24] See e.g. Transgender Europe 'Rollback in trans-specific healthcare for youth' (3 May 2023) < https://tgeu.org/rollbacks-in-trans-specific-healthcare-for-youth/> accessed 27th September 2023.

Accordingly, the HC's approach in *Bell* regarding the child's ability to provide consent is of continued interest as it reveals normative expectations regarding childhood and insight into the gender autonomy of the child. In *Bell,* the HC outlined that children over the age of 16 were presumed to be capable of consenting to this type of treatment although if there is a dispute between them, clinicians or their parents the court encouraged further use of the courts. The Court suggested that all cases regarding gender affirming interventions in 16 and 17 years old adolescents should also attain court authorisation (Per 152). Recognising that section 8 of the Family Law Reform Act 1969 permits 16- and 17-year-olds to give consent to medical and dental treatment as if they were full majority, the Court nevertheless went on to say that:

> We do however recognise that in the light of the evidence that has emerged, and the terms of this judgment, clinicians may well consider that it is not appropriate to move to treatment, such as PBs or CSH, without the involvement of the court. We consider that it would be appropriate for clinicians to involve the court in any case where there may be any doubt as to whether the long-term best interests of a 16 or 17 year old would be served by the clinical interventions at issue in this case. (per 147)

Consequently, the HC attempted to push decision-making regarding gender affirming interventions as close to the age of full majority as possible. *Bell* thus reflects a legal policing of the gender identities of children, delaying as much as possible, in direct challenge of clinical practice, the ability for individuals to access gender affirming interventions until they reach the 'official' adulthood. This policing is far more constraining than the previous clinical approach to gender care and even basic legal principles regarding capacity and consent. Without being able to interfere with the jurisdiction of the FLRA 1969, this meant focusing on the administration of PBs to those under 16. Indeed, the CA noted that the HC's declaration could *only* apply to under 16's owing to the jurisdiction of the FLRA 1969 (per 83). In this context, *Bell* overlooked the present psychological distress of the child in a bid to avoid the *future* risk of impairing sexual functioning, fertility and normal and healthy relationships (Griffiths 2021). In this instance doing nothing in terms of medical interventions and allowing puberty to continue can foreclose promise and potential whilst doing something can open up space to conceive new horizons of possibility.

In the next section we seek to highlight the temporal dimensions of gender present in these approaches towards gender diverse children. Our argument draws particular attention to the assumptions around linear understandings of development and the heteronormative ideologies that undergird the decision.

Temporal and Biological Determinism within Legal Decision-Making

The way in which *Bell* was rationalised by the HC offers important insights for the reluctance to provide interventions on gender diverse children. Time and temporality are recurring motifs in the *Bell v Tavistock* judgment. The two key discussions revolve around: the *rationale* for using puberty blockers and the reversibility of puberty blockers. Largely unspoken was the time-sensitive nature of these interventions. The effects of puberty are also, to a large extent, irreversible hence the need to allow puberty blockers as and when puberty occurs but this reasoning was never fully explored by the court. We will return to these themes in section four of this article. Nor was there a great deal of judicial reflection on the *current* distress that the child was experiencing.

'Pausing' as Problematic

One of the most important dimensions of *Bell* within the HC revolved around the reason behind using puberty blockers and the timing at which they are given with concern over this idea of a 'pause'. GIDS protocols allowed the prescription of puberty blockers once a child has reached Tanner Stage 2 (per 21). Crucially, the Tanner scale measures sexual maturity on the basis of secondary sex characteristic development. Due to natural variation, this cannot be based purely on age as children pass through the stages at different rates. This natural biological variation means that any attempt to frame decision making in terms of age is largely redundant - a point we shall return to as we discuss the conclusions that the case draws.

While the CA noted on appeal that judicial consideration of "disputed issues of fact or expert evidence" was "not for the court hearing a judicial review", (per 62) the HC considered the reasons for prescribing puberty blockers. Dr Polly Carmichael, for example, the Director of GIDS believed that "the primary purpose of PBs is to give the young person time to think about their gender identity" (per 52). The Court noted that this reasoning for the prescription of puberty blockers was present in "a number of the GIDS and Trust information documents" (per 52) and indeed, is consistent with the then international protocols and professional standards (Arnoldussen 2020). In this conception of time, puberty blockers are constructed as a temporal 'break' in the development of sex and gender. During this 'pause' the individual is given extra time and space to consider the gender that is right for them and with the correct psychosocial support can come to the decision that matches their best interests.

This understanding of puberty blockers was criticised, however, in an investigation led by the Health Research Authority in 2019. This investigation held that because the high volume of children on puberty blockers who go on to take cross-sex hormones the treatment may be responsible for 'generating persistence' rather than offering a genuine space for reflection. The Health Research Authority held that it would be more accurate to understand the purpose of puberty blockers being specifically for "children demonstrating a strong and persistent gender identity dysphoria at an early stage in puberty, such that the suppression of puberty would allow subsequent cross-sex hormone treatment without the need to surgically reverse or otherwise mask the unwanted physical effects of puberty in the birth gender" (per 52). In part, such a conclusion was fed by the high levels of persistence already demonstrated by the group and the active requesting of puberty blockers. In this understanding of PBs they are constructed as a linear and unbreakable path to cross-sex hormones and full gender reassignment. The temporality is one of 'progress' although the value of this progress is questioned by the different actors involved in the case. Prominent 'sex-based rights' commentators have agreed with this position outlining that "The notion that puberty blockers give time for dysphoria to resolve is simply untenable. Instead, they are part of a treatment pathway that ushers children towards adulthood identifying as a trans person." (Joyce 2021: 97).

