



Gender Dysphoria Treatment and Consent by Children and Young People

English and Welsh Statutes and Case Law

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TABLE OF CONTENTS

EXECUTIVE SUMMARY.....	1
I. INTRODUCTION	1
II. THE RESEARCH QUESTIONS	1
III. SUMMARY CONCLUSIONS	1
a) Consent to Medical Treatment in General.....	1
b) Consent in the Process of Transitioning. Differences in Stage 1 and Stage 2.....	2
LEGAL FRAMEWORK IN ENGLAND AND WALES.....	4
I. CONSENT TO MEDICAL TREATMENT IN GENERAL.....	4
a) Scope	4
b) Child’s Ability to Consent to Medical Treatment	5
c) Power of Parents/Legal Guardians to Consent to Treatment.....	8
d) Situations where Court Intervention is Needed.....	9
e) Power of the Medical Professional to Refuse to Treat	9
f) The Responsibility of Clinicians to Facilitate Informed Consent	10
II. CONSENT TO MEDICAL TREATMENT IN THE CONTEXT OF GENDER DYSPHORIA IN THE PROCESS OF TRANSITIONING.....	14
a) Framework.....	14
b) Case Law.....	14

EXECUTIVE SUMMARY

I. INTRODUCTION

1. OPBP has been asked by LawforLife, United Kingdom, to prepare a report on the statutory framework and case law underpinning consent to medical treatment for children and young people experiencing gender dysphoria, including the barriers to reaching informed consent amongst them. LawforLife is a charity working with an NHS service for children and young people experiencing gender dysphoria.
2. The report is intended to help the production of a high-quality, user-friendly informative document for both children and their parents or carers, to inform their decision whether to undertake medical treatment.

II. THE RESEARCH QUESTIONS

Question 1: Summarise the law in England and Wales (statutory framework and case law) regarding consent to medical treatment in general. When is a child able to consent to medical treatment? Where does the power of parents/legal guardians to consent to treatment end? What is informed consent? (What are the limits of parental authority? In which cases is a court's intervention required?)

Question 2: Specifically, in the context of gender dysphoria: Summarise the legal position (statutory framework and case law) in England and Wales regarding consent to Stage 1 (suppression of puberty involving blocking hormones) and Stage 2 (administering hormones, either estrogen or testosterone) of transitioning.

III. SUMMARY CONCLUSIONS

a) Consent to Medical Treatment in General

1. For treatment to be given lawfully by a doctor, two things must be satisfied in all cases. First, the treatment must be determined by the doctor to be in the best interests (or at least not harmful to) the patient. In deciding if the treatment will benefit the patient the views of

the patient can be an important factor. However, a patient has no right to demand a particular kind of treatment. Second, the doctor must receive effective legal consent to the treatment.

2. Consent can be provided by a competent child, a person with parental responsibility, or the court.
3. Children aged 16 and 17 years old are presumed to have capacity to consent under the Mental Capacity Act 2005, unless there is evidence they do not. So, in the case of 16- and 17-year olds there is no need to obtain parental consent to undertake treatment and medical professionals may provide treatment that they believe to be in the young person's best interests with their consent.
4. Children under the age of 16 can only consent to treatment if they are considered competent under the *Gillick* test which requires that the child: a) understand the nature of their medical condition and the proposed treatment; b) understand the moral and family issues involved; c) possess certain 'experience of life'; d) not be fluctuating between a state of competence and incompetence; e) can weigh the information appropriately to be able to reach a decision. A *Gillick*-competent child is entitled to confidentiality and medical professionals may not breach this right by informing the parents of the medical issues or proposed treatment.
5. The lack of *Gillick*-competency requires the consent of someone with parental responsibility. The consent of one person with parental responsibility is generally sufficient.
6. Clinicians have a responsibility to facilitate informed consent. This duty requires them to take reasonable care to ensure that the patient is aware of any 'material risks' involved in any recommended treatment, or of any reasonable alternative treatments. The doctor-patient relationship should be a continuing dialogue in which the doctor plays an advisory role respecting the autonomy of the patient. In the gender dysphoria context, this will involve the clinician providing information as to risks, benefits, and options in a way that is appropriate for the patient's circumstances, such as through simple language, leaflets, visual aids, etc.

