GENDER-AFFIRMING MEDICAL TREATMENT FOR MINORS: INTERNATIONAL LEGAL RESPONSES TO AN EVOLVING DEBATE

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Throughout the West, there has been a surge in clinical diagnoses among people aged under 18 of 'gender dysphoria' or 'gender incongruence'. Those individuals have sought treatment for distress and/or impaired functioning associated with a discrepancy between their sex assigned at birth and their experienced and/or expressed gender identity. A principal medical model for treating minors who are diagnosed with gender dysphoria or gender incongruence is controversial. Described as 'gender-affirming' or 'gender-affirmative' 'care', it can entail puberty blockers, hormone treatment, and sometimes surgical procedures. This article examines various arguments posited in the evolving debate in medical and lay communities about this intervention, and then explores examples of the wide diversity and mutability of legal responses to it in different jurisdictions in the West. The article analyses key issues that are pertinent to developing laws regarding this area of medicine and matters that might be taken into account in doing so.

I INTRODUCTION

In recent years, there has been a dramatic rise across the Western world in the number of individuals aged under 18 seeking treatment for distress and/or impaired functioning associated with an inconsistency between their sex assigned at birth and their experienced and/or expressed gender identity.[1] Their clinical diagnosis is labelled 'gender dysphoria' in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* ('*DSM-5-TR*'),[2] and 'gender incongruence' in the World Health Organization's 'International Classification of

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1 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Publishing, 5th ed, 2022) 451 ('*DSM-5-TR*'); Hedi Claahsen-van der Grinten et al, 'Gender Incongruence and Gender Dysphoria in Childhood and Adolescence: Current Insights in Diagnostics, Management, and Follow-Up' (2021) 180(5) *European Journal of Pediatrics* 1349, 1350 <10.1007/s00431-020-03906-y>.

2 *DSM-5-TR* (n 1) 451–3.

Diseases Version 11' ('ICD-11').[3] Young people who identify in different ways, including 'transgender, gender fluid, genderqueer, agender [and] non-binary', may be diagnosed with gender dysphoria/incongruence.[4] Since the 1990s, care described as 'gender-affirming' or 'gender-affirmative' has been one of the principal models adopted by the medical profession in the West for treating minors who receive this diagnosis.[5] In addition to psychological and social support for the minor (including for their gender experience and social transition to their asserted gender identity), it can entail the following medical interventions:

- 'puberty blockers' (to prevent development of secondary sex characteristics that would be consistent with the patient's sex assigned at birth);
- hormone treatment (to induce development of secondary sex characteristics in accordance with the individual's asserted gender identity); and/or
- surgical procedures (to change sex characteristics to conform with those of the individual's asserted gender identity), though they are more commonly performed on people aged 16 or 18 and over.[6]

Gender-affirming medical care is the subject of growing attention and research, as well as controversy, as demand for it has increased among children and adolescents (and especially people assigned female at birth), a high proportion of whom have diagnoses of Autism Spectrum Disorder ('ASD') and/or mental health problems.[7] In 2019, Melbourne's Royal Children's Hospital Gender Service, the 'largest pediatric gender service' in Australia, received 336 referrals, compared with just one in 2003, the year it was established.[8] That service estimates that 1.2%

3 'International Classification of Diseases for Mortality and Morbidity Statistics', *World Health Organization* (Web Page, 2022) HA60, HA61, HA6Z <https://icd.who.int/browse/2024-01/mms/en#411470068> ('ICD-11').

4 Stephanie Jowett and Ben Mathews, 'Current Legal and Clinical Framework for Treatment of Trans and Gender Diverse Youth in Australia' (2020) 56(12) *Journal of Paediatrics and Child Health* 1856, 1856 <https://doi.org/10.1111/jpc.15181>.

5 Marco A Hidalgo et al, 'The Gender Affirmative Model: What We Know and What We Aim to Learn' (2013) 56 *Human Development* 285 <https://doi.org/10.1159/000355235>; Hilary Cass, *Independent Review of Gender Identity Services for Children and Young People: Interim Report* (Report, February 2022) 78 <https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim-Report-Final-Web-Accessible.pdf>; Michelle Telfer et al, 'Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents' (Guideline No 1.3, The Royal Children's Hospital Melbourne, 2020) 2 ('Australian Standards'). Some nonetheless prefer to avoid these terms because they consider they are 'non-specific' and encompass 'heterogenous [sic] care practices that are defined differently in various settings': Eli Coleman et al, 'Standards of Care for the Health of Transgender and Gender Diverse People: Version 8' (2022) 23(sup1) *International Journal of Transgender Health* S1, S43 <https://doi.org/10.1080/26895269.2022.2100644>.

6 Cass (n 5) 36–9, 63; Telfer et al, 'Australian Standards' (n 5) 9–17, 25.

7 *DSM-5-TR* (n 1) 459; Cass (n 5) 32; Michelle A Tollit et al, 'The Clinical Profile of Patients Attending a Large, Australian Pediatric Gender Service: A 10-Year Review' (2023) 24(1) *International Journal of Transgender Health* 59, 59–60, 65 <https://doi.org/10.1080/26895269.2021.1939221>; Kasia Kozlowska et al, 'Australian Children and Adolescents with Gender Dysphoria: Clinical Presentations and Challenges Experienced by a Multidisciplinary Team and Gender Service' (2021) 1(1) *Human Systems* 70, 72 <https://doi.org/10.1177/26344041211010777>.

8 Tollit et al (n 7) 60.

of Australian school children identify as transgender,[9] and 93.8% of participants in 'Trans Pathways', the largest study of transgender and gender diverse young people in Australia, reported that they experienced 'body dysphoria'.[10]

This article examines the wide diversity and mutability of legal responses to gender-affirming medicine for people under 18 years of age in different jurisdictions in the West. At one end of the spectrum, some jurisdictions permit this intervention where the minor, their parents or guardians, and treating health practitioners agree to it, while others prohibit its provision to minors entirely.[11] Further, the law pertaining to various aspects of these treatments has undergone significant changes and remains uncertain in several jurisdictions. In the case of Australia, for example, the law in this area has developed through a series of inconsistent judicial decisions and some aspects of it are still unclear. The current legal position is that if a minor, their parents and medical practitioners agree to the minor having puberty blockers or hormone treatment, either the minor can consent to having them if they are considered competent to provide this consent or, if they are not, their parents can consent on their behalf.[12] Nevertheless, a superior court has not yet definitively confirmed whether court approval is required if the minor is seeking to have gender-affirming surgery.[13] Also not entirely clear is whether court involvement is mandatory if there is disagreement between the minor, their parents and/or medical practitioners regarding their competence to consent to gender-affirming treatment, their diagnosis of gender dysphoria/incongruence, and/or the proposed interventions and, if so, the matters on which the court must reach a decision.[14]

The article maintains that these laws and the dynamic nature of this area of the law reflect the swiftly evolving public debate about gender-affirming medicine for minors and the varied positions that are being adopted in it. Exploring this subject provides an opportunity to consider how the law can and should respond to an area of medicine about which the community is deeply divided and in relation to which scientific evidence is insubstantial compared with some other medical treatments, but is increasingly emerging.[15]

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9 James Harrison, 'Non-binary Students in Aussie Schools Increase Twentyfold in Four Years as Teachers Are Warned about Language', *Sky News* (online, 2 May 2024) <https://www.skynews.com.au/australia-news/nonbinary-students-in-aussie-schools-increase-twentyfold-in-four-years-as-teachers-are-warned-about-language/news-story/701a69a6c6c0ae63626828dd6be8701e>.

10 Penelope Strauss et al, 'Associations between Negative Life Experiences and the Mental Health of Trans and Gender Diverse Young People in Australia: Findings from Trans Pathways' (2020) 50(5) *Psychological Medicine* 808, 808, 814 <https://doi.org/10.1017/S0033291719000643>.

11 See below Part III.

12 *Re Jamie* (2013) 278 FLR 155, 178 [107]–[108], [140] (Bryant CJ); *Re Kelvin* (2017) 327 FLR 15, 41–2 [162]–[167], 44–5 [178]–[184] (Thackray, Strickland and Murphy JJ), [187] (Ainslie-Wallace and Ryan JJ).

13 Jowett and Mathews (n 4) 1858.

14 See, eg, *Re Jamie* (n 12) 184–5 [140] (Bryant CJ); *Re Kelvin* (n 12) 42 [167] (Thackray, Strickland and Murphy JJ); *Re Imogen [No 6]* (2020) 61 Fam LR 344, 351–2 [35], [38], 357 [63] (Watts J) ('*Re Imogen*'); *Re A* (2022) 11 Qd R 1, 6 [25]–[27] (Boddice J).

15 Coleman et al (n 5) S46; Annelou LC de Vries et al, '*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' (2021) 22(3) *International Journal of Transgender Health*

The next Part of this article briefly outlines the history of gender-affirming medicine for minors and then explores the complex debate about it, reviewing the key arguments advanced in favour of, and criticism of and concerns raised about this treatment. Part III of this article examines examples of some of the laws regarding gender medicine for minors in different jurisdictions in the West. In Part IV, legal issues regarding this area of medicine are analysed.

II GENDER-AFFIRMING MEDICINE FOR MINORS

A The Development of Gender-Affirming Medicine for Minors

At present, many aspects of gender-affirming medicine for minors are subjects of contention. As indicated above, even descriptions of the diagnosis for which it is administered are not uniform. A chapter of *DSM-5-TR* is devoted to 'Gender Dysphoria', which it defines as 'a marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration' that 'is associated with clinically significant distress or impairment in social … or other important areas of functioning'.[16] *DSM-5-TR* lists different manifestations of gender dysphoria for children and adolescents, at least six of which must be present for a diagnosis in children and two of which must be present for a diagnosis in adolescents.[17]

By contrast, ICD-11 refers to 'gender incongruence of adolescence and adulthood' and 'gender incongruence of children', in a chapter titled 'Conditions Related to Sexual Health'.[18] In 2019, the terms were shifted from a chapter on 'Mental and Behavioural Disorders', owing to views that they were 'not mental health illnesses and that classifying them as such can cause significant stigma'.[19] Nevertheless, ICD-11 is consistent with *DSM-5-TR* in referring to 'a marked incongruence' – and also 'persistent incongruence' in the case of adolescents – between an individual's 'assigned sex' and their 'experienced gender', and/or 'expressed gender' in the case of children.[20] The description of gender incongruence in ICD-11 does not refer to distress or impairment in functioning. This omission appears to be attributable to the understandings that 'expression of gender characteristics … that are not stereotypically associated with one's sex assigned

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217, 218–19 <https://doi.org/10.1080/26895269.2021.1904330>; Cass (n 5) 63. More empirical data is available regarding the use of puberty blockers and hormone therapy to treat conditions other than gender dysphoria, as they have been applied for those purposes for a longer time period than to treat gender dysphoria: see also Christina Lepore, Anne Alstott and Meredithe McNamara, 'Scientific Misinformation Is Criminalizing the Standard of Care for Transgender Youth' (2022) 176(10) *JAMA Pediatrics* 965, 965 <https://doi.org/10.1001/jamapediatrics.2022.2959>.

16 *DSM-5-TR* (n 1) 452. *DSM-5-TR* notes that gender dysphoria can be associated with impairment in functioning in 'school' for children and in 'occupational' functioning for adolescents: at 452–3.

17 Ibid 452–3.

18 'ICD-11' (n 3) ch 17, HA60, HA61.

19 Jeremi M Carswell, Ximena Lopez and Stephen M Rosenthal, 'The Evolution of Adolescent Gender-Affirming Care: An Historical Perspective' (2022) 95(6) *Hormone Research in Paediatrics* 649, 652 <https://doi.org/10.1159/000526721>.

20 'ICD-11' (n 3) ch 17, HA60, HA61.

at birth is a common … human phenomenon that should not be seen as inherently negative or pathological' or as a 'mental disorder', and not all individuals with gender incongruence will suffer distress or impairment in functioning.[21] However, it is recognised that the purpose of 'gender-affirming treatment' is to 'address' the 'distress or dysphoria' that some individuals with gender incongruence experience.[22] For convenience, this article will use the term 'gender dysphoria', as it encompasses the symptoms of distress and impairment of functioning that can be associated with it.

Gender-affirming medicine for minors has only recently been available in the West.[23] In the early 20th century, the 'Institut für Sexualwissenschaft' (Institute for Sexual Science) in Berlin offered surgery to adults who wished to change their gender,[24] but it was not until the 1970s and 1980s that some specialised clinics opened in various Western countries to provide care for transgender children and adolescents, and they focused on counselling patients.[25] For instance, the Tavistock Clinic in England began operating a 'child and adolescent gender identity development service' in 1989, while Sweden founded the first such service in Scandinavia in the 1990s.[26]

A gender identity clinic for children and adolescents that had opened in the Netherlands in 1987 pioneered a model of medical treatment for gender dysphoria in minors that became known as the 'Dutch Approach' or 'Dutch Protocol'.[27] For prepubertal children, the approach recommends counselling, therapy for 'concomitant emotional and behavioural problems' where relevant, investigations of other possible diagnoses, and encouragement of their parents to adopt a 'watchful waiting' approach.[28] Adolescents aged 12 and over undergo a 'psychodiagnostic assessment', psychiatric examination, and screening by a

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21 Coleman et al (n 5) consider that, rather than 'inherent to being' transgender and gender-diverse, the distress some individuals with gender incongruence experience is 'socially induced' and a product of the 'stigmatising' of 'gender nonconformity and diversity in gender identity': at S6–S7. See also Maura Priest, 'Transgender Children and the Right to Transition: Medical Ethics when Parents Mean Well but Cause Harm' (2019) 19(2) *American Journal of Bioethics* 45, 46 <https://doi.org/10.1080/15265161.2018.1557276>; Jowett and Mathews (n 4) 1856.

22 Coleman et al (n 5) S6–S7.

23 Joseph Elkadi et al, 'Developmental Pathway Choices of Young People Presenting to a Gender Service with Gender Distress: A Prospective Follow-Up Study' (2023) 10(2) *Children* 314:1–24, 19 <https://doi.org/10.3390/children10020314>.

24 Carswell, Lopez and Rosenthal (n 19) 651. Also in the early 20th century, there was some medical treatment of intersex children in the West: see Julian Gill-Petersen, *Histories of the Transgender Child* (University of Minnesota Press, 2018) 59, 62–3, 90–1, 97.

25 Michael Biggs, 'The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence' (2023) 49(4) *Journal of Sex and Marital Therapy* 348, 349 <https://doi.org/10.1080/0092623X.2022.2121238>. From the 1960s, some young people received treatment at gender identity clinics in the United States of America, but those clinics did not treat minors exclusively: Gill-Petersen (n 24) 62, 129, 131, 165–6, 179.

26 Riittakerttu Kaltiala et al, 'Time Trends in Referrals to Child and Adolescent Gender Identity Services: A Study in Four Nordic Countries and in the UK' (2020) 74(1) *Nordic Journal of Psychiatry* 40, 41 <https://doi.org/10.1080/08039488.2019.1667429> ('Time Trends in Referrals').

27 Carswell, Lopez and Rosenthal (n 19) 652–3; Annelou LC de Vries and Peggy T Cohen-Kettenis, 'Clinical Management of Gender Dysphoria in Children and Adolescents: The Dutch Approach' (2012) 59(3) *Journal of Homosexuality* 301, 303 <http://dx.doi.org/10.1080/00918369.2012.653300>.