Linked to the temporality indicated by puberty blockers is the temporal feeling of 'relief'. Though this is linked to the construction of 'delay' it elicits some of the emotive and affective dimensions associated with the delayed onset of puberty. Professor Butler a Consultant in Paediatric Endocrinology at University College Hospital London, for example highlighted that puberty blockers, "may have some help or advantage in the support of transgender adolescents in some aspects of mental health functioning, in particular with reducing the risk of reduction of suicidal ideation and actual suicidal actions themselves" (per 53). This point was further evidenced by the limited testimony of trans people called upon in the case. The Cass Review continues to consider the evidence base of this area (Cass 2022: 37).

In the *ratio* of the case the judiciary favoured the linear construction of temporality offered by the Health Regulation Authority. Notably, this linear construction was depicted as negative rather than evidence of the necessity of puberty blockers for this group of children. It reflects a discomfort around the idea of gender being capable of suspension, delay or reversal. This reasoning reveals that even where the legal subject is non-normative the judiciary still support the idea that gender is a linear process. This temporal construction was used to justify the Court's differentiation between PBs prescribed for gender dysphoria and PBs prescribed for

precocious (early on-set) puberty. The Court stated that in the context of precocious puberty, "PBs does not interfere with the onset of puberty at a normal biological age and, as such, will not interfere with normal development of puberty through adolescence." (per 48). Consequently, the use of PBs does not affect the concept of linear progress of gender. In contrast, the administration of PBs for gender dysphoria was deemed to interfere and disturb natural progress and irreversibly change the natural linear pathway of the child, even resulting in the "regression of the first stages of already developed sexual characteristics" (per 50). The Court's willingness to link 'regret' with heteronormative future experiences such as parenthood and marriage strongly links to Halberstam's (2005:4) conception of 'reproductive temporalities' and Edelman's (2004) notion of 'reproductive futurities' where reproduction is culturally framed as inevitable and natural. Although Halberstam was speaking in the context of adulthood, when discussing childhood we can see such expectations around when the window of certain phases of development should take place. In *Bell*, precocious puberty was conceived of as an 'unnatural' development in need of pausing to restore the 'normal' timeline of development. While puberty blockers to treat gender dysphoria were alternatively seen as diverting progress away from its 'natural' gender destiny and transferring it to an alternate or parallel linear process.

The *Tavistock* judgment clearly highlighted a conflict between practitioners and the judges as to whether or not gender could be 'paused'. Whilst healthcare practitioners were willing to see gender as capable of suspension, the judiciary aligned with sex-based rights approaches in conceiving of gender as linear (even if the end destination was malleable). Puberty blockers marked a 'fork in the road' although the temporality was still understood by the judiciary as constant. The Cass Review, in its overview of NHS England's service provision for gender diverse children ultimately left open the temporal question of what puberty blockers *do*, noting that:

> The most difficult question is whether puberty blockers do indeed provide valuable time for children and young people to consider their options, or whether they effectively 'lock in' children and young people to a treatment pathway which culminates in progression to feminising/masculinising hormones by impeding the usual process of sexual orientation and gender identity development. (Cass 2022: 38)

The temporality of gender diverse care healthcare for children in England remains, for the moment, unruly. Nonetheless, NHS England have seemingly taken a cautious approach

asserting that "the NHS will only commission puberty supressing hormones as part of clinical research" (NHS 2022: 1). Who or what these clinical trials will cover remains to be determined.

Reversibility, Irreversibility and Permanence

The *Bell* judgment further exemplifies a legal expectation that sex and gender pathways throughout childhood are not only linear but also *permanent.* Indeed, much of the discussion in *Bell* focused on the reversibility of puberty blockers and whether natural development could be 'restored'. In *Bell*, GIDS and the intervening Trusts argued that it was imperative to see puberty blockers and cross-sex hormones as two distinct modes of treatment. Consequently, puberty blockers were fully reversible and there was an insistence that children could stop taking them at any time and undergo puberty restoring their 'natural' development. Nonetheless, whilst there seemed to be broad agreement that the effects of puberty blockers were reversible, the high rate of children who progressed from PBs to CSHs meant that the Court insisted on coupling the two together. Consequently, the Court viewed CSH as an inevitable outcome of taking PBs stating that "in statistical terms once a child or young person starts on PBs they are on a very clear clinical pathway to CSH" (per 68). Accordingly, the implications of taking PBs could not be reversed as the individual would be on an inevitable pathway towards CSH and alternate gender pathway.

Again, this reasoning draws upon particular conceptions of gendered temporality. The defendant medical professionals (who notably work closely with gender diverse children) saw gender as not only capable of being *paused* but also *restored*. For clinicians, therefore, the temporality of gender becomes both malleable and effectively non-linear; this conceptualisation decouples the concept of a singular gender development progressing over time.

The judiciary, however, held on to the assumption that gender is a linear process focussing heavily on the lack of attrition from puberty blockers to cross-sex hormones. For the Court, puberty blockers simply could not be separated from CSH. As they noted, "The evidence shows that the vast majority of children who take [puberty blockers] 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" (per 136). The temporal construction of gender as

linear leaves the judiciary unable or unwilling to understand alternative temporal constructions of gender. As they continue:

> The defendant argues that PBs give the child "time to think", that is, to decide whether or not to proceed to cross-sex hormones or to revert to development in the natal sex. But the use of puberty blockers is not itself a neutral process by which time stands still for the child on PBs, whether physically or psychologically. PBs prevent the child going through puberty in the normal biological process. As a minimum it seems to us that this means that the child is not undergoing the physical and consequential psychological changes which would contribute to the understanding of a person's identity. There is an argument that for some children at least, this may confirm the child's chosen gender identity at the time they begin the use of puberty blockers and to that extent, confirm their GD and increase the likelihood of some children moving on to cross-sex hormones. Indeed, the statistical correlation between the use of puberty blockers and cross-sex hormones supports the case that it is appropriate to view PBs as a steppingstone to cross-sex hormones. (per 137).