b) Consent in the Process of Transitioning. Differences in Stage 1 and Stage 2

7. There is no specific statutory framework governing consent to Stage 1 (suppression of puberty involving blocking hormones) or Stage 2 (administering hormones, either estrogen or testosterone) of transitioning children. The Gender Identity Development Service for children and young people operates according to an NHS Standard Contract that includes provisions on competence to consent based on the *Gillick* criteria. Given that the level of understanding required to have capacity varies with the complexity and gravity of the decision, this might imply that a higher level of understanding is required for Stage 2 than it is for Stage 1. Decisions regarding competence are made jointly by the endocrine and psychological members of the Service's integrated team.
8. There is no case law on *Gillick* competency on Stage 1 or 2 treatments. One case on parental care that decided it was not appropriate for a child to remain in the care of a parent who forced them to live as the opposite gender established that a child should have a role in managing their own gender presentation (the case, however, did not involve medical intervention). The case did show the court respected the child's understanding of their gender.¹
9. Although unlikely, where a child lacks capacity and parents oppose treatment, a court may provide the necessary consent for treatment where the risks of the child's mental health are greater than if the treatment does not take place.
10. This report focuses on the legal framework in the UK. However, due to the scarcity of case law on this matter in the UK, it appears necessary to look into Australian case law. This is due to the fact that the underlying legal framework is similar, and because Australia has dealt with at least 64 cases on the issue of medical treatment of minors with gender dysphoria. However, there is no guarantee that English courts would adopt the same approach as Australia. Although the Australian courts previously held that Stage 2 treatment required court authorization, this is no longer the case. It has been held that current medical knowledge of gender dysphoria and its treatment (is such that it) requires no court authorization, where a non-*Gillick*-competent child's parents and medical professionals agree that such treatment is in the child's best interests. It has also been held that judicial determination of *Gillick*-competence is neither required nor appropriate in such circumstances.

¹ *Re J (A Minor)* [2016] EWHC 2430 (Fam).

LEGAL FRAMEWORK IN ENGLAND AND WALES

I. CONSENT TO MEDICAL TREATMENT IN GENERAL

Question 1: When is a child able to consent to medical treatment? Where does the power of parents/legal guardians to consent to treatment end? What is informed consent? (What are the limits of parental authority? In which cases is a court's intervention required?)

a) Scope

11. The basic rule is that medical professionals may not treat someone without consent, as to do so would give rise to criminal and tort liability for battery.²
12. Consent can be provided by any one of: a competent child; a person with parental responsibility over a non-competent child; or the court. In the case of gender dysphoria, it is unlikely that a medical professional would think it in the best interest of the child to compel them to engage in treatment against their wishes. It is also unlikely to address situations in which a child is severely cognitively or mentally impaired. Therefore, the following situations appear more likely to arise in practice:
 - a. the child, their parents, and the medical professionals all express a view that a particular treatment should occur;
 - b. the child, one parent, and the medical professionals express a view that a particular treatment should occur. The other parent is either uninvolved, or opposes the treatment;
 - c. the child, and the medical professionals express a view that a particular treatment should occur. The parents are either uninvolved or oppose the treatment; or
 - d. the child (or the child and their parents) express a view that treatment should occur, but the medical professional does not agree.

² Jo Bridgeman, 'The Provision of Healthcare to Young and Dependent Children: The Principles, Concepts, and Utility of the Children Act 1989' (2017) 25 Medical Law Review 363, 2. But see also, *Re Kelvin* [2017] FamCAFC 258 (Family Court of Australia) [199], where it is stated that this applies primarily to surgical interventions.

13. Additional considerations may apply to specific situations of children in care; with intersex characteristics; or with additional mental health, cognitive, or intellectual disability needs. Such situations, however, are beyond the scope of this report.

b) Child's Ability to Consent to Medical Treatment

i) Young People Aged 16 and 17 Years Old

14. Under English and Welsh law, a person under the age of 18 is a child.³ With regards to medical treatment, however, a young person aged 16 or 17 years old, is presumed to have capacity to consent to medical treatment. The relevant provision states:

The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.⁴

15. This includes diagnostic procedures, and procedures ancillary to the treatment such as administration of an anaesthetic.⁵ As a result, a 16- or 17-year-old does not require parental consent to undertake treatment, and medical professionals may provide treatment that they believe to be in the young person's best interests with their consent. The only exception would be where the medical professional had evidence that they lacked mental capacity under the Mental Capacity Act 2005.

ii) Children and Young People Aged under 16 Years Old

³ Children Act 1989, s 8(1). There are some exceptions, which are not relevant to present purposes.

