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The Consequences of Gender-Affirming Care: A Survey of U.S. and U.K. Law

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The Consequences of Gender-Affirming Care: A Survey of U.S. and U.K. Law

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The prevalence of youth experiencing "gender dysphoria" over the last decade has exploded. More minors than ever before are identifying as a different gender than their biological sex. Yet, there is a divergence among nations regarding what care is best for minors questioning their gender identity. The United Kingdom has begun to move away from prescribing minors puberty blockers and hormone therapies, as the federal government in the United States seeks to protect and promote gender-affirming care for youth. The response among the states is far more fractured. Some states have imposed bans on gender-affirming care for minors. While there is no consensus among medical experts, emerging studies suggest gender-affirming treatments for minors may cause permanent harm. The majority of legal scholarship however, unequivocally supports minors' ability to pursue treatment without consideration of their cognitive capacity to legally consent to such consequential decisions.

Until there is a better understanding of the potential long-term costs of treating youth with gender-affirming care, courts should apply the *Gillick* competence standard adopted by UK courts. This paper asks courts to consider the age at which a minor can legally consent to transgender treatments while highlighting the emerging concerns associated with such care.

I. Introduction

Over the last decade, the number of youth experiencing incongruence with their gender has sharply risen.[2] This phenomenon is not unique to any one region of the world. In a 2022 Pew Research Center study, roughly 1.6% of all Americans identified as transgender or nonbinary.[3] 2021 was the first census in which the United Kingdom ever collected information on citizens' gender identity.[4] At the time of the census, 0.5% of the U.K.'s population reported their gender identity was different from their sex registered at birth.[5] The statistics in both countries reflect an emerging trend of increasingly more people, especially minors, identifying as transgender or non-binary.

Physicians and counselors are faced with the task of adapting medical care and psychological treatment to minors in crisis regarding their gender identity. Some of the challenges transgender adolescents face as a result of their gender incongruence is an increased risk of homelessness,[6]

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[2] Nastasja M. de Graaf, Guido Giovanardi, Claudia Zitz, Polly Carmichael, *Sex Ratio in Children and Adolescents Referred to the Gender Identity Development Service in the UK (2009–2016)*, 47(5) Archives of Sexual Behavior 1301, 1301 (2018).

[3] Anna Brown, *About 5% of Young Adults in the U.S. Say their Gender is Different from their Sex Assigned at Birth*, Pew Research Center (June 7, 2022), https://www.pewresearch.org/short-reads/2022/06/07/about-5-of-young-adults-in-the-u-s-say-their-gender-is-different-from-their-sex-assigned-at-birth/.

[4] Id.

[5] Lauren Moss & High Parry, *Census Data Reveals LGBT+ Populations for First Time*, BBC News (Jan. 6, 2023), https://www.bbc.co.uk/news/uk-64184736.

[6] Eliza Chung, *Trans Adults Deserve a Right to Sue for Gender-Affirming Care Denied at Youth*, 24 CUNY L. Rev. 145, 166 (2021).

suicide,[7] and rejection from parents and close family.[8] Medical and mental health professionals have adopted "gender-affirming care" in response to such concerns.[9] There is limited research regarding the efficacy of gender-affirming care and an emerging concern regarding the long-term risks associated with its treatments. First, this paper will outline the historical background of gender-affirming care, then the paper will shift to a comparative discussion on the growing divergence between the United Kingdom and parts of the United States. Lastly, this paper will conclude with a discussion of the legal implications of gender-affirming care for minors including an analysis of whether minors can adequately consent to such treatments.

II. Historical Background

A. What is Gender Dysphoria

This relatively new phenomenon of individuals identifying as transgender is commonly attributed to society becoming increasingly open to variations in sexuality and gender identity over the last century. "Gender dysphoria" is defined as "a persistent aversion toward some or all of those physical characteristics or social roles that connote one's own biological sex."[10] Among the characteristics considered in a diagnosis of gender dysphoria include: "a strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experience/expressed gender," "a strong desire for the primary and/or secondary sex characteristics of the other gender," "a strong desire to be of the other gender," and a strong conviction that one has the typical feelings and reactions of the other gender."[11] The condition is commonly associated with significant experiences of impairment in "social, school and other important areas of functioning."[12] Specifically, "rapid onset gender dysphoria" is a phenomenon in youth with gender dysphoria which typically emerges around puberty.[13]

B. Current Standard of Care

Historically, medical professional organizations have endorsed gender-affirmative care for minors experiencing gender incongruence. The World Health Organization suggests that any "single or combination of a number of social, psychological, behavioral, or medical interventions designed

[7] Arnold H. Grossman & Anthony R. D'Augelli, *Transgender Youth and Life-Threatening Behaviors*, 37 Suicide & Life-Threatening Behavior 527, 528 (2007).
[8] Emily Ikuta, *Overcoming the Parental Veto: How Transgender Adolescents Can Access Puberty-Suppressing Hormone Treatment in the Absence of Parental Consent Under the Mature Minor Doctrine*, 25 S. Cal. Interdisc. L.J. 179, 186 (2016).
[9] Gender-affirming care is "a supportive form of health care [that] consists of an array of services [including] medical, surgical, mental health and non-medical services for transgender and non-binary people." US Department of Health and Human Services: Office of Population Affairs, *Gender-affirming care and young people*, https://opa.hhs.gov/sites/default/files/2023-08/gender-affirming-care-young-people.pdf, (last visited Sept. 29, 2023).
[10] Miriam Grossman, YOU'RE TEACHING MY CHILD WHAT? 18 (Regnery Publishing, 2009).
[11] Zowie Davy, *What is Gender Dysphoria? A Critical Narrative Review*, 3.1 Transgender Health 159, 160 (2018).
[12] Garima Garg, Ghada Elshimy, and Raman Marwaha, GENDER DYSPHORIA 10 (StatPearls Publishing, 2023).
[13] Greta R. Bauer, Margaret L. Lawson, and Daniel L Metzger, *Do Clinical Data from Transgender Adolescents Support the Phenomenon of "rapid Onset Gender Dysphoria"?,* 243 Journal of Pediatrics 224, 224 (2022).