The Court in *Bell* accordingly viewed the biological process of puberty incapable of being dislocated from time.[25] It is therefore inherently connected to the timeframe of adolescence and once lost, cannot be restored. Nevertheless, in its judgement, the Court was not acting solely on the child seeking treatment in the present but rather the Court was also acting upon a future temporality: the adult that child would become. Notably, an adult grieving the loss of normative development and heteronormative milestones and marked by regret; considerable space was given to the doubt and regret narratives put forward in the claimants' submissions. Considering that this move to another gender pathway was permanent and fraught with risk, the Court wanted children to be able to also understand the risks posed by CSH, including:

> iv) the fact that CSH may well lead to a loss of fertility; (v) the impact of CSH on sexual function; (vi) the impact that taking this step on this treatment pathway may have on future and life-long relationships; (per 138)

The Court went on to state that: "There is no age appropriate way to explain to many of these children what losing their fertility or full sexual function may mean to them in later years" (per 144). The Court therefore placed considerable weight on minimising these heteronormative 'future' potential losses that might arise from permanent breaks and transitions out of a 'natural' linear gender process. The legal understanding of gender as linear and permanent are reflected in other legal documents such as the Births and Deaths Registration Act 1953 and the requirement in section 2(3) of the Gender Recognition Act 2004 that the applicant intends to

[25] This reasoning is contested by trans experience. As Ruth Pearce (2018: 67) notes transitioning at any time involves puberty, whether that's at 15 or 75.

continue to live in their acquired gender 'until death'. Such approaches require trans people to take an approach to gender not required of other legal subjects (Grabham 2010: 109). The need for permanence is guided by heteronormative and nationalistic ideals. As Grabham writes:

> [Permanence] invokes, and works in conjunction with, two of those 'eternal' constructs which are thought to be most affected by trans recognition: the institution of marriage, and… the UK as a nation, which 'includes' trans people and grants them rights to live in their 'acquired' gender. (Grabham 2010: 119)

This linear and problematically heteronormative construction of gender may therefore represent a particular *legal* temporal construction of gender clashing with more flexible psychosocial approaches to gender. Consequently, sex-based rights arguments find allyship in a legal system that focuses on the permanence of sex and consequently does not allow individuals to fully break free from their gendered histories. (Sharpe 2009, 2012, Travis 2019, Cowan 2009, Grabham 2010). The sex-based rights approaches assert that most gender diverse children will 'grow out of' these feelings if they are forced to go through puberty (Joyce 2021, Lawford-Smith 2023). The Court in *Bell* focussed on the future trajectory of gender diverse children to the detriment of those affected children currently experiencing gender dysphoria. In doing so *Bell* overlooked the real emergency posed by psychological distress of the child in a bid to avoid speculative *future* risks (Edelman 2004, Griffiths 2021). In this regard, then, the *Bell* proceedings have restored and reified the normative construction of sex and gender as a linear and permanent process throughout childhood. Indeed, as the next and final section argues, this has sought to challenge recent shifts in healthcare which have reframed the temporal pathways from childhood to adulthood from singular to multiple futures. In this sense, Law attempts to constrain medical developments in gender care for minors. Consequently, the judiciary play a key locus in the reinforcement of heteronormative temporalities in keeping with Chowdhury's contention that: "social structures can shape judicial temporalities either through the inclusion or elision of those very social structures in the courts rending of fact." (Chowdhury 2020: 38)

The Politics of Temporality: Reproducing Heteronormative Bodies

The previous section set out how temporality and biological determinism has informed legal approaches to gender diverse children. This section sets out the *politics* of these temporalities by the judiciary. The decision in *Bell* is actively working to re-establish normative pathways

designed to reproduce heteronormative bodies and ensure heteronormative temporal pathways to adulthood. It does so through two mechanisms: First, law downplays current emergencies and, second, law limits the ability of 'pausing' in a way that reduces the agency of gender diverse minors. The consequence of this is that it places pressure on gender diverse children to follow heteronormative pathways.

Downplaying Current Emergencies

The Courts were concerned with speculative future risks that gender diverse children might face rather than considering current psychosocial stressors. In their words:

> On the defendant's case, they suffer considerable psychological distress by reason of their GD and are highly vulnerable. In those circumstances, the consequences of taking PBs on their fertility for example, or on their sexual life, may be viewed as a relatively small price to pay for what may be perceived as a solution to their immediate and real psychological distress. It would not follow however that their weighing of risks and benefits when they might start taking PBs would prevail in the longer-term. (per 142).

Future risks to heteronormative adulthood outweighed the distress of the child with gender dysphoria (which we return to in part four); having gender dysphoria as a child was not depicted as an emergency (Griffiths 2021). As Joyce asserts "Doubters are treated as bigots who could not care less if gender-dysphoric children kill themselves, rather than as whistle blowers looking out for children's interests. This medical scandal, which has been unfolding for years, is now coming to wider notice" (Joyce 2021: 93-94). Indeed, Joyce spends considerable time in her book outlining that the suicide risks for gender diverse children are 'overblown' (Joyce 2021: 110-111).