⁴ Family Law Reform Act 1969, s 8(1). There are some minor exceptions to the principle that 16- and 17-year-olds can consent to treatment.

⁵ Ibid, s 8(2).

16. A child who is under the age of 16 can consent to medical treatment if they are ‘*Gillick*-competent.’⁶ This test is named after a case in which a child under 16 was given contraceptive advice without her parent’s consent. In it, the House of Lords:

accepted that if a doctor decided that it was in the best interests of an under-16-year-old that she be given the contraceptive advice she sought and that she was competent to understand the issues involved, then the doctor was permitted to provide the treatment without obtaining consent of the parents.⁷

17. In other words, where a child is *Gillick*-competent, medical professionals may provide treatment that they believe to be in the child or young person’s best interests with the consent of that child or young person. Parental consent is not required.

iii) How to Decide if a Child or Young Person is Gillick-competent?

18. The *Gillick*-competence test applies to all types for medical treatment decisions. Specifically, it has been held that the Guidelines outlined in *Gillick* ‘can be and should be adapted to deal with advising and providing treatment for all sexual matters.’⁸

19. Herring has summarized the questions to consider in assessing *Gillick*-competence, as follows:

- a. *‘Does the child understand the nature of their medical condition and the proposed treatment?’*⁹ The child must be able to understand the proposed treatment including possible-side effects, and the possible consequences both of consenting to, and of refusing treatment.¹⁰ Some medical treatments may constitute an ‘invasive and irreversible surgical procedure with potentially serious risks, consequential and side effects.’¹¹

⁶ *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, [1985] 3 All ER 402, [1985] 3 WLR 830 (HL).

⁷ Jonathan Herring, *Family Law* (8 edn, Pearson 2017), 491.

⁸ *R (Axon) v Secretary of State for Health (Family Planning Association intervening)* [2006] QB 539; [2006] 1 FCR 175, [95].

⁹ Herring (n 6) 493.

¹⁰ *Gillick v West Norfolk and Wisbech Area Health Authority* [174]; *R (Axon) v Secretary of State for Health (Family Planning Association intervening)* [10].

¹¹ *R (Axon) v Secretary of State for Health (Family Planning Association intervening)* [83], [87], [88].

The courts have recognized that surgical abortions fall into this category, and it is likely that some treatments for gender dysphoria would be seen similarly. But, the question of whether the child understands its nature remains.

- b. *Does the child understand the moral and family issues involved?*¹² These include emotional issues to do with fertility, as well as the child's relationships with their parents.¹³
- c. *How much experience of life does the child have?*¹⁴ For example, a 14-year old Jehovah's Witness child who had lived a very sheltered life was held not to be competent to reject a life-saving blood transfusion.¹⁵ It is conceivable, but seems highly unlikely, that an otherwise competent child with gender dysphoria would have led such a sheltered life as to be unaware of the various community opinions on their condition and proposed treatment.
- d. *Is the child in a fluctuating mental state?*¹⁶ If a child is fluctuating between a state of competence and incompetence (for example due to intermittent psychosis), they are to be treated as non-competent.¹⁷
- e. *Is the child capable of weighing the information appropriately to be able to reach a decision?*¹⁸ This requires the child to show, not mere knowledge, but an ability to make wise choices in their own interests, in alignment with their own goals and values.¹⁹

iv) *Confidentiality and the Gillick-competent Child*

20. A *Gillick*-competent child is entitled to confidentiality, and medical professionals may not breach this confidentiality by informing the parents of the medical issues, or proposed treatment, without the child's consent. This is especially important in cases with sexual and

¹² Herring (n 6) 493.

¹³ R (*Axon*) v Secretary of State for Health (*Family Planning Association intervening*) [12].