to support and affirm an individual's gender identity" are appropriate methods.[14] This approach to healthcare aims to alleviate "distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth."[15] The World Professional Association for Transgender Health (WPATH) advises that all treatment options should be offered but only recommends surgery be performed after age 18, and after the individual has lived in their desired gender role for at least two years.[16] The Endocrine Society recommends treating gender-dysphoric adolescents with hormone suppression treatment once they have entered puberty and their gender incongruence persists. [17] The guidelines suggest that most adolescents have the capacity by 16 years old to give informed consent to "partially irreversible treatment."[18] Regarding surgical treatment, the Endocrine Society warns that treating physicians must confirm the treatment criteria used by the referring practitioner and collaborate on decisions regarding gender-affirming surgery.[19] Advocates of gender-affirmative care criticize any delay in transition, arguing that going through puberty only causes more distress between an adolescent's self-identified gender and their biological sex.[20] They rely on studies that suggest transgender people who lack access to gender-affirming care are particularly predisposed to negative outcomes such as depression, anxiety, and suicide.[21] One survey conducted by the Trevor Project revealed that 52% of transgender and nonbinary youth contemplate suicide.[22] Fears that adolescents and children could potentially end their lives without affirmative treatment have shaped much of the guidance in the medical community thus far.

C. Emerging Criticism

Despite the prevalence of minors identifying as transgender and non-binary, there remain many unresolved questions among pediatric physicians and scientists on the long-term outcomes of gender-affirming care. One concern is the lack of evidence-based treatments to support consequential healthcare protocols. Critics point out that in the Endocrine Society's evaluation of its own guidelines, it concluded the "natural history and effects of different cross-sex hormone therapies…are extremely sparse and based on the low quality of evidence."[23] The Endocrine

[14] World Health Organization [WHO], Gender Incongruence and Transgender Health in the ICD, https://www.who.int/standards/classifications/frequently-asked-questions/gender-incongruence-and-transgender-health-in-the-icd.
[15] World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People [7th Version]*, (2012), https://www.wpath.org/publications/soc.
[16] E. Coleman, et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 International Journal of Transgender Health S3, S46 (2022).
[17] Wylie Hembree, Peggy T Cohen-Kettenis, Louis Gooren, Sabine E Hannema, Walter J Meyer, M Hassan Murad, Stephen M Rosenthal, Joshua D Safer, Vin Tangpricha, Guy G T'Sjoen, *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, J Clin Endocrinol Metab. 3869, 3871 (2017).
[18] *Id.* at 3780.
[19] *Id.*
[20] Florence Ashley, *Thinking an Ethics of Gender Exploration: Against Delaying Transition for Transgender and Gender Creative Youth*, 24.2 Clinical Child Psychology and Psychiatry 223, 228 (2019).
[21] *See* Jack L. Turban, Dana King, Jeremi M. Carswell, and Alex S. Keuroghlian, *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, 145(2) Pediatrics 1, 7 (2020).
[22] The Trevor Project, *The Trevor Project National Survey on LGBTQ Youth Mental Health 2021, https://www.TheTrevorProject.org/survey-2021/* (last visited September 28, 2023).
[23] Wylie C Hembree, Peggy T Cohen-Kettenis, Louis Gooren, Sabine E Hannema, Walter J Meyer, M Hassan Murad, Stephen M Rosenthal, Joshua D Safer, Vin Tangpricha, and Guy G T'Sjoen, *Endocrine Treatment of*

Society even concedes that "more rigorous evaluations of the effectiveness and safety of endocrine and surgical protocols" are needed to assess the effects of delayed puberty in adolescents and the potential consequences on bone health, gonadal function, and the brain.[24] The World Professional Association for Transgender Health's standard of care guidelines have also come under criticism for not being "evidence-based."[25] Critics observe that the guidelines are susceptible to bias and possess "significant shortcomings."[26] Several reviews of the evidence supporting the use of puberty blockers, hormones and surgeries have been conducted by the UK National Institute for Health and Care Excellence, the Swedish National Board of Health and Welfare, and the Chorance review.[27] All three reviews concluded there was insufficient evidence to determine whether the risks of gender-affirming treatments outweigh the benefits.[28]

Another criticism of gender affirmation care is the rise of "de-transitioners" or those who claim that early treatment caused them preventable harm.[29] While the literature is still limited on the topic, additional research is being dedicated to studying transgender individuals who later express regret. The largest study to date was the U.S. Transgender Survey in 2015 which examined the experiences of 27,175 Americans who had transitioned.[30] It found that 8% of respondents had at some point de-transitioned, most citing pressure from a parent (36%) followed by transitioning being "too hard" (33%).[31]

Finally, one relatively novel concern emerging among critics is the overrepresentation of autism spectrum disorder in gender dysphoria. One recent study concluded that despite the limited literature, there is some evidence of "overrepresentation of co-occurring [gender dysphoria] and [autism spectrum disorder] compared to what would be expected by chance based on the estimated prevalence in the general population of both conditions."[32] One concern is that professionals are providing young people with gender-affirmative treatment when they may be experiencing other complexities related to an undiagnosed cognitive condition.