For the Court, the move from childhood to adulthood is understood by the court as not only linear, but also singular – shutting down a multitude of potential futures (Griffiths 2021).[26] The Court ignored the clinical level of distress that must accompany a diagnosis of gender dysphoria in childhood and how such a diagnosis is a very real emergency.[27] These children can experience increased concomitant psychopathology such as anxiety or depression leading to an increase in suicidal thoughts or self-harm as a result of the levels of distress they are experiencing (Mann et al 2019). In fact, distress was framed in a way to challenge the child's capacity, a point we return to below. Indeed, the Cass Review has outlined a need for a greater

[26] This is counter to clinical developments as we discuss below.
[27] DSM-5 302.6 (F64.2): "clinically significant distress or impairment in social, school, or other important areas of functioning"

focus on potential co-morbidities and called for them to be fully explored during the assessment phase (2022). The HC was concerned about the disruptive impact PBs and CSH had on 'natural' biological (as well as cisnormative[28] and heteronormative) development despite the fact that, as the Court of Appeal pointed out, judicial review proceedings "did not provide a forum for the resolution of contested issues of fact, causation and clinical judgement" (Per 64).

In this sense, the Court actively appears to be restricting the approach within the clinical sphere in a bid to reaffirm ideas about linearity, sex, gender and childhood. Childhood as a temporality thus becomes a political tool through which to prevent the troubling of sex and gender. The decision to defer to medicine is thus part of this, dependent on the reproduction of those conservative and heteronormative norms.

Reducing the agency of gender diverse children

An additional temporal motif in *Bell* was that relating to age and capacity of the child. This motif, however, seems to sit apart from the others in that it actively works to undermine the agency of the child by reasserting the linear and biological determinism associated with childhood. To go back to our earlier discussion of 'pause' as problematic, law's refusal to acknowledge or even allow space through which the individual can stop, reflect and begin to imagine alternative futures also works to limit their ability to actively challenge the heteronormative underpinnings of childhood. The linear conception of sex and gender operate in a way that actively reduces the agency of gender diverse people by denying children and adolescents both the time and reflective space to consider matters relating to their current and future selves. As children gain capacity it becomes harder to completely exclude them from decision-making – particularly in healthcare decisions that so heavily effect their sense of self. This is an inevitability given that the provision of gender care for minors, by its very nature, is driven by the lived experience of that individual child and *their* account of their own gender, not by adults (Garland et al 2023). It is perhaps no surprise then that in *Bell,* the majority of the judgment was given up to discussions of consent and capacity. Whilst the judgment drew upon the decision in *Gillick* and subsequent judgments that developed capacity to consent to medical treatment on a case-by-case basis the Court was repeatedly lured into discussing age as a basis for assessing capacity.

[28] Where birth sex and gender identity align

For, example, in the conclusion of the judgment the Court held that 13 years olds were highly unlikely to be able to give consent whilst 14 and 15 year olds were doubtful (per 151). Here it is clear that the courts are constructing childhood as a linear process whereby capacity progresses in a direct and causal relationship with age. Of course, this directly contradicts the previous case law which specifically criticised such an approach for failing to take into account the different rates at which children mature and have the capacity to make decisions about their own bodies. The very premise of *Gillick* competence recognises that age is not linked to capacity; developing maturity and intelligence is an individualised experience that is also locally specific. For example, while children might have *Gillick* capacity in one context, they might not be deemed to have it in the next.

Here the judiciary seem to oscillate between an understanding of childhood as a temporally and institutionally co-constituted process and childhood as a duration of time. The healthcare professionals associated with GIDS understood their obligations to these children through a temporal understanding of age where information could be varied, explained in different ways and through alternating mediums, in conjunction with parents. As a result of this approach, informed consent was always *possible* even if this was only after several meetings and information sessions. Consent could be achieved by working with *any* patient and through an assessment of their needs, and levels of understanding.[29]

The Court disagreed with this approach, however. Instead, they stated that there were some things that (particularly young) children *could not* understand. Having their own biological children and sexual fulfilment were two examples whereby the judges felt that young people would not be able to give meaningful consent on account of their lack of understanding of the subject matter. Of course, puberty blockers do not impact on these issues, but the Court was influenced by its own conflation of puberty blockers and cross-sex hormones. Setting aside the heteronormative and gendered implications of the examples the courts raise, the Court used this reasoning to conclude that children will not be able to consent to these interventions. As they write, "the increased maturity of the child means that there is more possibility of achieving competence at the older age" (per 140). Moreover, the distress that the child experienced was used by the Court to further question the child's ability to make the 'right' decisions about their bodies.

[29] An approach not dissimilar from Article 12 of the UN Convention on the Rights for Persons with Disabilities and its focus on 'supported decision making'. See for example Clough (2014) in relation to a discussion of disability and consent to sex.

Children challenging their 'natural' sex, therefore, even if this is through pausing sex development, are held to a higher standard of competence than other medical interventions. In part, this may be because it challenges the biologically determined 'gender destinies' offered by assigned sex outlined in the discussions of giving birth and sexual fulfilment. Again, such notions may be over reliant on heteronormative assumptions of what Halberstam refers to as "reproductive temporalities" (2005: 4). Certainly, in *Bell*, the Court wanted the *Gillick* competence threshold to require children to understand the risks that gender affirming interventions may place them outside of normative constructions of reproduction and family life. For the Court, children were incapable of conceiving what this truly means. As Halberstam writes, this temporality, charts "the emergence of the adult from the dangerous and unruly period of adolescence as desired process of maturation…." (Halberstam 2005: 4). Trans temporalities, however, allow us to

> …rethink the adult/youth binary… [disrupting] conventional accounts of youth culture, adulthood and maturity. Queer subcultures produce alternative temporalities by allowing their participants to believe that their futures can be imagined according to logics that lie outside of those paradigmatic markers of life experience – namely, birth, marriage, reproduction and death." (Halberstam 2005: 2)

Engaging with trans and gender diverse subjects, therefore, may enable a different set of assumptions about the priority of having children, marriage and (hetero)sexual pleasure. This is crucial for legal decision making that seeks to regulate gender diverse children – particularly where this flies in the face of clinical reasoning that is centred around the patient experience.

