

# The architecture of exception: a multidimensional analysis of the 2025 puberty blocker ban

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## ABSTRACT

**AIM:** Our aim was to analyse how New Zealand's 2025 restriction on initiating puberty blockers for people aged <18 was translated into delegated medicines regulation and whether the public record reflects a differential evidentiary and governance standard.

**METHODS:** We assembled a 67-document policy corpus and extracted a 32-field matrix from 12 core documents (statutory instruments, the Ministry of Health – Manatū Hauora evidence brief and key institutional/stakeholder texts). Using a seven-pillar “Regulatory Exceptionalism” framework, we analysed evidentiary framing, process signals and rights/equity treatment.

**RESULTS:** The restriction was made by regulation under section 105 of the *Medicines Act 1981* (signed on 17 November 2025; announced on 19 November 2025; gazetted on 20 November 2025; scheduled to commence on 19 December 2025). The record treats evidentiary uncertainty as a categorical trigger for restricting initiation, bypassing routine governance tools used to manage off-label prescribing (professional standards, service governance, monitoring and auditing). Executive texts provide limited explicit engagement with proportionality, discrimination and equity obligations, and leave review criteria and decision thresholds under-specified.

**CONCLUSION:** The decision is consistent with Regulatory Exceptionalism: higher evidentiary and governance standards are applied to a discrete population/indication than elsewhere in paediatrics. If uncertainty is the operative concern, proportionate alternatives include published multidisciplinary team thresholds, registry-based monitoring and time-limited policy with explicit review triggers rather than categorical prohibition.

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On 19 November 2025, the New Zealand Government announced and implemented via subordinate legislation a restriction on initiating puberty blockers (gonadotropin-releasing hormone analogues; GnRH<sub>a</sub>) for people under 18 with gender dysphoria or gender incongruence.<sup>1-3</sup> The public ministerial announcement was issued by Minister of Health Hon Simeon Brown on 19 November 2025, and the legal sequence is central: the regulations were signed on 17 November 2025, published in the *New Zealand Gazette* on 20 November 2025 and, subject to the *Legislation Act 2019* 28-day publication rule, were scheduled to commence on 19 December 2025.<sup>1-3</sup> An amendment regulation was published on 4 December 2025 to ensure the restriction did not inadvertently apply to adults transitioning.<sup>3</sup> Existing patients and other indications (e.g., central precocious puberty, endometriosis, prostate cancer) were not targeted.<sup>1,4</sup>

On 17 December 2025, in interim proceedings, the High Court declined to make mandatory orders preventing commencement but declared the Crown should take no steps to enforce the regulations pending an expedited judicial review. In assessing interim relief, the Court treated key

judicial review grounds as at least arguable and observed that the evidential record supported the contention of the Professional Association for Transgender Health Aotearoa (PATHA) that the decision was “*a political decision*” and “*contrary to advice from the Ministry*”.<sup>3</sup>

This article focusses on the *architecture* of the restriction: how a contested evidentiary question was translated into a regulatory instrument, what was emphasised in the public record and what was left implicit. We do not attempt to resolve the underlying clinical debate about net benefit in any particular patient. Rather, our claim is narrower: when uncertainty is the operative concern, medicines policy typically responds by strengthening governance (service standards, monitoring, and decision transparency). Here, uncertainty was treated as a categorical trigger for prohibition on *initiation* for a defined group, while ongoing prescribing for existing patients and other indications remained available. That asymmetry makes the governance choice analytically visible.

For brevity, we use “ban” as shorthand for the categorical restriction on *initiation* for people aged <18, while recognising that ongoing prescribing

for existing patients and other indications remained lawful.

## Regulatory mechanism and scope

The mechanism matters for both legal analysis and for clinical governance. The restriction is not a Pharmac funding instrument, and it does not operate by reclassifying GnRHa as “unapproved medicines”. Rather, it uses regulation-making power (section 105) to restrict initiation for a specific indication, displacing the ordinary clinician-discretion model for off-label use of approved medicines and, more broadly, over-riding the usual expectation that such decisions are managed through the regulator (Medsafe), professional standards, service governance, monitoring and accountability rather than indication-specific prohibition.<sup>2,3,5</sup> This sits alongside a broader pattern in medicines governance: off-label prescribing is routine in paediatrics and is usually managed through clinical standards, prescribing guidance, monitoring and professional accountability rather than executive prohibition.<sup>5,6</sup>

## International context and policy transfer

New Zealand’s decision cannot be understood without the wider international shift in paediatric gender medicine in 2024 and 2025, particularly the United Kingdom (UK) *Cass Review* and subsequent NHS England restructuring. The *Cass Review* framed the evidence base for puberty suppression as weak and recommended a more standardised, research-contingent pathway.<sup>7</sup> The UK context also included legal and governance scrutiny of clinical decision-making, including *Bell v Tavistock* and subsequent service redesign.<sup>8,9</sup> *Cass* has also attracted major critique, including a detailed methodological challenge published by the Yale Law School Integrity Project; while contested, such critiques underscore the risks of decontextualised policy transfer.<sup>10</sup>

New Zealand’s announcement materials explicitly invoked uncertainty and the prospect of future evidence generation in the UK, rather than documenting local clinical governance failures, confirmed harms or any New Zealand trial pathway.<sup>14</sup> Public NHS England communications indicate trial recruitment was *expected* to commence only after the establishment of the new specialist services, with a multi-year horizon for results; the High Court record described the trial

as expected to take “*five to six years*”.<sup>3,11</sup>

A closely timed and structurally similar executive-restriction pathway occurred in Queensland, Australia. In *AB v Chief Executive of Queensland Health*, the Supreme Court set aside a Queensland Health directive on administrative-law grounds without adjudicating merits.<sup>12</sup> Queensland also commissioned an independent review (the Vine Review) and issued a ministerial direction restricting initiation of hormone therapies for minors in the public system.<sup>13,14</sup> Notably, Queensland’s own 2024 independent evaluation of the paediatric gender service had reportedly found the service evidence-based, safe and aligned with best practice, while recommending expansion and better resourcing rather than contraction.<sup>15</sup> These parallels support the interpretation that the New Zealand decision sits within a broader pattern of rapid executive restriction in comparable jurisdictions. They do not, on their own, demonstrate co-ordination; rather, they show a similar sequence of justification, review-commissioning and executive instrument use that is consistent with policy transfer or convergence.