¹⁴ Herring (n 6) 493.

¹⁵ Re L (*Medical Treatment: Gillick Competency*) [1998] 2 FLR 810

¹⁶ Herring (n 6) 494.

¹⁷ Re R (*a minor*) (*wardship: medical treatment*) [1992] 1 FLR 190, [1992] 2 FCR 229.

¹⁸ Herring (n 6) 494.

¹⁹ *ibid.*

reproductive health dimensions.²⁰ The courts have stated that in the usual course of events a medical professional should encourage the child to talk to their parents.²¹ If, however, the child is not prepared to talk to their parents, or allow the medical professional to talk to the parents, and it is a situation where unless treatment is provided the child's 'physical or mental health of both are likely to suffer'²² and their best interests require that they receive treatment without parental consent, the medical professional is justified in providing treatment to a *Gillick*-competent under the Lord Fraser Guidelines without parental involvement.²³

c) Power of Parents/Legal Guardians to Consent to Treatment

21. Where a child is under 16 years old, and is also not *Gillick*-competent, the general rule is that any surgical or medical treatment requires the consent of someone with parental responsibility.²⁴ Mothers automatically have parental responsibility, but not all fathers do.²⁵ There are, however, some cases in which parental consent is not sufficient, and the authorisation of a court is required. These are outlined below.

22. Generally, it is only necessary for one person with parental responsibility to consent to the treatment.²⁶ According to *Bridgeman*, however, where there is parental disagreement in the contentious areas of (non-therapeutic) male circumcision and vaccinations (which are public health measures), it is necessary to seek a court order.²⁷ While gender dysphoria treatment is

²⁰ R (*Axon*) v Secretary of State for Health (*Family Planning Association intervening*) [60]-[75]. There are very narrow exceptions to the principle.

²¹ *Gillick v West Norfolk and Wisbech Area Health Authority* [174] cited with approval in R (*Axon*) v Secretary of State for Health (*Family Planning Association intervening*) [10].

²² *Gillick v West Norfolk and Wisbech Area Health Authority* [174].

²³ See also R (*Axon*) v Secretary of State for Health (*Family Planning Association intervening*) [10], [89], [90].

²⁴ *ibid* [1]. The term 'parent' is used here to mean a person with parental responsibility.

²⁵ They will need to show they are married to the mother; registered as the father on the birth certificate; have a parental responsibility agreement with the mother lodged at the court; or that the court has made a parental responsibility order.

²⁶ *An NHS Trust v SR* [2012] EWHC 3842 (Fam) Children Act 1989, s 2(7); Herring (n 6) 495.

²⁷ *Bridgeman* (n 1) 381-2.

subject to public controversy, it can be distinguished from those cases on the grounds that it is performed therapeutically, for the benefit of the individual patient.²⁸

d) Situations where Court Intervention is Needed

23. If the medical professional believes that the parents' decision to refuse medical treatment for a child is contrary to the child's best interests, they must bring it to the court. This is usually done by way of the inherent jurisdiction of the High Court, although often a specific issue order could be sought from the Family Court instead.²⁹

24. '[T]he inherent powers of the court under its *parens patriae* [inherent] jurisdiction are theoretically limitless and that they certainly extend beyond the powers of a natural parent.'³⁰ As a result, the High Court exercising its inherent jurisdiction can consent in cases where a parent cannot. Situations in which it is a parent's duty to bring a matter to the court for a decision, include the sterilisation of a girl with severe intellectual disabilities and high health needs, in order to avoid the risk of pregnancy.³¹ Where, however, a hysterectomy is indicated on therapeutic grounds, an application to the court is not necessary, even though an effect of the operation is to end the person's fertility.³²

e) Power of the Medical Professional to Refuse to Treat

25. Where the medical professional disagrees with the treatment sought (whether by a parent, *Gillick*-competent child, or child aged 16-17), they cannot be required to provide treatment. In such a situation, the person seeking the treatment may be able to approach another medical professional.³³ Where a court disagrees with the medical professional's decision not

²⁸ See discussion of *Re Kelvin*, below.

²⁹ *Bridgeman* (n 1) 364-71.

³⁰ *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64, 81.