28 de Vries and Cohen-Kettenis (n 27) 306–9.

paediatric endocrinologist.[29] If they have reached Tanner Stages 2–3 of puberty, received a diagnosis of gender dysphoria (which, according to this protocol, is based partly on an assessment that they are 'suffering from a very early onset gender dysphoria that has increased around puberty'), and 'live in a supportive environment', and 'no serious psychosocial problems interfering with the diagnostic assessment or treatment' have been identified, they will be eligible for prescription of 'gonadotropin releasing hormone analogues (GnRHa) to suppress puberty'.[30] The phase in which adolescents take puberty blockers 'is still considered diagnostic' and they receive counselling with a psychologist and support in transitioning socially to their preferred gender identity.[31] At 16 years of age, patients whose diagnosis of gender dysphoria persists and do not have major psychosocial problems are eligible for 'cross-sex hormones', which initiate puberty of the individual's preferred gender: transgender males receive testosterone, while transgender females receive oestrogen.[32] The final stage of 'gender reassignment surgeries' is available to those aged 18 or older who continue to meet the eligibility criteria.[33] These may include, for transgender males, mastectomy, hysterectomy, oovariectomy, and metaidoioplasty or phalloplasty, and for transgender females, vaginoplasty and augmentation mammoplasty.[34]

The Dutch Protocol has been implemented, with modifications, in many clinics in the West and various guidelines based on it have been developed.[35] The most widely applied today are 'Standards of Care for the Health of Transgender and Gender Diverse People, Version 8' ('SOC-8'), published in 2022 by the World Professional Association for Transgender Health.[36] They identify '[t]he goal of gender-affirming care' as being to 'partner' with transgender and gender diverse ('TGD') people 'to holistically address their social, mental, and medical health needs and well-being while respectfully affirming their gender identity'.[37] SOC-8 favours a 'patient-centered care model', involving 'multidisciplinary consultation and care coordination', and recommends training for healthcare professionals who work with TGD minors.[38] Stated preconditions for suggesting gender-affirming medical treatments include: a diagnosis of gender incongruence under ICD-11, 'the experience' of which has been 'marked and sustained over time'; the minor's demonstration of 'the emotional and cognitive maturity required to provide informed consent/assent for the treatment'; and assurance that 'mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed'.[39] SOC-8 suggests

29 Ibid 310.
30 Ibid 310–11. 'Tanner Stage' is a 'classification of puberty by stage of development': Cass (n 5) 84.
31 de Vries and Cohen-Kettenis (n 27) 310, 312.
32 Ibid 313.
33 Ibid 314.
34 Ibid.
35 Carswell, Lopez and Rosenthal (n 19) 653–4.
36 Coleman et al (n 5) S5. These standards were developed in 1979.
37 Ibid S7.
38 Ibid S7, S49, S70.
39 Ibid S48.

giving prepubescent TGD children information about medical interventions and their potential impact on their fertility, and involving 'relevant disciplines, including mental health and medical professionals' in subsequently determining if treatments are 'appropriate and remain indicated' until the minor transitions to 'adult care'.[40]

B The Debate regarding Gender-Affirming Medicine for Minors

In the 21st century, the number of minors diagnosed with and seeking medical treatment for gender dysphoria has grown significantly and rapidly throughout the West and in greater proportion to adults.[41] The reasons for this are unclear and have not yet been comprehensively researched,[42] but hypotheses include: increased visibility, acknowledgment and acceptance of gender diversity;[43] 'a societal shift in which people feel more able to come forward for help';[44] expanded public information about, and media endorsement and availability of gender-affirming medical treatments;[45] and minors' experiences of peer pressure and/or 'social contagion', and mental health conditions.[46] There has been a striking recent increase in diagnoses of gender dysphoria and desire to access gender-affirming treatment among people assigned female at birth, individuals who have first experienced or expressed gender diversity in adolescence, and minors with diagnoses of ASD and/or mental health conditions, including depression, anxiety, self-harming, and suicidal ideation.[47] These shifts, and lengthy wait lists for gender-affirming medical intervention in clinics across the West,[48] have generated a heated debate about this field of medicine. Now examined are some of the main viewpoints of those who support minors' access to gender-affirming medicine and those who oppose or raise questions about it.

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40 Ibid S56, S75.

41 Ibid S43; Kaltiala et al, 'Time Trends in Referrals' (n 26) 41–3.

42 Kaltiala et al, 'Time Trends in Referrals' (n 26) 41, 43.

43 Michelle Telfer et al, 'Transgender Adolescents and Legal Reform: How Improved Access to Healthcare Was Achieved through Medical, Legal and Community Collaboration' (2018) 54(10) *Journal of Paediatrics and Child Health* 1096, 1097 <https://doi.org/10.1111/jpc.14124> ('Transgender Adolescents and Legal Reform'); Georgina Jacko, 'Consent Rights of Gender Diverse Children in Australia and the United Kingdom: Will the Court's Involvement End?' (2022) 29(4) *Journal of Law and Medicine* 1269, 1269.

44 de Vries et al (n 15) 220.

45 Kaltiala et al, 'Time Trends in Referrals' (n 26) 42–3; Biggs (n 25) 360.

46 Teresa Baron and Geoffrey Dierckxsens, 'Two Dilemmas for Medical Ethics in the Treatment of Gender Dysphoria in Youth' (2022) 48(9) *Journal of Medical Ethics* 603, 604 <https://doi.org/10.1136/medethics-2021-107260>; Mike O'Connor and Bill Madden, 'In the Footsteps of Teiresias: Treatment for Gender Dysphoria in Children and the Role of the Courts' (2019) 27 *Journal of Law and Medicine* 149, 152.

47 Cass (n 5) 16, 32–4, 58, 87; Coleman et al (n 5) S45; Baron and Dierckxsens (n 46) 603, 605; Kaltiala et al, 'Time Trends in Referrals' (n 26) 43; Telfer et al, 'Transgender Adolescents and Legal Reform' (n 43) 1096.

48 Coleman et al (n 5) S43.

1 Support of Gender-Affirming Medicine for Minors

A central argument advanced in favour of minors' access to gender-affirming medicine is that studies have demonstrated its potential to improve their mental health and wellbeing.[49] As they consider the treatments can reduce those individuals' distress, depression, anxiety, and rates of self-harm and suicidal ideation, they maintain that they may be 'lifesaving'.[50] Some contend that they can also enhance young people's 'body image' and 'sexual wellbeing'.[51]

Puberty blockers in particular are endorsed for the following asserted reasons. It is considered that this early intervention may ameliorate or even prevent the minor's experience of 'psychological suffering' and anxiety that can accompany development of secondary sex characteristics that are incongruent with their gender identity,[52] and enhance these patients' self-confidence and social adjustment.[53] Puberty blockers are perceived to 'buy time' during which young people can 'explore' their gender identity and the possibility of further treatment without the pressure of undergoing pubertal changes.[54] Given their effects on physical appearance, it is maintained that administration of puberty blockers may preclude the need for some invasive and costly surgical procedures in adulthood, and improve the results of surgery that is ultimately undertaken.[55] Some believe that effects of puberty blockers are reversible and puberty recommences if they are withdrawn.[56] Early use of hormone therapy in minors is also recommended so that they undergo pubertal development consistent with their gender identity at the same rate as their peers.[57] Although advocates of gender-affirming treatments recognise that some of them have side effects, they consider them to be manageable

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49 Telfer et al, 'Transgender Adolescents and Legal Reform' (n 43) 1096; Michele A O'Connell et al, 'Pharmacological Management of Trans and Gender-Diverse Adolescents' (2022) 107(1) *Journal of Clinical Endocrinology and Metabolism* 241, 248 <https://doi.org/10.1210/clinem/dgab634>; de Vries et al (n 15) 219; 'Outlawing Trans Youth: State Legislatures and the Battle over Gender-Affirming Healthcare for Minors' (2021) 134(6) *Harvard Law Review* 2163, 2168 ('Outlawing Trans Youth'); Simona Martin, Elizabeth S Sandberg and Daniel E Shumer, 'Criminalization of Gender-Affirming Care: Interfering with Essential Treatment for Transgender Children and Adolescents' (2021) 385(7) *New England Journal of Medicine* 579, 580 <https://doi.org/10.1056/nejmp2106314>; Abby Walch et al, 'Proper Care of Transgender and Gender Diverse Persons in the Setting of Proposed Discrimination: A Policy Perspective' (2021) 106(2) *Journal of Clinical Endocrinology and Metabolism* 305, 307 <https://doi.org/10.1210/clinem/dgaa816>.

50 Carswell, Lopez and Rosenthal (n 19) 654; O'Connell et al (n 49) 248–9; Lepore, Alstott and McNamara (n 15) 965; Martin, Sandberg and Shumer (n 49) 580.

51 O'Connell et al (n 49) 248, 251.

52 de Vries et al (n 15) 218–19; Jason Rafferty, 'Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents' (2018) 142(4) *American Academy of Pediatrics* e20182162:1–14, 5 <https://doi.org/10.1542/peds.2018-2162>; O'Connell et al (n 49) 243; Cass (n 5) 31.

53 'Outlawing Trans Youth' (n 49) 2170.

54 de Vries et al (n 15) 218; Simona Giordano, Fae Garland and Soren Holm, 'Gender Dysphoria in Adolescents: Can Adolescents or Parents Give Valid Consent to Puberty Blockers?' (2021) 47(5) *Journal of Medical Ethics* 324, 327 <https://doi.org/10.1136/medethics-2020-106999>; Cass (n 5) 31; O'Connell et al (n 49) 243, 252; Rafferty (n 52) 5; Walch et al (n 49) 307.

55 Priest (n 21) 51; de Vries et al (n 15) 221; Rafferty (n 52) 5.

56 Priest (n 21) 51; Lepore, Alstott and McNamara (n 15) 965; Walch et al (n 49) 307; de Vries et al (n 15) 218.

57 O'Connell et al (n 49) 252.

and believe that various risks can be lessened. They highlight the important roles of counselling patients, and monitoring and forewarning them of side effects, as well as the availability of fertility preservation methods in particular.[58]

Advocates of gender-affirming medicine for minors emphasise that individuals who have one form of treatment do not 'invariably' and 'inevitably' progress to others.[59] While they recognise that studies indicate that many minors who have puberty blockers proceed to hormone therapy and/or surgery, they contend that the initial treatment does not 'cause' them to do so.[60] Rather, they believe this reflects health professionals' careful evaluation of patients who are suited to treatment (including because, if they do not receive it, they are likely to continue to experience distress associated with gender dysphoria).[61] It is also considered that the decisions of some minors to discontinue or refrain from having further treatment do not confirm that: they have 'desisted' in their desire to transition to a gender identity that differs from their sex assigned at birth; their initial treatment was misguided; or they regret having had it.[62] Certain patients may consider that the treatment they have had has changed their bodies sufficiently or prefer to resume treatment when they are older, while for others, their gender identity might be 'fluid, dynamic' or 'non-binary'[63] ('a gender identity that does not fit into the traditional gender binary of male and female').[64] In any event, some contend that results of past empirical studies of desistance are unreliable due to their methodological problems, so the number of minors who desist is unknown.[65] Those who support minors' access to gender-affirming treatments also believe there has been a low rate of reports of patients' 'regret' and 'detransitioning'[66] (choosing to discontinue treatment and/or undergoing surgery to reverse its effects),[67] and cite reports of participants in some studies of detransitioners that 'external pressures (most commonly family pressure and social stigma)' influenced their decision.[68]

Some proponents of gender-affirming medicine for minors acknowledge that scientific evidence regarding its effectiveness and outcomes 'is still emerging and not yet robust', and further research is necessary.[69] They note that several prospective long-term longitudinal studies are underway, but consider there is no reason to

58 Ibid 249–51; Lepore, Alstott and McNamara (n 15) 965; Martin, Sandberg and Shumer (n 49) 580. SOC-8 notes that '[e]stablished [fertility preservation] options, such as embryo, oocyte, and sperm cryopreservation, may be available for postpubertal transgender individuals': Coleman et al (n 5) S156. These options may not be available, however, for young people who have puberty blockers before reaching puberty.

59 de Vries et al (n 15) 219–20.

60 Ibid; Giordano, Garland and Holm (n 54) 326.

61 de Vries et al (n 15) 220; Giordano, Garland and Holm (n 54) 326.

62 O'Connell et al (n 49) 252; Giordano, Garland and Holm (n 54) 327.

63 O'Connell et al (n 49) 252; Giordano, Garland and Holm (n 54) 327; 'Outlawing Trans Youth' (n 49) 2178.

64 Cass (n 5) 84.

65 Giordano, Garland and Holm (n 54) 326; Priest (n 21) 49–50.

66 O'Connell et al (n 49) 251; de Vries et al (n 15) 219–20; Coleman et al (n 5) S47.

67 Cass (n 5) 81.

68 O'Connell et al (n 49) 252.

69 Ibid 252–3; de Vries et al (n 15) 218–19; Coleman et al (n 5) S46.

halt use of these interventions before more extensive data becomes available, which could take years.[70] They emphasise that previous studies and clinicians have observed benefits of this treatment, and especially improvements in the mental health and quality of life of TGD young people, who are often 'marginalized and vulnerable'.[71] Further, they are satisfied there is sufficient consensus among experts in this area that, based on the existing evidence, current treatments and guidelines for their use are appropriate.[72]

Advocates of gender-affirming treatments reinforce, too, that gaps in present knowledge do not justify refraining from providing them to minors, and observe that withholding such treatments is not a 'neutral act'.[73] They refer to research indicating the potential 'harmful effects' of doing so, including patients' heightened distress, depression, anxiety, and risk of suicide, sexual function problems, physical discomfort, and social integration difficulties.[74] Even a delay in providing puberty blockers to a young person with gender dysphoria is perceived by some as risking the extension or exacerbation of their mental ill health, and/or diminution or loss of the possible benefits of this and subsequent treatment.[75] They argue that denial of puberty blockers to an individual can lead to them undergoing irreversible physical changes, which can render their lives unsatisfactory.[76] They are also concerned that, if prevented from accessing gender-affirming medicine expeditiously or at all, minors could be tempted to obtain unregulated and possibly unsafe substitute treatments online and/or from private providers.[77] In addition, they observe that puberty blockers and hormone therapy have been used safely and effectively to treat other conditions (for example, precocious puberty, endometriosis, and acne) for many years.[78]

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70 O'Connell et al (n 49) 253; Ken C Pang, Jeremy Wiggins and Michelle M Telfer, 'Gender Identity Services for Children and Young People in England' (2022) 377 *British Medical Journal* o825:1–2, 1 <https://www.doi.org/10.1136/bmj.o825>; de Vries et al (n 15) 219.

71 O'Connell et al (n 49) 253; de Vries et al (n 15) 218, 220; Pang, Wiggins and Telfer (n 70) 1.

72 de Vries et al (n 15) 218; Priest (n 21) 49; Pang, Wiggins and Telfer (n 70) 1; 'Outlawing Trans Youth' (n 49) 2165–6, 2181.

73 de Vries et al (n 15) 218, 221; Coleman et al (n 5) S48; Telfer et al, 'Transgender Adolescents and Legal Reform' (n 43) 1096; 'Outlawing Trans Youth' (n 49) 2185; O'Connell et al (n 49) 253.

74 de Vries et al (n 15) 218, 221; Giordano, Garland and Holm (n 54) 327; 'Outlawing Trans Youth' (n 49) 2168, 2178, 2185; Telfer et al, 'Transgender Adolescents and Legal Reform' (n 43) 1096; Stephanie Jowett and Fiona Kelly, '*Re Imogen*: A Step in the Wrong Direction' (2021) 34(1) *Australian Journal of Family Law* 31, 34; Coleman et al (n 5) S48; O'Connell et al (n 49) 253.

75 Pang, Wiggins and Telfer (n 70) 1; Jowett and Kelly (n 74) 34.

76 Priest (n 21) 55–6.

77 Ibid 52; Cass (n 5) 46; Telfer et al, 'Transgender Adolescents and Legal Reform' (n 43) 1097; LM Shirley, 'Dismantling Obstacles to Gender Affirmation: Reimagining Consent to Medical Treatment by Transgender, Gender Diverse and Non-binary Minors' (2022) 29(2) *Journal of Law and Medicine* 545, 555.