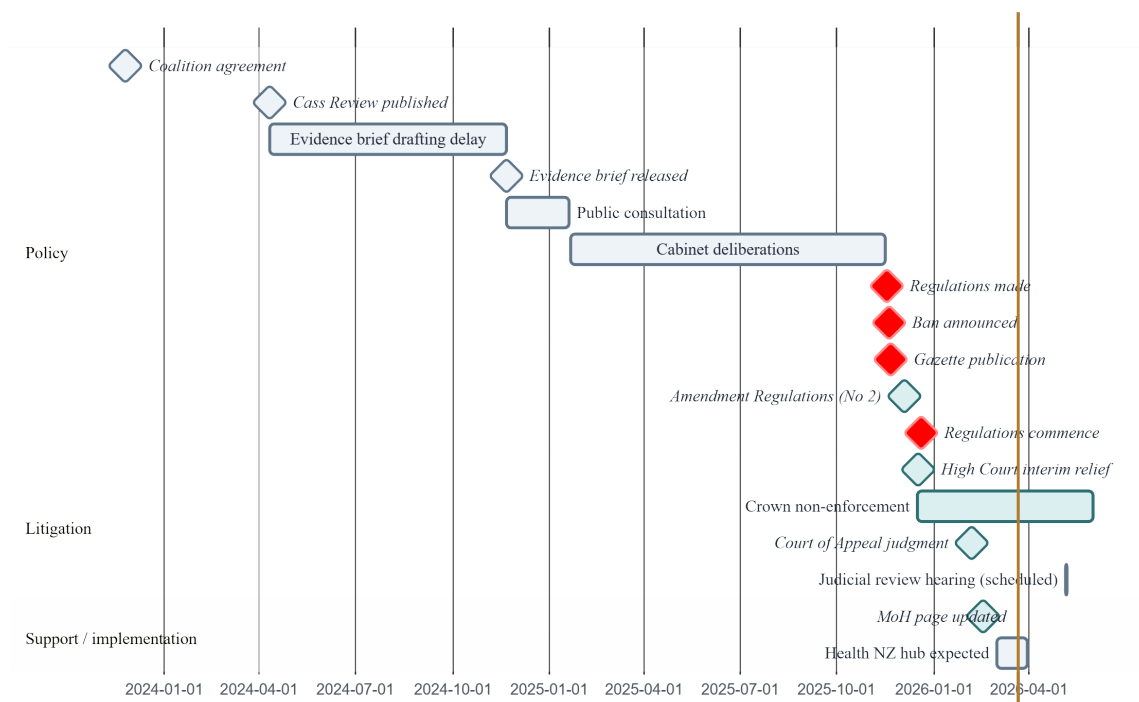
## Aim and analytic approach

We analyse this episode as “Regulatory Exceptionalism”: a policy design in which 1) uncertainty is treated as uniquely disqualifying for one population/indication, 2) normal medicines-governance pathways are bypassed, and 3) rights and distributional effects are under-acknowledged in the official record. Our approach is documentary and interpretive: we examine what the public record *does and does not* contain, and how that record frames evidence, risk and governance. The analysis complements clinical descriptive work already published in New Zealand on puberty blocker prescribing and international comparisons but shifts the lens to governance architecture and administrative-law vulnerability.<sup>16</sup>

## Methods

We assembled a 67-document corpus of publicly retrievable materials (legislation and statutory instruments; Ministry of Health – Manatū Hauora evidence and position materials; ministerial announcements; Medsafe/Pharmac materials; official information responses; and statements from professional, Māori, rainbow and human rights organisations). From this corpus, we selected 12 core policy documents that directly structure the restriction (the statutory instruments; the

**Figure 1:** Policy timeline for the New Zealand puberty blocker ban, 2023 to early 2030s.



Schematic timeline showing key events from coalition formation and the publication of the United Kingdom (UK) *Cass Review*, through the Ministry of Health – Manatū Hauora evidence brief and public consultation, making and publication of the regulations (including the 4 December 2025 amendment noted in the interim litigation record), the announcement and commencement sequence, interim litigation and the multi-year horizon for prospective UK trial evidence described in the policy record. The underlying Ministry of Health – Manatū Hauora evidence brief was released in November 2024 but states that its contents were current only to September 2023; the local policy record was later supplemented by a 2025 addendum; and the UK trial horizon remained prospective rather than completed at the time of the New Zealand decision.

Key milestones reflected in Figure 1: 1) coalition agreement signed in late 2023; 2) *Cass Review* published on 10 April 2024; 3) Ministry of Health – Manatū Hauora evidence brief released in November 2024, based on material current to September 2023; 4) regulations signed on 17 November 2025, announced on 19 November 2025 and published in the *New Zealand Gazette* on 20 November 2025; 5) amendment regulation published on 4 December 2025; 6) interim High Court relief/judgment sequence in December 2025; and 7) UK PATHWAYS evidence remained a future dependency rather than completed evidence at the time of the New Zealand decision. NZ = New Zealand; MoH = Ministry of Health – Manatū Hauora.

Ministry evidence brief; and pivotal stakeholder and institutional texts referenced in the decision pathway).

Each of the 12 documents was extracted into a 32-field analytic matrix capturing bibliographic metadata, legal basis, stated objectives, evidentiary framing, uncertainty treatment, consultation signals, rights and equity language (including references to Te Tiriti o Waitangi and the *New Zealand Bill of Rights Act 1990* [NZBORA]), procedural features and discourse characteristics. We interpreted this material through a seven-pillar framework of Regulatory Exceptionalism (epistemological, economic, procedural, constitutional, discourse, ethical, and political economy). A duplicate extraction run was used as a quality check to confirm internal consistency of field capture. The same coder re-extracted the 12 core documents into the same 32-field template and compared the two versions field-by-field; no discrepancies were identified.