III. Comparative Analysis: Divergence Among the West

A. Healthcare in the UK and the US, Moving in Opposite Directions

Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, 102.11 The Journal of Clinical Endocrinology & Metabolism 3869, 3889 (2017).

[24] *Id.* at 3874.

[25] J. Cohn, *Politics Aside, Healthcare Considerations Motivate More Caution before Medical Intervention for Trans-Identifying Youth*, 3(1) Journal of Controversial Ideas 1, 3 (2023).

[26] *Id*. at 4.

[27] *Id.*

[28] *Id.*

[29] Jennifer Block, *Gender Dysphoria in Young People is Rising—and So is Disagreement*, 380 BMJ 382, 382 (2023).

[30] Michael S Irwig, *Detransition Among Transgender and Gender-Diverse People—An Increasing and Increasingly Complex Phenomenon*, 107.10 The Journal of Clinical Endocrinology & Metabolism e4261, e4261 (2022).

[31] *Id.*

[32] Anna I.R. Van Der Miesen, Hannah Hurley & Annelou L.C. De Vries, *Gender Dysphoria and Autism Spectrum Disorder: A Narrative Review*, International Review of Psychiatry 70, 78 (2016).

While the United States has widely adopted gender-affirmative care for youth despite there being no formal empirical studies of clinical outcomes in transgender children and adolescents,[33] several European countries have begun to move in the opposite direction.[34] These countries cite deficiencies in the evidence of medical interventions for transgender youth.[35] One deficiency epidemiologists cite is that gender-affirmative healthcare rests on several assumptions including "that a teenager's transgender identity once expressed is permanent; that it will cause lifelong suffering if no medical interventions are offered; and that gender-affirming interventions are safe and effective at improving short-term and long-term psychological outcomes."[36] The National Institute for Health and Care Excellence recently evaluated the use of puberty blockers and cross-sex hormones on youth and reported that positive findings were unreliable due to poor methodology.[37] The report was commissioned by NHS England to examine the care of gender-nonconforming children.[38] To evaluate the clinical effectiveness of treatment, the report considered ten observational studies.[39] The review concluded that the impact of gender-affirming hormones on mental health and psychological impact on children and adolescents with gender dysphoria was "very low."[40] The review also concluded that the use of gender-affirming hormones did not significantly improve depression, anxiety, suicidality, or overall quality of life.[41] Distinguished pediatrician and former president of the Royal College of Pediatrics and Child Health, Dr. Hilary Cass led the reviews to better assess the efficacy of the gender affirmative approach advanced as "GIDS" (Gender Identity Development Service), the United Kingdom's largest gender-affirming clinic.[42] Some of the concerns outlined in the interim report included the clinic's inability to keep up with the demand in referrals.[43] The report concluded that a single national provider for the rapidly growing population of youths struggling with gender identity was not sustainable.[44] Another concern was the limited research on gender-affirmative care and its

[33] Johanna Olson-Kennedy, Yee-Ming Chan, Robert Garofalo, Norman Spack, Diane Chen, Leslie Clark, Diane Ehrensaft, Marco Hidalgo, Amy Tishelman, Stephen Rosenthal, *Impact of Early Medical Treatment for Transgender Protocol for the Longitudinal, Observational Trans Youth Care Study*, 8(7) JMIR Res Protoc e14434, e14434 (2019).
[34] Frieda Klotz, *A Teen Gender-Care Debate Is Spreading Across Europe*, The Atlantic, (April 28, 2023), https://www.theatlantic.com/health/archive/2023/04/gender-affirming-care-debate-europe-dutch-protocol/673890/.
[35] Stephen B. Levine & E. Abbruzzese, *Current Concerns About Gender-Affirming Therapy in Adolescents*, 15 Curr Sex Health Rep 113, 114 (2023).
[36] *Id.*
[37] *See* National Institute for Health and Care Excellence (NICE), *Evidence Review: Gender-Affirming Hormones for Children and Adolescents with Gender Dysphoria*, pg. 14 (2020); National Institute for Health and Care Excellence (NICE), *Evidence review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria*, pg. 13 (2020).
[38] David Pilgrim, *British Mental Healthcare Responses to Adult Homosexuality and Gender Non-Conforming Children at the Turn of the Twenty-First Century*, History of Psychiatry (2023).
[39] National Institute for Health and Care Excellence (NICE), *Evidence Review: Gender-Affirming Hormones for Children and Adolescents with Gender Dysphoria*, pg. 4 (2020) https://cass.independent-review.uk/nice-evidence-reviews/.
[40] *Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria*, pg. 13 (2020). https://cass.independent-review.uk/nice-evidence-reviews/.
[41] *Id.* at 22–27.
[42] *The Observer View on Gender Identity Services for Children*, The Guardian, (Mar. 20, 2022), https://www.theguardian.com/commentisfree/2022/mar/20/observer-view-cass-review-gender-identity-services-young-people.
[43] The Cass Review, *Independent Review of Gender Identity Services for Children and Young People: Interim Report*, pg. 32 (2022).
[44] *Id.* at 66.