78 Martin, Sandberg and Shumer (n 49) 580; Lepore, Alstott and McNamara (n 15) 965; 'Outlawing Trans Youth' (n 49) 2181.

2 Opposition to and Doubts about Minors' Access to Gender-Affirming Medicine

Gaps in the available evidence regarding gender-affirming medicine for minors are a chief concern for many who oppose or question its use.[79] They are troubled by a lack of conclusive research, and especially large, high-quality, well-designed, longitudinal studies, randomised control trials, and long-term, follow-up data, in relation to several matters, including the following:[80]

- the growth in the number of minors seeking this treatment and the demand especially from people assigned female at birth who have late-onset gender dysphoria;[81]
- optimal management of and treatments for minors with gender dysphoria;[82]
- the effectiveness, safety, and psychological and physiological impacts of gender-affirming medical treatments;[83]
- cognitive, psychosocial, sexual, and developmental long-term outcomes of puberty blockers in particular (as existing evidence regarding their effects is mostly gleaned from studies of their short-term use to treat precocious puberty, rather than their application to prevent minors ever experiencing puberty consistent with their sex assigned at birth);[84] and
- patients' satisfaction with, and regret about, having had gender-affirming medical treatments, and their decisions to detransition.[85]

In addition, some have expressed concern that 'experience-based knowledge' of 'experts' in this field of medicine 'is less uniform' than in the past.[86] As more

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79 Cass (n 5) 15; Michael Laidlaw, Michelle Cretella and G Kevin Donovan, 'The Right to Best Care for Children Does Not Include the Right to Medical Transition' (2019) 19(2) *American Journal of Bioethics* 75, 75 <https://doi.org/10.1080/15265161.2018.1557288>; Kozlowska et al (n 7) 72–3; Elkadi et al (n 23) 2; Hannah Barnes, *Time to Think: The Inside Story of the Collapse of the Tavistock's Gender Service for Children* (Swift Press, 2023) 6; Socialstyrelsen, The National Board of Health and Welfare, *Care of Children and Adolescents with Gender Dysphoria: Summary of National Guidelines* (Report, December 2022) 3 <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2023-1-8330.pdf>.

80 Cass (n 5) 19, 36; Elkadi et al (n 23) 7; Alison Clayton, 'Gender-Affirming Treatment of Gender Dysphoria in Youth: A Perfect Storm Environment for the Placebo Effect' (2023) 52(2) *Archives of Sexual Behavior* 483, 485, 488 <https://doi.org/10.1007/s10508-022-02472-8>; Riittakerttu Kaltiala et al, 'Adolescent Development and Psychosocial Functioning after Starting Cross-Sex Hormones for Gender Dysphoria' (2020) 74(3) *Nordic Journal of Psychiatry* 213, 214 <https://doi.org/10.1080/08039488.2019.1691260> ('Adolescent Development'); Barnes (n 79) 6.

81 Cass (n 5) 19, 36, 39; Lisa Littman, 'Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners' (2021) 50(8) *Archives of Sexual Behavior* 3353, 3364–5 <https://doi.org/10.1007/s10508-021-02163-w>; Elkadi et al (n 23) 20; Kaltiala et al, 'Time Trends in Referrals' (n 26) 43.

82 Cass (n 5) 18, 28; Clayton (n 80) 488–9; Baron and Dierckxsens (n 46) 604–5.

83 Kaltiala et al, 'Adolescent Development' (n 80) 214; Elkadi et al (n 23) 7, 20; Cass (n 5) 39; Riittakerttu Kaltiala-Heino et al, 'Gender Dysphoria in Adolescence: Current Perspectives' (2018) 9 *Adolescent Health, Medicine and Therapeutics* 31, 33 <https://doi.org/10.2147/AHMT.S135432>; Clayton (n 80) 488; Socialstyrelsen (n 79) 3.

84 Cass (n 5) 19; Elkadi et al (n 23) 18, 20; Kaltiala-Heino et al (n 83) 33; Barnes (n 79) 5–6; Baron and Dierckxsens (n 46) 604.

85 Cass (n 5) 19, 36; Elkadi et al (n 23) 18, 20; Socialstyrelsen (n 79) 4.

86 Socialstyrelsen (n 79) 4.

minors have received gender-affirming treatments, those administering and undertaking research about them have increasingly reported different views from one another about appropriate care for people with gender dysphoria.[87] Others highlight the risk that ideological beliefs will influence interpretation of existing data,[88] as well as future research in this area, thereby reducing the accuracy of information produced about this healthcare.[89]

Owing to the known side effects of gender-affirming medical treatments, and the view that further investigation into their other possible adverse impacts is imperative, some believe that the appropriateness of minors' access to them at present should be carefully considered.[90] Of particular concern is the potential of these treatments to impair sexual function and fertility.[91] Some maintain that use of puberty blockers impedes the development of genitalia, resulting in 'limited to absent [sexual] functioning as an adult' (and in people assigned male at birth, 'erection, orgasm, and ejaculation, will be significantly impaired to absent').[92] They note that procedures to harvest and freeze sperm and ova can be costly and have detrimental health effects,[93] which may partly explain the seemingly low number of minors having gender-affirming medical treatments who choose to undergo them.[94] Some observe that, while people who have reached a late stage in or completed puberty consistent with their sex assigned at birth can use established fertility preservation methods (sperm, oocyte and embryo cryopreservation), only 'experimental' methods (such as 'testicular and ovarian tissue cryopreservation') are available for minors who have gender-affirming treatments before they commence puberty.[95] They emphasise that infertility may in turn lead to mental health problems.[96]

Other possible risks of puberty blockers that some highlight are that they could: reduce bone mineral density and development, increasing chances of osteoporosis and fractures; interrupt brain, emotional, and sexual development (especially if 'adolescent hormone surges' are inhibited); affect height and body shape (including causing weight gain); impede the development of sex organs (with the consequence of reduced tissue in transgender females to perform a vaginoplasty

87 See, eg, O'Connell et al (n 49). Cf Kozlowska et al (n 7).
88 Cass (n 5) 19.
89 Kozlowska et al (n 7) 88.
90 Baron and Dierckxsens (n 46) 604–5; Clayton (n 80) 485–6, 488–9; Cass (n 5) 18–24; Roberto D'Angelo et al, 'One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria' (2021) 50 *Archives of Sexual Behavior* 7, 12–13 <https://doi.org/10.1007/s10508-020-01844-2>; Elkadi et al (n 23) 20.
91 Clayton (n 80) 485–6; Kaltiala et al, 'Time Trends in Referrals' (n 26) 40; Laidlaw, Cretella and Donovan (n 79) 75–6; O'Connor and Madden (n 46) 161–2; Baron and Dierckxsens (n 46) 605; Cass (n 5) 36.
92 Laidlaw, Cretella and Donovan (n 79) 76.
93 Baron and Dierckxsens (n 46) 605.
94 Laidlaw, Cretella and Donovan (n 79) 76; Leena Nahata et al, 'Low Fertility Preservation Utilization among Transgender Youth' (2017) 61(1) *Journal of Adolescent Health* 40, 42–3 <http://dx.doi.org/10.1016/j.jadohealth.2016.12.012>.
95 Nahata et al (n 94) 41; Laidlaw, Cretella and Donovan (n 79) 76.
96 Laidlaw, Cretella and Donovan (n 79) 75.

satisfactorily); and cause headaches, hot flushes, low mood, fatigue, and anxiety.[97] It is asserted that some effects of hormone treatment are irreversible, while the reversibility of others is still unknown,[98] there are risks of its links with acne, mood swings, thromboembolic disease, and increased blood pressure,[99] and evidence has confirmed 'increased cardiovascular risks, osteoporosis, and hormone-dependent cancers' in adults who have received hormone therapy.[100] The potential for gender-affirming surgery to result in complications is also emphasised.[101]

Some are unconvinced that gender-affirming medical treatments are vital for improving the mental health of minors who are diagnosed with gender dysphoria.[102] They do not infer from the high rate of psychiatric conditions in this cohort that those conditions are 'secondary' to gender dysphoria and thus that such intervention will necessarily resolve them.[103] They observe 'the difficulties of untangling gender dysphoria from comorbid factors',[104] and note that, for certain participants in research studies, their pre-existing mental health issues persisted or new problems emerged following gender-affirming medical interventions, necessitating psychological or psychiatric treatment.[105] Referring to statistics indicating that the suicide rate among young people with gender dysphoria is low, some argue that medical intervention is unjustified based on a suicide risk in this cohort.[106]

It is contended that available evidence does not confirm that medical treatments are more effective than psychological care and psychosocial support in ameliorating distress in minors with gender dysphoria.[107] Indeed, some favour a 'watchful waiting' approach, treatment of minors' psychological conditions, and/or undertaking 'psychosocial interventions', prior or as an alternative to any medical treatment.[108] The possibility has been raised that, influenced by the gender-affirming treatment model, some minors are convinced that medical intervention will completely alleviate their distress.[109] They may therefore experience a 'placebo effect' when they attend gender medical clinics: the treatment context with its promise of relief from suffering, rather than the intervention itself, assists them.[110]

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97 Cass (n 5) 38; Clayton (n 80) 485; D'Angelo et al (n 90) 12; Elkadi et al (n 23) 11, 17–18; Laidlaw, Cretella and Donovan (n 79) 76; O'Connor and Madden (n 46) 160–1; Baron and Dierckxsens (n 46) 605; Biggs (n 25) 352–3, 358–60; Barnes (n 79) 6.

98 Baron and Dierckxsens (n 46) 604; Elkadi et al (n 23) 18; Clayton (n 80) 485; O'Connor and Madden (n 46) 160–1; Cass (n 5) 36.

99 Laidlaw, Cretella and Donovan (n 79) 75; O'Connor and Madden (n 46) 161–2.

100 Cass (n 5) 36; Clayton (n 80) 485.

101 Clayton (n 80) 485.

102 O'Connor and Madden (n 46) 157–8, 162.

103 Kaltiala et al, 'Adolescent Development' (n 80) 213, 218; Kaltiala-Heino et al (n 83) 38; O'Connor and Madden (n 46) 157–8.

104 Kozlowska et al (n 7) 71.

105 Kaltiala et al, 'Adolescent Development' (n 80) 217–18; Elkadi et al (n 23) 7, 13–14, 16, 18.

106 Baron and Dierckxsens (n 46) 605. See also O'Connor and Madden (n 46) 162.

107 Baron and Dierckxsens (n 46) 604–6; Clayton (n 80) 488–9; Elkadi et al (n 23) 20; Littman (n 81) 3365.

108 D'Angelo et al (n 90) 12; Clayton (n 80) 488–9; Laidlaw, Cretella and Donovan (n 79) 77; Baron and Dierckxsens (n 46) 606; Kozlowska et al (n 7) 92–3.

109 Elkadi et al (n 23) 7; Kozlowska et al (n 7) 91–2; Littman (n 81) 3365.

110 Clayton (n 80) 483–4, 487–8.

Some believe there is even a risk that minors' mental health could deteriorate as a consequence of receiving gender-affirming medical treatments.[111] This might be the case, they consider, if minors experience reduced self-esteem, increased anxiety, social ostracism, and/or victimisation due to the disjunction between their physical appearance and behaviour and those of their peers who are undergoing puberty consistent with their sex assigned at birth.[112] It has been asserted that, especially if an individual detransitions as an adult, gender-affirming medical treatments received during their youth could have a detrimental impact on their future wellbeing due to the irreversible physical changes they induced and associated social difficulties and health problems they suffer.[113] Accepting and pathologising, rather than challenging, minors' experiences of their gender identity have also been considered to have the potential to harm them.[114]

Some are reluctant to conclude that medical intervention is necessary to treat distress associated with gender dysphoria while, as they consider, its aetiology remains unclear.[115] Further, they argue that medical treatments would be unlikely to address many of the factors that have been conjectured might contribute to minors' distress, some of which may have a reduced influence on them as they mature, so that it could have resolved in any event without medical intervention.[116] In addition to mental health conditions, they include: minors' experiences of bullying,[117] sexual abuse, trauma, depression, and/or family conflict;[118] their homophobia and/or fear of being homosexual or bisexual;[119] their poor coping strategies;[120] peer pressure, 'social contagion', and promotion of the benefits of gender-affirming medical treatments in social and other forms of media, on internet sites, and by health professionals;[121] and undergoing the changes of adolescence in a climate where gender identity is the subject of social and political polemical debate.[122] It is also hypothesised that features of ASD could lead minors with this diagnosis to experience gender dysphoria. For example, some consider that: gender identity may be a 'special interest' that individuals with ASD pursue with unusual intensity or obsessiveness, but on which, in time, they may cease to focus; due to their social communication challenges, they might not recognise social cues regarding gender norms or could identify with the opposite sex when they do not fit in with peers of the same assigned sex; and/or

111 Kaltiala et al, 'Adolescent Development' (n 80) 218.
112 O'Connor and Madden (n 46) 159, 162; Baron and Dierckxsens (n 46) 605.
113 D'Angelo et al (n 90) 13; Elkadi et al (n 23) 17.
114 Kozlowska et al (n 7) 72–3.
115 Kaltiala-Heino et al (n 83) 38; Cass (n 5) 55–7; Littman (n 81) 3364–5; Socialstyrelsen (n 79) 3.
116 Littman (n 81) 3365; Baron and Dierckxsens (n 46) 606.
117 Baron and Dierckxsens (n 46) 605; O'Connor and Madden (n 46) 157; Kaltiala et al, 'Adolescent Development' (n 80) 213.
118 Kozlowska et al (n 7) 86–8; Cass (n 5) 57; Elkadi et al (n 23) 10.
119 Littman (n 81) 3365; D'Angelo et al (n 90) 12; Cass (n 5) 57.
120 Littman (n 81) 3365.
121 Baron and Dierckxsens (n 46) 605; Elkadi et al (n 23) 19; Littman (n 81) 3365; Kaltiala-Heino et al (n 83) 38; Laidlaw, Cretella and Donovan (n 79) 76; O'Connor and Madden (n 46) 152.
122 Elkadi et al (n 23) 3–4.

owing to their rigid thinking, they could struggle to engage flexibly with 'gender variant feelings' that can be an incident of adolescent development.[123]

It is suspected that certain health professionals have not candidly discussed with one another the possibility that minors' distress about their gender identity is attributable to the abovementioned matters, and thus whether medical intervention is the most appropriate response.[124] As a consequence, their assessments of minors seeking gender-affirming treatments may be inadequate and superficial.[125] This is considered worrying, especially because a diagnosis of gender dysphoria depends to a large extent on the minor's report (not on an objective scientific test), which may be unreliable if any of the abovementioned factors have led to the minor's distress and to their conviction that medical intervention will resolve it.[126] Further, some argue that medical treatment that affirms a minor's asserted gender identity could lead to a 'false positive'.[127]

Some suggest that it is premature to provide gender-affirming medical treatments to any minors who present with distress associated with their gender identity. They emphasise that, for many individuals, childhood and adolescence involves exploration of identity alongside biological, cognitive, and emotional development and maturation.[128] During this time, gender identity can remain fluid.[129] It is considered that gender dysphoria may be fleeting and attributable to temporary discomfort with pubertal changes, and thus abate.[130] Some maintain that it could precede and even be integral to confirming an individual's homosexual or bisexual, rather than transgender, identity.[131] It is argued that gender-affirming medical interventions could interfere with, rather than appropriately support, this developmental process.[132]

Prescription of puberty blockers for prepubescent children is suspected to be especially hasty given evidence indicating that those who assert a gender identity that differs from their sex assigned at birth will often identify with their assigned sex when they reach puberty.[133] Some acknowledge that early studies suggested that those who continued to experience gender dysphoria in puberty were unlikely to desist.[134] Yet they query whether this observation remains pertinent for the current, different social climate and cohort of minors diagnosed with gender dysphoria.[135] Further, they observe that it may be difficult for health professionals to predict which individuals' gender dysphoria will continue or remit, and thus whether it is

123 Kozlowska et al (n 7) 87; Kaltiala-Heino et al (n 83) 34.
124 Cass (n 5) 16–17, 48.
125 Ibid 17; Littman (n 81) 3360, 3366; Elkadi et al (n 23) 7.
126 Baron and Dierckxsens (n 46) 604; O'Connor and Madden (n 46) 152; Elkadi et al (n 23) 7.
127 Baron and Dierckxsens (n 46) 604.
128 Kaltiala et al, 'Adolescent Development' (n 80) 213; Kaltiala et al, 'Time Trends in Referrals' (n 26) 43.
129 Cass (n 5) 36, 56.
130 D'Angelo et al (n 90) 12; Cass (n 5) 56; Littman (n 81) 3365; Baron and Dierckxsens (n 46) 606.
131 D'Angelo et al (n 90) 12; Littman (n 81) 3365; Biggs (n 25) 360–1.
132 Littman (n 81) 3365; Kaltiala et al, 'Time Trends in Referrals' (n 26) 43; Kozlowska et al (n 7) 73; O'Connor and Madden (n 46) 159.
133 Kaltiala et al, 'Time Trends in Referrals' (n 26) 40; O'Connor and Madden (n 46) 162.
134 Cass (n 5) 56.
135 Ibid.

useful to provide medical treatment to them.[136] Moreover, it is feared that puberty blockers could reinforce minors' gender dysphoria and become a 'self-fulfilling prophecy'; minors may proceed to hormone therapy because it becomes difficult or inconceivable psychologically to resile from their asserted gender identity or their progress towards desistance has been interrupted.[137]

The facts that some people have experienced regret at having had gender-affirming medical treatments and/or detransitioned, and that the rate of detransitioning is still unknown, are also interpreted as indicating that this intervention could be premature.[138] An apparent increase in the number of people reported as falling within this category has been highlighted, and some consider it is probably an underestimate, including because those who detransition may be unlikely to inform the health professionals who provided gender-affirming treatments to them of their decision.[139] They refer to studies in which some participants reported that they detransitioned because their distress associated with gender dysphoria resolved and/or they recognised that it was attributable to other factors.[140]

III LAWS REGARDING GENDER-AFFIRMING MEDICAL TREATMENT FOR MINORS

In this Part, some laws that apply to gender-affirming medical treatment for minors in different countries in the West are considered. This is not intended to be a comprehensive examination of relevant laws in all jurisdictions, or even the laws within each of the jurisdictions discussed (which can be varied). Rather, examples have been chosen to illustrate the notable diversity in legal approaches that are being taken to this branch of medicine, the mutability of this area of the law, and the frequent lack of clarity regarding various aspects of it.