Documents were identified using 1) forward- and backward-tracing from the statutory instruments and the Ministry evidence brief, 2) targeted searches of official publication sites (Beehive, *New Zealand Gazette*, New Zealand Legislation, Ministry of Health – Manatū Hauora, Medsafe, NHS England, Queensland Health), and 3) capture of stakeholder responses referenced in the decision pathway or subsequent litigation record. Inclusion criteria were: direct relevance to the restriction's legal basis, evidentiary rationale, implementation framing, or articulated impacts (clinical, rights, equity, and service design). Exclusion criteria were: duplicative media reporting without primary content, and commentary not referenced or relied upon in the core policy record.

The study protocol and project record are available on the Open Science Framework (OSF).<sup>17</sup>

We treated the extracted matrix as a transparency tool rather than a statistical dataset. Our interpretive stance is that omissions in official documentation are themselves analytically meaningful in administrative law and public governance: what is not recorded or not grappled with can shape proportionality assessment and downstream accountability.<sup>18</sup> No human participants were involved, and no personal data were collected.

## Findings

### Pillar one: epistemological exceptionalism (uncertainty as a prohibition trigger)

Across the core documents, the primary jus-

tification is the claim that the evidence base for puberty blockers is uniquely weak or uncertain, with uncertainty treated as dispositive for prohibition rather than as a familiar feature of paediatric/adolescent prescribing managed through clinical governance.<sup>1,4,7</sup> The policy discourse invokes long-horizon end points (e.g., later-life physical and psychosocial outcomes) that are structurally slow to generate. This enables an “impossible standard” dynamic: the time required to produce the demanded evidence becomes a justification for restricting access in the interim.<sup>3</sup>

The exceptionalism claim is sharpened by comparison to routine off-label use under uncertainty elsewhere in paediatrics. Proton pump inhibitors are widely used in infant reflux contexts despite guidance that benefits are limited for non-specific symptoms and stewardship is required; uncertainty is managed through guideline restraint and clinical judgement, not ministerial prohibition.<sup>19–21</sup> Similarly, symptom overlap between ADHD and trauma-related presentations is recognised in child mental health practice and can complicate diagnosis; this is typically managed through assessment, review and governance rather than blanket prescribing prohibition.<sup>22</sup>

### Pillar two: economic exceptionalism (contagion versus diffusion of unmet need)

A subset of documents frame rising demand as a “social contagion” phenomenon. A more policy-standard interpretation is diffusion and latent demand: as information, service pathways and stigma conditions change, previously unmet need becomes visible and referrals rise without implying pathology or manipulation.<sup>23</sup> In this framing, rising demand is expected under pathway formation, and policy attention should focus on capacity, triage and clinical governance rather than blanket restriction.

### Pillar three: procedural exceptionalism (bypassing medicines governance norms)

The restriction routes a contested clinical issue through an executive regulation pathway (section 105), with minimal reliance on established contestable governance mechanisms (clinical guidance, specialist service design, and regulator/professional governance processes centred on Medsafe and clinical accountability). This is notable given the government's parallel deregulatory direction in medicines approval policy (reliance/verification pathways) that tolerates uncertainty to accelerate access in other contexts.<sup>24</sup> The result

is a procedural double standard: uncertainty is managed via access-accelerating reforms in general but treated as uniquely disqualifying in this indication.

Procedural choice also affects accountability pathways. Clinical guidance and service standards can be iteratively revised, include explicit review points and are typically embedded within professional regulation and quality systems. Delegated legislation, by contrast, tends to be binary and slower to recalibrate once made. Where the public justification is “insufficient evidence”, the relevant policy question becomes: what is the review mechanism, what new evidence would be sufficient to change course and who bears the burden of proving it? In the available record, those design elements are comparatively under-specified, even though the policy rationale relies heavily on prospective evidence generation.<sup>1,11</sup>

#### **Pillar four: constitutional exceptionalism (rights and proportionality under-addressed)**

Core executive texts contain limited engagement with Te Tiriti o Waitangi obligations, *NZBORA* proportionality and discrimination implications, despite stakeholder responses foregrounding rights and equity concerns. *NZBORA*'s protection against discrimination (section 19) is relevant because the restriction targets a specific indication and population while leaving the same medicines available for other indications.<sup>25</sup> The *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* also establishes the Crown's duty of active protection in health equity, raising questions about whether the restriction's equity impacts were assessed in a robust way.<sup>26</sup>

The interim High Court decision treated several judicial review grounds as at least arguable, including concerns about evidential justification and process.<sup>3</sup> On orthodox administrative-law analysis, delegated legislation must be made for proper purposes and supported by a rational evidential basis; measures that appear arbitrary or inconsistent with stated objectives are vulnerable.<sup>18</sup>

A proportionality-oriented frame is useful even where courts ultimately apply orthodox judicial review rather than a structured proportionality test. If the policy objective is safeguarding, then the public record should ordinarily articulate 1) the concrete harm being prevented, 2) why less restrictive governance tools are inadequate (e.g., standardised multidisciplinary team [MDT]

pathways, monitoring, auditing and reporting), and 3) how equity impacts have been assessed for Māori and other groups with differential access to specialist services. The *NZBORA*'s discrimination protections (section 19) mean that differential treatment requires a justification that is not merely asserted but evidenced and reasoned; the *Hauora* report reinforces that equity impacts are not incidental in health policy but integral to Crown obligations.<sup>25,26</sup>

