Mia Florin-Sefton //

On December 1st 2020, three High court judges in the UK effectively ruled that trans persons under the age of 18 will likely need a court order in order to gain access to puberty blockers in England and Wales. This highly publicized judgement was the result of a legal complaint first lodged against the NHS Gender Identity Development Service (GIDS) in 2019, which alleged that advice around hormone therapy was "potentially misleading," and that true "informed consent" could not be given under such circumstances. Currently still reeling from the ruling, trans activists, advocates, and legal scholars have since been forced to protest and rage at the outcome. Loudest amongst these powerful critiques are the following: the ruling constitutes a fundamental transgression of trans and adolescent rights; it amounts to a barely concealed attempt to medically and socially detransition trans youth; and it is both the product and extension of a fully-fledged moral panic now rife across the UK, that promises to only further legitimize and license transphobic discourses.[1]

The case itself, now referred to most commonly as Bell v Tavistock, was brought by two claimants —23-year-old Kiera Bell and Claimant A—against the Tavistock NHS Portman Trust, which currently provides the only Gender Identity Development Service (GIDS) for trans youth in England and Wales. When reading the approved judgement it quickly becomes clear that, rather than trying to determine whether or not the Tavistock successfully complied with the standards required in order to elicit consent, the court instead asked "*whether informed consent in the legal sense can be given by* ***such*** *children and young persons.*" The conclusion the court reached reads as follows:

"*It is highly unlikely that a child aged 13 or under would ever be Gillick competent* **[2]** *to give consent to being treated with PBs. In respect of children aged 14 and 15 we are also very doubtful that a child of this age could understand the long-term risks and consequences of treatment in such a way as to have sufficient understanding to give consent . . . we consider that it would be appropriate for clinicians to involve the court in any case where there may be any doubt as to whether the long-term best interests of a 16- or 17-year-old would be served by clinical interventions.*"

One of the many cruel travesties of the ruling, therefore, is its presumption that, while children and young people can, under other circumstances, be "Gillick competent," trans adolescents are *highly unlikely to ever be* "Gillick competent," especially when it comes to matters regarding their own transition and gender identity. Lawyer Wendy Lu surmises thus: "I think what the court is really saying is not that kids can't understand the medical treatment—the Gillick test—but that they can't understand their own gender identity." Which is all to say that perhaps the real perversity of

the outcome lies in the fact that, through brandishing the loud and colourful banner of "moral and bodily autonomy," the British state has ultimately only increased its mandate for biopolitical intervention, surveillance, and paternalistic "protections." It is for this reason that the outcome forces us to ask difficult, yet urgent, questions regarding the model of informed consent for the future of trans healthcare. To borrow the words of scholar and trans historian Jules Gill-Peterson: "the UK decision goes to show that the legal model of consent (and informed consent medicine) isn't enough; we can't pin our hopes for trans medicine on it."

To give a little necessary background: puberty blockers (GnRHa) have historically been used widely in clinical practice to treat a number of different medical conditions, including, but not limited to, precocious puberty, congenital adrenal hyperplasia, prostate cancer, IVF fertility treatments, and uterine disorders. With regards to trans healthcare, what has come to be known as the "Dutch protocol" was first introduced in 2000: GnRHa is prescribed to "halt puberty," usually after a child has reached 12 years old.[4] In the UK the Tavistock began prescribing puberty blockers as part of an "Early Intervention Study" in 2011. A year later the World Professional Association for Transgender Health (WPATH) published its Standards of Care, Ed.7, which recommended the prescription of puberty blockers to transgender adolescents in order to alleviate gender dysphoria and to "give adolescents more time to explore gender nonconformity," i.e., to buy them more time and prevent the development of sex characteristics that "are impossible to reverse if adolescents continue on to pursue sex reassignment" (WPATH).