A United States of America

Particularly since 2020, in many states within the federal system of the United States of America ('US'), legislative or executive action has been taken in attempts to modify the law or introduce new laws regarding gender-affirming medicine for minors.[141] These moves have occurred largely along political party lines, with Republican Party law-makers eager to curtail use of the treatments.[142] There is a separation of powers between the executive, legislative, and judicial branches of

136 Baron and Dierckxsens (n 46) 604; Laidlaw, Cretella and Donovan (n 79) 76.
137 Biggs (n 25) 352; Elkadi et al (n 23) 17; Laidlaw, Cretella and Donovan (n 79) 76; D'Angelo et al (n 90) 12; Cass (n 5) 38; Kaltiala-Heino et al, 'Gender Dysphoria' (n 83) 38.
138 Baron and Dierckxsens (n 46) 604; Littman (n 81) 3354, 3364–5; Clayton (n 80) 486; Elkadi et al (n 23) 7.
139 Baron and Dierckxsens (n 46) 603–4; Littman (n 81) 3364–5, 3367; D'Angelo et al (n 90) 13; Clayton (n 80) 486.
140 Littman (n 81) 3365; Elkadi et al (n 23) 7.
141 Elana Redfield et al, *Prohibiting Gender-Affirming Medical Care for Youth* (Report, March 2023) 3, 6–11.
142 Devan Cole, 'GOP Lawmakers Escalate Fight against Gender-Affirming Care with Bills Seeking to Expand the Scope of Bans', *CNN* (online, 13 February 2023) <https://edition.cnn.com/2023/02/11/politics/gender-affirming-care-bans-transgender-rights/index.html>.

government in the US.[143] While their relative authority differs between states, in some instances, certain branches of government have been able to obstruct efforts to amend laws pertaining to gender-affirming care.[144] Changes to laws may also be impeded if they are found to have contravened federal constitutional and statutory obligations.[145]

In several states, legislatures have enacted statutes prohibiting provision of puberty blockers and hormone treatment to and/or the conduct of gender-affirming surgery on people under the age of 18 or 19 (depending on the state) for the purpose of treating gender dysphoria, or bills have been introduced proposing such bans.[146] Most of the legislation permits the use of these interventions for specified other reasons, such as treatment of a 'disorder of sex development' (Missouri and Idaho),[147] 'precocious puberty' (Utah),[148] or a 'physical disorder', 'injury', or 'illness' that would 'place the person in imminent danger of death, or impairment of a major bodily function unless surgery is performed' (West Virginia).[149] In some states (such as Mississippi and Iowa), 'aiding' or 'abetting' the provision of gender-affirming medical treatments for gender dysphoria is also proscribed,[150] as is 'offering to perform' or 'administer' them (for instance, Tennessee).[151] Some of this legislation (such as Alabama and Tennessee) nonetheless emphasises that it is not intended to prevent health professionals from providing psychological and counselling services.[152] Bills in certain states (including Missouri) also propose that parents and guardians will face liability for enabling minors to access gender-affirming care.[153] In addition, some bills would ban insurers from covering health

143 Beryl A Radin and Joan Price Boase, 'Federalism, Political Structure, and Public Policy in the United States and Canada' (2000) 2(1) *Journal of Comparative Policy Analysis* 65, 67 <https://doi.org/10.1080/13876980008412636>.

144 See ibid 67–8, 71, 76–7.

145 Letter from Kristen Clarke, Assistant Attorney General, to State Attorneys General, 31 March 2022 <https://www.justice.gov/opa/press-release/file/1489066/download>.

146 See, eg, Alabama's legislation, which prohibits provision of gender-affirming medical treatments to people under 19 years of age: *Vulnerable Child Compassion and Protection Act*, Ala Code §§ 26-26-3–26-26-4 (2022) ('*Compassion and Protection Act*'); Ala Code § 43-8-1(18) (2006). See also legislation in Mississippi, Tennessee, Idaho, West Virginia, and Utah, which prohibit provision of these treatments to people under 18 years of age: Mississippi's *Regulate Experimental Adolescent Procedures (REAP) Act*, 41 Miss Code Ann §§ 41-141-3, 41-141-5 (2023) ('*REAP Act*'); Tenn Code Ann §§ 68-33-102(6), 68-33-103, 68-33-104 (LexisNexis 2023); Idaho Code Ann §§ 18-1506B(2), (7) (2023); W Va Code §§ 30-3-20(a)–(b) (2024); Utah Code Ann §§ 58-1-603(1)(g), 58-1-603.1(2) (2023).

147 *Missouri Save Adolescents from Experimentation (SAFE) Act*, Mo Rev Stat § 191-1720-8(1) (2023) ('*SAFE Act*'); Idaho Code Ann § 18-1506B(4) (2020).

148 Utah Code Ann § 58-1-603(1)(e)(ii)(A) (2023).

149 3 W Va Code § 30-3-20(c)(4) (2024). This legislation also creates an exception, allowing provision of such treatments to an individual who 'has been diagnosed as suffering from severe gender dysphoria' in specified circumstances, including if it is deemed 'medically necessary to treat the minor's psychiatric symptoms and limit self-harm, or the possibility of self-harm, by the minor': at § 30-3-20(c)(5).

150 *REAP Act* (n 146) § 41-141-5(2); An Act Relating to Prohibited Activities regarding Gender Transition Procedures Relative to Minors, and Including Effective Date and Applicability Provisions, S 538, 90th Congress § 2(b) (2023).

151 Tenn Code Ann § 68-33-103(a)(1) (2023).

152 Ibid § 68-33-109; Ala Code § 26-26-6 (2022).

153 Redfield et al (n 141) 13; An Act to Amend Chapter 191, RSMo, by Adding Thereto One New Section Relating to Gender Reassignment for Children under Eighteen Years of Age, SB 281, 102nd Congress, § 3 (2023).

professionals for claims against them related to their provision of gender-affirming care to minors and/or the use of state funds to cover the cost of the treatments and insurance related to them.[154]

Consequences of breaching current prohibitions on provision of gender-affirming care under this legislation vary depending on the state, but can be extremely serious. Some state bodies that license health professionals may find that the practitioners have engaged in 'unprofessional conduct' and impose disciplinary measures, including revocation of their licences to practise their profession (for instance, Mississippi and Missouri).[155] In certain states, this behaviour has been classified as a criminal 'felony' that can attract a sentence of imprisonment of up to 10 years (for example, Idaho and Alabama).[156] Further, some states permit the initiation of civil suits against health practitioners who contravene the laws, which could result in the imposition of a monetary penalty (such as in Tennessee).[157]

The titles of these statutes often reflect the legislature's views on gender-affirming medical treatments for minors, such as Missouri's *Save Adolescents from Experimentation (SAFE) Act* (2023) and Idaho's *Vulnerable Child Protection Act* (2023). In addition, some of this legislation articulates reasons for its proscription of such treatments. For example, Alabama's statute states: 'This unproven, poorly studied series of interventions results in numerous harmful effects for minors, as well as risks of effects simply unknown due to the new and experimental nature of these interventions'; and '[m]inors, and often their parents, are unable to comprehend and fully appreciate the risk and life implications … that result from' them.[158] Tennessee's legislation refers to the state's 'legitimate, substantial, and compelling interest in protecting': 'minors from physical and emotional harm'; 'the ability of minors to develop into adults who can create children of their own'; and 'the integrity of the medical profession … by prohibiting medical procedures that are harmful, unethical, immoral, experimental, or unsupported by high-quality or long-term studies'.[159]

Courts have temporarily halted the operation of legislation prohibiting provision of gender-affirming treatments to minors in several states, including South Dakota, Utah, Alabama, and Arkansas, in response to legal challenges to them.[160] In Alabama and Arkansas, for example, courts issued injunctions to

154 Redfield et al (n 141) 13–14. See, eg, Oklahoma State Bill, HB 1466, 59th Congress § 5 (2023) ('Oklahoma Bill').

155 *REAP Act* (n 146) § 41-141-9(1); *SAFE Act* (n 147) § 191.1720(5).

156 Idaho Code Ann §§ 18-1506B(2), (6), 18-1506C(5) (2022); *Compassion and Protection Act* (n 146) §§ 26-26-4(a), (c); Ala Code § 13A-5-6(a)(3).

157 Redfield et al (n 141) 12; Tenn Code Ann § 68-33-106(b) (2023).

158 *Compassion and Protection Act* (n 146) §§ 26-26-2(11), (15).

159 Tenn Code Ann § 68-33-101(m) (2023).

160 Lepore, Alstott and McNamara (n 15) 965; Laura E Kuper, M Brett Cooper and Megan A Mooney, 'Supporting and Advocating for Transgender and Gender Diverse Youth and Their Families within the Sociopolitical Context of Widespread Discriminatory Legislation and Policies' (2022) 10(3) *Clinical Practice in Pediatric Psychology* 336, 337 <https://doi.org/10.1037/cpp0000456>; United States Department of Justice, 'Justice Department Challenges Tennessee Law That Bans Critical, Medically Necessary Care for Transgender Youth' (Press Release, 26 April 2023) <https://www.justice.gov/opa/pr/justice-department-challenges-tennessee-law-bans-critical-medically-necessary-care>; Jo Yurcaba, 'Judge Blocks Alabama's Felony Ban on Transgender Medication for Minors', *NBC News* (online, 15 May

prevent enforcement of relevant legislation, and permit minors to access this care while litigation concerning it remains on foot.[161] In addition, the federal Department of Justice has sent a letter to the states' Attorneys General emphasising that proscriptions on gender-affirming treatment for minors may breach federal anti-discrimination laws.[162]

Some state governors have been vocal in supporting bans on gender-affirming care for minors, arguing that they would 'protect' minors.[163] Executive action to achieve this end has been particularly controversial in the state of Texas. In response to a request from the Chair, House Committee on General Investigating, Texas House of Representatives, Texas's Attorney General produced an opinion, stating that these treatments could constitute 'child abuse' under the *Texas Family Code* (including by causing 'physical injury that results in substantial harm to the child').[164] Although the opinion was not legally binding, in response to it, Texas's Governor directed the Department of Family and Protective Services (which 'is responsible for protecting children from abuse') to investigate 'any reported instances of these abusive procedures'.[165] The Texas State Legislature subsequently passed a bill prohibiting provision of gender-affirming treatments to minors for gender dysphoria.[166] In response to a legal challenge, a District Court judge ordered an injunction staying the operation of the legislation, but on appeal, the Texas Supreme Court refused to reinstate it.[167]

Some states led by Democratic Party governments have passed legislation seemingly intended to counteract the effects of statutes enacted in Republican states. For instance, Massachusetts's *An Act Expanding Protections for Reproductive and Gender-Affirming Care* (2022) confirms that a health professional will not be subject to

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2022) <https://www.nbcnews.com/nbc-out/out-politics-and-policy/judge-blocks-alabamas-felony-ban-transgender-medication-minors-rcna28607>; Jennifer Block, 'Raft of US State Laws Restrict Access to Treatments for Gender Dysphoria' (2023) 380 *British Medical Journal* p533:1 <https://doi.org/10.1136/bmj.p533>.

161 Redfield et al (n 141) 8–9; Cole (n 142).

162 Clarke (n 145).

163 Maxime Tamsette, Pamela Kirkland and Jack Forrest, 'Georgia's Governor Signs Ban on Certain Gender-Affirming Care for Minors', *CNN* (online, 23 March 2023) <https://edition.cnn.com/2023/03/23/politics/brian-kemp-georgia-gender-affirming-care/index.html>; Sydney Kashiwaga, 'South Dakota Governor Signs Bill Prohibiting Gender-Affirming Treatment for Transgender Minors', *CNN* (online, 13 February 2023) <https://edition.cnn.com/2023/02/13/politics/south-dakota-kristi-noem-transgender-minors/index.html>.

164 Letter from Ken Paxton, Attorney General of Texas to Matt Krause, Chair, House Committee on General Investigating (18 February 2022) 2 <https://texasattorneygeneral.gov/sites/default/files/global/KP-0401.pdf>.

165 Letter from Greg Abbott, Governor of Texas to Jaime Masters, Commissioner, Department of Family and Protective Services (22 February 2022) 1 <https://gov.texas.gov/uploads/files/press/O-MastersJaime202202221358.pdf>; Cole (n 142).

166 Relating to Prohibitions on the Provision to Certain Children of Procedures and Treatments for Gender Transitioning, Gender Reassignment, or Gender Dysphoria and on the Use of Public Money or Public Assistance to Provide Those Procedures and Treatments, TX SB 14, 88th Congress (2023).

167 Chris Boyette and Kaanita Iyer, 'Texas Supreme Court Allows Ban on Gender-Affirming Care for Most Minors to Take Effect Friday', *CNN* (online, 31 August 2023) <https://edition.cnn.com/2023/08/31/politics/texas-gender-affirming-care-ban/index.html>.