effect on sexual, cognitive, or broader developmental outcomes.[45] The report found that the clinic left young people "at considerable risk" for poor mental health despite aiming to alleviate anxiety associated with gender dysphoria.[46] Furthermore, the studies questioned whether a young person who expresses a desire to transition fully understands its implications.[47] In response to these growing concerns over the clinic's services and gaps in research, England's National Health Service (NHS) adopted new guidance for the treatment of gender dysphoria in minors.[48] The U.K. National Health Service responded to the report by closing GID's.[49] At a minimum, the "lack of consensus and open discussion" outlined by the report was sufficient for the U.K. to provide gender-affirmative care to youth until the long-term effects are better understood.[50]

The United States' approach to transgender care is far more fractured. While the federal government and its agencies have holistically embraced gender-affirming care for minors, various states have sought to categorically prohibit it. The Department of Health & Human Services instructs that early gender-affirming care is "crucial" to overall health and well-being for transgender children and adolescents.[51] Any attempts to restrict, challenge, or falsely characterize gender-affirming care for minors as "abuse," HHS considers "dangerous."[52] HHS argues affirmative healthcare is "critical" for positive outcomes and has been demonstrated to "yield lower rates of adverse mental health outcomes, build self-esteem, and improve overall quality of life for transgender and gender diverse youth."[53] Though a recent Pew Research survey found that more Americans are in favor of making it illegal for medical professionals to provide someone younger than eighteen with medical care for a gender transition, the majority of American medical associations holistically endorse such care.[54] The American Academy of Pediatrics refused in 2018 to evaluate the UK Cass Report evidence and its implications choosing to continue to endorse gender affirmative care as appropriate for minors.[55] The American Medical Association argues that decisions about medical care "belong within the sanctity of the patient-physician relationship," and that states which seek to legislate against gender-affirming care "are never appropriate and limit the range of options physicians and families may consider when making decisions for

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[45] *Id.*
[46] *Id.*
[47] NHS England, *Interim Specialist Service for Children and Young People with Gender Incongruence*, (June 9, 2023), https://www.england.nhs.uk/wp-content/uploads/2023/06/Interim-service-specification-for-Specialist-Gender-Incongruence-Services-for-Children-and-Young-People.pdf.
[48] *The NHS Ends the "Gender-Affirmative Care Model" for Youth in England*, (October 24, 2022), https://segm.org/England-ends-gender-affirming-care.
[49] *World's Largest Pediatric Gender Clinic Shut Down Due to Poor Evidence, Risk of Harm and Operational Failures*, (July 29, 2022), https://segm.org/UK_shuts-down-worlds-biggest-gender-clinic-for-kids.
[50] The Cass Review, *supra* note 44, at 42.
[51] OASH, *Gender-Affirming Care and Young People*, (2023), https://opa.hhs.gov/sites/default/files/2023-08/gender-affirming-care-young-people.pdf.
[52] U.S. Dep't of Health & Human Services, *HHS Notice and Guidance on Gender Affirming Care, Civil Rights, and Patient Privacy*, (March 2, 2022).
[53] OASH, *supra* note 61.
[54] Kim Parker, Juliana Menasce Horowitz, and Anna Brown, *Americans' Complex Views on Gender Identity and Transgender Issues*, Pew Research Center, (June 28, 2022), https://www.pewresearch.org/social-trends/2022/06/28/americans-complex-views-on-gender-identity-and-transgender-issues/.
[55] Alec Schemmel, *Pediatric group accused of silencing debate about 'affirmative care' for trans youth*, WPDE TV, (July 21, 2022), https://wpde.com/news/nation-world/pediatric-group-accused-of-silencing-debate-about-affirmative-care-for-trans-youth**;** Jason Rafferty, et al., *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142.4 Pediatrics, 1 (2023).

pediatric patients."[56] The American Psychological Association ("APA") echoes similar concerns about states introducing legislation around restricting gender-affirming care for minors.[57] Despite a majority of American professional medical organizations endorsing gender-affirming care, nineteen states including Texas have introduced legislation to restrict gender-affirming healthcare on youth.[58] At the same time, California, and other states have passed bills designed to protect gender-affirmative healthcare.[59] The legal landscape in the United States continues to shift as cases begin to make their way through the courts, potentially inviting the Supreme Court to provide clarity on various constitutional concerns.

B. UK: Statutory Framework for Minor Consent

Laws in the United Kingdom have evolved as more citizens identify as "transgender." In 2004, Parliament introduced the Gender Recognition Act which allows people to change their legal gender.[60] The Act enables people over the age of eighteen to update their birth certificate to their preferred gender on the basis of "living in the other gender" or having changed their gender in another country.[61] In 2010, Parliament extended protection under the Equality Act to prohibit discrimination against individuals who have transitioned to another sex.[62] Neither statute extends protection to minors who desire to make their sex change complete before the age of eighteen. Section 8 of the Family Law Reform Act of 1969 does however require minors over the age of sixteen to consent to medical treatment.[63]

C. US: Fractured Federalism

As in the United Kingdom, laws in the United States have evolved in response to the progression of transgenderism. In 2021, the Equality Act was introduced in the U.S. House of Representatives to prohibit discrimination based on gender identity.[64] The bill sought to amend the Civil Rights Act of 1964 to explicitly include gender identity as a protected class pertaining to employment and public spaces.[65] While the bill ultimately was not enacted, the Biden administration issued an executive order that sought to expand access to gender-affirming care.[66] The executive order also

