Special or Not Special Enough? The Legal Status of Gender-Affirming Hormones and the Curious Case of "Q"

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[A] INTRODUCTION

For the vast majority of decisions about medical treatment, even those that are life-limiting, a young person (if *Gillick* competent)[1] and/or their parents/carers with parental responsibility can consent to the same and no court intervention is required. However, it has been suggested that there are certain medical interventions that fall within a "special category" of medical treatment, namely treatments where judicial oversight and authorization is required before the medical intervention can be administered, either because there is a common law rule or it is a matter of good practice.[2] Against a backdrop of significant legal and regulatory changes, the question has inevitably arisen whether gender-affirming hormones can or should be regarded as falling into this "special category". This article will explore this concept of a "special category" of medical treatment, the status of gender-affirming hormones, and whether the decision in respect of "Q" marks a deviation from the established approach.

[1] *Gillick v West Norfolk and Wisbech Area Health Authority* (1986) held that a minor can consent to medical treatment, in that case contraception, without the approval of the parent, provided that the child has sufficient intelligence and understanding, which is a question for medical professionals, done on a case-by-case basis, not for the court to attempt to give general principles.

[2] In *AB v CD and Others* (2021), Mrs Justice Lieven (paragraph 72) took the view that there was "a distinction without much difference" between whether the "special category" is invoked with reference to common law or good practice, as a principle of good practice is likely to have a similar effect to a legal requirement.

[B] "SPECIAL CATEGORY" OF MEDICAL TREATMENT

The concept of a "special category" of medical treatment appears to have arisen for the first time in the courts in the case of *Re D (A Minor) (Wardship Sterilisation)* (1976). Re D concerned an 11-year old girl—"D"—who had been diagnosed with Sotos syndrome, the symptoms of which included accelerated growth during infancy, epilepsy, generalized clumsiness, an unusual facial appearance, and behavioural problems, including emotional instability, certain aggressive tendencies, and some impairment of mental function. The extent of the impairment of her mental function was unknown and was a matter of disagreement between medical and educational professionals; however, it was common ground amongst both the professionals and D's parents that D had the capacity to marry.

When D was a young child, her parents had decided that they should apply to have her sterilized when she was about 18 years old to prevent her from having children who might also be "abnormal". When D reached puberty at the age of 10, her mother became increasingly concerned that she would be "seduced" and possibly give birth to an "abnormal" child (D's father had died in the interim). She consulted with D's paediatrician, under whose care D had been since birth, and he took the view that there was a real risk that D would give birth to an "abnormal" foetus. The paediatrician also raised concerns that D's epilepsy might cause her to harm a child and that there were "social reasons" why she should not have children, namely that D would:

> … be unable in the future to maintain herself save in a sheltered environment, her inability due to epilepsy and other handicaps to cope with a family if she were to marry, without substantial support, the deterioration in her behaviour for which he said there was no known method of improvement and the possibility that she might have to enter an institution as he alleged for social or criminal reasons in the future (*Re D* 1976).

The paediatrician suggested that D should be sterilized immediately, without waiting until her 18th birthday, and D's mother agreed. The operation—a hysterectomy—was scheduled to be carried out in May 1975. Other professionals involved in D's care raised concerns about this course of treatment, which would be irreversible and permanent; however, the paediatrician refused to defer the operation. D's educational psychologist, who was attached to the educational department of D's local authority, initiated wardship proceedings to make D a ward of the court and to prevent D from being sterilized.

In support of D's mother, D's paediatrician argued that, provided that the parent or parents consented, the decision to sterilize a child was made pursuant to the exercise of the clinician's judgment and there should be no interference with his clinical freedom. The other medical experts who were consulted disputed this assertion and submitted that the decision to sterilize a child was not entirely within a doctor's clinical judgment, save where sterilization was the treatment of choice for some disease (ie where the treatment was for "therapeutic" purposes). Heilbron J agreed, noting:

> I cannot believe, and the evidence does not warrant the view, that a decision to carry out an operation of this nature performed for non-therapeutic purposes on a minor, can be held to be within the doctor's sole clinical judgment (*Re D* 1976).

In other words, sterilization falls into a special category of medical intervention that requires judicial oversight. Ultimately, the court held that the sterilization of D was neither "medically indicated nor necessary".

Following on from *Re D*, the concept of a "special category" of medical treatment has typically arisen in cases regarding the forced sterilization of incapacitated women[3] and decisions to withdraw clinically assisted nutrition and hydration, though any ambivalence in respect of the latter seems to have been put to rest by the Supreme Court in *NHS Trust v Y (Intensive Care Society Intervening)* (2019).[4] Only two reported cases concerned children under the age of 17, namely the aforementioned *Re D* and *Re E (A Minor) (Medical Treatment)* (1991).