Reproducing Heteronormativity

One important aspect of the *Bell* case is the construction of sex development as linear and the focus on the gender destinies that arise from such linearity. Puberty blockers for gender diverse children disrupt such linear conceptions of both time and gender. The ability to pause, suspend and reverse gender destinies works in stark contrast to law's own construction of sex and gender as linear, permanent and biologically predetermined.

A key dimension missing from the Court's reasoning in *Bell* is the ways in which the temporality of institutions construct the outcomes for gender diverse children. Whilst the Court alluded to the 22-26 month waiting list for access to GIDS they did not speculate about the effect this would have on persistence in accessing PB's and CSH's. It seems obvious that the lengthy waiting times would have a hugely discouraging effect on children who were unsure

about whether PB's were right for them. This coupled with the typical six or more consultation appointments over six months would have an important 'weeding out' effect of some children whilst increasing the determination of others. The time sensitive nature of these interventions in addition to the long waiting list highlights the persistence of these children engaging with GIDS long before they get an appointment. As a result, the waiting time to access GIDS may well contribute to the coupling of puberty blockers and cross-sex hormones that comes under such scrutiny in the judgment. As Grabham notes in a different context:

> … durations, waiting periods and down-time… could serve to intensify the somatic experience of gender, 'hot-housing' normative gender expressions and negotiations of identity into particular moments or time spans, and concentrating the social expression of particular gender ideologies. Prescribed periods of time are conceptually linked with high pressure and it is this spatio-temporal experience of intensity… that helps to move trans subjects 'forward' to a legally ratified transition. (Grabham 2010: 118)

This sentiment is echoed in the finidings of the Cass Review that noted through its interviews with gender diverse children that, "By the time they are seen in the GIDS clinic, they may feel very certain of their gender identity and be anxious to start hormone treatment as quickly as possible. However, they can then face a period of what can seem like intrusive, repetitive and unnecessary questioning. Some feel that this undermines their autonomy and right to self-determination" (Cass 2022: 45). As a result, we can construe that the judiciary fail to consider the ways in which the temporality of gender diverse adolescence is constructed through the context of healthcare. The low desistance rate criticised by the judiciary is a temporal outcome of an overstretched health service. For gender diverse children caught in this "limbo" the experience of a denial of agency can ultimately be harmful to health (Pearce 2018). The lack of engagement with these issues within the judgment is deserving of criticism but may not be noticed unless scholars pay attention to the temporal issues in the case. Acknowledgement of these circumstances, is important, as it allows for the determination of relevant "facts in adjudication and rendering subjects of law who are more fully situated in their social reality." (Chowdhury 2020: 4). Indeed, the lack of contextualising of the gender diverse child in their 'effective histories' (Chowdhury 2020:65) has an important framing effect in the judiciary's construction of a future pathway that is irreversible, linear and unavoidable. By failing to take into account the desires of the gender diverse child that led them to access GIDS in the first place, the judgment takes an abstract (and thus cisnormative and heteronormative) approach to the legal subject as well as the relevant conditions that "pre-figure the legal event" (Chowdhury 2020:65). To use Chowdhury's terminology this approach characterises this as an abstract rather than concrete legal judgment (Chowdhury 2020:69). A more concrete legal judgment

would focus further on the conditions and social structures in which trans children are situated (Chowdhury 2020: 97, Dietz 2018, 2022, Travis 2019, Garland and Travis 2023).

Clinicians, parents and children work similarly in trans healthcare - coming together to form decisions about the child's gender destiny. When placed into a legal context, however, the *voice* and consent of the child seem, at least in *Bell,* much less important than the child's assigned sex. Gender diverse children are thus not afforded autonomy over their gender identity. For law then in this decision, heteronormative expectations outweigh the wishes and desires of gender diverse children. The law constructs a gendered future for these children that potentially neither the children, nor parents and clinicians, are seeking.[30] Such a decision reconfirms Chowdhury's contention that "Different conceptions of adjudicative temporalities… determine which facts count as facts and reveal the potentialities of transformation in such types of determination" (Chowdhury 2020:12). Law, we argue, has taken an important role in the 'naturalisation' of gender as a linear process. This move is part of a larger judicial project whereby "linear, substantivalist time is juridically produced*"* (Chowdhury 2020: 30). As a result, we argue against temporal and biological determinism in the regulation of children and push for greater recognition of law's own place in the construction of gendered temporality. Engaging with law's privileging of linear experiences of time shows an even greater need for *Gillick* competence for gender diverse children with capacity based on temporal rather than time-based constructions of childhood. Moreover, it requires a move away from temporal and biological determinism that may be applied in the child's best interests. Such moves are necessary, particularly due to the underlying heteronormative biases inherent to juridical decision making in this area temporalized through certainty and knowability whilst eliding the needs and experiences of individual subjects.