> revocation, suspension or cancellation of the certificate of registration or reprimand, censure or monetary fine, for providing or assisting in the provision of … gender-affirming health care services … if the services as provided would have been lawful and consistent with good medical practice if they occurred entirely in the commonwealth [of Massachusetts].[168]

Also, an application for registration as a physician in Massachusetts cannot be subject to 'adverse action … based on a criminal or civil action, disciplinary action by a licensing board of another state … arising from the provision of … gender-affirming health care services' if the services would have been lawful in Massachusetts.[169]

Amendments to the *Civil Code* in California prohibit a healthcare provider from releasing

> medical information related to a person or entity allowing a child to receive gender-affirming health care … in response to any civil action … based on another state's law that authorizes a person to bring a civil action against a person or entity that allows a child to receive gender-affirming health care.[170]

Further, amendments to California's *Family Code* endow state courts with 'temporary emergency jurisdiction if the child is present in this state and the child has been abandoned or it is necessary in an emergency to protect the child … because the child has been unable to obtain gender-affirming health care' in another state.[171] Also added to the *Family Code* was the following:

> A law of another state that authorizes a state agency to remove a child from their parent or guardian based on the parent or guardian allowing their child to receive gender-affirming health care … is against the public policy of this state and shall not be enforced or applied in a case pending in a court in this state.[172]

Minors in California must nonetheless obtain their parents' consent to receive gender-affirming medical treatments, unless they are at least 15 years of age, living separately from their parents/guardian, and managing their own financial affairs, or they are 'emancipated' (married).[173]

B Australia

Australia also has a federal system and separation of powers between the legislative, executive, and judicial branches of government. Nevertheless, by contrast to the US, Australian laws surrounding minors' access to gender-affirming medical treatments have derived mostly from case law, rather than legislative or executive action.[174] Decisions of the Family Court of Australia have largely governed this area of the law, as it has 'jurisdiction to make orders relating to the welfare of children' (known as the 'welfare' or 'parens patriae' power), and 'parenting orders' that 'deal with' the child's 'welfare … or any other aspect of parental responsibility for a

168 *An Act Expanding Protections for Reproductive and Gender-Affirming Care*, 112 Mass Gen Laws § 5F1/2 (2022).
169 Ibid.
170 Cal Civ Code § 56.109(a) (West 2022).
171 Cal Fam Code § 3424(a) (West 2023).
172 Ibid § 3453.5(a).
173 Ibid §§ 6922(a), 7002, 7050(e)(1).
174 Jowett and Mathews (n 4) 1857–8.

child'.[175] As the Family Court is a federal court, its judgments apply in all Australian states and territories. In the years since its first decision regarding medical treatment for a minor with gender dysphoria in 2004,[176] the Court has produced several significant and often inconsistent judgments in this area. There remains uncertainty regarding some aspects of the law and particularly, as noted above, whether court involvement is required in circumstances where the minor and their parents and/or medical practitioners disagree about their ability to consent to treatment, their diagnosis of gender dysphoria, and/or the proposed treatment.

In Australia, parents have legal responsibilities for their children who are under the age of 18, including to consent to and make decisions on their behalf regarding their medical treatment.[177] Nevertheless, as the High Court of Australia confirmed in 1992 in *Secretary, Department of Health and Community Services v JWB* ('*Marion's Case*'), 'parental power to consent to medical treatment on behalf of a child diminishes gradually as the child's capacities and maturity grow'.[178] The Court adopted the proposition articulated by Lord Scarman in the House of Lords' case of *Gillick v West Norfolk and Wisbech Area Health Authority* ('*Gillick*') that 'the parental right to determine whether or not their minor child … will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed', at which time the child will be able to 'give a consent valid in law'.[179] Subsequent case law has described a minor with this capacity as being '*Gillick* competen[t]'.[180] Also in *Marion's Case*, the High Court distinguished between 'therapeutic' medical procedures to which a parent or *Gillick* competent child can consent, and 'non-therapeutic' procedures.[181] Decisions regarding whether a child can access some 'non-therapeutic' medical procedures will 'not come within the ordinary scope of parental power to consent to medical treatment', and 'court authorisation is necessary' even if the child is deemed *Gillick* competent.[182] The Court held that court approval will be required especially where (as in *Marion's Case*, which concerned a proposal to perform a hysterectomy and ovariectomy

175 *Family Law Act 1975* (Cth) ss 64B(2)(i), 67ZC(1) ('*Cth Family Law Act*'); *Re Jamie* (n 12) 189 [170] (Finn J); *Re Kelvin* (n 12) 26 [66] (Thackray, Strickland and Murphy JJ).

176 *Re Alex* (2004) 180 FLR 89; Fiona Kelly, 'Australian Children Living with Gender Dysphoria: Does the Family Court Have a Role to Play?' (2014) 22(1) *Journal of Law and Medicine* 105, 107–8 ('Australian Children').

177 *Cth Family Law Act* (n 175) ss 61B–61C; *Secretary, Department of Health and Community Services v JWB* (1992) 175 CLR 218, 237 (Mason CJ, Dawson, Toohey and Gaudron JJ) ('*Marion's Case*'); Malcolm K Smith, 'The Requirement for Trans and Gender Diverse Youth to Seek Court Approval for the Commencement of Hormone Treatment: A Comparison of Australian Jurisprudence with the English Decision in *Bell*' (2022) 31(1) *Medical Law Review* 47, 51 ('Requirement for Trans and Gender Diverse Youth'). Each Australian state and territory has passed legislation confirming that 18 is the age of majority.

178 *Marion's Case* (n 177) 237 (Mason CJ, Dawson, Toohey and Gaudron JJ).

179 Ibid, quoting *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, 188–9 (Lord Scarman).

180 Ben Mathews and Malcolm Smith, 'Children and Consent to Medical Treatment' in Ben White, Fiona McDonald and Lindy Willmott (eds), *Health Law in Australia* (Lawbook, 3rd ed, 2018) 159, 164.

181 *Marion's Case* (n 177) 250 (Mason CJ, Dawson, Toohey and Gaudron JJ).

182 Ibid.

on an intellectually-disabled adolescent) the procedure involves 'invasive, irreversible and major surgery', there is a 'significant risk of making the wrong decision, either as to a child's present or future capacity to consent or about what are the best interests of a child who cannot consent', and 'the consequences of a wrong decision are particularly grave'.[183]

In recent years, the Family Court of Australia has changed its approach to the question of whether some gender-affirming medical treatments are therapeutic or constitute 'special medical procedures' – as they have been described in subsequent relevant cases – which require court approval to be administered to people under the age of 18.[184] Before 2004, parents could consent to their children having medical treatments, other than surgical procedures, for gender dysphoria.[185] Nevertheless, in the case of *Re Alex* that year, Nicholson CJ considered that 'hormonal therapies' administered for gender dysphoria did not constitute 'treatment … to cure a disease or correct some malfunction', but rather special medical procedures for which court authorisation was necessary.[186] In 2013, the Full Court of the Family Court partly altered this position in its judgment in the case of *Re Jamie*. It classified puberty blockers (described as 'stage 1 treatment') as 'therapeutic' on the bases that they are intended to address a 'psychological' 'disease', their effects were considered reversible, and thus 'the risks of a wrong decision and resulting grave consequences do not arise'.[187] Therefore, if a child was not *Gillick* competent, their parents could consent to them having stage 1 treatment and court approval was not required.[188]

The Court in *Re Jamie* also held that a court determination of whether a child was *Gillick* competent was still required where hormone treatment, described as 'stage 2 treatment', was being considered; although it was also deemed therapeutic, the trial judge found that it was 'irreversible in nature' and carried 'risks of a wrong decision' being made and of 'grave consequences' flowing from such a decision.[189] If the Court found the child to be *Gillick* competent and there was no 'controversy', they could consent to the treatment and, if the Court found the child was not *Gillick* competent, the Court would decide whether to authorise treatment.[190] In that case, Bryant CJ commented that, 'if there is a dispute about whether [stage one or stage two] treatment should be provided … and what form treatment should take, it is appropriate for this to be determined by the court' under its welfare power.[191] Her Honour also stated:

> If there is a dispute between the parents, child and treating medical practitioners, or any of them, regarding the treatment and/or whether or not the child is *Gillick*

183 Ibid 229, 250.

184 See, eg, *Re Alex* (n 176) 116 [152] (Nicholson CJ); Fiona Kelly et al, 'Parental Consent and the Treatment of Transgender Youth: The Impact of *Re Imogen*' (2022) 216(5) *Medical Journal of Australia* 219, 219 <https://doi.org/10.5694/mja2.51431>.

185 Kelly, 'Australian Children' (n 176) 107–8.

186 *Re Alex* (n 176) 92 [4], 94 [19]–[21], 124–5 [196], [200]–[201] (Nicholson CJ).

187 *Re Jamie* (n 12) 178 [106]–[108], 184–5 [140] (Bryant CJ), 191 [179] (Finn J), 193 [193] (Strickland J).

188 Ibid 178 [108], 184–5 [140] (Bryant CJ), 189 [172] (Finn J).

189 Ibid 184–5 [140] (Bryant CJ), 191–2 [180]–[186] (Finn J).

190 Ibid 184–5 [139]–[140] (Bryant CJ), 192 [188] (Finn J), 193 [195]–[196] (Strickland J).

191 Ibid 184 [140].

> competent, the court should make an assessment about whether to authorise stage two having regard to the best interests of the child as the paramount consideration.[192]

In 2017, the Full Court of the Family Court shifted the law in this area again in the case of *Re Kelvin*. Departing from the decision in *Re Jamie*, it held that, where a child is not considered *Gillick* competent, their parents can consent to stage 2 treatment and court authorisation is not required.[193] If the child consents to stage 2 treatment, their medical practitioners agree they are *Gillick* competent, and the parents do not object, it is unnecessary to apply to the court for a determination of whether the child is *Gillick* competent and the treatment can proceed.[194] The Court explained that these changes to the law were necessary to keep pace with developments in medical knowledge (namely, the risks and consequences of the treatment 'can no longer be said to outweigh [its] therapeutic benefits', there was 'increased knowledge of the risks associated with not treating a minor who has Gender Dysphoria', and following updates to the *DSM-5-TR*, gender dysphoria was no longer labelled a 'disorder').[195] The majority nonetheless confirmed that the court has jurisdiction if 'there is a genuine dispute or controversy as to whether the treatment should be administered; e.g., if the parents, or the medical professionals are unable to agree',[196] and the minority similarly indicated that the court could have a 'role to play' if 'there is a dispute about consent or treatment'.[197]

The Court in *Re Kelvin* did not consider and it remains unsettled whether court approval must be obtained before a minor can undergo gender-affirming surgery ('stage 3 treatment') if they, their parents and their medical practitioners consent to it.[198] Decisions by single judges of the Family Court have reached divergent views on the question of whether the court needs to assess if the minor is *Gillick* competent prior to this treatment commencing.[199]

After *Re Kelvin*, the Royal Children's Hospital published the 'Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents', which stated that an adolescent's clinicians can 'determine their capacity to provide informed consent for treatment' and '[a]lthough obtaining consent from parents/guardians for commencement of hormone treatment is ideal, parental consent is not required when the adolescent is considered to be competent to provide informed consent'.[200] Nevertheless, in 2020, Watts J stated in the Family Court case of *Re Imogen [No 6]* ('*Re Imogen*') that this did 'not accurately reflect

192 Ibid. The *Cth Family Law Act* (n 175) requires the court to 'regard the best interests of the child as the paramount consideration' when 'deciding whether to make an order' 'relating to the welfare of children': at s 67ZC.

193 *Re Kelvin* (n 12) 42 [163]–[166] (Thackray, Strickland and Murphy JJ), 45 [187] (Ainslie-Wallace and Ryan JJ).

194 Ibid 44–5 [178]–[184] (Thackray, Strickland and Murphy JJ), 45 [187] (Ainslie-Wallace and Ryan JJ).

195 Ibid 40–2 [152]–[162], 44 [177] (Thackray, Strickland and Murphy JJ).

196 Ibid 42 [167] (Thackray, Strickland and Murphy JJ).

197 Ibid 45 [189] (Ainslie-Wallace and Ryan JJ).

198 Jowett and Mathews (n 4) 1858.

199 Jowett and Kelly (n 74) 40–1. See, eg, *Re LG* [2017] FCWA 179; *Re Matthew* [2018] FamCA 161; *Re Ryan* [2019] FamCA 112; *Re Imogen* (n 14).

200 *Re Imogen* (n 14) 349 [27] (Watts J); Kelly et al (n 184) 219.

current Full Court authority … in circumstances where there is a dispute about treatment'.[201]

In *Re Imogen*, Watts J held that, before administering stage 1, 2, and 3 treatments, medical practitioners must ascertain whether the child's parents or legal guardians consent to it.[202] If there is no 'dispute by the child, the parents and the medical practitioner', the medical professional bodies can 'regulate what standards should apply to medical treatment'.[203] However, if a parent of the child or their medical practitioner 'disputes' the child's *Gillick* competence, the diagnosis of gender dysphoria and/or the proposed treatment for it, 'an application' to the Family Court is 'mandatory', and the treating practitioner 'should not administer stage 1, 2 or 3 treatment without court authorisation'.[204] Watts J considered that, in that instance, the court must make a finding about whether the child is *Gillick* competent and, if the dispute only concerns their competence and the court declares they are competent, the child can 'determine their treatment without court authorisation'.[205] If the dispute is about the diagnosis and/or proposed treatment, regardless of whether the court finds that the child is *Gillick* competent, the court must 'determine the diagnosis', 'determine whether treatment is appropriate, having regard to the adolescent's best interests as the paramount consideration', and 'make an order authorising or not authorising treatment … on best interest considerations'.[206]

Although *Re Imogen* appears to have expanded on previous Family Court judgments, as the decision of a single judge, it constitutes persuasive, but not binding authority.[207] Notably, in the 2022 case of *Re A*, Boddice J treated as obiter dicta Bryant CJ's comments in *Re Jamie*, which according to his Honour indicated that court authorisation was required if there was a dispute between the minor's parents regarding the treatment.[208] Boddice J stated that 'if it were necessary to decide' (though it was not in *Re A*), 'I would find that both *Re Jamie* and, as a consequence, *Re Imogen*', which 'followed' Bryant CJ's 'interpretation', 'do not correctly state the law' and 'I would decline to follow those cases'.[209] In that case, Boddice J held that, as the minor was *Gillick* competent and consented to stage 2 treatment, there was no need for court authorisation of it, even though the parents disagreed about whether the minor should have the treatment.[210]

C England and Wales

Like Australia, the law regarding gender-affirming medical treatment for minors in the jurisdiction of England and Wales in the United Kingdom is largely

201 *Re Imogen* (n 14) 349 [27].
202 Ibid 357 [63].
203 Ibid.
204 Ibid 351 [35], 352 [38], 357 [63].
205 Ibid 351 [35].
206 Ibid.
207 Kelly et al (n 184) 219.
208 *Re A* (n 14) 6 [26] (Boddice J).
209 Ibid 6 [27].
210 Ibid 4 [1], [4], 6–7 [28].

evolving through the common law. However, in contrast to Australia, recent judicial decisions appear to have reduced the court's potential oversight of this branch of medicine (though there is similarly still some lack of clarity regarding the law). Further, courts' confirmation that the minor, their parents and medical practitioners principally determine the gender-affirming care they receive has occurred following, and might be regarded as being consistent with, the enactment of legislation in England and Wales that reflects respect for people's gender identity where it differs from their sex assigned at birth. This legislation provides for: protection of human rights that may be construed as relevant for TGD people in particular; protection against discrimination of people who have received or are intending to obtain gender-affirming care; and legal recognition of people's 'acquired gender'.[211]

The *Human Rights Act 1998* (UK) gives effect to rights protected by the *European Convention on Human Rights* ('*Convention*').[212] This statute requires courts to act in ways that are compatible with *Convention* rights and, if determining an issue related to a *Convention* right, to take into account decisions of the European Court of Human Rights.[213] Several of those decisions have confirmed that the *Convention* rights to 'respect for … private and family life' and 'enjoyment of the rights and freedoms' it recognises 'without discrimination' provide various protections for TGD people, including of their access to legal gender recognition.[214]

Consistent with this legislation, the *Equality Act 2010* (UK) prohibits discrimination against a person on the basis of their 'protected characteristics', one of which is 'gender reassignment'; a person is recognised as having this characteristic if they are 'proposing to undergo', are 'undergoing' or have 'undergone a process … for the purpose of reassigning the person's sex by changing physiological or other attributes of sex'.[215] In addition, the *Gender Recognition Act 2004* (UK) enables a person who is at least 18 years old to apply for a 'gender recognition certificate' 'on the basis of (a) living in the other gender, or (b) having changed gender under the law of a country or territory outside the United Kingdom'.[216] An application on the basis of living in the other gender will be granted if, inter alia, the applicant produces a report of a medical practitioner and/or psychologist confirming their diagnosis of gender dysphoria and any treatment for 'modifying sexual characteristics' they have undertaken or plan to have.[217] With a gender recognition certificate, the person is 'considered in law to be of their acquired gender'.[218]

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211 Catherine Fairbairn, Doug Pyper and Bukky Balogun, '*Gender Recognition Act* Reform: Consultation and Outcome' (Research Briefing, House of Commons Library, 17 February 2022) 4.