#### **Pillar five: discourse exceptionalism (how “risk” is constructed)**

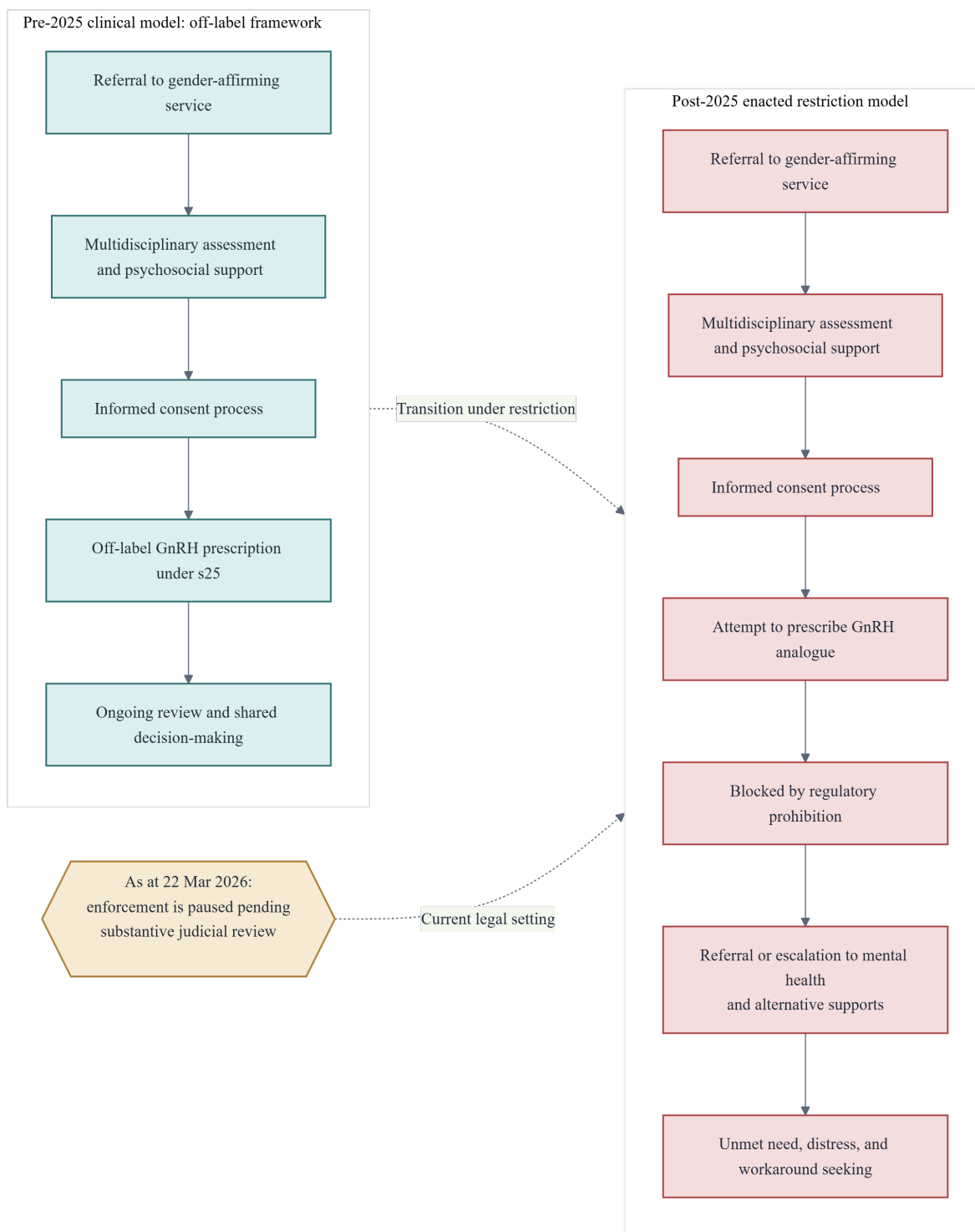
The documentary record repeatedly re-describes puberty blockers as uniquely experimental, morally risky or a “safety crisis”, while remaining comparatively silent on standard tools for managing uncertainty (guidelines, monitoring, service design). This is a classic policy move: reframing a contested clinical question into a public safety problem changes what governance responses appear “available”.<sup>27</sup> Relatedly, the invocation of “social contagion” draws on a broader genre of “making up people” through classificatory narratives, with downstream effects on how populations are governed.<sup>28</sup> The *Cass Review*'s influence in New Zealand also highlights how evidence-hierarchy language can be mobilised in policy, and how debates about appraisal methods become proxies for deeper normative disagreement.<sup>7,29</sup>

#### **Pillar six: ethical exceptionalism (the harm trade-off)**

The policy's ethical structure prioritises avoiding uncertain long-term harms over addressing documented present distress, and it does so by removing the option of individualised risk-benefit judgement for initiation. Standard bioethics frameworks emphasise that non-maleficence and beneficence require weighing harms of action *and* harms of inaction; prohibitions can transfer risk rather than eliminate it.<sup>30</sup> Professional bodies have raised concerns that restricting access for a vulnerable group may itself produce harm, including through untreated distress or displacement to unregulated pathways.<sup>31</sup>

To make the risk-transfer logic concrete, consider a hypothetical patient aged 12 years (pre-menarche) who has completed a long MDT assessment pathway and is awaiting initiation. Under the restriction, the MDT pathway becomes administratively closed at the point of initiation; distress may persist, pubertal development

**Figure 2:** Standard paediatric pathway versus puberty blocker pathway.



Process diagram contrasting the handling of medicines in other paediatric contexts (clinical need, variable evidence, off-label use managed by clinician discretion within standard medico-legal settings) with the *Cass*/puberty-blocker pathway (low/uncertain evidence, an asymmetrically elevated evidence threshold, demand for high-certainty long-horizon evidence, evidence deemed “insufficient”, ministerial ban). SID = supply-induced demand; RCT = randomised controlled trial.

progresses, and the family may seek alternatives outside the monitored public pathway. This is not an argument about the *merits* of any specific clinical decision; it illustrates how a population-level prohibition displaces individualised governance tools.