Conclusions

In conclusion we have exemplified the ways in which law and sex-based rights approaches are similar in their construction of temporality – particularly gendered conceptions of time. Noting these conceptual overlaps are important as together they work to privilege heteronormative conceptions of sex and gender development and fail to account for the ways in which gender

[30] Although where parents, children's and clinicians wishes are in accordance the decision in *AB* v *CD & Ors* [2021] EWHC 741 (Fam) will allow access to puberty blockers for gender diverse children over 16.

diverse children might disrupt such accounts. Moreover, they explain why law is selective in the medical accounts that it defers too, favouring some approaches over others.

In particular, we highlighted how legal discomfort around the idea of 'pausing' and 'reversing' sex development allowed for sex-based rights arguments to flourish in this emerging area of law. Indeed, the decision in *Bell* stresses a need for children to consent to the permanence of medical interventions that *are not permanent*. As Naezer et al recently commented, intervening with puberty blockers for trans children, "constructs healthcare interventions as steering children in a certain direction with regard to their gender identity, while refraining from intervening is constructed as the neutral option that allows children to grow up 'the way they are': with the body they were born in." (Naezer et al 2021: 7). The irreversibility of puberty itself, however, means that these decisions are *not neutral* but political determinations of – and allegiances to - heteronormativity. These approaches were notably divergent from medical accounts of sex development which were much more capable of seeing sex development as non-linear, reversible and impermanent. Whilst it would be foolhardy to argue that the perspective of medical professionals should be privileged in all aspects of law (Garland and Travis 2023, 2020b) we believe that in this instance, clinicians have worked hard to build their practice around the experiences and needs of gender diverse children. As such, this patient-centred approach needs to be reflected in the legal regulation and oversight of this area particularly as NHS England set out to enact the findings of the Cass Review. .

Judicial discomfort with granting autonomy to gender diverse children was further highlighted in the HC's approach to capacity and its shift to an approach that conflated calendar age with growing capacity. This understanding of capacity was clearly unjustified but was motivated once again by the HC's heteronormativity. The arguments that children and adolescents could not understand issues around fertility, parenthood, marriage and (hetero)sexual relationships were clearly grounded in a heterosexual understanding of the life course. Engaging with the trans and gender diverse community would highlight alternative ways of living rewarding and joyous lives (Halberstam 2005, Edelman 2004). One element of this would be to focus on enhancing the agency and autonomy of gender diverse children and allowing them to actively participate in decisions over their own lives.

In the penultimate section, we focussed on the context in which this decision was made. It is unfortunate that the decision making in this case failed to examine the 22-26 month waiting list for accessing GIDS as an important hurdle in generating persistence. If children, left

without support for two years, are still attempting to access puberty blockers after that time then of course it is likely that they will move from puberty blockers to cross-sex hormones – persistence and determination are crucial to navigating the institutional structures of accessing gender diverse healthcare.

Finally, we return to the socio-political backdrop against which this case takes place. Whilst this was only one case and its appeal it is emblematic of a broader contemporary battle over the meaning of sex and gender. Although this case was overturned we would argue that important convergences between arguments around sex-based rights and law have been drawn. Identifying these, and their conceptual grounding in notions of temporality, are important for pushing back against them – allowing for a breaking down of gender roles across society. Pressingly, however, these 'debates' continue to punish gender diverse children. It is crucial that we centre their voices, needs and desires and focus on the harms being generated in the present rather than an abstract idealistic version of childhood where potential harms are generated in a speculative heteronormative future.

Bibliography

Arnoldussen, Marijn, Thomas D. Steensma, Arne Popma, Anna IR van der Miesen, Jos WR Twisk, and Annelou LC de Vries. 2020. Re-evaluation of the Dutch approach: are recently referred transgender youth different compared to earlier referrals?. *European child & adolescent psychiatry* 29: 803-811.

Barras, Abby and Carlile, Anna. 2022. *Mermaids Short Report: Everything Feels Stacked Against Us* BvT-short-report-December-2022.pdf (mermaidsuk.org.uk) Accessed 29 September 2023.

Beattie, Cameron. 2022. High court should not restrict access to puberty blockers for minors. *Journal of Medical Ethics* 48: 71-76.

Butler, Judith. 2021. Why is the idea of 'gender' provoking backlash the world over. *The Guardian* 23 October. https://www.theguardian.com/us-news/commentisfree/2021/oct/23/judith-butler-gender-ideology-backlash. Last Accessed 29 September 2023.

Cass, Hilary. 2022. *The Cass Review: Independent Review of Gender Identity Services for Children and Young People. Interim Report*. London: NHS England.

Cave, Emma. 2014. Goodbye Gillick? Identifying and resolving problems with the concept of child competence. *Legal studies* 34: 103-122.

Chau, Hillary. 2022. Consent to Treatment for Transgender Youth: The Next Chapter – *Bell & Anor v The Tavistock and Portman NHS Foundation Trust & Ors*. *Modern Law Review* 86: 214-225.

Chowdhury, Tanzil. 2020. *Time, temporality and legal judgment*. Oxon: Routledge.

Clough, Beverley. 2014. Vulnerability and capacity to consent to sex-asking the right questions. *Child & Fam. LQ* 26: 371.

Cooper, Davina, and Flora Renz. 2016. If the state decertified gender, what might happen to its meaning and value?. *Journal of Law and Society* 43: 483-505.

Cooper, Davina. 2022. What does gender equality need? Revisiting the formal and informal in feminist legal politics. *Journal of Law and Society* https://doi.org/10.1111/jols.12393

Cowan, Sharon. 2009. Looking back (to) wards the body: Medicalization and the GRA. *Social & Legal Studies* 18: 247-252.