In *Re E*, a severely mentally challenged young woman—"J"—suffered from serious menorrhagia (excessive menstruation). J was under the full-time care of her parents and unable to make decisions for herself. The only viable treatment for J's condition was a hysterectomy, and there was no dispute between the clinicians and the parents that the surgery should be undertaken. The purpose of the operation was not to sterilize J; however, it would be the inevitable result of the treatment.

The Medical Defence Union advised J's consultant that he should not take any steps unless the court made an order approving treatment in the wardship proceedings. In an effort to clarify the legal position of doctors and parents placed in a similar position to J's parents, the Official

[3] See, for example, *Re B (A Minor) (Wardship Sterilisation)* (1987); *F v West Berkshire Health Authority* (1990); *Re E (A Minor) (Medical Treatment)* (1991); *Re GF (Medical Treatment)* (1992); and *Re S (Sterilisation Patient's Best Interests)* (2000) 2 FLR 389.

[4] In *NHS Trust v Y (Intensive Care Society Intervening)* (2019), the Supreme Court made it clear that the common law did not require that an application must be made to the courts in every case where clinically assisted nutrition and hydration was being considered: see paragraph 93 in particular.

Solicitor, who was the guardian *ad litem* for J, made an application to the court as an interlocutory application in wardship proceedings. No party sought to argue against the proposed treatment and the court agreed that it was in J's best interests. As such, the principal issue before the court was whether such treatment required an application to the court in the first instance, regardless of the consent of all of the relevant parties to the same. In other words—though the term is not specifically referenced in the judgment itself —whether the proposed hysterectomy fell into the "special category" of medical intervention that requires court oversight.

The Official Solicitor argued that it did not. He submitted that there was a distinction to be made between cases where an operation is required for genuine therapeutic reasons and those where the operation is designed to achieve sterilization, such as *Re D* (though *Re D* was not cited in the judgment). Where an operation is required for genuine therapeutic reasons, he maintained that it ought not be necessary for a responsible doctor to have to seek the formal consent of the court for carrying out the operation. The court agreed and held that consent was not required. As such, *Re D* appears to be the only case[5]—and non-therapeutic sterilization the only medical treatment—where the court has identified a legal requirement for the matter to come to court to consider the proposed treatment for a child, notwithstanding the consent of the parents and agreement of the treating clinicians.

As the above discussion intimates, there is no statutory definition of or criteria for what defines a medical intervention as falling into a "special category" of medical treatment, and the court has been resistant to extending principles or guidance applied in cases in respect of incapacitated adults to cases involving children and young people. A "special category" of medical treatment is thus a narrow category in the first instance, and even narrower in respect of children and young people.

[C] THE LEGAL STATUS OF GENDER-AFFIRMING HORMONES

Gender-affirming hormones (also known as cross-sex or masculinizing/feminizing hormones) are used to achieve physical changes that align with a person's affirmed gender identity, for example, breast development or the deepening of the voice. These include testosterone, oestrogen, progesterone and antiandrogens. In the United Kingdom, gender-affirming

5 This was confirmed in *AB v CD and Others* (2021), which sets out a very helpful summary of the line of cases that have dealt with the concept of a "special category" of medical treatment. See paragraphs 71-99.

hormones are available on the National Health Service (NHS) to treat young people with gender incongruence from around their 16th birthday, subject to meeting strict eligibility criteria and not meeting any of the exclusion criteria.[6] Gender-affirming hormones, unlike puberty blockers, are also available privately; neither the private sale nor supply of gender-affirming hormones to young people is prohibited by law.[7]

The question of whether gender-affirming treatment constituted a "special category" of medical treatment for young people was first considered in the case of *AB v CD* (2021), albeit in respect of puberty blockers.[8] In *AB v CD*, AB, the mother of XY, applied for a declaration that she and CD (the father of XY) had the ability in law to consent on behalf of XY to the administration of puberty blockers, without the need for a "best interests" decision from the court. The main question for the court was whether parents/carers could provide consent on their child's behalf (as part of their exercise of parental responsibility) or whether puberty blockers fell into a "special category" of medical treatment which required court oversight.

Mrs Justice Lieven—who was one of the presiding judges in the (later successfully appealed) first instance decision in *Bell v The Tavistock and Portman NHS Foundation Trust* (2020)—reiterated the concerns raised in that case about the safety and efficacy of puberty blockers. In particular, she made reference to the allegedly poor evidence base for puberty blockers; the lack of full and long-term testing; their use being highly controversial, including within the medical community; the lifelong and life-changing consequences of the treatment, which in some ways are irreversible; and the idea that puberty blockers were "experimental treatment", all of which had been accepted in *Bell v Tavistock* (2020: see, in particular, paragraphs 36-37). Indeed, Her Ladyship indicated that it might be argued that—in light of *Bell v Tavistock*—puberty blockers

6 On 24 March 2024, NHS England published a Clinical Commissioning Policy as part of the Children and Young People's Gender Service" which sets out the "eligibility and readiness" criteria that all patients must meet in order to access gender affirming hormones, as well as the "exclusionary criteria" would prevent a patient from accessing treatment (NHS England 2024).