³¹ *Re HG (Specific Issue Order: Sterilisation)* [1993] 1 FLR 587, 595; *Bridgeman* (n 1) 383.

³² *Re E (A Minor) (Medical Treatment)* [1991] 2 FLR 585, *Bridgeman* (n 1) 383.

³³ *Re J (A Minor) (Child in Care: Medical Treatment)* [1992] 3 WLR 507 (CA), 516.

to treat, a Health Trust ‘would have a duty to assist the parents to find alternative means of securing the treatment.’³⁴

f) The Responsibility of Clinicians to Facilitate Informed Consent

26. The key case on a clinician’s duty of care in the context of consent to treatment is the UK Supreme Court judgement of *Montgomery v Lanarkshire Health Board*.³⁵

27. *Montgomery* established the ‘reasonable patient’ test for consent, which places the clinician under a ‘duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments’.³⁶ As stated by the court:

[T]he doctor’s advisory role involves dialogue, the aim of which is to ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision.³⁷

i) Material Risks

28. In a move away from the ‘reasonable clinician’ to the ‘reasonable patient’ test, the Supreme Court in *Montgomery* outlined the new test as follows:

The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient’s position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.³⁸

29. The *Bolam* test, which reflected the ‘reasonable clinician’ perspective, provided that a doctor will not have breached their duty of care if they acted in accordance with a practice accepted

³⁴ Bridgeman (n 1) 373-4.

³⁵ [2015] UKSC 11

³⁶ *ibid* [87] (emphasis added).

³⁷ *ibid* [90].

³⁸ *ibid* [87].

as proper by a responsible body of medical practitioners skilled in that particular art.³⁹ However, *Montgomery* deemed this test unsuitable for disclosure of risk in the context of consent to treatment, given that the extent to which a clinician may be inclined to discuss risks with a patient is not determined by medical learning or experience.⁴⁰

30. The paternalistic approach where the clinician ‘recommends a course of treatment to which the patient either consents or refuses, has been superseded by an approach based on respect for the autonomy or right to self-determination of the individual patient’.⁴¹ The focus is now on what is significant from the perspective of the patient.⁴²
31. In the context of gender dysphoria, the risks involved in hormonal treatment, gender reassignment surgery, or other treatments fall to be determined by medical professionals and gender-related specialists.
32. The clinician will need to disclose such risks that a reasonable person or the particular patient considering treatment for gender dysphoria would attach significance to. The assessment as to significance of risk is therefore fact-sensitive as well as sensitive to the characteristics of the patient.⁴³ It requires a balancing between the values of the particular patient as well as the values of a reasonable person in the patient’s position.⁴⁴
33. Notably, clinicians are entitled to withhold information about a risk from a patient if they reasonably consider that disclosure would be seriously detrimental to the patient’s health.⁴⁵

³⁹ *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, 587.

⁴⁰ *Montgomery* (n 34) [84].

⁴¹ Kenneth Boyd, ‘The Impossibility of Informed Consent?’ (2015) 41 *Journal of Medical Ethics* 44, 44.

⁴² Jonathan Herring and others, ‘Elbow Room for Best Practice? *Montgomery*, Patients’ values, and Balanced Decision-Making in Person-Centred Clinical Care’ (2017) 25 *Med LR* 582, 585.

⁴³ *Montgomery* (n 34) [89].

⁴⁴ Herring and others (n 41) 589, 591.

⁴⁵ *Montgomery* (n 34) [88].

ii) *Supported Decision-Making*

34. The court in *Montgomery* made it clear that the doctor-patient relationship is a dialogue, in which the doctor plays an advisory role.⁴⁶
35. The role of the doctor is to provide expert guidance to enable individuals to make their decision.⁴⁷ It is a model of consent based on autonomy through partnership, in which dialogue is essential.⁴⁸ Patients and clinicians are viewed as partners: where the clinician has a unique set of skills and clinical knowledge, while the patient is seen as having knowledge of their own beliefs, personal value systems, and conception of self with regard to 'gender identity'.⁴⁹
36. Informed consent is not a one-off event, but a continuing dialogue. Achieving such consent involves two conditions. Firstly, the provision of information about the consequences and known risks as well as the possibility of unknown risks. Secondly, the actual consent process, which requires a discussion over time as part of a trusting relationship.⁵⁰
37. As part of this dialogue, the doctor must take steps to ensure the information provided is comprehensible and understood by the patient. The doctor's duty will not be fulfilled where they have bombarded 'the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form'.⁵¹
38. It is therefore not enough for a clinician to merely recite all risks to the patient/parent or provide an information sheet and then ask for a signature on the consent form. The law requires doctors to maximise understanding of risks and treatment options to facilitate informed consent.