Cowan, Sharon, and Sean Morris. 2022. Should 'Gender Critical' Views about Trans People Be Protected as Philosophical Beliefs in the Workplace? Lessons for the Future from Forstater, Mackereth and Higgs. *Industrial Law Journal* 51: 1-37.

de Vries, Annelou LC., Christina Richards, Amy Tishelman, Joz Motmans, Sabine Hannema, Jamison Green and Stephen Rosenthal. 2021. *Bell v Tavistock and Portman NHS Foundation Trust* [2020] EWHC 3274: Weighing current knowledge and uncertainties in decisions about gender-related treatment for transgender adolescents. *International Journal of Transgender Health* 22:217-224.

Dietz, Chris. 2018. Governing legal embodiment: On the limits of self-declaration. *Feminist Legal Studies* 26: 185-204.

Dietz, Chris. 2022. *Self-declaration in the Legal Recognition of Gender*. Oxon: Routledge.

Dimopolous, Georgina. 2021. Rethinking *Re Kelvin*: A Children's Rights Perspective. *UNSW Law Journal*. 44: 637 – 672

Edelman, Lee. 2004. *No Future*. Duke: Duke University Press.

Eugster, Erica. 2019. Treatment of Central Precocious Puberty. *Journal of the Endocrine Society* 28: 965-972.

Fox, Marie, and Michael Thomson. 2017. Bodily integrity, embodiment, and the regulation of parental choice. *Journal of Law and Society* 44: 501-531.

Fox, Marie, Michael Thomson, and Joshua Warburton. 2020. Embodied integrity, shaping surgeries and the profoundly disabled child. In *A Jurisprudence of the Body,* ed. Chris Dietz, Mitchell Travis and Michael Thomson, ed., 281-314, Oxon: Palgrave.

Greenhouse, Carol J. 1988. Just in time: Temporality and the cultural legitimation of law. *Yale LJ* 98: 1631-1652.

Garland, Fae, and Mitchell Travis. 2018. Legislating intersex equality: Building the resilience of intersex people through law. *Legal Studies* 38: 587-606.

Garland, Fae, and Mitchell Travis. 2020a. Temporal bodies: emergencies, emergence, and intersex embodiment. In *A Jurisprudence of the Body,* ed. Chris Dietz, Mitchell Travis and Michael Thomson, ed., 119-147, Oxon: Palgrave.

Garland, Fae, and Mitchell Travis. 2020b. Making the state responsible: intersex embodiment, medical jurisdiction, and state responsibility. *Journal of law and society* 47: 298-324.

Garland, Fae, and Mitchell Travis. 2023. *Intersex Embodiment: Legal Frameworks Beyond Identity and Disorder*. Bristol: Bristol University Press.

Garland, Fae , Edmund Horowicz, Georgina Dimopolous et al, (forthcoming) From Clinical to Judicial Decision-Making, and Back Again in Bell v Tavistock? Preparing for the Legacy of Court Involvement in Gender Care for Minors *Medical Law International*,

Giordano, Simona, and Søren Holm. 2020. Is puberty delaying treatment 'experimental treatment'?. *International Journal of Transgender Health* 21: 113-121.

Grabham, Emily. 2010. Governing permanence: Trans subjects, time, and the Gender Recognition Act. *Social & Legal Studies* 19: 107-126.

Grabham, Emily. 2012. Bodily integrity and the surgical management of intersex. *Body & Society* 18: 1-26.

Grabham, Emily. 2014. Legal form and temporal rationalities in UK work–life balance law. *Australian Feminist Studies* 29: 67-84.

Grabham, Emily. 2016. *Brewing legal times: Things, form, and the enactment of law*. Toronto: University of Toronto Press.

Griffiths, David Andrew. 2021. Queering the moment of hypospadias "Repair". *Glq* 27: 499-523.

Halberstam, J. Jack,. 2005. *In a queer time and place: Transgender bodies, subcultural lives*. New York: NYU press.

Harrington, John. 2016. *Towards a rhetoric of medical law*. Oxon: Routledge.

Herring, Jonathon. 2019. *Family Law*. Oxon: Pearson.

Hewitt, Jacqueline and Margaret Zacharin. 2015. Hormone replacement in disorders of sex development: Current thinking. *Best Practice & Research Clinical Endocrinology & Metabolism*29:437-447.

Hines, Sally. 2020. Sex wars and (trans) gender panics: Identity and body politics in contemporary UK feminism. *The Sociological Review* 68: 699-717.

Joyce, Helen. 2021. *Trans: When Ideology Meets Reality*. London: Simon and Schuster.

Lawford-Smith, Holly. 2023. *Gender Critical Feminism*. Oxford: Oxford University Press.

Lee, Peter A., Anna Nordenström, Christopher P. Houk, S. Faisal Ahmed, Richard Auchus, Arlene Baratz, Katharine Baratz Dalke et al. 2016. Global disorders of sex development update since 2006: perceptions, approach and care. *Hormone research in paediatrics* 85: 158-180.

Liao, Lih-Mei, and Katrina Roen. 2021. The role of psychologists in multi-disciplinary teams for intersex/diverse sex development: interviews with British and Swedish clinical specialists. *Psychology & Sexuality* 12: 202-216.

Lundberg, Tove, Katrina Roen, Carina Kraft, and Peter Hegarty. 2021. How young people talk about their variations in sex characteristics: making the topic of intersex talkable via sex education. *Sex Education* 21: 552-567.

Mann, Georgina, Amelia Taylor, Bernadette Wren, and Nastasja de Graaf. 2019. Review of the literature on self-injurious thoughts and behaviours in gender-diverse children and young people in the United Kingdom. *Clinical child psychology and psychiatry* 24: 304-321.

