

Progressive autonomy and informed consent in adolescent gender transition treatments: a dialectical legal and bioethical analysis of *Bell v. Tavistock*

Autonomía progresiva y consentimiento informado en tratamientos de transición de género en adolescentes: un análisis jurídico y bioético dialéctico del caso *Bell vs. Tavistock*

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Abstract

The case of Bell v. Tavistock, adjudicated by UK courts between 2020 and 2021, represents a significant development in the ongoing debate

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regarding adolescent autonomy in consenting to gender transition treatments. This litigation contested the use of puberty blockers for teenagers under 16 by the Gender Identity Development Service (GIDS) of the National Health Service (NHS), thereby illuminating critical bioethical issues such as informed consent, the application of progressive autonomy under the Gillick competency standard, scientific uncertainty concerning long-term consequences, and the division of responsibilities between clinical and judicial authorities. Examination of the legal and bioethical dimensions through both principalism and ontological personalist frameworks facilitates analysis of progressive autonomy, adolescent vulnerability, and therapeutic proportionality. The High Court is argued to have adopted a prudential position aligned with personalism, whereas the Court of Appeal restored a principled approach that prioritizes clinical judgment and progressive autonomy consistent with the Gillick doctrine.

Keywords: Gender-affirming hormone therapy, gender affirmation, bioethical models, principlism, ontological personalism, Bio law.

1. Introduction

Gender incongruence is a condition in which a person experiences a persistent and marked incongruence between their gender identity and their biological sex assigned at birth (1). This definition from the eleventh edition of the International Classification of Diseases (ICD-11) classifies gender incongruence as a medical condition rather than a mental disorder, thereby eliminating the stigma associated with the pathologization of sex-gender diversity found in ICD-10. The significance of this reclassification of gender incongruence in ICD-11 lies in its reflection of conceptual progress in the social sphere, policy, research, clinical practice, and human rights laws and standards, now recategorizing it as a “Condition Related to Sexual Health” and moving beyond the mind/body dichotomy inherent in ICD-10. Gender identity disorders in the ICD-11 have been reconceptualized as gender incongruence (2). It should be noted that the

definition of gender dysphoria in the American Psychiatric Association's 2013 Diagnostic and Statistical Manual of Mental Disorders (DSM-5) no longer classified gender dysphoria as a psychiatric mental disorder; instead, it is described as a form of distress that should not be labeled as a psychiatric disorder (3). Therefore, gender dysphoria is part of gender identity, which in itself is not a disorder; thus, this definition focuses the clinical issue on distress caused by sex-gender incongruence and recognizes transsexual and transgender identity as a normal variation of the human experience. This is reinforced by international, regional, and national frameworks that recognize sex-gender diversity as a human right and part of human dignity. This has been recognized by the United Nations High Commissioner for Human Rights (OHCHR):

Sex-gender diversity encompasses the plurality of gender identities, gender expressions, and sexual orientations that exist in human societies, understood as part of human dignity and protected by the principles of equality and non-discrimination (4).

The international protection of sex and gender diversity is grounded in a framework composed of treaties and interpretive standards. Although the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social, and Cultural Rights (ICESCR) do not expressly mention these categories, their treaty bodies have recognized that they are encompassed by the principles of equality and privacy, as in *Toonen v. Australia* (5). In the Inter-American system, the Inter-American Court of Human Rights affirmed in OC-24/17 that gender identity, gender expression, and sexual orientation are fully protected by the rights to dignity, autonomy, and non-discrimination (6). The Inter-American Convention against All Forms of Discrimination and Intolerance is the only treaty that explicitly mentions OSIEGCS (7).

The shift in the conceptualization of gender incongruence allows it to be considered a health condition or distress requiring care without pathologizing the individual, which implies access to health,

social, and legal services such as: psychological support, cross-sex hormone therapy, gender-reassignment surgery, and social and legal transition to the desired gender (3).

Gender-affirming therapies, also known as gender-affirming care, include various treatments such as puberty blockers, hormone therapy, psychological counseling, and gender-affirming surgeries. The earliest reports of gender identity change date back to ancient times in both Egypt and Rome. However, gender-affirming therapies have been developed since the 20th century, primarily in Europe and the United States. Some important historical milestones include: the first gender-affirming surgery was performed in Berlin, Germany, by Dr. Magnus Hirschfeld, considered the pioneer of medical care for transgender people and founder of the Institute for Sexual Science in Berlin. This was the world's first institute dedicated to sexology and the site of the first documented gender-affirming surgery: orchiectomy, penectomy, and vaginoplasty on a transgender patient; and the founding by Dr. Harry Benjamin of the Harry Benjamin International Gender Dysphoria Association (HBIGDA), which established standards of care for transgender people seeking medical and surgical treatment. In 2007, the HBIGDA became known as the World Professional Association for Transgender Health (WPATH), which is a professional organization dedicated to the care and treatment of people with gender dysphoria today (8). In the United States, Johns Hopkins University opened the Gender Identity Clinic in 1966, making it the first clinic in the U.S. to offer gender-affirming surgeries. The clinic remained open until 1979, when, under pressure from the head of psychiatry, Paul R. McHugh, who argued that gender-affirming healthcare was futile, until it reopened in 2017 with a commitment to providing healthcare to the LGBTIQ community, including gender-affirming treatments (9).

The Dutch Protocol is the first to establish guidelines for adolescents with gender incongruence, stating that it is vital to provide psychological support and use puberty blockers (PBs) in order to buy time before proceeding with other gender-affirming procedures,

including surgeries. The intervention is justified on the grounds that it is reversible and serves as a diagnostic tool, but these claims are considered increasingly less credible by some physicians. The evidence for the Dutch Protocol came from a study of 70 adolescents treated with puberty suppression, cross-sex hormones, and surgery. The initial results were generally positive, though limited by the small number of cases and inconsistent measurements. A follow-up study in the United Kingdom found no improvements. While some effects, such as bone density, have been studied, others, such as sexual functioning, remain largely unexplored (10).

