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R v Tavistock, Gender Dysphoria and Children: puberty blockers "interlinked" with cross-sex hormones such that informed consent extends to understanding future physical consequences of treatment; under 16s "highly unlikely" to be *Gillick* competent

Introduction

In *R v Tavistock*[1], the UK High Court has held that treatment for Gender Dysphoria ("**GD**") is contingent on court approval by finding that puberty blockers are "*interlinked*" with cross-sex hormones, such that informed consent of young trans patients extends to an understanding of complex future physical consequences of treatment. Medical matters directed to future loss of fertility and sexual fulfilment were considered to be beyond age-appropriate explanation and the contemporary comprehension of children, such that informed consent is impossible.

Further, the Court determined that the experimental yet lifelong and lifechanging treatment renders it "*highly unlikely*" that under 13s would ever be *Gillick*[2] competent, and "*very doubtful*" that persons under 15 could demonstrate the requisite understanding to give consent. Despite a presumption of capacity for over 16s, court authorisation for treatment is appropriate. An appeal of this decision is foreshadowed.

Young patients[3] and gender dysphoria

Two claimants applied to the High Court to review the lawfulness of the practice of UK's only specialised gender clinic for children, the Gender Identify Development Service ("**GIDS**"), [4]prescribing puberty blocking drugs ("**PBs**") to children and young persons[5] with GD. The Court examined the medical classification of GD, noting that GD is a psychological condition[6] where the person experiences significant distress and problems functioning because of a mismatch between their perceived identity and their natal (naturally assigned) sex[7]. To fulfil this classification, children must display a "*strong desire to be of the other gender, or an*

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[1] *R (Quincy Bell) and A v Tavistock and Portman NHS Foundation* Trust [2020] EWHC 3274 (Admin) ("Tavistock").

[2] Gillick competency refers to the precedential common law test elucidated by the House of Lords in *Gillick v West Norfolk* and Wisbech Health Authority [1986] AC 112 for assessing whether a child under 16 can legally consent to medical treatment, as accepted by the High Court of Australia in Re Marion, Secretary of the Department of Health and Community Services v JWB and SMB, (1992) 175 CLR 218. Parental responsibility terminates when the child "achieves sufficient understanding and intelligence to understand fully what is proposed", citing Lord Scarman.

[3] 'Young patients' collectively refers to children and young persons, see below n 5.

[4] The defendants are collectively referred to as 'GIDS' by the Author. GIDS is run by The *Tavistock and Portman NHS Trust* and has been operating since 1989 following commissioning by the National Health Service Commissioning Board. See above n 1, at [13] – [17] for further information as to the relationship and purpose of each body.

[5] Above n 1, at [11]: references to "child" or "children" relates to under 16s, and "young person(s)" are those between 16 – 18 years.

[6] GD is recognised in the Diagnostic and Statistical Manual of Mental Disorder (DSM-5), published by The American Psychiatric Association (APA) in 2013 and updated in 2020. GD is an overarching diagnosis with specific criteria for children and for adolescents and adults, of which at least two must persist, for at least 6 months, see Above n 1, at [12].

[7] Above n 1, at [3].

insistence that one is the other gender."[8] As age increases, so too does the permeating threshold on the psyche.[9]

Paradoxically, the condition has no direct physical manifestations, however treatment has direct physical consequences.[10] Stage 1 involves the use of PBs to halt the development of natal sex characteristics, the effects being reversible. Stage 2 comprises the administration of cross-sex hormones ("**CSH**") which can only be prescribed from 16-years to induce feminine or masculine development, with irreversible features. Lastly, Stage 3 is gender reassignment surgery which is only available to over 18s.[11]

The claimants covered a wide field of experience with GIDS. Quincy [Keira] Bell had herself undergone the full spectrum of gender reassignment treatment, and as at 2019, had begun the process of de-transitioning following the realisation that her desire to be male was "*strictly a fantasy and that it was not possible*" and that she lacked some 'unspoken code' that cannot be medically implanted.[12] The second claimant, Claimant A, was the mother of a 15-year-old autistic girl, not yet referred to GIDS, but who she believed to be at risk of undergoing a sex change without understanding the implications.[13] The Court heard from a number of young persons with differing experiences and motivations for GD treatment.[14] A common theme in the evidence was a distraction by the immediate psychological condition, rather than full consideration of the future physical implications of treatment.[15]

GIDS does not themselves provide treatment for GD, rather they counsel, assess and consent young patients who are referred to the Service.[16] If appropriate, GIDS then on-refers the young patient to one of two separate endocrine services for treatment, both being NHS Trusts ("**treatment Trusts**").[17] Evidence revealed that children as young as 10 years old had been provided services by GIDS, and the treatment Trusts.[18] More than 50% of the 161 referrals to GIDS in the year 2019/20 were under the age of 16,[19] 76% of all referrals were natal females,[20] and a disproportionate number referrals also had an autistic spectrum disorder.[21]

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[8] Above n 1, at [3].

[9] Above n 1, at [12]: adolescents and adults are required to demonstrate a *"marked incongruence"* between one's experienced and expressed gender and a *"strong conviction"* that one
has feelings/reactions typical of the other gender.