⁴⁶ *ibid* [78], [90].

⁴⁷ *ibid* [90].

⁴⁸ Herring and others (n 41) 588.

⁴⁹ Sarah L Schulz, 'The Informed Consent Model of Transgender Care: An Alternative to the Diagnosis of Gender Dysphoria' 58 *Journal of Humanistic Psychology* 72, 85.

⁵⁰ *ibid*; MD Kirby, 'Informed Consent: What Does It Mean?' (1983) 9 *J Med Ethics* 69, 71.

⁵¹ *Montgomery* (n 34) [90].

39. The Mental Capacity Act 2005 highlights the need for doctors to support and facilitate patient decision-making. It provides that:

A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).⁵²

40. Although this Act only applies to people who are older than 16 years of age, the idea of assisted decision-making can be used as a way to maximise autonomy and facilitate informed consent for all patients.⁵³

41. In the gender dysphoria context, the clinician will need to take reasonable steps to support the decision-making process of the child or youth. This will involve the clinician providing the information as to risks, benefits, and options in a way that is appropriate for the patient's circumstances, such as through simple language, leaflets, visual aids, or any other means.

⁵² s 3(2).

⁵³ s (2)(5); Herring and others (n 41) 592; *Re S (Child as Parent: Adoption: Consent)* [2017] EWHC 2729 (Fam).

II. CONSENT TO MEDICAL TREATMENT IN THE CONTEXT OF GENDER DYSPHORIA IN THE PROCESS OF TRANSITIONING

Question 2: Specifically, in the context of gender dysphoria: Summarise the legal position (statutory framework and case law) in England and Wales regarding consent to Stage 1 (suppression of puberty involving blocking hormones) and Stage 2 (administering hormones, either estrogen or testosterone) of transitioning.

a) Framework

42. There is no specific statutory framework governing consent to Stage 1 (suppression of puberty involving blocking hormones) or Stage 2 (administering hormones, either estrogen or testosterone) of transitioning for children. Rather, the Gender Identity Development Service (GIDS) for children and young people operates according to an NHS Standard Contract with a Service Specification that includes provisions on competence to consent based on the *Gillick* criteria.⁵⁴ Of particular note is that the level of understanding required for competence purposes will vary with the complexity and gravity of the decision, which might imply that a higher level of understanding is required for Stage 2 compared to Stage 1 treatment. The Service emphasises the need to understand the nature and consequences of each particular intervention. Furthermore, decisions regarding competence are made jointly by the endocrine and psychological members of the Service's integrated team. It is also noted that concerns with regard to the child's capacity to understand and consent could influence the complexity and length of a child's assessment.

b) Case Law

43. There is virtually no English case law on the matter of children's ability to consent to hormonal treatment in the context of gender dysphoria. In *Re J (A Minor)* it was established that it was not appropriate for a child to remain in the care of a parent who forced that child to live as the opposite gender.⁵⁵ Although this case did not involve surgery, it did establish

⁵⁴ NHS Standard Contract for Gender Identity Development Service for Children and Adolescents: Schedule 2 – The Services (NHS England, 2013) <<https://www.england.nhs.uk/wp-content/uploads/2017/04/gender-development-service-children-adolescents.pdf>> accessed 6 June 2018.

⁵⁵ *Re J (A Minor)* [2016] EWHC 2430 (Fam).

that a child should have a role in managing their own gender presentation. To do otherwise would be harmful to that child.