7 On 30 May 2024, shortly before Parliament was dissolved, Victoria Atkinson, the then-health secretary, brought into effect emergency legislation banning the sale and supply of puberty blockers, namely the Medicines (Gonadotrophin-Releasing Hormone Analogues) (Emergency Prohibition) (England, Wales and Scotland) Order 2024/727. On 11 December 2024, the ban was made indefinite under the Medicines (Gonadotrophin-Releasing Hormone Analogues) (Restrictions on Private Sales and Supplies) Order 2024, with a review scheduled for 1 October 2027.

8 The (successfully appealed) first instance decision in the judicial review case of *Bell v Tavistock* (2020) did not specifically consider whether puberty blockers fell into a "special category" of medical treatment, as it only dealt with the patient's consent, rather any larger consideration of parental consent.

were sufficiently different from other medical treatments as to be treated differently, though was hampered by the fact that none of the parties sought to make this argument. Notwithstanding her apparent disquiet, Mrs Justice Lieven ultimately accepted that parents could consent to puberty blockers on their child's behalf without the matter requiring court oversight; in other words, puberty blockers did not fall into a "special category" of medical intervention.

Mrs Justice Lieven's reasoning was subsequently adopted by Mrs Justice Judd in *O v P* (2024) to confirm that gender-affirming hormones also do not fall into a "special category" of medical intervention. This was reconfirmed in *O v P and Q* (2024), both of which will be discussed in greater detail below.

[D] FIRST INSTANCE DECISION: *O v P* (2024)

The facts of *O v P* (2024) can be summarized as follows: "Q" was born female but began to identify as male when he reached the age of 12 years old. Supported by his father, Q sought to access gender-affirming care; however, Q's mother, who did not accept that Q was transgender, applied for a prohibited steps order under section 8 of the Children Act 1989 to prevent Q from accessing private gender-affirming treatment (the parties had already agreed that Q could join the waiting list for treatment through the NHS). The mother subsequently agreed that Q could be assessed by Gender Plus, a private provider, and invited the court to adjourn the proceedings until the assessment was completed. She sought for the court to retain oversight in the event that Gender Plus prescribed gender-affirming hormones, which the mother firmly opposed.

Additionally, the mother sought a declaration that any proposed prescribing of puberty blockers or gender-affirming hormones to a person under the age of 18 years of age by a private provider must be subject to the oversight of the court. She argued that, in light of the findings contained in Dr Hilary Cass's *Independent Review of Gender Identity Services for Children and Young People* (2024) (the Cass Review), the decisions of *Bell v Tavistock* and *AB v CD* could no longer stand. In other words, puberty blockers and gender-affirming hormones should now be regarded as falling into a "special category" of medical treatment. Conversely, Q's father and Q asked the court to dismiss the mother's applications on the basis that Q should be assessed and then left to make decisions as to any treatment offered on his own with the assistance of treating clinicians.

Mrs Justice Judd held that the findings of the Cass Review did not justify her departing from the decisions in *Bell v Tavistock* and *AB v CD*.

Her starting point was that Q was *Gillick* competent and therefore he was entitled to consent to his own treatment. Whilst she acknowledged that there may be situations where it might be necessary to invoke the inherent jurisdiction of the court to prevent gender-affirming treatment—for example, where a child was particularly vulnerable or was accessing an unregulated provider—this did not apply to Q; there was "no realistic basis" on which she could override Q's consent to treatment by a regulated provider or clinician in the United Kingdom (*O v P* 2024: paragraph 61). As such, there was no legitimate purpose in adjourning the proceedings for court oversight, and it was in Q's best interests to conclude the proceedings.

Likewise, Mrs Justice Judd declined to make a declaration that any prescribing of puberty blockers or hormone treatment to a person under the age of 18 by a private clinic should be subject to the oversight of the court, rejecting the argument that puberty blockers or gender-affirming hormones fell into a "special category" of medical treatment. She echoed the warning given by Lord Philips of Worth Matravers as to the dangers of a court grappling with issues which are divorced from the specific facts of a case (*O v P* 2024: paragraph 64).