[10] Above n 1, at [135].

[11] Above n 1, at [15].

[12] See above n 1, at [78]–[83]: for the evidence provided by Bell at hearing, including commencement of puberty blockers at age 15 following referral to GIDS.

[13] Above n 1, at [89].

[14] Above n 1, at [85]–[89].

[15] One witness gave evidence that his decision to commence PBs at age 12 was made without full consideration of future issues because *"I had a poor quality of life and without immediate treatment I did not feel I had a future at all"*. The same witness said discussions as to sex at age 12 *"disgusted"* him — see above n 1, at [86]. Another witness remarked at age 13 that romantic relationships were not on his radar — see above n 1, at [87].

[16] Above n 1, at [16]: *"GIDS takes referrals from across England and Wales and from a wide range of professionals in health, social services and education sectors, and the voluntary sector".*

[17] Being the University College London Hospitals NHS Foundation Trust or Leeds Teaching Hospitals NHS Trust.

[18] Above n 1, at [29]–[30].

[19] Above n 1, at [29].

[20] Above n 1, at [32].

[21] Above n 1, at [33].

Informed consent

The claimants contended that the practice of prescribing PBs to persons under 18 years was unlawful on the basis that the information provided by GIDS to young trans patients in respect of the treatment is "*misleading and insufficient*", such that informed consent could not be given.[22]

GIDS maintained that their consent process[23] was sound on the basis that it was a "*discursive and iterative one that involved multiple discussions and answering any questions*" the young patients (or their parents) might raise.[24] If *Gillick* competency cannot be reached initially, more time, information and counselling is provided until the requisite maturity is reached. The information provided by GIDS broadly acknowledged that consequences of treatment can be life changing, that there is limited scientific evidence for treatment, and that a person may not continue to identify as transgender in the future.[25]

In assessing one's ability to achieve *Gillick* competency, the Court found that treatment stages 1 and 2 were "interlinked" such that the young patient needed to demonstrate that they understood "*not simply the implications of taking PBs but those of progressing to cross-sex hormones*".[26]

The fullness of the information provided to young patients was found to be insufficient to allow them to understand, retain and weigh the eight material factors identified by the Court as demonstrable of the requisite understanding of PBs, being:[27]

- the immediate physical and psychological consequences;
- the fact that PBs are considered to be a pathway to much greater medical interventions;
- the relationship between CSH and further surgery, and the implications of the same;
- the fact that CSH may lead to infertility;
- impacts of CSH on sexual function;
- impacts on future and life-long relationships;
- the unknown physical consequences of PBS; and
- the highly uncertain evidential basis for treatment.[28]

Then Court concluded that there is no age-appropriate way to explain to vulnerable young patients what losing their fertility or full sexual function may mean to them in later years.[29] The answer, the Court noted, was not "*simply to give the child more, and more detailed, information*" [30] The Court noted that a young patient may understand the conceptual impacts of treatment, but this is not the same as understanding how this will affect their adult life. A child's attitude to biological options (such as the ability to conceive or

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[22] Above n 1, at [7].

[23] The consent relationship between GIDS and the respective treatment Trusts is somewhat muddy and artificial in that GIDS obtained consent to *refer* the young patient to a further service
having (allegedly) put them in a position to provide informed consent to treatment. Further counselling and information are then provided to the young patient by the treatment Trusts,
at which time informed consent for *treatment* is obtained.

[24] Above n 1, at [39].

[25] Above n 1, at [37].

[26] Above n 1, at [138].

[27] Above n 1, at [138].

[28] Above n 1, at [138].

[29] Above n 1, at [144].

[30] Above n 1, at [144].

birth children, including by way of egg or sperm preservation) are likely to change between childhood and adulthood.[31] Further, the Court acknowledged the psychological vulnerability of the subject cohort rendered it possible that their decision to commence treatment could be influenced by their immediate distress, rather than a meaningful consideration of longer-term effects.[32]

A further complicating factor identified by the Court in respect of achieving informed consent was the lack of evidence as to the efficiency of PBs in treating GD. The mere fact that a treatment is experimental does not prevent valid consent, however the combination of lifelong and lifechanging being offered to children is cause for concern.[33] In these circumstances, the provision of more and more information to a young patient is not sufficient to cure consent. This is because there is no age appropriate way to explain certain implications of treatment that only manifest later in life.[34]

Further, the Court concluded that it would be "*highly unlikely*" that a 13 year old child would ever be *Gillick* competent, and "*very doubtful*" that those aged 14 or 15 would understand the long-term risks.[35] Persons aged 16 and over are in a different legal position as there is a presumption of capacity.[36] So long as the young person has mental capacity and the medical opinion is that the treatment is their best interests then, absent a dispute with a clinician or parent, the Court generally has no role to play other than its inherent jurisdiction in respect of specific medical matters, which in the circumstances of PBs is appropriate and protective.[37] The Court based this commentary on the fact that the treatment involved is "*truly life changing, going as it does to the very heart of an individual's identity*" and is presently best categorised as experimental or innovative in the sense that there is limited evidence of the efficacy or long term effects.[38]