Now that we have introduced the main concepts related to the topic of this article, we will proceed with a brief summary of the *Bell v. Tavistock* case, whose legal arguments will be analyzed in depth later. The *Bell v. Tavistock* challenged the use of puberty blockers on minors at the Tavistock Health Center, an integral part of the Gender Identity Development Service (GIDS), which was the specialized NHS service in the United Kingdom responsible for the clinical care of children and adolescents with gender incongruence or dysphoria. The Tavistock clinic has since closed, and a restructuring of health, social, and legal services is currently being reconsidered (11). In 2020, the High Court held that minors under the age of 16 could hardly provide informed consent due to the complexity and long-term consequences of the treatment, further characterizing it as experimental. It also required a clear understanding of the risks and the high probability of progression to cross-sex hormone therapy and noted that physicians might need judicial authorization before treating anyone under 16, and possibly even some 16 to 17 year-olds, due to the novelty and transformative nature of the treatment (12). In 2021, the Court of Appeal overturned this decision, stating that the assessment of competence falls within the realm of clinical judgment and not that of the courts (13).

The case influenced subsequent policies, including restrictions on blockers for minors, and led to the reorganization of the Tavistock. It remains a dilemma in the debate over adolescent consent, experimental medical interventions, and clinical ethics in gender dysphoria.

The main objectives of this article are to analyze the bioethical dilemma raised by the *Bell v. Tavistock* case, which centers on whether adolescents under the age of 16 can provide informed consent—without requiring parental or judicial authorization—once they are deemed Gillick-competent based on clinical judgment, thereby allowing them to decide whether or not to begin gender-transition treatments, specifically puberty blockers (PBs) and cross-sex hormones. This analysis is conducted using the principalist and ontological personalist bioethical models to identify how the principles of each model apply and their possible responses to the bioethical dilemma at hand, and to examine the similarities and contrasts between them. Furthermore, the article considers the judicial decisions in this case, which interpreted the scope of healthcare professionals' clinical judgment and Gillick competence—or the criteria for interpreting Informed Consent (IC) for adolescents in the United Kingdom—in different ways. The qualitative methodology used in this article is a mixed approach combining both law and bioethics. The legal methodologies employed include a dogmatic-legal approach for reviewing the first- and second-instance rulings in the case, and the axiological and balancing methods to identify the principles and human rights interpreted by the courts of the United Kingdom; the bioethical methodology involves analyzing the case through the methods of principlism and personalism, with the aim of comparing them to identify how the principles of each are applied, as well as the possible solutions to the bioethical dilemma from these two perspectives.

The theoretical framework of this article is based on three pillars: the bioethical models of principlism and personalism, international human rights law, and the concepts of progressive autonomy and Gillick competencies. Principlism provides criteria for evaluating medical decisions through the principles of autonomy, beneficence, nonmaleficence, and justice, which allow for an assessment of the minor's capacity to provide valid informed consent. Personalism, for its part, emphasizes the intrinsic dignity and enhanced protection of the minor as a vulnerable individual, highlighting prudential limits

on interventions that affect their holistic development, in its physical, psychological, social, moral, and spiritual dimensions. From a human rights perspective, minors are recognized as rights-holders with evolving capacity, which lays the normative foundation for progressive autonomy. Within this framework, the Gillick competencies serve as a legal and clinical standard for determining whether an adolescent possesses sufficient maturity to consent to medical treatments, thereby integrating bioethics and human rights into the assessment of the *Bell v. Tavistock* case. This framework allows us to examine how the High Court of First Instance favored a more paternalistic and personalist approach, while the Court of Appeals reestablished clinical discretion based on the Gillick criteria to uphold a more principlist interpretation of autonomy.

The article is divided into three sections: the first analyzes the legal arguments of the United Kingdom's courts of first instance (High Court) and courts of second instance (Court of Appeal) regarding the scope of clinical judgment and the interpretation of the Gillick criteria applicable to adolescents' capacity in health matters; the second section examines the bioethical dilemma based on the principlist model, and the final section analyzes it based on the personalist model.

2. Legal Arguments of the UK courts in the case of *Bell v. Tavistock*

The following section will analyze the two judgments from the first and second instances of the case using the dogmatic method of case summarization to identify the main arguments underlying their decisions and facilitate their understanding and comparison.

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2.1 Analysis of the first-instance judgment in Bell v. Tavistock

Judgment of the High Court of Justice (Queen's Bench Division), issued by Dame Victoria Sharp (President), Lord Justice Lewis, and Mrs. Justice Lieven, on December 1.

Relevant facts: The case arises from the treatment provided by the Gender Identity Development Service (GIDS) of the Tavistock and Portman NHS Foundation Trust to minors with gender dysphoria, specifically the prescription of puberty blockers. The plaintiffs, Quincy Bell—a young woman who received the treatment—and “Mrs. A,” the mother of a minor on the waiting list, argued that adolescents lack the cognitive maturity to understand the nature, risks, and long-term consequences of puberty blockers, especially given their frequent subsequent transition to cross-sex hormones, which have irreversible effects. They further alleged that informed consent was insufficient and that the treatment lacked a robust scientific basis.

Procedural Background: The matter was brought via judicial review to challenge the legality of GIDS's administrative practice regarding minors' consent for gender-affirming treatments. Individual clinical decisions were not reviewed; rather, the focus was on the service's policy and operational framework.

Legal Issues: The High Court was essentially required to answer two questions: Whether a minor under the age of 16 can be competent under the Gillick standard to consent to treatment that has long-term consequences, potential future impact on fertility, and a virtually inevitable link to irreversible treatments; and whether the information provided by GIDS was adequate to enable fully informed consent (12).

Applicable rules: The ruling applied the legal doctrines of “competent Gillick,” which are based on the 1986 court decision *Gillick v. West Norfolk*, recognizing the capacity of adolescents under the age of 16 to give informed consent for health treatments, specifically regarding contraceptives. This capacity is based on the progressive

autonomy of will; that is, the development of maturity and cognitive understanding enables adolescents to make decisions provided they demonstrate the intelligence and maturity to understand medical treatments, their risks, benefits, and effects (12).