212 *Human Rights Act 1998* (UK) s 1.

213 Ibid ss 2, 6.

214 *Convention for the Protection of Human Rights and Fundamental Freedoms*, opened for signature 4 November 1950, 213 UNTS 221 (entered into force 3 September 1953) arts 8, 14; European Court of Human Rights, 'Guide on the Case-Law of the *European Convention on Human Rights*' (Guide, 31 August 2022) 17–24, 36–7 <https://www.echr.coe.int/documents/d/echr/Guide_LGBTI_rights_ENG>.

215 *Equality Act 2010* (UK) ss 4, 7, 13, 19.

216 *Gender Recognition Act 2004* (UK) s 1 ('*Gender Recognition Act*').

217 Ibid ss 2–3.

218 Ibid ss 9–10; Fairbairn, Pyper and Balogun (n 211) 3.

Pursuant to legislation in England and Wales, it is assumed that a minor aged between 16 and 18 is able to consent to medical treatment (including gender-affirming interventions) without needing to obtain their parents' or guardians' consent.[219] In *Bell v The Tavistock and Portman NHS Foundation Trust* ('*Bell Court of Appeal*') the Court of Appeal held that it was 'inappropriate' for the Divisional Court in that matter (*Bell v The Tavistock and Portman NHS Foundation Trust* ('*Bell Divisional Court*')) to have provided 'guidance' recommending that clinicians seek court approval before prescribing puberty blockers or hormone treatment for 16 and 17 year olds especially if there is 'doubt as to whether [their] long-term best interests … would be served by the clinical interventions', which is not a legal requirement.[220]

In England and Wales, parental responsibility for minors under 16 years of age entails making decisions about their medical treatment on their behalf in their 'best interests',[221] but the decision in *Gillick* applies. In *Bell Court of Appeal*, the Court concurred with Lieven J who, in the case of *AB v CD* ('*UK AB*') in the Family Division, held that if a child is *Gillick* competent and makes a decision regarding their gender-affirming medical treatment, their parent cannot override that decision; if a child is *Gillick* competent, but has not made a decision about this treatment and has not objected to their parent consenting to it on their behalf, the parent can validly consent to the treatment in the child's best interests (provided they are not overriding the child's decision); and if a child is not *Gillick* competent, their parent can consent to treatment on their behalf (without needing to apply to the court for a determination about whether the treatment is in their best interests and for authorisation of it).[222]

The Court in *Bell Court of Appeal* also agreed with Lieven J's view expressed in *UK AB* that puberty blockers should not 'be placed in a special category by which parents are unable in law to give consent' to their prescription and for which court approval is required.[223] If the treating clinician of a child under 16 years of age considers them to be *Gillick* competent to consent to puberty blockers and the child consents, they can prescribe them without seeking the court's approval.[224] In *Bell Court of Appeal*, the Court set aside a 'declaration' made by the Divisional Court regarding matters that a child under 16 would need to understand in order to

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219 *Family Law Reform Act 1969* (UK) ss 1, 8(1); Malcolm Smith, 'Transgender Minors and the Commencement of Hormone Treatment for Gender Dysphoria: Is Recent English Case Law Likely to Influence the Australian Legal Position?' (2022) 29 *Journal of Law and Medicine* 50, 52 ('Transgender Minors').

220 *Bell v The Tavistock and Portman NHS Foundation Trust* [2021] EWCA Civ 1363; 1 All ER 416, 473 [86] (Lord Burnett CJ for the Court) ('*Bell Court of Appeal*'); *Bell v The Tavistock and Portman NHS Foundation Trust* [2020] EWHC 3274; 1 All ER 416, 450–2 [147], [152] (Sharp P, Lewis LJ and Lieven J) ('*Bell Divisional Court*').

221 *Children Act 1989* (UK) ss 2(1), 3(1); *Mental Capacity Act 2005* (UK) ss 1(2), (5); *AB v CD* [2021] EWHC 741 (Fam) [39]–[42] (Lieven J) ('*UK AB*'); Smith, 'Requirement for Trans and Gender Diverse Youth' (n 177) 60.

222 *UK AB* (n 221) [68]–[69], [114] (Lieven J); *Bell Court of Appeal* (n 220) 464 [48] (Lord Burnett CJ for the Court).

223 *UK AB* (n 221) [128] (Lieven J); *Bell Court of Appeal* (n 220) 464 [48] (Lord Burnett CJ for the Court).

224 *Bell Court of Appeal* (n 220) 467 [58], 470–1 [76], 473 [87] (Lord Burnett CJ for the Court).

provide informed consent to the prescription of puberty blockers.[225] The Court also considered it 'inappropriate' for the Divisional Court to have provided 'guidance' that: there should be an application to the court for approval to prescribe puberty blockers even if the child, their parents, and treating practitioners consider it is in their best interests (which is not required by law); and 'it is highly unlikely that a child aged 13 or under would ever be *Gillick* competent to give consent to being treated with' puberty blockers, and 'doubtful that a child' aged 14 or 15 'could understand the long-term risks and consequences of [this] treatment in such a way as to have sufficient understanding to give consent' to it.[226]

In *Bell Court of Appeal*, the Court nonetheless contemplated that '[t]here may be circumstances where there are disputes between one or more of clinicians, patients and parents where an application [to the court] will be necessary'.[227] Similarly, Lieven J in *UK AB* stated that a court application for authorisation of prescription of puberty blockers should be made if the child's treating clinicians are 'concerned that the parents are being pressured to give consent', 'the clinicians consider the case to be finely balanced, or there is disagreement between the clinicians'.[228] It therefore seems that in England and Wales, as is the case in Australia, a superior court has not conclusively determined when it is necessary to obtain court authorisation for prescription of puberty blockers to minors where there is conflict between relevant parties regarding this treatment. Yet a minor with a diagnosis of gender dysphoria might seek to rely on the human rights and anti-discrimination legislation discussed above to contest the restriction by a court – or indeed a health practitioner or parent – of their access to gender-affirming medical care.

Although the abovementioned cases in England and Wales involved prescription of puberty blockers, it seems that court approval would also not be required in this jurisdiction before administering hormone treatment and gender-affirming surgery to minors (at least where there is no disagreement between the minor, their parents and/or their medical practitioners). In *Bell Court of Appeal*, the Court emphasised that treatment of children for gender dysphoria – including puberty blockers and 'cross-sex hormones' – is lawful in England and Wales, and policy decisions concerning whether this treatment is 'wise' and 'should be available' in this jurisdiction 'are for the National Health Service, the medical profession and its regulators and Government and Parliament'.[229] Further, it seems that the courts' views that puberty blockers do not constitute a 'special category' of medical treatment that requires court authorisation would apply to other gender-affirming treatments.

Relevant laws in England and Wales might be clarified in light of the recent release of the final report from the four-year independent review into gender identity services for minors, which was commissioned by the National Health

225 Ibid 454–5 [8], 473–4 [84], [91]; *Bell Divisional Court* (n 220) 449 [138], 452 [153] (Sharp P, Lewis LJ and Lieven J).

226 *Bell Court of Appeal* (n 220) 473–4 [85]–[86], [89], [91] (Lord Burnett CJ for the Court); *Bell Divisional Court* (n 220) 450–1 [145], [149], [151] (Sharp P, Lewis LJ and Lieven J).

227 *Bell Court of Appeal* (n 220) 473 [89] (Lord Burnett CJ for the Court).

228 *UK AB* (n 221) [127]–[128] (Lieven J).

229 *Bell Court of Appeal* (n 220) 452–3 [3] (Lord Burnett CJ for the Court).

Service ('NHS') and the NHS Improvement's Quality and Innovation Committee, and chaired by paediatrician, Dr Hilary Cass.[230] In response to this review, the NHS published 'a new evidence based clinical policy on … puberty blockers … that makes clear access is no longer routinely available as part of the NHS children and young people's gender service'.[231] The NHS 'concluded that there is not enough evidence to support the safety or clinical effectiveness of … [puberty blockers] to make the treatment routinely available at this time'.[232] In addition, the NHS announced that it would 'review the use of gender affirming hormones through a process of updated evidence review and public consultation'.[233] Further, '[i]n the meantime', following the review's advice 'that the new providers should be "extremely cautious" when considering whether to refer young people under 18 years for consideration of hormone intervention', the NHS 'established a national multi-disciplinary team (MDT) that will review and need to agree [to] all recommendations for hormone intervention'.[234]

D British Columbia, Canada

The legal position for minors seeking gender-affirming medical treatment in the province of British Columbia in Canada is different again from the jurisdictions discussed above and is relatively clear, with one exception.[235] Courts have indicated that they will generally have limited involvement in gender-affirming care for minors in British Columbia, and have referred in relevant cases to legislation that prioritises, in the first instance, the views of the minor and their treating health practitioner regarding their medical treatment. Like England and Wales, this approach appears to reflect the influence of human rights law and, in particular, legal protection of TGD people from discrimination at both provincial and federal levels in Canada's federal system.[236]

In the last few years, most Canadian provinces and territories, and the federal jurisdiction, have added to human rights legislation specific prohibitions on discriminating against people on the basis of their gender identity and/or expression.[237] British Columbia amended its *Human Rights Code* in 2016 so that it

230 Cass (n 5) 87, app 1.

231 John Stewart and James Palmer, 'NHS England's Response to the Final Report of the Independent Review of Gender Identity Services for Children and Young People', *NHS England* (Web Page, 10 April 2024) <https://www.england.nhs.uk/long-read/nhs-englands-response-to-the-final-report-of-the-independent-review-of-gender-identity-services-for-children-and-young-people/>.

232 National Health Service England, 'Puberty Suppressing Hormones (PSH) for Children and Young People Who Have Gender Incongruence/Gender Dysphoria' (Policy Statement, 12 March 2024) <https://www.england.nhs.uk/wp-content/uploads/2024/03/clinical-commissioning-policy-gender-affirming-hormones-v2.pdf>.

233 Stewart and Palmer (n 231).

234 Ibid.

235 Barbara Findlay, 'Legal Rights of Transgender Youth Seeking Medical Care' (2022) 64(2) *British Columbia Medical Journal* 65, 65–6.

236 Ibid 67.

237 Brenda Cossman, 'Gender Identity, Gender Pronouns, and Freedom of Expression: Bill C-16 and the Traction of Specious Legal Claims' (2018) 68(1) *University of Toronto Law Journal* 37, 38–9 <https://doi.org/10.3138/utlj.2017-0073>.

prohibits discrimination against people – including through publications and denial to them of publicly available accommodation, services or facilities – 'because of' their 'gender identity or expression'.[238] In 2017, the Government of Canada similarly amended the *Canadian Human Rights Act*, RSC 1985 to add 'gender identity or expression' to the grounds of discrimination that the Act proscribes.[239] The stated purpose of that statute was expanded: it '[gives] effect … to the principle that all individuals should have an opportunity … to make for themselves the lives that they are able and wish to have … without being hindered in or prevented from doing so by discriminatory practices based on … gender identity or expression'.[240]

Under the *Family Law Act,* SBC 2011, parents' responsibility for 'giving, refusing or withdrawing consent to medical … treatments for' their child who is under 19 years of age is subject to section 17 of the *Infants Act,* RSBC 1996 ('*Infants Act*').[241] That provision states that 'an infant may consent to health care' and, if they do so, 'the consent is effective and it is not necessary to obtain a consent to the health care from the infant's parent or guardian'.[242] However, 'a request for or consent, agreement or acquiescence to health care by an infant' will only 'constitute consent to the health care' if:

> the health care provider providing the health care:
> (a) has explained to the infant and has been satisfied that the infant understands the nature and consequences and the reasonably foreseeable benefits and risks of the health care, and
> (b) has made reasonable efforts to determine and has concluded that the health care is in the infant's best interests.[243]

Applying this legislation to gender-affirming medical treatments for minors, in *AB v CD* ('*British Columbia AB*'), the Court of Appeal for British Columbia confirmed in 2020 that:

> At law, [the minor] is exclusively entitled to consent to a specific treatment for gender dysphoria only if that specific treatment is one he understands and that a health care provider has determined is in his best interests. If these requirements are not met, his consent to treatment remains the responsibility of those accorded that parenting responsibility on his behalf.[244]

Thus, if the treating practitioner of a person under 19 years of age has satisfied the abovementioned requirements, regardless of the minor's age, their decision to access gender-affirming medical treatment will prevail over that of their parent/guardian.[245] In *AM v Dr F*, following *British Columbia AB*, MacDonald J in the Supreme Court of Canada confirmed that this legislation 'entrusts healthcare

238 *Human Rights Code*, RSBC 1996, ss 7(1), 8(1). See also at ss 9–11, 13; Bill 27, *Human Rights Code Amendment Act 2016,* 5th sess, 40th leg, British Columbia, 2016 (assented to 28 July 2016), SBC 2016, c 26.

239 *Canadian Human Rights Act*, RSC 1985, c H-6, s 3(1) ('*Canadian Human Rights Act*'); *An Act to Amend the Canadian Human Rights Act and the Criminal Code*, SC 2017, c 13.

240 *Canadian Human Rights Act* (n 239) s 1.

241 *Family Law Act*, SBC 2011, c 25, s 41(f).

242 *Infants Act,* RSBC 1996, c 223, s 17(2).

243 Ibid s 17(3).

244 *AB v CD* [2020] BCCA 11, [142] (Bauman CJ and Fisher J, Groberman J agreeing) ('*British Columbia AB*') (emphasis in original).

245 Findlay (n 235) 66–7.

providers with assessing a minor's capacity to consent' and those practitioners are 'entitled to significant deference', provided the practitioners have met the legislative test.[246] If the health practitioner determines that the minor is not capable of consenting to such treatment (for the reason that they do not understand its nature, consequences, benefits, and risks), their parents/guardians are empowered to decide whether they can access it.

A court could only override a minor's decision to access gender-affirming medical treatment that was sanctioned by a health practitioner if it is established that valid consent was not provided, and not simply if their parents/guardians disagree with the decision.[247] Also in *British Columbia AB*, the Court of Appeal stated that a court can review a minor's consent to treatment, but its 'jurisdiction is limited'; it is confined to ascertaining if the health care provider has complied with the abovementioned requirements of the *Infants Act* and thus 'the prerequisites to a valid consent set by' that statute have been met.[248]

In *British Columbia AB*, a minor (AB) wished to obtain hormone treatment for gender dysphoria, they had the approval of their medical team and support of their mother, but their father opposed it, which led to litigation.[249] The Court held that 'there was no reason to interfere with the finding that AB's consent was valid'.[250] Consequently, the Court did not need to determine whether court authorisation for a minor to obtain gender-affirming medical treatment is required if their treating health practitioner determines they are unable to consent to it and their parents disagree with one another about whether they should be permitted to access it. However, the parents might initiate litigation to seek a court's decision in that circumstance. A minor with gender dysphoria may nonetheless attempt to rely on the human rights legislation in this jurisdiction to challenge a limitation on their access to gender-affirming medical treatment.

IV LEGAL ISSUES REGARDING GENDER-AFFIRMING MEDICAL TREATMENT FOR MINORS

It is desirable that minors, their parents/guardians, and health practitioners have clarity and certainty about laws pertaining to gender-affirming medical treatment.[251] However, it may be inevitable that this area of law remains dynamic while new research findings about these interventions continue to emerge and they are still the subject of intense debate. Indeed, it is crucial that the law keeps pace with medical developments, and also takes into account their social and political context. In the case of gender-affirming medicine for minors, relevant background factors include

246 *AM v Dr F* [2021] BCSC 32, [103] (MacDonald J).
247 Findlay (n 235) 67.
248 *British Columbia AB* (n 244) [130], [133], [138] (Bauman CJ and Fisher J, Groberman J agreeing).
249 Ibid [1]–[3].
250 Ibid [7].
251 Calina Ouliaris, 'Consent for Treatment of Gender Dysphoria in Minors: Evolving Clinical and Legal Frameworks' (2022) 216(5) *Medical Journal of Australia* 230, 232 <https://doi.org/10.5694/mja2.51357>.

growing acceptance of gender diversity and denunciation of discrimination against TGD people, as well as conflicting perspectives on minors' autonomy, rights, and best interests.[252] Given the differences between the legal systems of various jurisdictions in the West – which, as indicated above, can be considerable – the same approach to this issue may not suit all of them.