### **Pillar seven: political economy (risk, accountability and where costs land)**

Finally, the restriction sits within a political economy in which the benefits of prohibition (political clarity; perceived risk aversion) are immediate and visible, while the costs (service displacement; litigation; mental health presentations; workforce effects) are diffuse and occur elsewhere in the system. The close timing with Queensland's executive restrictions and subsequent administrative-law reversal shows how "process" can be used to create the appearance of procedural legitimacy while outcomes are determined by executive instruments.<sup>12,14</sup>

## **Discussion**

This analysis shows how a medicines-governance tool (section 105 regulations) can be used to displace routine regulatory processes and clinical discretion (off-label prescribing) for one indication and population, while comparable uncertainty in other paediatric contexts is managed through stewardship and oversight rather than prohibition. The interim litigation record strengthens the inference that the decision is contestable on orthodox administrative-law grounds, and it highlights the centrality of process and evidential justification in delegated legislation.<sup>3,18</sup>

### **Readability check: what would a proportionate governance response look like?**

If the central concern is evidentiary uncertainty, there is a well established set of governance responses that preserve clinical discretion while tightening accountability. These tools are familiar in other contested areas of paediatric and adolescent medicine where long-horizon outcomes are slow to measure, heterogeneous and ethically difficult to randomise.<sup>32</sup>

First, the system can specify *thresholds and process* rather than proscribe a medicine. This may include published MDT criteria for initiation, minimum assessment elements (capacity assessment, comorbidity screening, family engagement), and explicit documentation requirements that make

decision-making auditable. Second, a national registry can be used to strengthen active surveillance and standardise outcome tracking (including reasons for discontinuation, adverse events and mental health trajectories), with pre-specified reporting intervals. Third, review mechanisms can be built into policy: a time-limited constraint with transparent triggers for renewal or withdrawal, aligned to realistic evidentiary timelines. Indeed, this is a common existing mechanism for medicines governance in New Zealand. Without these design elements, a "wait for better evidence" policy risks becoming path-dependent, because the burden of proof shifts onto a small patient group while the time-to-evidence is used to justify ongoing restriction.

### **Policy transfer: importing a template versus importing a governance model**

*Cass* is often treated as a decisive template, but the *Cass* programme is also a UK service-governance intervention responding to local institutional history and commissioning settings. The existence of substantive critique (including on evidence appraisal choices and framing) reinforces that policy transfer should be explicit about what is being imported: a service model, an evidentiary judgement or a political rationale.<sup>7,10</sup> New Zealand's own Ministry of Health – Manatū Hauoroa evidence brief, and the interim litigation record, suggest the domestic decision pathway was not merely a technical adoption of a foreign review but a contested governance choice within New Zealand's administrative setting.<sup>3,4</sup>

A plausible alternative architecture would treat uncertainty as a governance challenge rather than a disqualification trigger. Options include: 1) standardised MDT pathways with published thresholds for initiation, 2) registry-based monitoring and adverse event reporting, and 3) time-limited restrictions coupled with a funded evidence programme and clear criteria for review. These are routine policy tools for contested interventions; they preserve accountability while retaining capacity for individualised judgement.

## **Strengths and limitations**

Strengths include theory-guided analysis of a defined policy corpus and structured extraction of core documents. Limitations include reliance on publicly available materials and single-author interpretation; the analysis cannot capture unpublished deliberation and should be read as an assessment of the public documentary record

rather than a full account of internal decision-making. We also note that this article is not a clinical practice guideline; it analyses governance choices and their implications.

## Conclusion

New Zealand's 2025 restriction on initiating puberty blockers is best understood as "Regulatory Exceptionalism": uncertainty is treated as uniquely disqualifying, standard medicines-governance

pathways are bypassed and rights/distributional impacts are under-addressed in the official record. The policy creates a differential evidentiary and governance standard for transgender youth compared with routine off-label prescribing under uncertainty elsewhere in paediatrics. If uncertainty is the central concern, a more proportionate response is to strengthen clinical governance (clear thresholds, monitoring, and review points) and to fund evidence generation, rather than to prohibit initiation by regulation.

**COMPETING INTERESTS**

Nil.

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## Appendix

### S1. Corpus and sampling

The analysis draws on a structured corpus of 67 documents spanning the period 1 January 2020 to 31 December 2025. The corpus includes:

- *Medicines Act* instruments and related legislative material (e.g., Section 105 regulations) (Parliament, 1981 @ MedicinesAct #25)
- Cabinet and Ministry of Health – Manatū Hauora papers and regulatory impact material (Cabinet Social Policy Committee, 2025 @CabPaper #006; Ministry of Health – Manatū Hauora, 2025 @RIS #010)
- Medsafe and Pharmac documents on puberty blockers and selected comparator medicines (Medsafe, 2024 @EvBrief #003; Pharmac, 2024 @PharmacSildenafil #17)
- *Official Information Act 1982 (OIA)* responses from Health New Zealand – Te Whatu Ora, the Ministry of Health – Manatū Hauora and other agencies
- Statements and submissions from professional bodies, Māori and rainbow organisations, and human rights institutions (e.g., Professional Association for Transgender Health Aotearoa [PATHA], New Zealand Nurses Organisation [NZNO], Royal Australasian College of Physicians [RACP], Royal New Zealand College of General Practitioners [RNZCGP], Human Rights Commission [HRC]) (PATHA, 2025 @ PATHA2025 #51; NZNO, 2025 @NZNO2025 #96; RACP, 2025 @RACP2025 #97; HRC, 2025 @HRC2025A #98)
- Key community and media texts that articulate support or opposition to the ban (Rainbow Support Collective, 2025 @ rainbow2025overreach #49; RNZ, 2025 @ RNZ2025 #80)

The documents were identified through targeted searches of New Zealand legislation and government websites, proactive releases, OIA portals, professional and community organisation sites, and selected media outlets, as detailed in the registered protocol.

From this corpus, a core subsample of 12 policy-structuring documents was selected for full extraction because they directly create, justify or contest the ban. These include:

- The Section 105 regulations and relevant

*Medicines Act* provisions

- Cabinet papers and minutes
- The Ministry of Health – Manatū Hauora evidence brief and formal position statement [Ministry of Health, 2024 @ MoHEvidenceBrief #2]
- Key Medsafe/Pharmac materials and regulatory summaries
- Pivotal stakeholder texts that directly engage with the proposed restrictions (e.g., PATHA, NZNO, RACP, RNZCGP, HRC)

The remaining 55 documents are used for contextual triangulation and illustrative quotations rather than full matrix comparison.