[56] Letter from James L. Madara to Bill McBride (April 26, 2021), https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-4-26-Bill-McBride-opposing-anti-trans-bills-Final.pdf.
[57] American Psychological Association, *Criminalizing Gender Affirmative Care with Minors*, https://www.apa.org/topics/lgbtq/gender-affirmative-care.
[58] Annette Choi and Will Mullery, *19 States Have Laws Restricting Gender-Affirming Care, Some with the Possibility of a Felony Charge*, CNN, (June 6, 2023), https://www.cnn.com/2023/06/06/politics/states-banned-medical-transitioning-for-transgender-youth-dg/index.html.
[59] Dana Ferguson, Scott Maucione, Bente Birkeland, Rick Pluta, Colin Jackson, and Acacia Squires, *Minnesota to Join at Least 4 Other States in Protecting Transgender Care This Year*, Politico (April 21, 2023), https://www.npr.org/2023/04/21/1171069066/states-protect-transgender-affirming-care-minnesota-colorado-maryland-illinois.
[60] Gender Recognition Act 2004, c. 7, § 1, (U.K.).
[61] *Id.* at c. 7 § 1(a)(b).
[62] Equality Act 2010, c. 15, § 1.7 (U.K.).
[63] Family Law Reform Act 1969, c. 46, § 8, (U.K.).
[64] Equality Act, H.R. 5, 117th Cong. § 2(a)(1).
[65] The Human Rights Campaign, *The Equality Act*, https://www.hrc.org/resources/equality.
[66] Exec. Order No. 14,075, 87 Fed. Reg. 37,189 (Jan. 15, 2022).

directed the Department of Health and Human Services to "take steps to address the barriers and exclusionary policies" within gender-affirming care.[67]

Despite the government's efforts to protect gender-affirming care at the federal level, states are moving in diverging directions. Whereas some states consider any efforts to delay or prevent gender-affirming care as "conversion therapy," others view such practices on minors as "abuse."[68] In 2022, California Governor Gavin Newsome signed a bill into law that protects the ability of transgender children and their families to receive gender-affirming care.[69] The law effectively enables youths to receive transgender treatment within California without fear of penalty from another state that criminalizes such care.[70] In contrast, Texas recently passed a bill that prohibits reassignment procedures on children under the age of eighteen.[71] The bill specifically aims to prevent surgeries that sterilize the child and the prescription of drugs that induce transient or permanent infertility.[72]

IV. A Comparative Analysis of United Kingdom and United States Case Law

A. The Legal Principle of Informed Consent

Both the United Kingdom and the United States case law address the concept of informed consent within the context of minor medical care. In *Gillick v. West Norfolk and Wisbech Area Health Authority*, the House of Lords held that children under age 16 could consent "provided they understand the nature and consequences of the proposed treatment and can retain, use and weigh the information."[73] However, the court noted that competence is integral to providing legitimate consent.[74] The *Gillick* decision examined the circumstances under which a minor under the age of sixteen could receive contraceptive advice without a parents' permission.[75] Lord Scarman described how "parental rights yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence."[76] There is some debate, however, as to when a child is sufficiently capable of consenting to making an informed decision. Various factors are considered when assessing a child's ability to consent to treatment.[77] A child's stage of cognitive

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[67] *Id.*
[68] Daliah Silver, *Transforming America's Perspective: How Recognizing the Rights of Transgender Youth Will Empower the Next Generation*, 39 Child. Legal Rts. J. 233, 252 (2019); Amir Vera and Ashley Killough, Texas AG *Declares Pediatric Gender Affirming Procedures to be Child Abuse Legal Opinion Says*, CNN News, (Feb. 23, 2022), https://www.cnn.com/2022/02/23/us/texas-attorney-general-gender-affirmation-child-abuse/index.html.
[69] Mackenzie Mays, *Newsom Signs Bill Protecting Transgender Youths and Families Fleeing Red-State Policies*, Los Angeles Times (Sept. 29, 2022), https://www.latimes.com/california/story/2022-09-29/with-new-law-california-welcomes-out-of-state-transgender-youth.
[70] Cal. Civ. Code § 56.109 (West 2023).
[71] Tex. S.B. 14, 88th Leg., R.S. (2023).
[72] *Id.*
[73] Emma Cave, *Adolescent Consent and Confidentiality in the UK*, 16.4 European Journal of Health Law 309, 311 (2009).
[74] Mike Shaw, *Competence and Consent to Treatment in Children and Adolescents*, 7 Advances in Psychiatric Treatment 150, 151 (2018).
[75] *Id.* at 154.
[76] Osifunke Ekundayo, *Legal Basis for the Court's Intervention over Medical Treatment of Children*, 121 J.L. Pol'y & Globalization 39 (2022).
[77] J Pearce, *Consent to Treatment During Childhood. The Assessment of Competence and Avoidance of Conflict*, 165 British Journal of Psychiatry 713, 714 (1994).

development is integral to the analysis of whether they understand the significance of the risks and benefits of having or not having treatment.[78]

Similarly, doctors in the United States are required to inform patients of the nature of the treatment, potential alternatives, and the possible risks and/or benefits involved in proceeding or forgoing treatment.[79] A number of courts have adopted the "patient rule" which asks whether a "reasonable prudent person in the exposition of the plaintiff would attach significance to it in deciding whether or not to submit to the proposed treatment."[80] In traditional tort law, if a doctor does not provide enough information for the patient's decision to be considered "informed," the doctor may be held liable for negligence.[81] In general, minors lack the ability to give informed consent until age eighteen.[82] This is because U.S. law presumes minors have less mental capacity for making important decisions.[83]