Legal grounds: The High Court found that:

- GIDS and its centers used the Dutch Protocol to provide gender-affirming transition treatments to adolescents with gender dysphoria or gender incongruence, which consists of three phases: (i) Puberty blockers (PB), which are administered when the adolescent reaches Stage II on the Tanner scale, that is, at the onset of puberty, with changes such as the growth of pubic hair and the beginning of genital or breast development. (ii) Administration of cross-sex hormones, which are prescribed upon reaching age 16 and continue throughout the person's life. (iii) Sex reassignment surgery, which may be performed once the individual reaches the age of majority or turns 18 (12).
- BP, or the first phase of treatment, aims to delay puberty and give adolescents more time to decide whether or not to proceed with the other phases (12). Some studies show that puberty blockers reduce suicidal ideation among adolescents with dysphoria or gender incongruence (High Court, 2020, 53), but they do not always reduce mood swings and psychological stress (12). The High Court criticizes the lack of statistics at GIDS and its centers regarding adolescents who decided not to proceed with the second phase—or cross-sex hormone therapy—from 2011 to 2019, noting that the limited data that has begun to be analyzed since 2019 shows that a majority continue with cross-sex hormone therapy (12). However, the Court cites studies conducted in the Netherlands showing that 1.9% of cases that begin with a gender-affirming consultation do not proceed with cross-sex hormone therapy (High Court, 2020, 57). Consequently, the studies show that, rather than providing more time to decide, gender-affirming care

leads adolescents to persist in continuing with the second phase of treatment, which is the administration of cross-sex hormones (12). Regarding the reversibility of puberty blockers, statistics available from the World Professional Association for Transgender Health (WPATH) and the International Society of Endocrinologists indicate that puberty blockers are reversible; however, these statistics were derived from diagnoses of precocious puberty, and only the studies conducted in Amsterdam specifically address gender dysphoria. Therefore, puberty blockers cannot be considered reversible in a practical sense, given the high rate of transition to subsequent irreversible treatments and their effects on bone, neurological, and psychological development (12).

- The available evidence regarding the short-, medium-, and long-term effects of puberty blockers (PBs) is limited, and the treatment is experimental in nature. Furthermore, it is unclear what the purpose of PBs is: whether to provide a pause for the adolescent to reflect on their gender identity or to block puberty to make it easier to proceed with complex medical procedures, including cross-sex hormone therapy and gender-affirming surgeries. The High Court considered that the long-term consequences are so complex that they have lifelong effects and result in a long-term change in personal identity (12), and notes that gender dysphoria is a psychological condition without physical symptoms; however, the Dutch Protocol—which includes treatment with puberty blockers and subsequent cross-sex hormone therapy and gender-affirming surgery—has direct effects on the body and its functions, including the potential loss of reproductive capacity (12).
- The understanding required of the minor should have encompassed the fact that BP treatment leads to the subsequent phase of cross-sex hormone therapy and the implications of these treatments for fertility, adult sexual function, and unknown risks, given that these are experimental therapies,

which the court deemed unlikely in minors under 16 years of age (12). Furthermore, the Court notes that gender-affirming treatments have unclear effects on bone density and strength, height, neurological function, and the development of sexual organs, and are known to have direct effects on the production of reproductive gametes, which may affect reproductive capacity (12). Studies conducted in the United States demonstrate that blockers have physical, psychological, and neurological effects, and that little is known about the latter. Therefore, adolescents with gender dysphoria who are treated with PBs halt their natural development, which has a social and psychological impact that can be described as irreversible (12).

- The information provided by GIDS and its centers prior to June 2020 downplayed the psychological effects of PBs and their relationship to cross-sex hormone therapy for subsequent transition (12).

Ruling: The court concluded that:

- It is highly unlikely that minors under the age of 16 possess the necessary capacity to consent to puberty blockers, due to the complexity of the treatment and the need to understand the progression of treatment toward cross-sex hormones and gender-affirming surgery (12). Many adolescents fully comprehending the long-term effects, and most report feeling an aversion to sexual relations and giving little thought to fertility (12). Therefore, the Court notes that children under 13 are highly unlikely to understand the risks and long-term consequences of puberty blockers, and that 14- to 15-year-olds are unlikely to understand the risks; thus, they would not meet the Gillick standard of competence to receive puberty blockers and subsequent gender-affirming treatments.
- The information provided by Tavistock regarding BP was insufficient because it did not address the long-term effects, which are not fully understood given that the treatment is

experimental. The Court notes that the fact that it is an experimental treatment does not preclude informed consent; rather, it is the complexity involved, requiring subsequent medical treatments that are both lifelong and life-altering, that is the issue (12).

- Although 16- and 17-year-olds enjoy a legal presumption of capacity under the Family Law Reform Act, it is advisable to seek a court order before beginning treatment, given the significance of its effects. Therefore, clinical judgment should consider the two main characteristics of this treatment, that it is life-altering by affecting personal identity and that it is lifelong, and it is vital to seek a court ruling to determine whether gender-affirming treatments are in the best interests of adolescents (12).

2.2. Analysis of the second instance ruling by the court of appeal in the case of Bell v. Tavistock (2021)

Judgment of the Court of Appeal (Civil Division), composed of Sir Geoffrey Vos MR, Underhill LJ, and Jackson LJ, issued on September 17, 2021.

Relevant facts: The appeal was brought by the Tavistock Center, part of the GIDS, against the High Court's judgment at first instance, which had imposed strict limits on minors' capacity to consent to puberty blockers (PB). The Tavistock Center argued that the High Court overstepped its authority by substituting informed consent and clinical assessment with a general judicial rule, thereby affecting adolescents, medical practice, and service delivery. Furthermore, the Tavistock Center argued that the plaintiffs filed legal action solely against that center, without considering that its responsibilities do not include prescribing PBs, and that the treatment is provided directly by the University College London Hospitals (UCH) network and Leeds Teaching Hospitals (13).

