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# Trans-Parenthood and a Minor's Ability to Consent to Gender-Changing Medical Treatment

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## Introduction

Societal and cultural attitudes towards sexuality, family forms and creation have evolved dramatically in recent years. Just 55 years ago, abortion was a criminal act,[1] as were all private and public acts of homosexuality,[2] and contraception was not readily available on the National Health Service.[3] The introduction of the Human Rights Act in 1988 and the provisions of the European Convention for the Protection of Human Rights and Fundamental Freedoms introduced scope for further dramatic change. Article 8, which protects and demands "respect" for family life has been interpreted with remarkable breadth, especially within surrogacy arrangements. A dramatic example of this is in the Strasbourg decision of *Kroon v The Netherlands*,[4] where even though the man and the woman were not married and did not live together, the fact they had a stable relationship which produced four children was interpreted by the courts as amounting to "family life". Article 14, which prohibits discrimination in relation to rights and freedoms on certain grounds, has also proved to be a powerful judicial tool in preventing discrimination in relation to parenthood.

As medical reproductive techniques have developed to enable state-of-the-art fertility treatments and family creation, the law will always be forced to play catch-up, not least since its role is usually to react to new concepts rather than create them. Indeed, the pace of change is such that the drafting of legislation, if too tightly drawn, may have unforeseen consequences. Judges find themselves tasked with considering the complex medical, social, philosophical and ethical dilemmas that modern family law presents. Examples include considering the right of a trans-man who gives birth to being named "father" on the child's birth certificate and whether a minor has the requisite capacity to consent to puberty-blocking medication.

Although the rise of trans-parents has led to moral and political outrage from some factions, the research of Professor Susan Golombok shows that the children of trans-parents are able to adapt. In her book, "We are Family", she writes:

> "*Families with trans-parents challenge conventional ideas about what it means to be a mother or a father, but our research so far has shown that changing identity does not preclude parents from being protective of, and loving towards their children, and neither does it cause children to develop psychological problems. In spite of the hurdles they face, children seem to adapt to their parent's transition.*"[5]

So as pregnant trans-men challenge the conventional notion of fatherhood and raise fundamental questions regarding the assignment of parentage – how have the courts approached this?

## Trans-Parents

### McConnell

McConnell was registered as female at birth but had chosen to live as male. He underwent testosterone therapy and a double mastectomy but retained the female reproductive system in the hope of always being able to have a child. His passport and NHS records were amended following his self-identification as male. Upon registering at a licensed fertility clinic for intra-uterine insemination ("IUI"), he was recorded as male. In January 2017, McConnell applied for a Gender Recognition Certificate ("GRC") pursuant to the Gender Recognitions Act 2004 ("GRA"). He produced, with his application, medical evidence confirming his gender dysphoria and a declaration of his permanent intention to live in his acquired gender. In April 2017, he received his GRC stating he had become, pursuant to s.9(1) of GRA "for all purposes the acquired gender".

Following the birth of his son YY, conceived with donor sperm, McConnell was informed by the Registry Office that he could only be registered as YY's mother on his child's birth certificate. McConnell brought a claim for judicial review and sought a declaration that, as a matter of law, he should be regarded as YY's "father", "parent" or "gestational parent". Further, McConnell submitted if the law recognised him as "mother", he should be entitled to a declaration of incompatibility under s.4 Human Rights Act 1998 ("HRA") as the law was not compatible with the right to respect for private and family life and the right to enjoy the rights and freedoms without being discriminated against (under Articles 8 and 14, respectively). An application was also issued under s.55A Family Law Act 1986 on behalf of McConnell's son, seeking a declaration that McConnell was his father.

However, McFarlane P refused the application for judicial review, stating, *inter alia*, parental legal status is derived from the biological process of carrying and giving birth to a child. McFarlane held there was no incompatibility between s.12 GRA[6] (the acquired gender under the Act) and McConnell's rights under the European Convention.