B. UK: *Bell v. Tavistock*

1. Analysis of the High Court:

In *Bell v. Tavistock*, the High Court analyzed whether a child under the age of sixteen can legally consent to the use of puberty blockers. The case involved a biological female who began experiencing gender discomfort at a young age.[84] At age fourteen she began to question her gender identity and was referred to GIDS a year later.[85] After she began testosterone at seventeen, changes to her body began quickly, including changes to her genitals, voice, and growth of facial and body hair.[86] Despite being on testosterone for three years, she began to doubt her transition.[87] At age twenty, however, she proceeded with a double mastectomy despite her doubts.[88] Upon realizing she was now dependent on testosterone for the rest of her life to maintain her male appearance and needed a hysterectomy because of the "atrophy" of her reproductive organs if she continued the hormones, she decided to stop taking hormone drugs.[89] Only after puberty did she consider having children and the consequences of her treatments stating, "I made a brash decision as a teenager, (as a lot of teenagers do) trying to find confidence and happiness, except now the rest of my life will be negatively affected. I cannot reverse any of the physical, mental, or legal changes I went through. Transition was a very temporary, superficial fix for a very complex identity issue."[90] The

[78] Id.
[79] Lynn E. Lebit, *Compelled Medical Procedures Involving Minors and Incompetents and Misapplication of the Substituted Judgments Doctrine*, 7 J.L. & Health 107, 111 (1992).
[80] Barry A. Lindhal, *Informed Consent—What Must be Disclosed—Lay/material Risk Standard; Patient Rule*, 3 Modern Tort Law: Liability and Litigation (2d ed.) at § 24:56 (2023).
[81] Lawrence Schlam & Joseph P. Wood, *Informed Consent to the Medical Treatment of Minors: Law and Practice*, 10 Health Matrix 141, 146 (2000).
[82] Sonja Shield, *The Doctor Won't See You Now: Rights of Transgender Adolescents to Sex Reassignment Treatment*, 31 N.Y.U. Rev. L. & Soc. Change 361, 394 (2007).
[83] *Id.* at 393-394.
[84] *Bell v. Tavistock* [2020] EWHC 3274, ¶ 78.
[85] *Id.* at ¶ 78, 79.
[86] *Id.*
[87] *Id.* at ¶ 80.
[88] *Id.* at ¶ 81.
[89] *Bell v. Tavistock* [2020] EWHC 3274, ¶ 78.
[90] *Id.*

clinic claimed they only refer puberty blockers to minors if they determine that person is competent to give consent.[91] The High Court reasoned that a determination of whether a person under age sixteen is *Gillick* competent will depend on the "nature of the treatment proposed as well as that person's individual characteristics." The court concluded the administration of puberty blockers to people going through puberty is a "very unusual treatment" for several reasons including the uncertainty over consequences, the lack of clarity over the purpose of the treatment, and the long-term risks associated with the treatment.[92] The court also considered that treatment for gender dysphoria which "has no direct physical manifestation" requires treatments that have direct physical consequences.[93] To achieve *Gillick* competence, the High Court reasoned, a child would have to understand the implications of taking both puberty blockers and cross-sex hormones since the treatments are treated as one clinical pathway.[94] The High Court remarked how it would be "difficult" for a child under sixteen to understand the concept of loss of fertility with the same depth as an adult.[95] Given the gravity of the consequences of puberty blockers and hormones, the court considers gender dysphoria treatment to be "entirely different in territory" than other types of medical treatments normally considered.[96] Acknowledging that experimental treatments often produce certain unknown outcomes, the High Court writes that it is the "combination [sic] of lifelong and life-changing treatment being given to children, with very limited knowledge of the degree to which it will or will not benefit them…that gives significant grounds for concern."[97] The High Court concluded that it is highly unlikely a child under the age of sixteen can legally consent to the long-term risks and consequences associated with puberty blockers.[98]

2. Analysis on Appeal:

In 2021, the Court of Appeal overturned the High Court of Justice's decision in *Bell v. Tavistock.* The Court of Appeal reasoned that the evidence presented by the Clinic demonstrated that treatment was "safe, internationally endorsed, reversible and subject to a rigorous assessment process at each stage."[99] Citing *Gillick*, the appellate court reasoned that it was "for doctors and not judges to decide on the capacity of a person under 16 to consent to medical treatment."[100] The court departed from the lower court's reasoning finding that the nature and implications of treatment with puberty blocks are not distinguishable from the use of contraception in *Gillick.*[101] Furthermore, the court wrote, that physicians are subject to civil action if they treat patients without first obtaining informed consent.[102] Because GIDS requires informed consent before any treatment is given, the appellate court reasoned that the case does not involve children who lack the capacity to make decisions.[103] Rather it is for clinicians, not courts to "decide on competence."[104]

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[91] *Id.* at ¶ 83.
[92] *Id.* at ¶ 134. .
[93] *Id.* at ¶ 135.
[94] *Id.* at ¶ 135–38.
[95] *Bell v. Tavistock* [2020] EWHC 3274, ¶ 139.
[96] *Id.* at ¶ 140.
[97] *Id.* at ¶ 143.
[98] *Id.* at ¶ 151.
[99] *Bell v. Tavistock* [2020] EWCA Civ., ¶ 74.
[100] *Id.* at ¶ 76.
[101] *Id.*
[102] *Id.* at ¶ 81.
[103] *Id.* at ¶ 83.
[104] *Id.* at ¶ 87.