The full corpus catalogue is available in the OSF repository.

### S2. Extraction matrix (32 fields)

Each of the 12 core documents was extracted into a 32-field matrix (the extraction spreadsheet contains 33 columns because it includes an additional source-identifier metadata column). The fields are grouped into seven analytic domains:

1. **Bibliographic and context**  
*source\_id, issuing\_body, year, jurisdiction, document\_type, title, url*
2. **Policy instrument and objectives**  
*legal\_basis, policy\_objective, target\_population, indications*
3. **Evidence framing**  
*evidence\_quality, key\_cited\_sources, uncertainty\_treatment*
4. **Rights and equity**  
*te\_triti\_mention, nzbora\_mention, discrimination\_mention, equity\_impacts*
5. **Economic claims**  
*cost\_saving\_claims, demand\_contagion\_mention*
6. **Governance and process**  
*procedural\_steps, consultation, health\_technology\_assessment\_deviation*
7. **Discourse and risk**  
*problem\_representation, metaphors, silences, risk\_construction, notes*

These fields are aligned with the seven analytical pillars described in the manuscript (epistemological, economic, procedural, constitutional, discourse, ethical, political economy).

### S3. Intra-rater reliability of extraction

To assess the stability of the extraction, the 12 core documents were re-extracted independently

by the same investigator using the same 32-field schema. This produced a re-run matrix, which was aligned with the original matrix on *source\_id*.

For each of the 32 fields, the original and re-run entries were compared cell-by-cell across all 12 documents. The re-run comparison yielded:

- 12/12 documents matched
- 32/32 fields matched per document
- Overall agreement: 100% (all fields identical across all documents)

This intra-rater agreement supports the reliability of the descriptive coding. Interpretation remains a single-author process and is treated as such in the manuscript; the re-run check is presented as a quality control step rather than a claim of objectivity.

#### S4. Reflexivity and audit trail

The study is single-author and interpretive. To manage and make visible the investigator’s

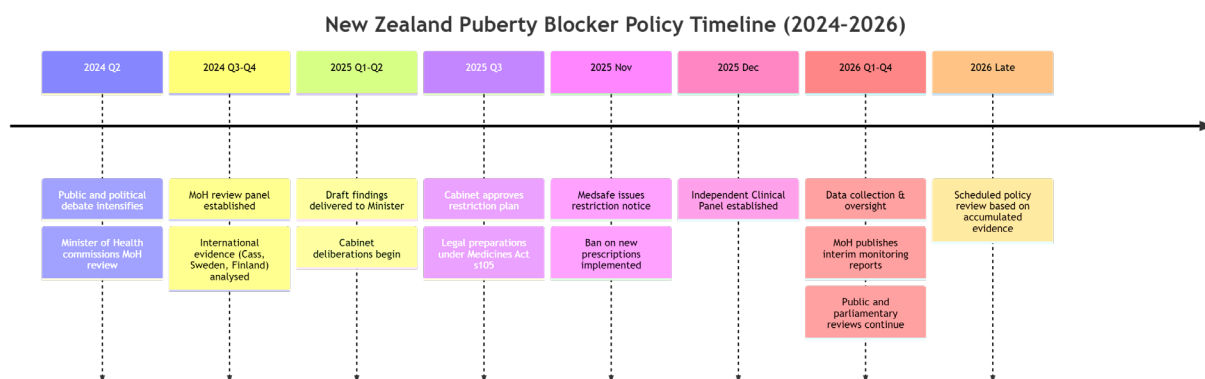
positionality and potential biases, two additional layers of documentation were maintained:

- A *reflexive diary* with dated entries recording positionality (as a paediatrician, clinical geneticist, medical administrator and health economist), emotional responses to the material and key analytic decisions.
- A set of *analytic memos* linking patterns in the matrix to the seven pillars (e.g., how *evidence\_quality* and *uncertainty\_treatment* underpin epistemological claims; how *demand\_contagion\_mention* and *cost\_saving\_claims* feed into economic arguments).

Together with the corpus catalogue and extraction matrices, these materials form an audit trail. They allow readers to see how the argument in the manuscript was built from the underlying documents.

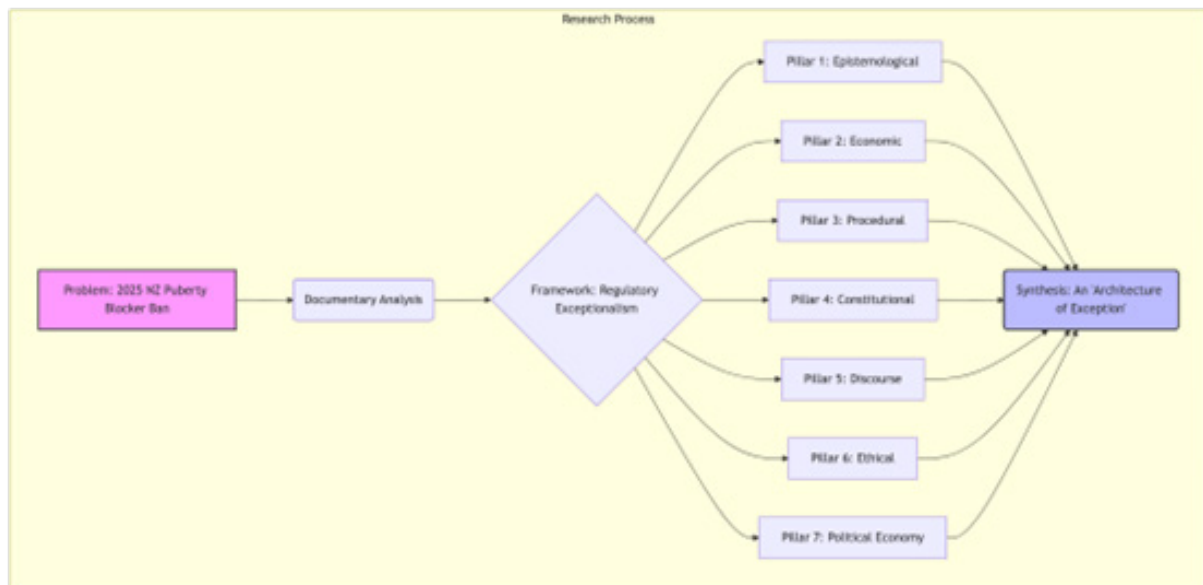
#### S5. Appendix figures

Appendix Figure 1: Policy timeline (New Zealand, 2024–2026).