On appeal, the Court of Appeal held that the provisions of the GRA 2004 were such that McConnell could only be registered as YY's mother on the birth certificate. The Court also agreed that there was no incompatibility between the Act and the Convention, and that any infringement of McConnell's rights was justified. Accordingly, there was no recourse to ss3 and 4 of the Human Rights Act 1998 and McConnell's appeal (and that of his son) were dismissed. After the Supreme Court refused to consider his appeal, McConnell is now taking his challenge to Strasbourg.

### BGH

A similar trans-parent/parenthood matter has been proceeding through the German courts (BGH). OH, a German trans-man, gave birth to the child GH, conceived using donor sperm, in March 2013.[7] OH has also been assigned the legal status of "mother" for the purposes of birth registration.

Following the recent Court of Appeal[8] (and Supreme Court) and the German Federal Court of Justice decisions, the children of McConnell and OH are left with the confusing narratives of having a father in reality, but a mother under the law. The German and English courts in BGH and McConnell accept that there are tangible difficulties for both applicants arising from the disparity between their legal status and their reality. For McConnell, the implication is that he might be required to produce a full birth certificate to demonstrate his legal motherhood, as opposed to a short form one. The Court of Appeal accepted that a situation whereby a trans-person was obliged to declare in an official document that their gender in not, in fact, their legal gender, but their gender at birth, is a significant interference with an individual's sense of identity. They also accepted that it amounted to an interference with the right to respect for family life (as the relationship is described as mother and son instead of father and son on the long form of the child's birth certificate).

### Court opinions

The courts in both cases weighted their decisions in favour of certainty: the need to preserve a coherent recording of the registration of births, where the person who gives birth is consistently registered as "mother" in accordance with the rule *mater semper certa est*.[9]

McFarlane P, in the High Court, and later repeated in the Court of Appeal, stated that "mother" is the individual who "undergoes the physical and biological process of carrying a pregnancy and giving birth"[10] irrespective of the legal gender of that person. This results in the courts attributing parental status on birth-assigned gender, which creates a confusing narrative for any resultant child. However, the prospect of trans-men who give birth being recognised as fathers of their children currently seems remote.

## Gender Dysphoria – Minors' Consent to Puberty Blockers and Cross-Sex Hormones

In December 2020, Quincy Bell (aka Kiera) and Mrs A, the mother of an adolescent daughter, brought a claim for judicial review against the Tavistock and Portman NHS Foundation Trust (and two other NHS trusts). The claim was in respect of the treatment and consent to treatment for gender dysphoria. For the purposes of this judgment, the court took it upon themselves to distinguish between minors below 16 and those 16–18 years of age.

### Quincy Bell and Mrs A

Quincy Bell was born female (with the name Kiera Bell) but later began to identify as male. She was treated at the Tavistock and Portman's Gender Identity Development Service ("GIDS"). At 15, she commenced puberty blockers ("PBs"), progressing to cross-sex hormones at 16. Aged 20, she underwent a double mastectomy. Following the surgery, the gender transition progressed following the development of a man's build, a man's voice and the adoption of the male name "Quincy". However, Quincy began to realise that becoming male was not fulfilling his expectations:

> *"My biological make-up was still female and it showed, no matter how much testosterone was in my system or how much I would go to the gym. I was being perceived as a man by society, but it was not enough. I started to just see a woman with a beard, which is what I was. I felt like a fraud and I began to feel more lost, isolated and confused than I did when I was pre-transition."*

Quincy wanted to revert to being female, even beginning to consider having children in the future.

The second claimant, Mrs A, was concerned that her 15-year-old daughter, who had been diagnosed with Autism Spectrum Disorder ("ASD") and behavioural problems, would be soon referred to GIDS and start PBs. Both claimants submitted that minors were simply not capable of giving informed consent to treatment for gender reassignment, the implications being outside of their level of understanding. After all, a high level of competence is required for a high-level decision.