Accordingly, the Court of Appeals set aside the High Court's decision, deferring treatment matters to clinicians and patients.[105]

C. US: An Emerging Circuit Split

Despite the uniform endorsement of gender-affirming care among American professional medical associations and the federal government, several states have sought to ban minors from receiving gender-affirming care. The bans have been working their way up through the courts, most recently landing at the Sixth Circuit which reversed a preliminary injunction that has stopped Kentucky and Tennessee's efforts to bar doctors from treating gender-dysphoric youth with puberty blockers and cross sex-hormones.[106] The cases before the court were *L.W. v. Skrmetti* and *Doe v. Thornbury.*[107] Acknowledging that parents have a fundamental right "to make decisions concerning the care, custody, and control of their children," the Sixth Circuit reasoned this narrow right does not extend to "receive new medical or experimental drug treatment.[108] The Sixth Circuit concluded that states have an abiding interest in "preserving the welfare of children…and in protecting the integrity and ethics of the medical profession: sufficient to limit parental freedom.[109] Judicial deference to the legislatures the court writes, is "'especially appropriate where medical and scientific uncertainty exists."[110] The Eleventh Circuit of Appeals reached a similar conclusion by upholding Alabama's Vulnerable Child Compassion and Protection Act in *Eknes-Tucker v. Governor of the State of Alabama*.[111] Citing precedent, the Eleventh Circuit noted that none of the binding decisions establishes a fundamental right to "treat one's children with transitioning medications subject to medically accepted standards."[112] The court noted that states may limit the authority of parents where "it appears parental decisions will jeopardize the health or safety of the child, or will have a potential for significant social burdens.[113] Like the Sixth Circuit, the Eleventh Circuit concluded that the state of Alabama has a compelling interest in "safeguarding the physical and psychological wellbeing of minors" and thus satisfies rational basis review.[114] Both circuit courts concluded that the right to treat one's children with transitioning medications is not a substantive right guaranteed by the due process clause.[115] Accordingly, if American jurisprudence does not consider gender affirmation a "fundamental right", states' legislative bans are likely sufficient to satisfy rational basis review.

The Eighth Circuit, however, arrived at a different result in *Brandt by and through Brandt v. Rutledge*. In analyzing the constitutionality of an Arkansas law that prohibited healthcare professionals from providing gender transition procedures to individuals under eighteen, the

[105] *Bell v. Tavistock* [2020] EWCA Civ., ¶ 91–92.
[106] Mary Anne Pazanowski, *Trans Youths Denied Access to Affirming Care in Sixth Circuit*, Bloomberg Law (Sept. 28, 2023), https://news.bloomberglaw.com/health-law-and-business/trans-youths-denied-access-to-affirming-care-in-sixth-circuit.
[107] *Id.*
[108] *L. W. by & through Williams v. Skrmetti*, 73 F.4th 408, 417 (6th Cir. 2023).
[109] *Id.*
[110] *Id.*
[111] *Eknes-Tucker v. Gov. of Ala.*, 80 F.4th 1205, 1225 (11th Cir. 2023).
[112] *Id.* at 1224.
[113] *Id.*
[114] *Id.* at 1230.
[115] *L. W. by & through Williams v. Skrmetti*, 73 F.4th 408, 418 (6th Cir. 2023); *Eknes-Tucker v. Gov. of Ala.*, 80 F.4th 1205, 1224 (11th Cir. 2023).

Eighth Circuit upheld the district court's preliminary injunction.[116] Unlike the Sixth and Eleventh Circuits, the Eighth Circuit analyzed the issue under heightened scrutiny.[117] The Eighth Circuit reasoned that the Arkansas Act draws a distinction on the basis of biological sex regarding "who may receive certain types of medical care and who may not."[118] Accordingly, to satisfy judicial review the court reasoned the Act must be supported on an "exceedingly persuasive justification."[119] The Eighth Circuit is not the only court granting injunctions to legislative bans on gender-affirming care. State and district courts in Florida,[120] Montana,[121] Georgia,[122] and Indiana[123] have all blocked state legislatures' attempts to ban gender-affirming care. The divergence in the circuits at various levels makes this issue ripe for the Supreme Court's intervention.

1. Can Minors Sufficiently Consent to Gender Affirming Care?

The pending cases at the circuit level in the United States include arguments under both the Fourteenth Amendment's Equal Protection Clause and the Due Process Clause. Those challenging state legislative bans on gender-affirming care claim the bills violate the Equal Protection Clause which prohibits governments from discriminating against groups of individuals on the basis of various classifications including sex.[124] However, what remains to be determined is whether classifications of gender identity are subject to the same scrutiny as traditional sex classifications. Some courts including the Eighth Circuit hold that sex and gender identity are treated the same under the constitution. The Eighth Circuit reasoned that the legislative ban defines "sex" "without regard to an individual's psychological, chosen, or subjective experience of gender."[125] Because the Act prohibits 'transition procedures' which are "defined as procedures or medications that are intended to change the individual's biological sex," the Eighth Circuit concludes the legislation discriminates on the *basis of sex.*[126] However, this interpretation is out of step with Supreme Court precedent which has yet to equate gender identity with the same level of protection as biological sex. Cases that involve minor transgender care are easily distinguished from *Bostock,* where the Court held that the Civil Rights Act prohibits employers from discriminating against employees on the basis of gender identity. *Bostock* however specifically limits sex discrimination against *adults* in the context of *employment* under Title VII of the Civil Rights Act.[127] The Sixth Circuit distinguishes the legislative ban on gender-affirming treatment for minors writing that in *Bostock,*