McNeilly, Kathryn. 2019. Are rights out of time? International human rights law, temporality, and radical social change. *Social & Legal Studies* 28: 817-838.

McNeilly, Kathryn. 2021. How time matters in the UN Human Rights Council's universal periodic review: Humans, objects, and time creation. *Leiden Journal of International Law* 34: 607-627.

Meoded Danon, Limor. 2018. Time matters for intersex bodies: Between socio-medical time and somatic time. *Social Science & Medicine* 208: 89-97.

Moreton, Kirsty. 2021.A Backwards-Step for Gillick: Trans Children's Inability to Consent to Treatment for Gender Dysphoria – *Quincy Bell & Mrs A v The Tavistock and Portman NHS Foundation Trust and Ors* [2020] EWHC 3274 (Admin). *Medical Law Review* 29: 699 – 715.

Naezer, Marijke, Anke Oerlemans, Gijs Hablous, Hedi Claahsen–van der Grinten, Anna van der Vleuten, and Chris Verhaak. 2021. 'We just want the best for this child': contestations of intersex/DSD and transgender healthcare interventions. *Journal of Gender Studies* 30: 830-843.

National Academies of Sciences, Engineering, and Medicine. 2019. The promise of adolescence: Realizing opportunity for all youth. London: National Academies Press. NHS England. 2017. NHS standard contract for gender identity development service for children and adolescents: schedule 2—the services. , https://www.england.nhs.uk/wp-content/uploads/2017/04/gender-development-service-children-adolescents.pdf Accessed 29 September 2023.

NHS England. 2022. Implementing advice from the Cass Review. https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical-programme/implementing-advice-from-the-cass-review/ Last Accessed 23 September 2023.

Pearce, Ruth. 2018. *Understanding trans health: Discourse, power and possibility*. Bristol: Policy Press.

Pearce, Ruth, Sonja Erikainen, and Ben Vincent. 2020. TERF wars: An introduction. *The Sociological Review* 68: 677-698.

Renz, Flora. 2023. Gender-Based Violence Without a Legal Gender: Imagining Single-Sex Services in Conditions of Decertification. *Feminist Legal Studies* 31: 43–66.

Renz, Flora, and Davina Cooper. 2022. Reimagining gender through equality law: What legal thoughtways do religion and disability offer?. *Feminist Legal Studies* 30: 129-155.

Rew, Lynn, Cara C. Young, Maria Monge, and Roxanne Bogucka. 2021. Puberty blockers for transgender and gender diverse youth—a critical review of the literature. *Child and Adolescent Mental Health* 26: 3-14.

Sharpe, Alex. 2007. Endless sex: The Gender Recognition Act 2004 and the persistence of a legal category. *Feminist Legal Studies* 15: 57-84.

Sharpe, Alex. 2009. *Foucault's Monsters and the Challenge of Law*. Oxon: Routledge-Cavendish.

Sharpe, Alex. 2009. Gender recognition in the UK: a great leap forward. *Social & Legal Studies* 18: 241-245.

Sharpe, Alex. 2012. Transgender marriage and the legal obligation to disclose gender history. *The Modern Law Review* 75: 33-53.

Sharpe, Alex. 2016. Expanding Liability for Sexual Fraud Through the Concept of 'Active Deception' A Flawed Approach. *The Journal of Criminal Law* 80: 28-44.

Sharpe, Alex. 2020. Will Gender Self-Declaration Undermine Women's Rights and Lead to an Increase in Harms?. The Modern Law Review 83: 539-557.

Slothouber, Van. 2020. (De)trans visibility: moral panic in mainstream media reports on de/retransition. *European Journal of English Studies* 24: 89-99.

Stock, Kathleen. 2021. *Material girls: Why reality matters for feminism*. London: Hachette.

Stock, Kathleen. 2022. The importance of referring to human sex in language. *Law & Contemp. Probs 85*: 25-46. Timmermans, Stefan, Ashelee Yang, Melissa Gardner, Catherine E. Keegan, Beverly M. Yashar, Patricia Y. Fechner, Margarett Shnorhavorian, Eric Vilain, Laura A. Siminoff, and David E. Sandberg. 2019. Gender destinies: assigning gender in Disorders of Sex Development-Intersex clinics. *Sociology of health & illness* 41: 1520-1534.

Travis, Mitchell. 2019. The vulnerability of heterosexuality: Consent, gender deception and embodiment. *Social & Legal Studies* 28: 303-326.

Truss, Liz. 2020. 'Priorities for the Gender Equalities Office' *Gender Equalities Office* 22 April 2020, https://www.gov.uk/government/speeches/minister-for-women-and-equalities-liz-truss-sets-out-priorities-to-women-and-equalities-select-committee Accessed 15 Feb 2023.

The World Professional Association for Transgender Health (WPATH). 2011. *Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People,* www.wpath.org Accessed 29 September 2023 .

The World Professional Association for Transgender Health (WPATH), Coleman, E., Radix, A. E., Bouman, W.P., Brown, G.R., de Vries, A. L. C., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A. B., Johnson, T. W., Karasic, D. H., Knudson, G. A., Leibowitz, S. F., Meyer-Bahlburg, H. F.L., Monstrey, S. J., Motmans, J., Nahata, L., ... Arcelus, J. 2022. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *International Journal of Transgender Health*, *23*:S1-S260.

Zillén, Kavot, Jameson Garland, and Santa Slokenberga. 2017. *The rights of children in biomedicine: Challenges posed by scientific advances and uncertainties.* Strasbourg: The Council of Europe, The Committee on Bioethics.