44. Relevant principles can also be extracted from other contexts. For example, it has been established that where a child lacks capacity to consent to a termination of pregnancy, the court may direct that a termination should take place. It may make such an order if the risk to the mental health of the child is greater by continuing rather than terminating the pregnancy, notwithstanding the wishes of the parents.⁵⁶ However, it may only do so where the child is accepting of and compliant with the termination and only the most clear and present risk to life would justify the use of force or restraint to compel compliance.⁵⁷ There must be more than mere acquiescence. As such, it is clear that where a child lacks capacity, the court may provide the necessary consent for treatment where the risks to the child's mental health are greater than if the treatment does not take place, regardless of the wishes of the parents.

i) *Australian Case Law on Court Authorization and Who Decides on Gillick-competence in Gender Dysphoria Cases*

45. This report focuses on the legal framework in the UK. However, due to the scarcity of case law on this matter in the UK, it appears necessary to look into Australian case law on this matter.

46. Australian courts have dealt with at least 64 cases on the issue of medical treatment of minors with gender dysphoria. Australian courts had previously held that at least Stage 2 treatment required court authorisation. That is no longer the case.

47. In *Re Kelvin*, the Australian Family Court (sitting as a Full Court) held that medical knowledge of gender dysphoria and its treatment had moved on to the extent that no court authorization was required, provided that the parents of a non-*Gillick*-competent child and

⁵⁶ *P (A Minor)*, Re 80 LGR 301.

⁵⁷ *In the matter of X (A Child)* [2014] EWHC 1871 (Fam).

the child's medical professionals agreed that such treatment was in the child's best interests.⁵⁸

The court considered the question:

why should the family of a child in one wing of the Hospital be forced to come to court before recommended medical treatment commences when the family of a child in another wing of the Hospital is not required to do so, in circumstances where both forms of treatment carry a significant risk of making the wrong decision as to a child's capacity to consent and with both forms of treatment the consequences of a wrong decision are particularly grave.⁵⁹

48. Having considered the medical evidence, the court held that '[t]he treatment can no longer be considered a medical procedure for which consent lies outside the bounds of parental authority and requires the imprimatur of the Court'.⁶⁰ In reaching this decision, the court noted that 'Between 31 July 2013 and 16 August 2017 the Family Court has dealt with 63 cases involving applications for either stage 2 or stage 3 treatment for Gender Dysphoria'.⁶¹ Treatment was allowed in 62 of those case (in the 63rd the young person had reached the age of 17 years and 11 months by the time of the hearing and, moreover, the court was not provided evidence as to their *Gillick*-competence). Furthermore, research into a sample of these cases showed that court proceedings were associated with an average of 8 months delay in treatment commencing, and considerable legal costs. The court also received evidence from the Royal Children's Hospital of Victoria which revealed:

96 per cent of all patients who were assessed and received a diagnosis of Gender Dysphoria by ... from 2003 to 2017 continued to identify as transgender or gender diverse into late adolescence. No patient who had commenced stage 2 treatment had sought to transition back to their birth assigned sex.⁶²

49. In reaching its decision in *Re Kelvin*, the court left open the possibility that court authorization may be needed 'where there is a genuine dispute or controversy as to whether

⁵⁸ *Re Kelvin* (n 1) [164].

⁵⁹ [116].

⁶⁰ Malcolm K Smith and Ben Mathews, 'Treatment for gender dysphoria in children: the new legal, ethical and clinical landscape' (2015) 202 (2) *Medical Journal of Australia* 102,

⁶¹ *Re Kelvin* (n 1) [51].

⁶² *ibid* [59].

the treatment should be administered’ such as if the parents, or the medical professionals were unable to agree.⁶³

50. Finally, the same line of Australian cases have been interpreted to mean that at least stage 2 gender dysphoria treatment fell into the category of cases ‘where there is the significant risk of making the wrong decision and the consequences of a wrong decision are particularly grave’, and for which it is appropriate for the court to determine *Gillick*-competence. The Full Family Court of Australia, however, found in the recent case of *Re Kelvin* that medical knowledge of gender dysphoria has now advanced to the point that neither Stage 1 nor Stage 2 treatment fall into this category. Hence, court determination of *Gillick*-competence is neither required nor appropriate, and this a matter of medical judgment.⁶⁴

⁶³ *ibid* [167].

⁶⁴ *Re Kelvin* (n 1) [181]-[182], see [188]-[189] for an alternative judicial statement of the previous case law.