Case history: Following the High Court's ruling, multiple services suspended the prescription of puberty blockers due to the uncer-

tainty created. The Court of Appeal examined whether the High Court acted within its powers of judicial review by issuing a general declaration regarding adolescents' individual competence and capacity and the clinical judgment of the medical team. Therefore, the Court of Appeal did not analyze whether puberty blocker (PB) therapy is a wise decision or not, as it is a legally valid treatment in England and Wales, and it falls within the purview of the National Health Service (NHS), Parliament, and medical standards to establish health policies (13).

Legal Issues: The Court of Appeal identified three issues: Whether the High Court acted improperly by issuing general guidance on the competence of minors; whether it was legitimate to require or recommend prior judicial intervention for 16- and 17-year-olds; and whether the High Court improperly transformed its analysis into clinical guidance, thereby exceeding its powers.

Applicable rules: the Gillick test, a legal doctrine in effect since 1986 that is based on an individualized assessment of adolescents under the age of 16 using criteria of maturity and cognitive intelligence to understand the effects, risks, and benefits of medical treatment (13). The authority of the judiciary is based on the principle of judicial review, particularly the prohibition against the judiciary substitute for clinical judgments, and the principle of separation of functions between courts and medical authorities. Gillick competencies do not establish a rigid general legal standard based on age categories to determine adolescents' capacity to decide on medical treatment; rather, they provide criteria or guidelines for clinical judgment (13). For an adolescent under the age of 16 to be deemed Gillick-competent, they must demonstrate the maturity and cognitive intelligence to understand the treatment, and the physician must assess whether they do so consciously; in such cases, neither parental consent nor court authorization is required, since clinical judgment, based on professional standards, is, a priori, a more sensitive and appropriate assessment for determining cognitive capacity than rigid legal precepts (13). It should be remembered that the Gillick competencies stem from judicial review regarding the prescription of contraceptives to

minors under 16, which in the 1980s was a controversial treatment, just like BP; therefore, the High Court's analysis misinterprets the Gillick competencies, as they are flexible criteria and not a rigid rule of law (13).

Legal grounds: The Court of Appeal held that:

- The plaintiffs filed the appeal without having standing to sue the defendant; that is, they included only the Tavistock Center, part of GIDS, but did not include UCH (University College London Hospitals) or LTH (Leeds Teaching Hospitals), which actually provided medical treatment to adolescents with gender dysphoria, and whose medical staff obtained the adolescents' informed consent for BP treatment (13).
- There was no adequate assessment of the documentary evidence submitted by the Tavistock Center, which included the international guidelines for medical services for children and adolescents with gender dysphoria from the World Professional Association for Transgender Health (WPATH), nor the guidelines from the Endocrinology Society, nor those from the NHS (13). The High Court evaluated clinical evidence regarding gender-affirming care, a field in which there is still no universal consensus on treatment, as procedural evidence, thereby exceeding its legal authority, since this falls under the purview of national and international health standards; furthermore, gender-affirming care is a legal treatment in England and Wales (13).
- The Tavistock Center's primary objective is to provide counseling, psychological support, and psychiatric treatment to children and adolescents with gender dysphoria; once they receive this care and it is evident that their gender dysphoria has persisted for more than two years, they are referred to the UCH or the LTH to receive treatment based on the Dutch protocol (13).
- The information provided by the Tavistock Center was sufficient, as the informed consent protocols were followed (13).

The informed consent protocols for minors with gender dysphoria require parental authorization for treatment at the Tavistock Center, followed by referral to the UCH or the LTH for hormone replacement therapy (HRT) and subsequent treatments; these requirements were also not assessed by the High Court in the first instance (13). Instead, the High Court analyzed the scientific evidence, regarding which there is no consensus on the use of BP and subsequent treatments, a task that was not part of the trial court's function and exceeded its mandate (13).

- By developing guidelines on age and comprehension requirements, the trial court effectively created a rigid judicial clinical guideline, which is inconsistent with the judicial function based on the principle of judicial review. Furthermore, it based its decision on contradictory scientific medical evidence and facts derived from statistics with an insufficient sample size, matters that fall within the realm of clinical judgment rather than legal judgment (13). The task of determining whether an adolescent understands the effects, risks, and benefits of puberty blockers (PBs) falls to trained medical professionals, not judges. This argument is based on the Gillick decision, which states that rigid regulation of the growth process and cognitive maturity of minors would be artificial and insensitive to the natural cycles of physical and social development (13).

Ruling: The Court of Appeal overturned the High Court's judgment in its entirety and ruled that:

- The Court of Appeal declares it inadmissible to review Tavistock's institutional policies, as the High Court had already determined that these were lawful practices and treatments (13).
- The Court of Appeal held that the High Court had unduly interfered in the clinical sphere by issuing a ruling that, in effect, functioned as a rigid rule regarding informed consent for

minors undergoing gender-affirming treatments, particularly puberty blockers and cross-sex hormones. By setting age thresholds for consent and requiring judicial intervention when a minor could not be considered competent under the Gillick test, the High Court caused unnecessary clinical delays and unduly involved the judiciary in processes that are the purview of medical practice (13). Furthermore, the rigid guidelines for determining competence or capacity to give informed consent constituted an intrusion into clinical judgment, which is already regulated by international, regional, and national health standards, as well as by the policies and regulations of the United Kingdom's National Health Service. Professionals who fail to comply with these standards may face administrative or civil sanctions, which demonstrates that oversight mechanisms already exist without the need for additional judicial intervention (13).

- The capacity of minors must be assessed strictly and, on a case, -by-case basis in accordance with the Gillick test criteria for adolescents under 16 years of age, without general legal rules that disregard the variability in the physical, emotional, and social development of patients with gender dysphoria. The Court of Appeals emphasizes that assessment of capacity is a component of clinical judgment, not judicial judgment, because medical personnel possess the specialized knowledge regarding the patient's circumstances, their family, and the applicable medical standards (13).
- There is no legal basis for requiring prior judicial intervention for adolescents aged 16 and 17, as family law recognizes their capacity to decide on medical treatments in accordance with the principle of progressive autonomy.
- Disputes regarding scientific consensus, medical evidence, risks, or uncertainties related to treatments fall within the purview of health authorities and agencies, not the courts.