In some respects, and in certain jurisdictions, enactment of legislation confirming the legal position on gender-affirming care for minors may be preferable to the evolution of the law in this area through judicial decisions.[253] Statutes can provide clarity regarding the law. Indeed, some have called for relevant legislation to be passed in Australia due to the current uncertainties.[254] As discussed above, legislatures in several US states have explicitly set out the law and provided reasons for it in their statutes, leaving the public in no doubt about the position (though if there is separation of powers, as is the case in those jurisdictions, courts may be able to suspend the operation of these laws in response to legal challenges to them). In some instances (such as in Texas), this legislation has also settled whether executive actions that have been taken regarding this issue are lawful. Legislation in British Columbia similarly outlines the law governing minors' access to medical treatment, though it does not specifically refer to gender-affirming interventions. Yet if relevant legislation reflects the views mostly of a dominant political party, as is the case in several US states, it may be inconsistent with a significant body of public opinion and the perspectives of many health professionals. Notwithstanding such circumstances and if legislation no longer reflects developments in medical knowledge, it can be difficult to change a statute, especially in a system with a bicameral legislature where both houses of Parliament must agree to its amendment.

Courts can generally be faster and more agile and responsive than legislatures.[255] As discussed above, in Australia, judges changed the law regarding gender-affirming care for minors in response to the evolution of medical knowledge about gender dysphoria and treatments for it. Likewise, it appears that courts in England and Wales and British Columbia have made decisions concerning this issue that are consistent with developments in human rights law in those jurisdictions. Nevertheless, courts can largely only make determinations in relation to claims before them, rather than consider all permutations of circumstances that could involve such treatments and their ethical implications.[256] As discussed above, in Australia and England and Wales, this has resulted in some uncertainties and confusion regarding aspects of the law for minors, their parents and health practitioners. Further, in Australia, judges sitting alone have provided inconsistent interpretations of superior courts' previous judgements, but the community must wait for a suitable case to come before a superior court for definitive clarification

252 Cass (n 5) 28; O'Connell et al (n 49) 253; 'The Struggle of Trans and Gender-Diverse Persons', *United Nations Human Rights Office of the High Commissioner* (Web Page) <https://www.ohchr.org/en/special-procedures/ie-sexual-orientation-and-gender-identity/struggle-trans-and-gender-diverse-persons>.

253 Jowett and Kelly (n 74) 56; Shirley (n 77) 548.

254 See, eg, Jowett and Mathews (n 4) 1859; Anthony Gray, 'The Treatment of Young Transgender People and the Law' (2023) 30(2) *Journal of Law and Medicine* 430, 451.

255 Smith, 'Requirement for Trans and Gender Diverse Youth' (n 177) 82.

256 See *UK AB* (n 221) [121] (Lieven J).

of the law and guidance regarding lawful medical practice. Relying on courts to determine the law in this area can also lead to the unpredictability of and frequent, significant changes to the legal position, which affects minors' access to gender-affirming care, as has occurred in Australia and England and Wales.

Regardless of whether legislatures and/or courts are responsible for determining the law regarding gender-affirming medical treatments, a central legal issue with which they will need to grapple is whether this intervention should be available to minors at all. The response to this question may have other legal ramifications. For instance, in some jurisdictions, an individual can only alter their stated gender on identity documents if they have received gender-affirming medical treatments and, in certain countries, they must have undergone procedures that have resulted in 'sterilisation'.[257] Nevertheless, this legal position has recently changed in several countries in the European Union,[258] and in England and Wales, an individual's treatment to '[modify] sexual characteristics' can substantiate, but is not a precondition for applying for a gender recognition certificate.[259]

If gender-affirming medical treatments are potentially legally available to minors, a further fundamental legal matter to address is who should be empowered to decide which individuals can access them. In the context of ongoing dissension in the medical and lay communities about these treatments, engaging with this issue will necessitate taking into account complex ethical considerations.

In jurisdictions where provision of gender-affirming medical treatments has been prohibited, such as some US states, legislatures have effectively determined that only they can decide who accesses them and they have concluded that this intervention will be unavailable to all minors. Such laws may be welcomed by those who are concerned about the potential adverse impacts of these treatments, question minors' capacity to appreciate their risks, and worry that minors are not adequately assessed or receive insufficient information about alternative treatments prior to being offered them.[260] As noted above, bans on gender-affirming care for minors in the US have been justified on the basis that they will protect minors from harm. Some may argue that it is appropriate to proscribe use of these treatments at least until more evidence is available regarding them. Ancillary possible benefits of banning gender-affirming treatments are that this may defuse conflicts between

257 Felicity Bell and Anthony Bell, 'Legal and Medical Aspects of Diverse Gender Identity in Childhood' (2017) 25(1) *Journal of Law and Medicine* 229, 232; 'New Report on Legal Gender Recognition in Europe', *Council of Europe* (Blog Post, 7 July 2022) <https://www.coe.int/en/web/sogi/-/new-report-on-legal-gender-recognition-in-europe>; Steering Committee on Anti-discrimination Diversity and Inclusion, Council of Europe, *Thematic Report on Legal Gender Recognition in Europe: First Thematic Implementation Review Report on Recommendation CM/Rec(2010)5* (Report, June 2022) 9 ('*Thematic Report*') <https://rm.coe.int/thematic-report-on-legal-gender-recognition-in-europe-2022/1680a729b3>; 'Czech Court Maintains Mandatory Sterilisation for LGR', *Transgender Europe* (Web Page, 6 April 2022) <https://tgeu.org/czech-court-maintains-mandatory-sterilisation-for-lgr/>; Stefano Osella, 'Reinforcing the Binary and Disciplining the Subject: The Constitutional Right to Gender Recognition in the Italian Case Law' (2022) 20(1) *International Journal of Constitutional Law* 454, 455–6 <https://doi.org/10.1093/icon/moac022>.

258 *Thematic Report* (n 257) 9.

259 Fairbairn, Pyper and Balogun (n 211) 11–13; *Gender Recognition Act* (n 216) ss 1–3B.

260 Block (n 160).

minors who seek medical intervention and their parents/guardians who oppose their access to it, and some parents/guardians will not experience the dilemma of whether or not to consent to their children obtaining it.

Laws prohibiting provision of gender-affirming medical treatments to minors may be premised at least in part on the basis that the risks of treatment outweigh any hazards that might ensue from denying minors this intervention. Yet, as discussed above, health professionals disagree about the accuracy of this assumption. In the US, several prominent organisations of health practitioners have endorsed gender-affirming care guidelines and castigated these laws,[261] which some fear could have detrimental consequences for minors' health and wellbeing,[262] and also for health professionals.[263] If they are prevented from obtaining medical treatments that some consider could improve their mental health in particular, minors may seek to obtain harmful alternative treatments from unregulated sources. The laws could also lead to adverse experiences for minors if they reflect hostility towards TGD people, as some suspect, and 'normalize' or fuel discrimination towards and abuse of them.[264] Further, these laws may disrupt health professionals' 'therapeutic relationships' with their patients who have diagnoses of gender dysphoria.[265] Some practitioners might be tempted to breach the laws and risk incurring associated penalties if they: believe it is in their patients' interests to access gender-affirming medical treatments; adhere to expert advice that endorses their use; and consider that refraining from providing them would violate the Hippocratic Oath to 'do no harm'.[266]

Proscription of gender-affirming medical treatments will limit the pool of patients receiving them, and thus slow the collation of new data regarding their efficacy and safety. However, some might consider that such evidence should only be gleaned from research studies that have appropriate oversight and approval from ethics boards, and minors must not be the subjects of what are deemed to be experiments outside those settings.

There are also potential advantages as well as disadvantages in endowing courts, rather than legislatures, with authority to determine whether minors can access gender-affirming medical treatments. Owing to the risks and consequences of using these treatments and the high emotions their availability to minors can generate, it may be preferable for judges, who are impartial adjudicators and have a mandate to protect minors and ascertain what is in their best interests, to make these decisions.[267] In Australia, for instance, it has been considered appropriate

261 Ibid; Kuper, Cooper and Mooney (n 160) 338.

262 Martin, Sandberg and Shumer (n 49) 579, 581; Walch et al (n 49) 307; Kacie M Kidd et al, '"This Could Mean Death for My Child": Parent Perspectives on Laws Banning Gender-Affirming Care for Transgender Adolescents' (2021) 68(6) *Journal of Adolescent Health* 1082, 1087 <https://doi.org/10.1016/j.jadohealth.2020.09.010>.

263 Lepore, Alstott and McNamara (n 15) 966.

264 Kuper, Cooper and Mooney (n 160) 338; Kidd et al (n 262) 1087; 'Outlawing Trans Youth' (n 49) 2181–2.

265 Martin, Sandberg and Shumer (n 49) 581.

266 Lepore, Alstott and McNamara (n 15) 966.

267 See *Bell Divisional Court* (n 220) 451 [149] (Dame Sharp P, Lewis LJ and Lieven J).

for the Family Court to have jurisdiction in this area by exercising its welfare power. It might be deemed especially useful for courts to determine the availability of gender-affirming care for minors where there is a dispute between the minor, their parents and/or treating medical practitioners. Nevertheless, clarification in legislation of when court involvement is necessary in such circumstances may be welcomed given the varied types of disagreements that could arise and consequent uncertainties regarding the law in this respect (as is the case at present in Australia, England and Wales and, to some extent, British Columbia).

As most judges are not trained in medicine, they may, however, have difficulty understanding scientific research about the treatments' nature and effects, and determining which evidence and expert opinions to follow when they are conflicting.[268] In addition, legal requirements for court approval of administration of gender-affirming treatments could lead to delays in minors' receipt of them.[269] Indeed, in Australia, the volume of applications to the Family Court grew after *Re Jamie* indicated that a court needed to decide whether a minor was *Gillick* competent before they could receive hormone treatment.[270] A long wait time for confirmation that a minor can have gender-affirming care might compromise the success of treatments they ultimately receive, and their mental health could deteriorate and their risks of self-harm and suicide may increase during the litigation process.[271] Some families may struggle to afford the costs of litigation and cope with the stress of court proceedings and their children's condition during them.[272] To circumvent the ordeal of applying to the court for approval of gender-affirming medical intervention, which carries the risk that they will be denied access to it, some minors might instead obtain unregulated substitute treatments that could harm them due to their content and/or the lack of oversight by a medical practitioner of their administration.[273]

Pursuant to the laws in some jurisdictions, such as Australia, whether court authorisation is required to access medical treatments depends on their classification as 'therapeutic' or 'non-therapeutic'. However, application of these laws to gender-affirming medical intervention may not be useful or appropriate.[274] Some might consider there is no basis for distinguishing gender-affirming intervention from

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268 See *UK AB* (n 221) [122] (Lieven J). Nevertheless, the UK Court of Appeal has affirmed the view that it was for the NHS and regulatory authorities, not the courts, 'to determine clinical disagreements between experts about the efficacy of a treatment': *Bell Court of Appeal* (n 220) 460 [31]–[32] (Lord Burnett CJ for the Court), quoting *Bell Divisional Court* (n 220) 434 [74] (Dame Sharp P, Lewis LJ, Lieven J).

269 Telfer et al, 'Transgender Adolescents and Legal Reform' (n 43) 1097; de Vries et al (n 15) 219; Fiona Kelly, '"The Court Process Is Slow but Biology Is Fast": Assessing the Impact of the Family Court Approval Process on Transgender Children and Their Families' (2016) 30(2) *Australian Journal of Family Law* 112, 114, 121, 123 ('Impact of Family Court Approvals'); Shirley (n 77) 555.

270 Smith, 'Transgender Minors' (n 219) 52, 54.

271 Kelly, 'Impact of Family Court Approvals' (n 269) 114, 121–3; Telfer et al, 'Transgender Adolescents and Legal Reform' (n 43) 1097; de Vries et al (n 15) 219; Shirley (n 77) 555.

272 Kelly, 'Impact of Family Court Approvals' (n 269) 114, 122–3, 125; Telfer et al, 'Transgender Adolescents and Legal Reform' (n 43) 1097.

273 Telfer et al, 'Transgender Adolescents and Legal Reform' (n 43) 1097; Shirley (n 77) 555.

274 See Felicity Bell, 'Children with Gender Dysphoria and the Jurisdiction of the Family Court' (2015) 38(2) *University of New South Wales Law Journal* 426, 436–8, 453; Gray (n 254) 442–5.

other therapeutic medical treatments that do not require court approval to administer, and welcome a reduction in the court's role in this area. Yet the justification for regarding them as therapeutic might be construed as being that gender dysphoria, and possibly also transgenderism, is a physiological or psychological problem that these interventions are intended to treat.[275] Nevertheless, as reflected in the changes to the categorisation of gender incongruence in ICD-11, there has been an impetus to 'depathologise' diversity in gender identity and gender incongruence (though still to regard distress associated with gender incongruence as a 'health concern' requiring treatment) and thereby avoid stigmatising TGD people.[276] Further, in some jurisdictions, such as England and Wales and British Columbia, it appears that reduced court involvement in determining minors' access to gender-affirming care may be considered to be consistent with other laws that seek to respect people's gender identity and protect their human rights.

Regardless of whether gender-affirming medical interventions are designated therapeutic or non-therapeutic, it is indisputable that they are medical treatments. Consequently, some may argue that health professionals with expertise in gender medicine who have thoroughly assessed young patients seeking these treatments are better equipped than courts and legislatures to determine whether they should be made available to them.[277] These practitioners might be trained to diagnose gender dysphoria, evaluate the degree of a minor's distress associated with their gender incongruence, predict the likely success of medical treatments in ameliorating it, and ascertain minors' ability to consent to this intervention.[278] In *British Columbia AB*, the Court of Appeal for British Columbia recognised that the legislature in that province considered that health professionals should make decisions concerning minors' medical treatment generally. It stated:

> The *Infants Act* has made it clear that health care professions, not judges, are best placed to conduct inquiries into the state of medical science and the capacity of their patients when it comes to questions of minors' medical decision-making.[279]

Likewise, courts in England and Wales, adhering to the decision in *Gillick*, appear to have confirmed that a minor's health practitioners should principally determine whether they are competent to consent to gender-affirming medical treatment.[280]

Health practitioners' professional bodies and licensing and regulatory authorities might establish standards for them to follow in this area and the latter could monitor their adherence to them.[281] In *Bell Court of Appeal*, the Court noted,

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275 See *Bell Divisional Court* (n 220) 448 [135] (Sharp P, Lewis LJ and Lieven J).

276 Ibid; Bernard M Dickens, 'Transsexuality: Legal and Ethical Challenges' (2020) 151(1) *International Journal of Gynecology and Obstetrics* 163, 164 <https://doi.org/10.1002/ijgo.13307>; Coleman et al (n 5) S67.

277 de Vries et al (n 15) 221–2.

278 Ibid. The World Professional Association for Transgender Health advises health professionals to 'only recommend gender-affirming medical or surgical treatments requested by the patient when … the adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment': Coleman et al (n 5) S48.

279 *British Columbia AB* (n 244) [137] (Bauman CJ and Fisher J).