Further, the information provided to the minor patients was insufficient and should not be relied upon as a basis for their consent to treatment. A significant concern related to the proven fact that for those who had commenced taking PBs, there was a strong likelihood that they would progress to the next treatment, which involved taking cross-sex hormones ("CSH"). These hormones are particularly problematic in the context of the consent of a minor because they can cause permanent alterations with profound medical and psychological implications. Further, whilst some young people say that puberty blockers have provided short-term relief by delaying the onset of physical characteristics of an unwanted sex, others have complained that blockers did nothing to alleviate feelings of dysphoria, even increasing a sense of alienation in keeping their bodies child-like.

Any treatment without a valid informed consent was an infringement of the minors' rights under Article 8 (the right to respect for private and family life) under the European Convention of Human Rights (1950) ("the Convention").

The defendant Trust, however, stated that their treatment at GIDS met with the requirements on consent and that the information provided to the minors was age-appropriate. In particular, in respect of minors under 16, the Trust argued that they did not need to understand the implications of cross-sex hormones on their fertility, or the sexual pleasure or functioning, as this was not prescribed to them until after the treatment with the PBs.

The court was tasked with examining the role of consent from minors to treatment for gender dysphoria. The claimants submitted that the treatment with PBs was experimental and they had concerns regarding the unknown long-term effects. The Trust, however, defended the administration of PBs, on the basis that without PBs, the patients can suffer a deterioration in their mental health, including an increase in self-harm and even suicide. The Trust acknowledged that there were concerns in respect of memory loss (brain fog), insomnia, weight gain, concentration, bone density, menopausal type-symptoms and possible fertility issues. Further, even if a patient wished to stop the treatment, it could take up to a year for sperm production and ovulation to commence.

Significantly, the Trust accepted that those who commenced PBs were most likely to progress to taking the cross-sex hormones. These cross-sex hormones might lead to a loss of future fertility, sexual pleasure and function. However, the Trust maintained that consent from minors was taken appropriately,[11] and that they were cognisant of the implications of the treatment and that the further consent being obtained by a Trust clinician provided an additional safeguard.

In the event of an objection from a parent, the Trust, however, would not resort to the court, believing this delay and adversarial approach would be harmful to the patient.

### Gillick competence

The law in respect of the consent of minors is set out in *Gillick v West Norfolk and Wisbech Area Health Authority and another* [1986] 1 FLR 224. In *Gillick*, the House of Lords outlined the list of matters to consider when determining whether a minor under the age of 16, is "Gillick competent". Such matters to consider included:

- the nature of the treatment proposed and the individual characteristics of the minor;
- where the consent related to a serious life-changing matter, there was a greater duty to ensure that the minor understood and was able to weigh the relevant information;
- the court might draw a distinct line with respect to some decisions to which a minor would never be able to consent;
- efforts should be made to allow minors to give valid consent, if and where possible;
- where the long-term consequences of the treatment were extreme and the benefits unclear, it might not be possible to achieve Gillick competence;
- if finding that a minor can consent, it was important not to set the bar too high; and
- when examining consent, the minor should be able to demonstrate an understanding of the significant facts when explained, including future implications.

The court was first concerned with the fact the first stage of the PB treatment was highly experimental and that some side-effects were unknown. Whist the Trust sought to argue that the administration of PBs and CSH was very much a two-stage process, the court disagreed, finding that once a minor had started on the PBs, most continued to take CSH. The Trust also submitted that it would be an intrusion on a young person's autonomy to restrict access to the drugs. However, the court rejected this: "In principle, a young person's autonomy should be protected and supported. However, it is precisely the role of the court to protect children, and particularly vulnerable children's best interest."

The court heard that 26 of the 161 children referred to the GIDs clinic in 2019/2020 were 13 years old or younger, with 95 of them being under 15. Some had been on PBs from the age of 10.