3. Analysis of the bioethical dilemma in the *Bell v. Tavistock* case from a principlist perspective

The bioethical dilemma raised by the *Bell v. Tavistock* case centers on whether adolescents can provide informed consent when clinical judgment deems them Gillick-competent, without requiring parental or judicial authorization, to begin gender-transition treatments, specifically puberty blockers (PBs) and cross-sex hormones. Principlism is an ethical model originating in the United States, developed by Tom L. Beauchamp and James F. Childress, authors of the seminal work **Principles of Biomedical Ethics** (1979). In this text, they introduced the principlism approach, grounded in four basic principles: autonomy, nonmaleficence, beneficence, and justice. In 1976, both authors served on the National Commission for the Protection of Human Subjects of Research, established by the U.S. government to create an ethical framework for protection (14).

The principlist analysis is based on a matrix of *prima facie* principles, understood as not absolute but as preceding bioethical scrutiny. These principles are applied generally when there is no conflict among them; otherwise, they must be weighed against one another. Beauchamp and Childress distinguish between *prima facie* principles, which are followed as long as they do not conflict, and *de facto* duties, which are derived from them (15).

This model is linked to utilitarian ethics, in that it seeks to maximize utility through a cost-benefit analysis in bioethical decisions. Within this framework, the principle of autonomy typically takes precedence over that of beneficence (16).

The analysis of the bioethical dilemma proceeds based on the principles of the aforementioned model:

Principle of respect for autonomy: Respect for autonomy involves recognizing personal will in health-related decisions, particularly regarding access to treatments and procedures. This principle entails a dual obligation: a negative obligation, consisting of refraining from interfering in individual decisions through manipulation or coercion; and

a positive obligation, aimed at ensuring the provision of sufficient information to enable informed deliberation and decision-making (15).

The legal analysis of the case reveals that for a minor under 16 years of age to be deemed Gillick-competent, the medical team has a legal obligation to evaluate two criteria: emotional maturity and the intellectual capacity to understand the short, medium and long-term effects, risks, and benefits of gender-affirming treatments, specifically, the puberty blockers that minors under sixteen may receive. The Gillick doctrine states that determining a minor's decision-making capacity rests on clinical judgment; therefore, the responsibility to provide adequate information falls on physicians. According to the principle of respect for autonomy, there are three essential conditions for freedom to be realized, which are: (i) Intentionality: that the act corresponds to the actor's conception, even if there is no plan for its execution; (ii) Understanding: a substantial understanding of the act, which does not imply total understanding, since this understanding develops progressively; certain conditions such as illness, irrationality, and immaturity influence the understanding of the act; and (iii) Lack of control: by external or internal factors that deprive the individual of autonomy. External control may take the form of coercion and manipulation, while internal control may involve mental disorders. The first characteristic, intentionality, has no degree; autonomous action is either performed intentionally or not. In contrast, the other two conditions, comprehension and lack of control, occur to varying degrees. An example of this is minors, who, as children, are controlled and demonstrate a limited capacity to exercise their own control: they exhibit varying degrees of resistance to influence as they mature, and their ability to take control and perform intentional actions, as well as to understand, gradually increases. Therefore, acts can vary in their degree of autonomy (15).

Consequently, based on the principle of respect for autonomy, minors under the age of sixteen who have been deemed Gillick-competent and diagnosed with gender dysphoria may choose whether or not to receive puberty blockers (PBs). Given that it is vital for the

medical team to provide the necessary information regarding the short-, medium-, and long-term effects, risks, and benefits of PBs, this information must include the Dutch protocol for all phases of PB treatment, cross-sex hormones, and the possibility of choosing gender-affirming surgeries as adults. According to Beauchamp and Childress, Informed Consent (IC) is a means of applying the principle of respect for autonomy; they note that IC must distinguish between the communication of information and approval and authorization, the latter of which must be granted solely by the patient without external influence; it is for this reason that they criticize informed consent as a whole, because it does not meet the requirement for patient approval and authorization (15). By requiring that IC for minors under 16 who are deemed Gillick-competent be granted by the adolescent, the Tavistock Centre upholds the principle of autonomy, since parental approval was not required, as noted by the Court of Appeal. However, it is concerning that in Bell's testimony, she indicated having experienced doubts about continuing with cross-sex hormones; nevertheless, the support of her friends and the community led her to downplay the effects until she underwent a mastectomy and began to feel worse. This demonstrates that informed consent is a dynamic process over time and can vary, so it must be updated (13), this demonstrates that gender identity is a dynamic process over time and can vary and therefore must be updated.

Non-maleficence: This principle requires physicians and their teams to refrain from intentionally causing harm. According to classical principlism, this principle should not be conflated with that of beneficence, since, although they are related, their rationale and objectives are different (15). The principle of non-maleficence focuses on the concept of harm, which distinguishes it from illegal actions that violate rights; harm may not necessarily result from an illegal act, as in cases of unforeseeable events, natural disasters, authorized omissions, and acts in which a person knowingly consents to harm, such as certain medical treatments, for example, the amputation of

a leg. This principle, like the others, is *prima facie*, that is, not absolute, and requires balancing against other principles to determine whether the action causing harm is in the patient's best interest and legitimate (15). Furthermore, they note that it is necessary to assess whether treatment is mandatory or optional (15).