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[116] *Brandt by & through Brandt v. Rutledge*, 47 F.4th 661, 672 (8th Cir. 2022).
[117] *Id.* at 670.
[118] *Id.*
[119] *Id.*
[120] *Doe v. Ladapo*, F. Supp. 3d *1 (N.D. Fla. 2023).
[121] *State v. Montana Thirteenth Jud. Dist. Ct., Yellowstone Cnty.*, No. OP 22-0552, 2023 WL 142673, at *1 (Mont. Jan. 10, 2023).
[122] *Koe v. Noggle*, F. Supp. 3d *1 (N.D. Ga. 2023).
[123] *K.C., et al. v. The Individual Members of the Medical Licensing Board of Ind. in their Official Capacities, et al.*, F. Supp. 3d *1 (S.D.Ind. 2023).
[124] **U.S. Const**. amend. X, IV.
[125] *Brandt by & through Brandt v. Rutledge*, 47 F.4th 661, 669 (8th Cir. 2022).
[126] *Id.*
[127] *Bostock v. Clayton, Cty., GA*, 590 U.S. 1734, 1754 (2020): "In Title VII, Congress adopted broad language making it illegal for an employer to rely on an employee's sex when deciding to fire that employee. We do not hesitate to recognize today a necessary consequence of that legislative choice: An employer who fires an individual merely for being gay or transgender defies the law."

the employers fired adult employees based on stereotypes, whereas the laws before the court "do not deny anyone general healthcare treatment based on any such stereotypes; they merely deny the same medical treatments to all children facing gender dysphoria if they are 17 or under, then permit all of these treatments after they reach the age of majority." [128] The concern about "potentially irreversible medical procedures," the court writes "is not a form of stereotyping."[129]

The case for gender-affirming care is even more vulnerable under the Due Process Clause. The Eleventh Circuit concludes that the use of "these medications in general—let alone for children—almost certainly is not 'deeply rooted' in our nation's history and tradition."[130] Supreme Court precedent strongly favors a parent's fundamental right to make decisions regarding the care and control of their children. Furthermore, the Eleventh Circuit recognizes that in all cases involving parental authority, there is a "common thread that states properly may limit the authority of parents where 'it appears that parental decisions will jeopardize the health or safety of the child, or have a potential for significant social burdens."[131] Accordingly, because the courts are split and the medical literature on the efficacy of gender-affirming care on minors is limited, this issue is best positioned for the Supreme Court to clarify the proper treatment of "gender identity" under the Fourteenth Amendment and instruct lower courts how to balance the interests between minors experiencing gender dysphoria, and the state's interest in protecting them from potentially irreversible harm.

Absent from the recent Circuit Court's analysis, however, is the consideration of whether minors possess the capacity to consent to transgender treatments. The age at which adolescents can *legally* consent to gender transition varies by jurisdiction.[132] Both the United Kingdom and the United States require medical professionals to provide information regarding the nature and risks associated with a patient's decision. Emerging studies cast doubt on even the medical professionals' ability to adequately inform patients of the long-term effects associated with transitioning before puberty is complete.[133] Some of the concerns include loss of fertility, impairment in sexual capacity for arousal and orgasm, and shortened life expectancy.[134] More researchers are beginning to consider whether "a post-pubertal onset of transgender identification can be a transient phase of identity exploration, rather than a permanent identity."[135] This emerging research is raising ethical concerns about trans-identifying youth being incapable of consent to treatment.[136] Because the risks associated with puberty blockers, cross-sex hormones, and gender-affirmative surgeries are becoming increasingly documented and recognized,[137] assent to the nature and consequences associated with such treatment is at a minimum, dubious.

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[128] *L. W. by & through Williams v. Skrmetti*, No. 23-5600, 2023 WL 6321688, at *17 (6th Cir. Sept. 28, 2023).
[129] *Id.*
[130] *Eknes-Tucker v. Governor of Alabama*, 80 F.4th 1205, 1220 (11th Cir. 2023).
[131] *Id.* at 1224.
[132] Stephen B. Levine, E. Abbruzzese, and Julia W. Mason, *Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults*, 48.7 Journal of Sex & Marital Therapy 706, 719 (2022).
[133] Stephen B. Levine, *Informed Consent for Transgender Patients*, 45.3 Journal of Sex & Marital Therapy 218 (2019); *Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults*, 48.7 Journal of Sex & Marital Therapy 706, 719 (2022).
[134] Stephen B. Levine, *Informed Consent for Transgender Patients*, 45.3 Journal of Sex & Marital Therapy 218, 222–23 (2019).
[135] Stephen B. Levine, E. Abbruzzese, and Julia W. Mason, *supra* note 131, at 711.
[136] *Id.* at 707.
[137] *Id.* at 718.

V. Conclusion

The United States would benefit from following the United Kingdom's lead in limiting access to gender-affirming treatments for minors. As gender dysphoria becomes more pervasive throughout the globe, courts will continue to be asked to resolve complicated questions such as the constitutionality of bans on transgender care of minors and the legality of informed consent. Given the gaps in evidence and unresolved medical questions, minors likely cannot adequately consent to treatment where there is so much uncertainty regarding the nature and consequences associated with treatment. Accordingly, it is in the best interest of minors for courts across jurisdictions to apply the *Gillick* competence standard to minors seeking to transition before eighteen. Courts around the globe that adopt this standard will better protect minors from making decisions they may later come to regret.