Implications of *Tavistock*

The Court confirmed in *Tavistock* that *Gillick* competency is the appropriate test in determining whether informed consent for treatment has been given. That test has always been treatment and person specific.[39] *Tavistock* does not adhere to this principle for obvious reason; rather it provides judicial commentary as to the requirements for informed consent in respect to a vulnerable cohort.[40]

Clear and critical judicial statements are made as to the capacity of this cohort to understand the future sexual implications of treatment which arises due to an apparent psychological barrier to matters which "*disgust them*" at the relevant time.[41] Their significant psychological distress may render certain physical risks as 'a small price to pay' for what is perceived as an immediate solution to their immediate and real psychological distress.[42] In this way, the Court recognised the potential that attitudes to future biological

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[31] Above n 1, at [139].
[32] Above n 1, at [142].
[33] Above n 1, at [143].
[34] Above n 1, at [143].
[35] Above n 1, at [145].
[36] Above n 1, at [146].
[37] Above n 1, at [149].
[38] Above n 1, at [148].
[39] Above n 1, at [145].
[40] Above n 1, at [145].
[41] Above n 1, at, [141].
[42] Above n 1, at [142].

risks may change between childhood and adulthood, notwithstanding that the primary diagnosis may persist.[43]

For this reason, the Court did not think competency could be cured by the provision of more and more information until the requisite maturity is reached.[44] Rather, setting out a more onerous threshold, which covers both direct and indirect consequences,[45] provides surety that relevant and material matters are understood and weighed in order for consent to be valid.

Linking treatment stages together, such that they are indivisible from a consent perspective is framed by the Court as the "reality" of treatment.[46] It is a contentious approach and has been foreshadowed by the defendant as forming the basis of an appeal.[47]

Australian position

Such an appeal could find support in the Australian position.[48] Building on cases before it, the decision of *Re Jamie*[49] determined that treatment for stage 1 of gender dysphoria with PBs was therapeutic, such that there was no significant risk of making the wrong decision, which itself would not be grave if made.[50] In this way, treatment stages were interpreted as entirely divisible and not contingent on an understanding of further risks and implications arising at an unknown time in the future. Prior to this decision, court authorisation for PBs and cross-sex hormone therapy was required.[51] While *Re Jamie* is not that simplistic, the fundamental interpretation of consent differs from the judicial conclusion in *Tavistock*.

Further, *Tavistock* recommends court authorisation to resolve a young person's *Gillick* competency as best practice. In contrast, the Australian judicature are clear that only disputed cases are appropriate for determination on the basis that "*it would be contrary to the Convention on the Rights of the Child, and to autonomous decision making to which a Gillick competent child is entitled, to hold that there is a particular class of treatment… [for GD], that disentitles autonomous decision making… whereas no other medical procedure does*".[52] Decisions as personal and essential to the perception of one's gender and sexuality 'would be the very exemplar' of when the rights of the *Gillick* competent child should be given full effect.[53]

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[43] Above n 1, at [139].

[44] Above n 1, at [144].

[45] Above n 1, at [136]: The court considered the evidence to show that once a young patient is commenced on PBs, it is *"extremely rare"* for a child to get off that pathway (to cross-sex hormones).

[46] Above n 1, at [136].

[47] The *Tavistock and Portman NHS Foundation Trust* website, *"Update on GIDS Judicial Review and timetable for clinical reviews, 22 December 2020"*, accessed 1 February 2021: tavistockandportman.nhs.uk/about-us/news/stories/update-gids-judicial-review-and-timetable-clinical-reviews-22-december-2020/

[48] For a comprehensive overview of the legal responses to medical treatment of young transgender people in Australia, see The Hon Justice Steven Strickland, Judge of the Appeal Division and Chair, Law Reform Committee, Family Court of Australia, *"To treat or not to treat: legal responses to transgender young people"* (paper presented to the Association of Family and Conciliation Courts 51st annual conference, Canada, May 2014).

[49] *Re Jaime* [2011] FamCA 248; *Re Jaime* (2013) 278 FLR 155; 50 Fam LR 369; [2013] FamCAFC 110; BC201350653; *Re Jaime* [2015] FamCA 455; BC201550521.

[50] *Re Jamie* [2015] FamCA 455; BC201550521 at [10], referring to precedential statements set out in *"Marion's case"*; *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218. See also HLB 26.2, *from Re Jamie to Re Kelvin: access to gender dysphoria treatment for transgender*, Luke McLean.

[51] See specifically *Re Alex* (2004) 31 Fam LR 503; [2004] FamCA 297.

[52] *Re Jamie* (2013) 278 FLR 155; 50 Fam LR 369; [2013] FamCAFC 110; BC201350653 at [134] per Bryant CJ.

[53] Above n 52, at [135] per Bryant CJ.

Further commentary on the UK decision, and its biopolitical implications for young trans persons, is expected.

This article was originally published by Australian Health Law Bulletin. This article was written by Principal Andrew Saxton and Associate Lauren Biviano. Please contact them if you have any questions or would like more information.

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