According to this principle, the Tavistock Center acted in accordance with it, since the Dutch Protocol is legal in England and Wales; furthermore, it is endorsed by the World Professional Association for Transgender Health (WPATH), even though there is no clinical consensus on the various gender-transition therapies, which include behavioral therapy (BP) and cross-sex hormones. The Tavistock Center did not cause harm to Bell, because she met the clinical criteria for persistent gender dysphoria, provided her informed consent for all psychological treatments, gender-affirming procedures, and cross-sex hormones, and, having reached the age of majority at 20, decided to authorize mastectomy surgery for breast removal. The evidence reviewed by the Court of Appeal demonstrates that medical protocols were strictly followed, including those for determining Bell's Gillick competence, thereby allowing her to make decisions regarding hormone replacement therapy at age 16 and cross-sex hormone therapy, which she began at age 17. Bell's medical record from the Center shows that she received information about the effects, risks, and benefits of BP; in fact, her psychiatrist told her on several occasions that gender dysphoria is a condition that may resolve itself during adolescence, and that it was not mandatory to begin cross-sex hormone therapy (12). However, given the existence of long-term harms without scientific certainty, the principle of non-maleficence, not that of beneficence, must be prioritized in the short, medium, and long term.

Principle of beneficence: It has three general norms: harm must be prevented, harm must be eliminated, and good must be promoted, which implies that risks and benefits must be weighed (15). The principle of beneficence has two subprinciples: positive beneficence requires that agents benefit others, and the principle of utility

requires that agents balance benefits, risks, and costs to achieve the best overall outcomes (15). In the present case, it is demonstrated that Bell suffered from constant stress, anxiety, and depression since childhood due to gender dysphoria and a persistent rejection of her body beginning at the onset of puberty; for these reasons, she was referred to the Tavistock Center, which, after a year of ongoing psychological and psychiatric care, confirmed her diagnosis permanently, and informed her that the next step is gender-affirming treatment, which is offered as a health service at the UCH. The purpose of this treatment is to provide adolescents with more time to decide whether to continue with their gender transition or to remain with their assigned sex at birth. Based on the proportionality analysis between benefits and risks, it can be inferred that the benefits of BP treatment, according to the scientific evidence from the Dutch Protocol and the WPATH, are: to alleviate the psychological distress caused by gender dysphoria during puberty, to reduce suicidal ideation, to halt bodily changes perceived as distressing, to avoid future, more invasive interventions, and to allow time for reflection before proceeding with irreversible treatments. These benefits were demonstrated by the medical record, and Bell herself noted in her testimony that there was relief from emotional stress, which allowed her to focus on other matters such as her education (12). As for cross-sex hormones, the medical consensus is not universal, and their effects and risks are even greater than those of blockers; although doctors repeatedly informed Bell of the effects, which include, but are not limited to, bone loss, impaired fertility, and developmental issues, she decided to continue with the treatment, despite her doubts, because, according to her testimony, she based her decision on the support of her friends and the trans community (12). This was despite the fact that her psychiatrist had recommended that she not proceed with the treatments, since gender dysphoria is a condition that may be resolved on its own (12). This presents the dilemma of how to balance intense current suffering against future risks that are only partially known. The case reveals that the principle of beneficence

must encompass: present well-being, future identity, and the possibility of significant regret. Current evidence shows that a significant percentage of young people abandon or reconsider their identity after early adulthood. The principle of beneficence must protect these possible life trajectories.

Justice. This principle seeks to ensure that, beyond formal equality, there is substantive equality that considers each person's contextual factors, so that true distributive justice may exist. Therefore, it considers the existence of material conditions that determine which ethically significant characteristics people must possess in order to have access to certain resources or distributions. However, justifying which properties are truly relevant poses theoretical and practical problems. Although tradition, social norms, and legal frameworks often indicate which criteria to apply, in many cases it is necessary to create new policies that define relevant properties or to revise established criteria (15). From a favorable interpretation of Beauchamp and Childress's principle of justice, the administration of BP to Bell could be considered just to the extent that the services were provided within a clinical framework that offered equal access to an intervention available to all patients who met clinical criteria for gender dysphoria. From this perspective, justice requires that therapeutic resources be distributed according to morally relevant criteria, such as clinical need, psychological suffering, and current professional standards, elements that were applied by Tavistock at the time. Furthermore, the free and voluntary consent given by Bell was formalized in accordance with current institutional procedures, indicating that there was no discrimination or arbitrary exclusion in access to treatment. Although the clinical evidence was limited, distributive justice does not require absolute certainty; rather, it requires that interventions be offered equitably and without unjustified privileges or restrictions. In this regard, the fact that Bell received the same treatment as other adolescents with similar clinical profiles suggests that the decision was consistent with a fair distribution of therapeutic opportunities. Furthermore, allowing the intervention respected

horizontal equity, by treating those in similar medical conditions equally, and vertical equity, by providing a specialized resource to a minor facing significant suffering. Thus, upon favorable analysis, the administration of puberty blockers can be considered fair because it was carried out according to universal, non-arbitrary criteria oriented toward clinical well-being, consistent with the requirements of the principle of justice.

Consequently, there is a clear tension between the legality of treatment in England and Wales based on the Dutch Protocol and the lack of scientific certainty regarding the long-term effects of the second-phase use of cross-sex hormones. The medical-scientific discussion on puberty blockers (PBs) by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society recommends PBs to give adolescents with gender dysphoria more time to decide whether to accept their sex assigned at birth or proceed with treatment. When Bell reaches the age of majority, the “competent Gillick” standard no longer applies, because under the law she has legal capacity, that is, the ability to enter into binding agreements and be held responsible for her decisions. Therefore, at age 20 —and still receiving psychological and medical support— Bell decided to undergo a mastectomy of her own free will, even though she stated in her testimony that she had doubts that were overshadowed by the support of her friends and the transgender community. Consequently, there is concern regarding the influence of third parties without technical medical or psychological expertise on Bell’s decision-making process, which could affect her personal autonomy.

4. Analysis of the Bioethical Dilemma in the Bell v. Tavistock Case from the Personalist Model

The ontological personalist model is grounded in personalist philosophical anthropology, which places the human person at the center of bioethical reflection, recognizing the person as the principle and

purpose of society. This entails understanding the person as an individual substance of a rational nature being complete in itself and, at the same time, an integral part of the cosmos (16).