Significantly, the increasing use of puberty suppressants to help trans adolescents experiencing gender dysphoria almost directly coincides with the increasing support for an "informed consent model" of transgender care. Notably, this is a model of care that evolved as an alternative to the standard model of care largely recommended by the WPATH, and instead seeks to better acknowledge and to better support the patient's right to personal autonomy in choosing care options.[5] Now, while this model has particular restrictions and implications for minors, it is generally celebrated amongst trans activists. This is largely due to the fact that it promotes a departure from the use of the diagnosis of "gender dysphoria" as a prerequisite for accessing transition services and, secondly, it attempts to impact the way that transgender individuals experience and access healthcare by removing the psychotherapy/gatekeeping requirement.[6] Most broadly put: "instead of a medical health practitioner assessing eligibility for and granting access to services, transgender patients themselves are able to decide on whether they are ready to access transition related health services."[7] In her work *Trans Kids: Being Gendered in the 21st Century*, Tey Meadow puts it thus: the informed consent model promises to "take seriously the question of gender as an adaptation without understanding it as a pathology."[8] This is to say that the "informed consent model" is seen to sidestep, in vital and important ways, medical and legal gatekeeping, and promises to recognize the presence and fluidity of trans subjectivities as a feature of human experience that is not necessarily *diagnosable*.

The alarming outcome of Bell v Tavistock, however, forces a careful reassessment of how this model operates in practice, specifically, in relation to minors and other so-called "vulnerable populations." Importantly, the concept of informed medical consent as fundamentally a "principle

of moral and bodily autonomy" has a very recent history that directly correlates with the rise of consumer-based models of care and increased legal interest in the right to self-determination. Indeed, in the first full study of the concept, *History and Theory of Informed Consent,* Ruth Faden and Tom Beauchamp detail how "informed consent" as we know now it, i.e., as a principle of autonomy, first emerged out of the Nuremberg Doctor's Trials, followed by the landmark decision *Salgo v Leland Stanford, Jr. University Board of Trustees* (1957). Baden and Beauchamp make clear, however, that it really wasn't until the early 1970s that there was any widespread interest in the issue. However, in the late 1970s the rise of biomedical ethics inaugurated a large flurry of publishing on the subject, and, suddenly, recognizing the individual as the "pivotal decision maker" and "respecting each person's interest in self-determination" (83) became understood as the primary moral issues in medical ethics.

As Gill-Peterson's pithy tweet makes clear, however, the concept of "informed consent" frequently hopscotches across medical *and* legal contexts. Moreover, while consent holds the most currency regarding contemporary medical ethics, "informed consent is" first and foremost "a creature of the law" (Faden, 97). Indeed, as Marxist feminists Catherine Waldby and Melissa Cooper argue in *Clinical Labor,* the informed consent first emerged out of tort law and fears of litigation, *before* it was ever elevated to the status of a human right by international bioethical conventions around 1980 (14). Thus, and as neatly illustrated by the history of the "consent form," the legal notion of "informed consent," far from serving in the interest of expanding patient rights, instead works to protect clinical practitioners and to safeguard the medical establishment from liability claims. In important ways, therefore, the legal notion of "informed consent" shares a direct genealogy with contract law; which is to say that the patient/worker is required to acknowledge the possibility of risk, and in so doing compromise their ability to pursue legal recourse. In other words: informed consent functions first and foremost as a "risk management strategy." Or, as legal scholar Joel Feinberg argues in *Failures of Consent*: "informed consent" depends upon and assumes the voluntary assumption of risk (281). *Volentia non fit injuria*.

To return to the approved judgement itself, it is worth paying attention to the following line: "*this case is concerned with the legal requirements of the process of obtaining consent for the carrying out of medical treatment*." This phrasing reveals an important priority of the court: can the *legal* requirements of consent be met? Joining these dots is crucial towards assessing the outcome and implications of the case because it forces into view the foundational hegemonic assumption driving the ruling: the assumption that transitioning is, fundamentally, a risk and that, given that it is a risk, it should be, like all risks, if possible, avoided. It is thus possible to apprehend that framing the issue in terms of "legal consent" unavoidably frames the use of puberty blockers as *necessarily* a "risky procedure," i.e., it will be seen as, regardless of any and all medical evidence to the contrary, "a possible harm." This is regardless of the crucial fact that it is widely agreed that the effects of puberty blockers are reversible, with no known longer term consequences.

Hence we see that, despite being rhetorically aligned with a gender-affirming model of care, the legal standard of informed consent frames the very possibility of taking PBs as inextricably and inevitably imbricated within a process of *risk mitigation* that only further pathologizes young

people's choice to transition. It thereby supports, and plays directly into the—often uninterrogated—prejudicial assumption that transition is *never not highly risky* and, consequently, should always be a last resort. In other words, informed consent in this context once again roots the transgender experience in a narrative of internal personal distress over gender identity and severe dysphoria. Shon Faye says it better when quipping on an Instagram live feed: "being told that your existence should be understood as a last resort is just—well—a bit harsh."