[E] THE APPEAL: *O v P AND Q* (2024)

Q's mother applied for leave to appeal Mrs Justice Judd's decision. The main issue before the Court of Appeal was whether Mrs Justice Judd was right to conclude that there was no legitimate purpose for adjourning the case in circumstances where it was agreed that Q was *Gillick*-competent and had mental capacity to consent to his treatment. The mother contended that there was a legitimate purpose in adjourning the proceedings because: (i) the legal and regulatory landscape for gender-affirming treatment was changing rapidly; (ii) the final report of the Cass Review was only published on 10 April 2024, a week prior to the hearing before Her Ladyship; (iii) the Government was continuing to take steps in response to the Cass Review (as evidenced by the ban on the private sale and supply of puberty blockers); and (iv) Gender Plus was a private provider, whose practices and procedures did not completely mirror those of the NHS. The appeal was opposed by the father and J, who argued that the court at first instance had been right to conclude the proceedings, which had already been going on for two years, as it was in J's best interests to do so.

The Court of Appeal, albeit "not without hesitation" (paragraph 7), held that Mrs Justice Judd had been wrong to refuse to adjourn the mother's

applications and to dismiss the proceedings. The Court of Appeal agreed with the mother that Mrs Justice Judd had not placed enough weight on the rapidly changing regulatory landscape of gender-affirming care nor the fact that Gender Plus did not conform to the recommendations of the Cass Review. In particular, the Court of Appeal highlighted that Gender Plus did not comply with recommendation 9 of the Cass Review, namely the need for the case to be discussed by a national multidisciplinary team. In those circumstances, the Court of Appeal took the view that the proceedings should have been adjourned and the mother's applications remained live to enable the court to maintain oversight of J's care. The appeal was granted and the case was adjourned with no continuing orders in place, with leave to the parties to restore the matter for further directions to be made.

In considering Mrs Justice Judd's decision, the Court of Appeal re-emphasized that gender-affirming hormones do not fall into a "special category" of medical treatment whereby there is a *prima facie* requirement to apply to the court for a best interests decision.[9] However, the reasoning for their decision to keep the proceedings live seems at odds with this established *dictum*. As Sir MacFarlane notes in his remarks in the judgment, where a young person is between 16 and 18 and capable of giving consent to treatment, the best interests jurisdiction is not a general welfare jurisdiction; the court will only override the young person's consent where it is necessary to intervene to protect them from "grave and irreversible mental or physical harm" (paragraph 46); quoting *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* (1993). Implicit in the decision of the Court of Appeal, therefore, is that the changing regulatory and medical landscape and/or the inability of private providers to meet NHS specifications may cause J "grave and irreversible mental or physical harm", which may lead the court to override his consent to treatment were the mother's applications to be determined; thus, the adjournment is legitimate and purposive.

[9] It is interesting to note that even though Sir Geoffrey Voss, Master of the Rolls, who took the lead in the judgment, indicated that the administration of gender-affirming hormones was not in a "special category" (*O v P and Q* 2024: paragraph 42), Sir Andrew McFarlane, President of the Family Division, reiterated the same in his brief remarks (ibid: paragraph 46).

Putting aside the reasonableness of that claim,[10] both of the arguments relied on—the changing regulatory and medical landscape and the inability of private providers to meet NHS specifications—are not specific to J's case; they are generalized concerns around gender-affirming hormones and would arise in any situation in which a young person seeks to access gender-affirming hormones privately. As such, the basis for the court's decision to keep the proceedings live seems to suggest that the administration of gender-affirming hormones requires court oversight and is therefore in a "special category" of medical treatment (regardless of the competent young person's consent), whilst simultaneously claiming that it does not fall into a "special category" of medical treatment.

[F] CONCLUSION

Since the case of *Bell v Tavistock* (2020), the family courts have increasingly been tasked with making decisions around gender-affirming medical care for young people. In doing so, established legal principles—from Gillick competence to parental consent to medical care—have been carefully scrutinized, but ultimately upheld. The courts have been clear that any changes to the legal status of gender-affirming hormones are the purview of Parliament, not the courts; they are to be treated like any other medical interventions. Notwithstanding the purported internal conflict in *O v P and Q* (2024), it seems that gender-affirming treatment is regarded as "special", but not "special" enough.

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[10] There are a number of difficulties with the court's reasoning in *O v P and Q* (2024) which are beyond the scope of this article, including: the extent to which the possibility, rather than actual, changes to the regulatory and medical landscape should affect decision-making around a specific child; the questionable suggestion that the administration of gender-affirming hormones by Gender Plus, which has an outstanding Care Quality Commission rating, solely because it has not adopted the NHS practice of a multidisciplinary assessment may cause a risk of "grave and irreversible mental or physical harm"; and the reliance on the Cass Review as a Ur-text, when it does not have any legal status and there are conflicting expert reports.

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