The court found that to achieve Gillick competence, a minor would have to understand the serious implications of CSH in addition to PBs (because one treatment led to the other, informed consent was required for both). The court, having heard expert evidence from a neuroscientist in respect of a minor's ability to comprehend complex information, found that a child under 13 was highly unlikely to achieve Gillick competence. On the back of this, the court also questioned whether 14- and 15-year-olds could understand the long-term risks and consequences of such experimental treatment.

However, in respect of minors aged 16 and above, there is a statutory presumption that they do have capacity to give valid consent to medical treatment.[12] The court stated:

> "*Given the long-term consequences of the clinical interventions at issue in this case, and given that the treatment is as yet innovative and experimental, we recognise that clinicians may well regard these as cases where the authorisation of the court should be sought prior to commencing the clinical treatment.*"

In January 2021, the Trust was granted permission to appeal against the court's decision to grant the claim for judicial review.

In the meantime, the defendant has paused all GIDs referrals to the Trust for the administration of treatment for those under 15. The NHS released a statement:

> "*The Tavistock have immediately suspended new referrals for puberty blocker and cross-sex hormones for the under 16s, which in future will only be permitted where a court specifically authorises it.*"

This case has brought to the fore the issue of consent in minors, especially when considering potentially experimental treatments with life-long consequences. Those advocating GIDs for minors rely upon the distress that remaining as their birth sex can bring if treatment is withheld or delayed. Further, for years, PBs have been described by trans-rights charities, such as Mermaids or Stonewall, as "a benign and reversible way of giving 'time to think'".[13]

A particular issue for the courts was the lack of empirical evidence concerning the long-term side-effects of the drugs when administered to minors. The Cass Review,[14] formed in Autumn 2020, aims to ensure children and young people who are exploring their gender identity and need support receive a "safe, holistic and effective" standard of care from NHS. Thus, pending the appeal from the Trust, those under 16 seeking PBs and CSH will need to apply to the court first.

## Gender Dysphoria – Parental Consent to the Administration of Puberty Blockers to Minors

In *AB v CD & Ors* [2021] EWHC 741, the Court was also concerned about the administration of puberty blockers to a teen with gender dysphoria. The case concerned an application by AB, the mother of the child, XY, for a declaration that she and CD, the child's father, had the requisite legal ability to consent to the administration of puberty blockers. The child, a boy, came out as transgender aged 10, had transitioned socially and had changed name by deed poll. The child was now 15.

This matter swiftly followed the Divisional Court's decision in *Bell v Tavistock and Portman NHS Foundation Trust & Ors* (referred to above) which set out the consideration that a child should understand, be able to retain and have the capacity to weigh up in order to have the necessary capacity in relation to puberty blockers. Although XY had given consent prior to the Division Court's decision in Bell, an updating capacity assessment had not been undertaken. Both parents hoped their consent on their child's consent would suffice.

The Court adopted this approach:

> "*It … cannot be established with certainty whether [XY] is, or is not, Gillick competent. In those circumstances, I am going to consider the matter on two alternative bases: either that [XY] is not Gillick competent, or that [XY] is Gillick competent, but it remains relevant whether [XY's] parents can also give operative consent to the treatment… If the child is Gillick competent, [XY] has not objected to her parent giving consent on her behalf. As such a doctor can rely on the consent given by her parents. Alternatively, the child is not Gillick competent. In that case, her parents can consent on her behalf. It is not necessary for me or a doctor to investigate which route applies to give the parents authority to give consent. Therefore, in my view, whether or not XY is Gillick competent to make the decision about PB's, her parents retain the parental right to consent to that treatment.*"

The Court continued to observe that whilst "*the ratio of Bell is that a child is very unlikely to be in a position to understand and weigh up the [Bell] factors …*", in order to establish the relevant Gillick competence, the evidence in this matter was such that the court found that XY's parents had come to a considered decision and that, as a matter of principle, the factors in Bell "*do not justify removing the parental right to consent*".