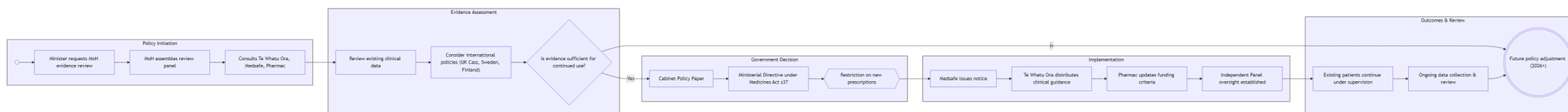
A descriptive timeline of the puberty blocker ban, from early debates and the *Cass Review* through to Cabinet decisions, regulatory instruments and stakeholder responses. It highlights the speed and sequencing of key events, and the points at which standard parliamentary or health technology assessment (HTA) scrutiny were bypassed. NZ = New Zealand; MoH = Ministry of Health – Manatū Hauora.

**Appendix Figure 2:** Conceptual framework (“architecture of exception”).



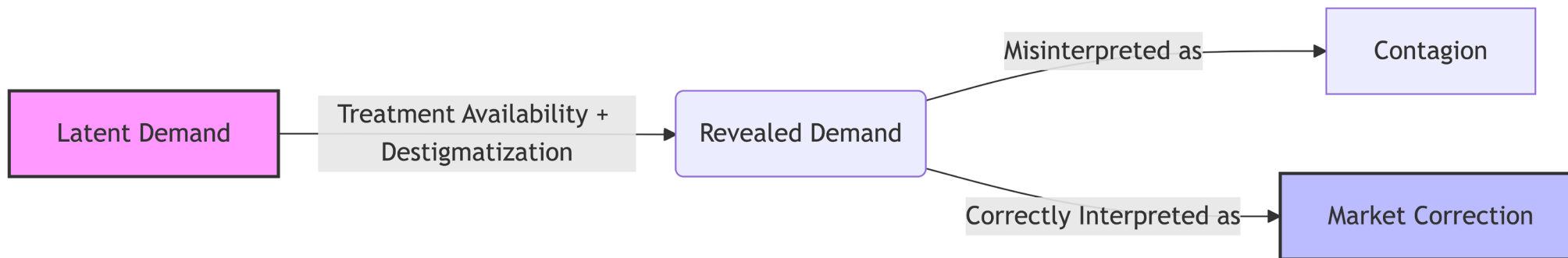
A visual summary of the seven pillars of regulatory exceptionalism (epistemological, economic, procedural, constitutional, discourse, ethical, political economy) and their links to the extraction fields and core documents.

Appendix Figure 3: Phased policy process.



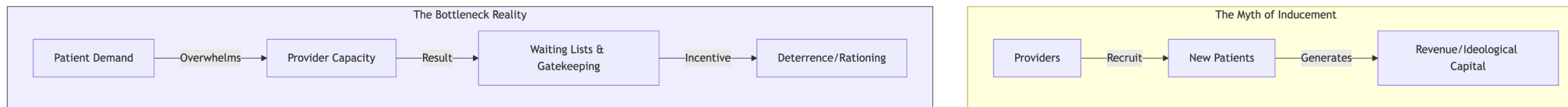
High-level phased policy process for the ban, from evidence review to regulation and enforcement (referenced in manuscript introduction).

Appendix Figure 4: Latent demand vs contagion.

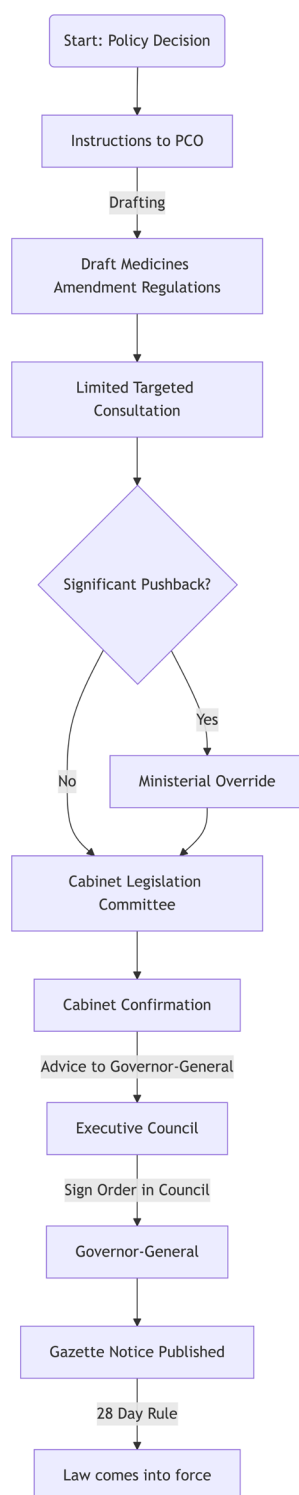


Economic diffusion/latent demand framing contrasted with “social contagion” narratives used to explain rising referrals (referenced in manuscript text).