Within this perspective, various forms of personalism are distinguished: relational or communicative, hermeneutic, and ontological. Ontological personalism, rooted in the Thomistic realist tradition, emphasizes the objective and existential dimension of the person, conceived as a spiritualized body that possesses dignity by virtue of what it is, beyond its capacity for choice. This bioethical approach recognizes the faculty of decision-making but situates it within a contextual framework, linked to the means and ends related to the community (16).

Principle of Respect for Physical Life: This principle recognizes the importance of physical life and the body, as it is a fundamental value that enables human fulfillment and participation in time and space. Through corporeality, human beings express their values and life plans and exercise their freedom. Therefore, the duty to respect, defend, and promote life is a categorical, universal, and rational imperative, an obligation of human beings both in their individual lives and in relation to others (16). Since the dimension of the human body is vital for upholding human dignity and health, it must be remembered that the structure of the person comprises five interrelated dimensions: the body, sexuality, spirituality, religiosity, and morality of the human person (17). Ontological personalist bioethics defines a person as an incarnate spirit, with the body serving as a necessary condition for inhabiting and living life; it represents the spirit's mode of existence and reveals and manifests the person (17).

The bioethical dilemma in Bell's case, viewed through the principle of respect for human life, raises the question of whether or not puberty-blocking treatment was necessary. It is important to consider that this treatment is reversible in the short term; its objectives are to provide more time to decide, reduce clinically significant distress, and prevent self-harming behaviors stemming from gender dysphoria; and it is legal in England and Wales. However,

there is insufficient scientific evidence regarding the long-term effects of the second phase of treatment—cross-sex hormone therapy—which is considered by some physicians and legal systems to be an experimental treatment; it has direct effects on natural pubertal development, bone density, and fertility. This principle requires the protection and promotion of the entirety of human life; therefore, even though Bell is Gillick-competent and can authorize her treatment without parental or judicial consent, the long-term effects of cross-sex hormone therapy affect the person's total integrity and all dimensions of her being (physical, psychological, social, moral, and spiritual). Therefore, the principle of respect for physical life is not upheld, since puberty blockers—despite their apparent reversibility—involve significant interference with the natural processes of biological maturation and entail risks that may compromise the minor's future physical integrity; and if cross-sex hormone therapy is initiated, the effects on personal integrity are short, medium and long-term. Within this framework, the adolescent's autonomy cannot take precedence over the moral duty to safeguard her physical development and her life in its entirety; therefore, authorization of the treatment does not fully satisfy the requirements of the personalist principle.

Principle of Freedom and Responsibility: This principle is based on the premise that every ethical act is a free and responsible act toward one's own life and the lives of others; thus, the right to physical life takes precedence over the right to freedom, because to be free we must first be alive and direct our responsible freedom toward preserving our own lives and those of others. This principle seeks to guide the individual to cooperate with the medical care necessary to safeguard their own life and the lives of others, and it limits medical practice so as not to make medical care mandatory, unless life is at stake (16). This principle reminds us that the moral and ethical obligation to care for life and health rests directly with the patient and the physician; therefore, if clinical judgment deems the patient's requests ethically unacceptable, the physician may offer recommen-

dations, encourage reflection, and even refer the patient to another physician:

Neither may the patient's conscience be violated by the physician, nor may the physician's conscience be forced by the patient: both are responsible for life and health as both personal and a social good (16).

The personalist principle of freedom and responsibility requires that decisions be not only formally valid but also aimed at protecting physical life. Although the High Court recognized that Bell gave informed consent, doubts remain as to whether a minor under the age of sixteen can exercise materially responsible freedom in the face of uncertain risks and profound effects on physical maturation and its impact on personal integrity. The fact that the physicians followed protocols does not eliminate ethical tension, as this principle requires an assessment of whether the intervention truly safeguards the minor's life, future health, and dignity. Furthermore, in the face of scientific uncertainty, the professional must promote prudent deliberation and even refrain from acting if bodily integrity is at risk. Taken together, the case reveals a gap between procedurally valid freedom and morally responsible freedom according to the personalist model.

Principle of Totality or Therapeutic Principle: This principle recognizes the possibility of medical intervention to safeguard a person's integrity and life. It specifies that the following conditions must be met for medical intervention to be justified:

The intervention must target the diseased part or the part that is the direct cause of the illness, in order to preserve the healthy body; there must be no other ways or means to address the illness; there must be a good, proportionally high, chance of success; and the patient's consent must be obtained (16).

In the Bell case, puberty blockers do not treat a "diseased" body part but rather intervene in normal biological processes to alleviate

psychological distress, which already calls into question the first condition. Furthermore, less invasive psychotherapeutic alternatives exist, so the requirement of strict necessity is not met. The limited evidence regarding benefits and the uncertainty surrounding long-term effects prevent us from asserting that there is a high probability of therapeutic success. Although Bell provided informed consent, this principle requires that consent be complementary to proportionality and clinical efficacy is not sufficient on its own. Taken together, the case does not fully satisfy the person-centered conditions necessary to justify the intervention.

Principle of Solidarity and Subsidiarity. This principle commits everyone to promoting the fulfillment of, and taking responsibility for, life and health both individually and collectively, as it is grounded in human sociability—a defining characteristic—meaning that life and health depend on others. Subsidiarity implies the recognition of social justice, that is, providing everyone with access to and necessary health care, even at the expense of those who have the most (16).

The personalist principle of solidarity and subsidiarity demands the promotion of individual and collective well-being, ensuring necessary and appropriate health care, especially for the most vulnerable. In the Bell case, the care provided by GIDS through Tavistock can initially be considered an act of solidarity in an attempt to alleviate the minor's suffering. However, solidarity requires actions that truly protect the person's integrity, and the lack of consensus regarding the scientific evidence, efficacy, and safety of blockers undermines this commitment. Subsidiarity entails providing necessary and justified interventions or ordinary means, not experimental or extraordinary treatments with unproven long-term benefits. Offering a procedure of uncertain efficacy to a minor does not fully satisfy this social obligation nor does it guarantee adequate protection of her future development. Taken as a whole, the dilemma does not fully comply with the principles of Sgreccia's ontological personalism.