Lieven J also addressed the issue of parents succumbing to undue pressure from the child to consent to taking PBs, advising that the process of establishing best practice guidelines and safeguards should fall to the various regulatory bodies, NHS England and the Care Quality Commission:

> "*It may well be that, given the particular issues involved, additional safeguards should be built into the clinical decision making, for example, by a requirement for an independent second opinion. Any such requirement is a matter for the regulatory and oversight bodies and may be a matter considered by the Cass Review. My view is that this is likely to be a better safeguard for the very vulnerable children concerned rather than removing the ability in law of the parents giving consent. The clinical expert who gave the second opinion could then have a role in advising whether or not the particular case should be brought to Court… The pressure on parents to give consent is something that all the clinicians are likely to be fully alive to… [if there is a concern] the parents are being pressured to given consent, then I have no doubt such a case should be brought to Court.*"

## Conclusion

The above cases are examples of the remarkable breadth of decisions the family court is tasked with making in this brave new world, and one where the court is always playing catch-up with developments in medicine. Family practitioners await the decisions of McConnell and BGH in Strasbourg with interest. The question of whether only a mother can be deemed to give birth for the purposes of birth registration strikes at the core of family law and will have to be considered alongside the rights and freedoms of the trans-parent as well those of the child (in having an accurate record of their birth narrative). For trans-teens, their parents, the NHS Trusts and the family courts, as Mrs Justice Lieven observed, "*the use of PBs for children with gender dysphoria raises unique and highly controversial ethical issues*". These matters demand not just judicial consideration and intervention, but guidance from the regulatory bodies to ensure adequate safeguards and a consistency of approach.

## Endnotes

1. Abortion Act 1967: legalised abortion in October 1967.
2. Sexual Offences Act 1967: decriminalised homosexuality July 1967.
3. National Health Service (Family Planning) Act 1967: enacted June 1967.
4. *Kroon et al. v The Netherlands*: ECHR 27 October 1994, https://www.servat.unibe.ch/dfr/em185359.html.
5. Professor Susan Golombok, "We are Family", Scribe, 2020.
6. Gender Recognition Act 2004. Section 12 Parenthood: The fact that a person's gender has become the acquired gender under this Act does not affect the status of the person as the father or mother of a child.
7. *O.H and G.H v Germany*, Application Nos 53568/18 and 54941/18, communicated on 6 February 2019.
8. *R (McConnell and YY) v Registrar General* [2020] EWCA Civ 559, 29 April 2020. On 9 November 2020, the Supreme Court refused McConnell's application for permission to appeal on the ground there was no "arguable point of law".
9. BGH (n 15) para. 27; R (McConnell and YY) (n 14) paras 64–71.
10. R (McConnell and YY) 9n 140 para. 35.
11. *Gillick v West Norfolk and Wisbech Area Health Authority and another* [1986] 1 FLR 224.
12. Section 8 Family Law Reform Act 1969.
13. Lucy Bannerman, "Landmark High Court ruling restricts puberty blockers for children", *The Times*, 2 December 2020, https://www.thetimes.co.uk/article/landmark-ruling-makes-it-harder-for-children-to-get-sex-change-drugs-8830h3hnc.
14. The Cass Review: an independent review of gender identity services for children and young people: https://cass.independent-review.uk/.

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Prior to joining Payne Hicks Beach, Sarah was in-house counsel for a US firm where she worked extensively on an ultra-high-net-worth Californian divorce and contested children proceedings. Thereafter she joined a specialist family law firm where she developed her expertise in complex international surrogacy, fertility and modern family law, representing internationally famous clients from the fields of sports and media.

"Possessed of that winning combination of intelligence, capacity for hard work and charm," Sarah is adept at handling her cases with the utmost discretion and sensitivity. She is "a true fighter in pursuit of her clients' interests" and determined to get the very best outcome for them. She is often called to comment on the latest legal developments by the national press and makes regular contributions to specialist family law journals.

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