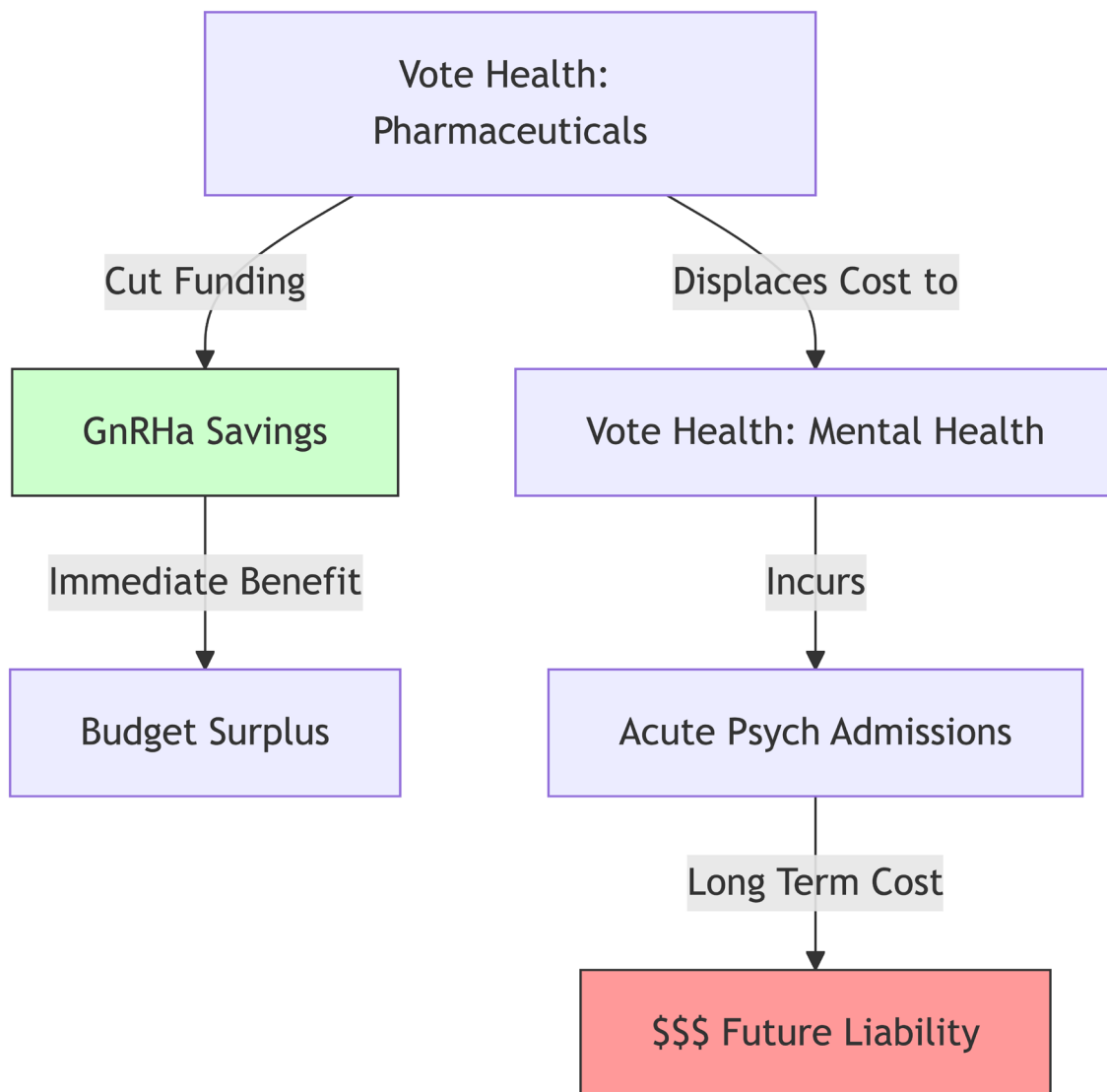
Appendix Figure 5: Supply-induced demand vs bottlenecks.



Shows why supply-induced demand claims are weak in the presence of capacity constraints and bottlenecks (referenced in manuscript text).

**Appendix Figure 6:** Legislative path (Section 105).

Detailed process map of the pathway used to enact the ban via *Medicines Act* Section 105, showing steps from public debate and ministerial commissioning, through Cabinet decision and Medsafe/Pharmac operationalisation (referenced in manuscript text).

**Appendix Figure 7:** Siloed budgeting.

Visualisation of how cost savings in one part of the system shift costs downstream (e.g., acute mental health), illustrating the ban's political economy (referenced in manuscript text).

## S6. Appendix tables

**Appendix Table 1:** Policy timeline map.

Date	Event	Source
Oct 2023	Coalition Government formed (National/ACT/NZ First)	Coalition agreements
Apr 2024	UK <i>Cass Review</i> final report published	@CassReview
Nov 2024	Ministry of Health – Manatū Hauora evidence brief released	@MoHEvidenceBrief
Nov 2024–Jan 2025	Public consultation period	MoH consultation
17 Nov 2025	Administrator signs Section 105 regulations	@Gazette
19 Nov 2025	Minister of Health announces ban	@PressRel
20 Nov 2025	Regulations published in <i>New Zealand Gazette</i>	@Gazette
17 Dec 2025	High Court interim judgment ( <i>PATHA v Minister of Health</i> )	@PATHA2025NZHC
19 Dec 2025	Regulations commence (28-day rule)	@Gazette
~2030–2031	Expected UK trial results (5–6-year horizon)	@NHSEnglandGenderCentres2024; @PATHA2025NZHC

Key dates in the New Zealand puberty blocker policy pathway (referenced in manuscript text).

### Full corpus catalogue

The full 67-document corpus with source IDs, issuing bodies, document types, and URLs is provided in *supplementary\_table\_sources\_v01\_20251126.md*.

### S7. Access to full materials

The following additional materials are available via the Open Science Framework (OSF) and the project repository:

- **Full corpus catalogue:** *catalogue/* directory—all 67 documents with metadata
- **Complete extraction matrices:** *analysis/data\_extraction\_matrix.csv* *catalogue/data\_*

*extraction\_matrix\_rerun.csv* (re-run)

- **Synthesis and robustness documentation:** *documentation/synthesis\_process.md*, *final\_report/robustness\_check\_report.md*
- **Extended legal and constitutional analysis (in preparation):** a separate legal appendix detailing the use of Sections 25, 29 and 105 of the *Medicines Act 1981* and relevant case law

These materials are not required to follow the main argument of the article but are provided to support transparency, replication of the documentary analysis and future comparative work.