280 Smith, 'Transgender Minors' (n 219) 59.

281 Block (n 160).

'[t]he clinicians are subject to professional regulation and oversight',[282] and was confident that:

> Clinicians will inevitably take great care before recommending treatment to a child and be astute to ensure that the consent obtained from both child and parents is properly informed … clinicians will be alive to the possibility of regulatory or civil action where, in individual cases, the issue can be tested.[283]

Nevertheless, if a complaint is made about a health practitioner regarding their provision of gender-affirming treatment to a minor, to investigate it, the regulatory authority may seek to access confidential information about the patient and their supporters, which they could feel uncomfortable disclosing.[284] Further, various pressures experienced by health professionals might result in their divergence from regulatory standards and/or failure to undertake comprehensive, individualised assessments of patients before administering gender-affirming treatments.[285] Their superficial evaluation of those minors could in turn lead to them making decisions that are not in their patients' best interests, as well as to the practitioners' exposure to disciplinary action by regulatory authorities and law suits, for instance, in negligence.[286]

Due to the increased demand for this treatment, practitioners might have a high number of patients and insufficient time to delve into matters that are causing each minor's distress.[287] Health professionals may be unduly influenced by expectations of minors and their parents/guardians that they will provide gender-affirming medical treatments and by their urging of them to do so.[288] Where a minor's parents disagree about the treatment they should have, the treating health practitioner may be persuaded by the more insistent parent.[289] Some health practitioners could feel coerced by their patients, colleagues, employers, and/or professional bodies to apply the affirmative care model without questioning whether it is an appropriate response to minors' distress about their gender identity, and fear they will suffer adverse consequences if they formulate a differential diagnosis to gender dysphoria or an alternative treatment plan.[290] For these reasons, as noted previously, some health practitioners might provide gender-affirming medical treatment to a minor without confirming that this is a reasonable course of action, even though they would thereby breach their obligations to comply with professional conduct standards. It has also been posited that the expression of 'polarized' views about gender-affirming medicine has encouraged certain health professionals to pursue a narrow treatment pathway for gender dysphoria, which some consider is complex and demands a 'holistic', 'biopsychosocial' treatment approach (examining

282 *Bell Court of Appeal* (n 220) 474 [93] (Lord Burnett CJ for the Court).
283 Ibid [92].
284 Findlay (n 235) 67.
285 Littman (n 81) 3366; Kozlowska et al (n 7) 92; Cass (n 5) 17.
286 Kozlowska et al (n 7) 92.
287 Ibid 90, 92–3; Cass (n 5) 32, 48.
288 Kozlowska et al (n 7) 89; Ouliaris (n 251) 232.
289 Ouliaris (n 251) 232.
290 Cass (n 5) 16–17, 48; Kozlowska et al (n 7) 89–90.

biological, psychological, social, and other factors that have contributed to the minor's 'life circumstances').[291]

In some jurisdictions, health practitioners may be unable to obtain insurance cover for claims they might receive concerning their provision of gender-affirming treatments to minors. As discussed above, bills in some US states propose to ban insurers from providing such cover.[292] Even if insurance of health practitioners who provide gender-affirming care is not prohibited, some insurers may choose not to cover claims relating to it. Indeed, in Australia, a prominent medical indemnity insurer recently advised that it would no longer cover medical practitioners for claims arising from 'their assessment that a patient under the age of 18 years is suitable for gender transition; or them initiating prescribing of gender affirming hormones for any patient under the age of 18 years'.[293] Other insurers may be inclined to follow this example; the insurer stated that it made this change in response to the 'medico-legal risks' and in the context of increased demand for gender-affirming treatments, 'criticism' of research underlying these interventions, and studies indicating that reported low rates of detransition are inaccurate.[294] If insurance companies do not protect medical practitioners from claims regarding their provision of gender-affirming treatments to minors, they may be reluctant to continue this area of practice even where courts and/or legislatures have confirmed that it is lawful.

Another option is that laws permit minors alone to decide whether they have gender-affirming medical treatments.[295] Some believe that minors are capable of having clarity about their gender identity,[296] and the emotional and cognitive maturity to determine if it is in their best interests to access gender-affirming medical treatments and to consent to them.[297] They might therefore contend that there is no justification for: denying such young people (expressed variously in different jurisdictions, such as '*Gillick* competent' in Australia and England and Wales, and a 'mature minor' in the US and Canada) power to make a decision to obtain gender-affirming treatments; requiring the involvement of or consultation with their parents/guardians or the court in this decision-making process; and giving them authority to override minors' decisions.[298]

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291 Kozlowska et al (n 7) 92–3.

292 Redfield et al (n 141) 13–14. See, eg, 'Oklahoma Bill' (n 154).

293 'Update in Cover for the Treatment of Gender Transition in Minors' *MDA National* (Web Page, July 2023) <https://www.mdanational.com.au/gender-transition-in-minors>.

294 Ibid.

295 See, eg, Georgina Dimopoulos and Michelle Taylor-Sands, '*Re Imogen*: The Role of the Family Court of Australia in Disputes over Gender Dysphoria Treatment' (2021) 39(Suppl 1) *Monash Bioethics Review* S42, S44 <https://doi.org/10.1007/s40592-021-00138-0>; Jowett and Kelly (n 74) 55.

296 'Outlawing Trans Youth' (n 49) 2177.

297 de Vries et al (n 15) 221; Lisa Young, 'Mature Minors and Parenting Disputes in Australia: Engaging with the Debate on Best Interests v Autonomy' (2019) 42(4) *University of New South Wales Law Journal* 1362, 1381–2 <https://doi.org/10.53637/RRNQ2588>; Gray (n 254) 453.

298 Jowett and Kelly (n 74) 47, 49, 53; Ouliaris (n 251) 232; Malcolm K Smith and Ben Mathews, 'Treatment for Gender Dysphoria in Children: The New Legal, Ethical and Clinical Landscape' (2015) 202(2) *Medical Journal of Australia* 102, 104 <https://doi.org/10.5694/mja14.00624>; Young (n 292) 1364, 1381–2.

Laws that allow minors to decide if they access gender-affirming medical treatments may be viewed as respecting their autonomy, entitlement to self-determination, and rights, including those that are protected by the United Nations' *Convention on the Rights of the Child* ('*CRC*').[299] One such right of a 'child who is capable of forming his or her own views' is to 'express those views freely in all matters affecting [them]', for their views to be 'given due weight in accordance with the age and maturity of the child', and for the child to have 'the opportunity to be heard in any judicial and administrative proceedings affecting' them.[300] The *CRC* also provides that State Parties must 'respect' parents' 'rights and duties … to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present *Convention*',[301] including 'direction … in the exercise of his or her right' to 'freedom of thought'.[302] These articles have been interpreted as confirming that children can seek guidance from their parents, but as they mature and their decision-making capacity develops, their parents' power to make decisions on their behalf decreases.[303]

The question of whether minors, their parents/guardians, treating health practitioners, or courts should determine whether they are capable of making a decision about their access to gender-affirming medical treatments is, nonetheless, likely to be contentious. Indeed, as discussed in Part III(B), the Family Court of Australia has provided inconsistent answers to this question in recent years. Moreover, some query if any minors can be considered competent in this respect.[304] They are concerned that gaps in the available evidence about and dissension in the medical community regarding the efficacy, risks, impacts, and safety of these treatments make it difficult or impossible to provide informed consent to having them.[305] They also doubt that minors have sufficient maturity and life experience to appreciate the potential implications of these treatments, and in particular possible loss of their fertility, impairment of their sexual functioning, as well as changes to their sex characteristics assigned at birth, especially where they have not yet commenced or completed puberty.[306] In addition, they consider there is a risk that, for some minors, mental health problems or neurodevelopmental

299 Ouliaris (n 251) 232; Priest (n 21) 46, 52; Georgina Dimopoulos, 'Rethinking *Re Kelvin*: A Children's Rights Perspective on the "Greatest Advancement in Transgender Rights" for Australian Children' (2021) 44(2) *University of New South Wales Law Journal* 637, 649, 672 <https://doi.org/10.53637/JJXO2236>; Jacko (n 43) 1273, 1279; *Bell Divisional Court* (n 220) 451 [149] (Sharp P, Lewis LJ and Lieven J); Gray (n 254) 451–7. See also Young (n 297) 1381–2, 1385.

300 *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990) art 12 ('*CRC*').

301 Ibid art 5.

302 Ibid arts 14(1)–(2).

303 Dimopoulos (n 299) 662–3; Young (n 297) 1368–9.

304 *Bell Divisional Court* (n 220) 448–50 [133]–[145] (Sharp P, Lewis LJ and Lieven J); Laidlaw, Cretella and Donovan (n 79) 75; Baron and Dierckxsens (n 46) 605.

305 *Bell Divisional Court* (n 220) 448 [134], 450 [143] (Sharp P, Lewis LJ and Lieven J); Laidlaw, Cretella and Donovan (n 79) 77; Baron and Dierckxsens (n 46) 605.

306 *Bell Divisional Court* (n 220) 449–50 [139], [141], [144]–[145] (Sharp P, Lewis LJ and Lieven J); Laidlaw, Cretella and Donovan (n 79) 75–7; Baron and Dierckxsens (n 46) 605; Kozlowska et al (n 7) 85.

disorders may impair their judgment and ability to navigate issues involved in having this treatment.[307] It might also be argued that minors' authority to make decisions to access gender-affirming medical intervention should be restricted if those treatments are deemed to pose a 'risk of serious harm' to them.[308]

In reaching the view that most minors would lack the capacity to consent to gender-affirming medical treatment, the Divisional Court in *Bell Divisional Court* observed that it is 'life changing, going as it does to the very heart of an individual's identity', entails 'significant … and … potentially irreversible long-term physical, and psychological consequences', and is 'experimental or innovative'.[309] Nevertheless, some dispute or question the notions that this treatment is experimental or innovative and that, even if it is, this is a reasonable justification for concluding that a minor cannot consent to it.[310] Other medical treatments that are available to patients can be classified in this way, particularly where it is ethically challenging to undertake research into and thus difficult to obtain long-term data about their effectiveness, and their impacts are similarly uncertain.[311]

A further possibility, which could apply especially if a minor is deemed incapable legally of consenting to gender-affirming medical treatment, is that their parents, rather than governments or courts in particular, have legal authority to decide if they can access it.[312] It has been argued that a model whereby the minor 'assents' to the treatment and their parents permit them to have it 'demonstrates respect for the young person and their developing autonomy'.[313] The *CRC* states: 'In all actions concerning children … the best interests of the child shall be a primary consideration'.[314] It might often be assumed that parents are in an optimal position to ascertain whether it is in their child's best interests to obtain gender-affirming interventions (and expected that they will make such determinations).[315]

However, giving parents legal power to decide whether their child can obtain gender-affirming medical treatments could lead to conflicts with their child or the child's other parent if they oppose their access to them, and necessitate a court application to resolve the disagreement.[316] Some parents may feel pressured to consent to their child's treatment despite their reservations. Further, authorising parents to make these decisions may be inappropriate in circumstances where they are not involved in their child's life or do not have a close relationship

307 Laidlaw, Cretella and Donovan (n 79) 76; Kozlowska et al (n 7) 87.
308 Young (n 297) 1382.
309 *Bell Divisional Court* (n 220) 450–1 [148] (Sharp P, Lewis LJ and Lieven J).
310 Michelle M Taylor-Sands and Georgina Dimopoulos, 'Judicial Discomfort over "Innovative" Treatment for Adolescents with Gender Dysphoria' (2022) 30(3) *Medical Law Review* 479, 481, 494–5, 502, 505 <https://doi.org/10.1093/medlaw/fwac018>; Giordano, Garland and Holm (n 54) 325.
311 Taylor-Sands and Dimopoulos (n 310) 494; Giordano, Garland and Holm (n 54) 325.
312 Lauren Notini, '*Bell v Tavistock*: Why the Assent Model Is Most Appropriate for Decisions regarding Puberty Suppression for Transgender and Gender Diverse Youth' (2021) 28(3) *Journal of Law and Medicine* 632, 633, 639.
313 Ibid 639.
314 *CRC* (n 300) art 3(1).
315 'Outlawing Trans Youth' (n 49) 2183–4; Jacko (n 43) 1273; Dickens (n 276) 166; *British Columbia AB* (n 244) [208] (Bauman CJ and Fisher J).
316 See Bell and Bell (n 257) 242–3; Shirley (n 77) 553.

with them, and result in litigation and delays in treatment.[317] Parents might find it extremely daunting to have to make a decision about whether their child can access gender-affirming treatments, though that does not render them incapable of doing so or invalidate a decision they make.[318] Many medical treatment decisions are emotionally fraught and parents can receive health professionals' guidance.[319]

Some have raised the potential for limits to be placed on parental authority or even for the state to remove children from their parents if parents are empowered, but refuse to consent to their children having gender-affirming interventions.[320] This might occur on the basis of an allegation of neglect: the parents have denied their children access to treatment that purportedly could prevent them from self-harming and/or that is 'an established standard of care'.[321] Nevertheless, both of those claims are contentious. By contrast, in certain jurisdictions, parents' consent to provision of gender-affirming care to their children could expose them to legal claims.[322] As noted above, bills in some US states have proposed that parents be subject to liability and penalties in this circumstance.[323]

V CONCLUSION

Given the surge in diagnoses of gender dysphoria in minors, and the high number of them seeking gender-affirming medical treatments, it is unlikely that demand for them will decrease in the near future. It is therefore critical that relevant legal issues are carefully considered. Whether or not a minor obtains these treatments is highly personal to that individual and their family.[324] Yet it can have an impact on the identity that the minor presents and the manner in which they lead their life in public. Moreover, as discussed in Part II of this article, this intervention has become the subject of controversy in medical and lay communities. It would be unhelpful for laws in this area to be developed in a vacuum without reference to matters that are being raised in that evolving debate and to its sociocultural and political context. Among the many factors that lawmakers will need to take into account are: research studies pertaining to this area of medicine; the nature and quantity of available scientific data about this intervention, including compared to other medical treatments; all the potential benefits and drawbacks associated with minors' use of gender-affirming medical treatments; and ethical implications of their access to them.

317 Jowett and Kelly (n 74) 51–2.
318 Giordano, Garland and Holm (n 54) 325.
319 Ibid.
320 Bell and Bell (n 257) 242–3; Priest (n 21) 56; Doriane Lambelet Coleman, 'Transgender Children, Puberty Blockers, and the Law: Solutions to the Problem of Dissenting Parents' (2019) 19(2) *American Journal of Bioethics* 82, 83 <https://doi.org/10.1080/15265161.2018.1557297>.
321 Priest (n 21) 56; Bell and Bell (n 257) 242–3; Coleman (n 320) 83.
322 See, eg, Redfield et al (n 141) 13.
323 Ibid.
324 Bell and Bell (n 257) 229.

As illustrated by the examples discussed in Part III of this article, different jurisdictions in the West have adopted diverse laws concerning gender-affirming medical treatments for minors. It is apparent from the analysis in Part IV of this article that advantages and disadvantages may attach to all of them, and no one legal model will suit every case or jurisdiction. In particular, the article has canvassed possible benefits and drawbacks of prohibiting all minors' access to gender-affirming treatments and, if that option is not pursued, of creating laws that empower courts, health professionals, minors, or their parents to decide whether they can obtain them. None of those legal options is flawless. In *British Columbia AB*, the Court of Appeal for British Columbia described relevant legislation in that province as having achieved a '[careful] … balance between parental responsibilities, medical expertise, the protection of young people, and the right of a capable individual to medical self-determination'.[325] Some may contest whether the legislation met this objective. However, many might agree that, in formulating laws regarding gender-affirming medical treatment for minors, it is important to weigh rights of minors, rights and responsibilities of their parents/guardians, and responsibilities of legislatures, courts, and health practitioners. They would probably also recognise that this is no easy feat.

Given the dissension regarding gender-affirming medical treatments for minors and the ongoing research regarding them, it may be inevitable that laws in this area remain subject to frequent change and, in some respects, uncertain. It might also be preferable that the law remains flexible, so it can respond to shifts in the debate, new research findings and empirical data about these interventions, as well as the lived experience of complying with different laws pertaining to them. The notion that the law should serve the interests and needs of minors who are vulnerable both by virtue of their youth and their distress surrounding their gender identity is probably uncontentious. Nevertheless, divergent views will undoubtedly be expressed about the nature of the interests and needs of minors generally, and of particular individuals. Perhaps all that can be concluded at this time is that laws concerning gender-affirming medical treatments for minors will provide useful lessons for lawmakers who need to address future developments in medicine that are similarly controversial.

325 *British Columbia AB* (n 244) [134] (Bauman CJ and Fisher J).