Importantly, pointing to this legal and epistemological framework is not meant to suggest that there is no possibility for misunderstanding or risk. As with almost all choices—medical, clinical, or otherwise—there is the possibility for regret, and subsequently some safeguarding mechanisms should be in place.[9] A blinkered and bigoted focus on safeguarding, however, obscures the simple fact that these terms and their illicit assumptions are completely contrary and opposed to the ways in which trans persons and young people conceive the necessary relief, the new and the uncompromising promise, and the potential joy of their future transition. In the words of scholar Grace Lavery: "reshaping one's endocrine system can be a beautiful self-love practice." Hardly *volentia non fit injuria*. For this reason, perhaps it is ultimately unsurprising, although no less cruel, that the court determined the possibility of "informed consent" in these cases to be "highly unlikely," given that what they were essentially asking was, *can a young person understand that, in consenting to transition, they are submitting themselves to an unnecessary risk against which they can claim no recourse?* Needless to say, if the court had actually permitted first-person testimony from trans persons or from organizations that work with trans youth during the hearing, perhaps some of these inconsistencies and contradictions in perspective could have been brought to light.

Finally, it is worth addressing the fact that in the UK the age of criminal responsibility is age ten. As such, one wonders where, and for whom, the burden of proof for "consent" and "responsibility" has to lie. Or, more to the point: for what ends are its limits tested? Indeed, given that a ten-year-old child can be held responsible enough for their actions to be brought to trial and sentenced, you would think that they might be able, at least in some instances, to achieve the level of understanding required to decide whether or not they think they want to delay puberty. What is more, when set against this backdrop, the collective public moral outrage and celebration of "childhood protections" in the British press this past week rings, if it were even possible, as even more shrill, hollow, self-serving and self-congratulatory. Once again, the overriding, and yet understated, logic is that childhood criminals are likely not worthy of state or social protections, while, conversely, it is now the duty of the state to protect all other young persons *from* the possibility of transition. Ultimately, it is on these terms that we should judge the judgement as we continue to evaluate the future of the informed consent model for trans healthcare.

In the meantime, you can donate to the Good Law Project and their Transgender Lives Legal Defense Fund here: https://www.crowdjustice.com/case/transgender-lives/.

[1] Critics of the ban have also been quick to point out that under the new proposal, waiting list times (which already average at around 18 months) will only increase, therefore only further

stifling and stymying any efforts to receive urgent and time-sensitive care for trans young persons.

[2] Gillick competency refers to the rights of a child under 16 to consent to medical examination and treatment without parental consent. It refers to the case *Gillick v West Norfolk and Wisbech AHA* (1986) where a mother of girls under 16 objected to the Department of Health advice that allowed doctors to give contraceptive advice and treatment to children without parental consent. In this instance the court ruled that doctors should be able to offer contraceptive advice and treatment, and since then the term has been used more widely as a means of assessing whether a child or young person has the maturity to make their own decisions and to understand the implications of those decisions, irrespective of parental input and opinion.

[3] The High Court ruled that in order for a child to be competent to give informed consent to puberty blockers, the child would have to understand, retain, and weigh all of the following information:

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

[4] The first transgender children's clinic to take an "affirmative approach" opened in the Netherlands in 1987, followed by the UK in 1989.

[5] https://journalofethics.ama-assn.org/article/informed-consent-medical-care-transgender-and-gender-nonconforming-patients/2016-11

[6] For more details on the benefits of the informed, see https://journals-sagepub-com.ezproxy.cul.columbia.edu/doi/full/10.1177/0022167817745217.

[7] See: Sarah L Schulz "The informed consent model of transgender care: an alternative to the diagnosis of gender dysphoria." *Journal of humanistic psychology* 58.1 (2018): p. 83

[8] See: Tey Meadow's *Trans Kids: Being gendered in the twenty-first century*. University of California Press, 2018; p. 91.

[9] Again, Shon Faye succinctly address this point, tweeting: “detransition shouldn’t be anymore of an influence on access to trans healthcare than abortion regret should be an access to pregnancy termination.” See: https://twitter.com/shonfaye.