5. Conclusions

- An analysis of the legal arguments in the case of *Bell v. Tavistock* and the bioethical dilemma, based on the bioethical models of principlism and personalism, demonstrates the tension that still exists between the legality of an extraordinary treatment and the lack of global scientific consensus regarding the diagnosis of gender dysphoria and its treatment. While some countries, such as England, use the Dutch protocol as their national standard, others —such as the United States— consider it an experimental treatment. In the U.S., the discretion regarding its application is part of the doctor-patient relationship (DPR): on the one hand, clinical judgment and the duty to inform; and on the patient's part, consent, approval, and authorization of the medical procedure. This raises the need to determine whether adolescents with gender dysphoria possess ethically significant characteristics that justify their access to interventions such as puberty blockers within a policy of fair distribution. The challenge lies in identifying which of these characteristics, age, decision-making maturity, psychological vulnerability, capacity for informed consent, or diagnostic stability, should be considered relevant for such distribution. The litigation highlights the tensions arising from the absence of agreed-upon medical-scientific criteria and practical uncertainty, compounded by questions regarding the legality of the treatment, which necessitates defining new policies or revising existing ones. Thus, the *Bell* dilemma becomes a paradigmatic case in which distributive justice requires balancing the protection of potentially vulnerable minors with the institutional duty to guarantee timely access to treatments that could prevent significant harm. The case demonstrates how justice demands clear, consistent policies based on clinically, legally, and ethically relevant criteria, avoiding both unjustified exclusion and indiscriminate access

without adequate guarantees of benefit and safety. Therefore, far from being confined to its judicial dimensions, the Bell case has become a global ethical discourse. It highlights that, in order to simultaneously protect autonomy and well-being, contemporary bioethics must move toward hybrid models capable of integrating the procedural emphasis of principlism with the ontological prudence of personalism. Only in this way will it be possible to formulate fair, prudent clinical decisions that respect human dignity in adolescents facing profound existential dilemmas related to their gender identity.

- The Court of Appeals, on appeal, overturned the lower court's ruling, finding: violations of due process, due to a failure to evaluate the evidence and lack of standing to be sued, as well as an illegal overreach by the High Court into the medical sphere —specifically regarding clinical judgment— by exceeding its authority to grant judicial protection and creating a rigid medical guideline that did not take into account current laws or case law on gender identity in minors. Furthermore, it emphasizes the importance of the medical field in determining its own healthcare protocols based on scientific evidence and experience. Likewise, rules that matter concerning scientific consensus, medical evidence, risks, or uncertainties regarding treatments fall within the purview of health authorities and agencies, not the courts.
- An analysis of the Bell case according to the personalist model shows that the bioethical dilemma does not fully comply with the fundamental principles of that model. The use of puberty blockers is not directly aimed at treating a physical pathology, since gender dysphoria in the United Kingdom is considered a psychological condition that may or may not be permanent, which undermines the principle of respect for physical life. The freedom exercised by the minor, although formally valid, falls short of the moral responsibility required when facing a treatment with uncertain risks, thereby violating the principle of responsible freedom. Nor are the condi-

tions of therapeutic proportionality and clinical necessity met, conditions essential for medical intervention according to Sgreccia. Finally, solidarity and subsidiarity are compromised by offering experimental intervention without sufficient evidence of comprehensive benefit. Overall, the case fails to consistently comply with the personalist bioethical model.

From the principlist model's perspective, the Bell case shows partial compliance with the principles. The principle of autonomy conflicts with the other principles, since, although Bell was deemed Gillick-competent and gave her informed consent for gender-affirming procedures and cross-sex hormones, debate persists regarding a minor's actual competence to make such complex decisions, especially when the long-term benefits, specifically of cross-sex hormone therapy, are unclear and there is little scientific evidence. Bell's testimony reveals that she began to have doubts about her gender transition at age 20, by which time she had reached the legal age of majority and was fully competent to make decisions; nevertheless, she states that she brushed these doubts aside due to the support of her friends and the trans community. It wasn't until she underwent a mastectomy and, months later, came to the realization that it had been a mistake —because she had eliminated her ability to breastfeed should she ever want to become a mother— that she fully understood the consequences. Therefore, while the doctor and the clinical team possess the technical knowledge, experience, and obligation to inform patients about the risks, benefits, and alternatives, the responsibility for authorizing medical treatments fell on Bell. What is concerning is the extent to which the decision was conscious, deliberate, free, and adequately informed and how it related to her sexuality and reproductive rights. Likewise, the beneficence and non-maleficence of these medical procedures are called into question due to the limited evidence regarding the benefits and potential risks of gender transition treatments, specifically cross-sex hormones and gender-affirming surgery. The principle of justice is met in terms of formal justice,

that is, ensuring equitable access to treatments, but there is the exposure of minors to interventions whose efficacy is uncertain, which conflicts with the principle of non-maleficence. Overall, the dilemma partially complies with principlism but reveals significant weaknesses in informed consent, the right to medical autonomy, the proportionality of short, medium and long-term risks, and equity in clinical decision-making.

The judicial decisions in *Bell v. Tavistock* reflect the application of distinct bioethical models. The High Court, at first instance, adopted an approach close to personalism, prioritizing the protection of the minor's bodily integrity, prudence regarding high-risk interventions, and a restrictive view of adolescent autonomy, which resulted in stricter, even paternalistic, requirements for validating consent. In contrast, the Court of Appeals aligned itself with the principlism of Beauchamp and Childress by emphasizing progressive autonomy, the Gillick doctrine, and the centrality of clinical judgment in assessing risks and benefits. While the High Court, in the first instance, prioritized the safety and protection of children and adolescents with guiding values aligned with ontological personalism, the Court of Appeals opted for a flexible balance of principles, relying on informed consent processes and medical expertise. Taking together, this contrast highlights how each court prioritized a legal analysis based on different ethical frameworks when addressing the same biomedical dilemma.

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