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Health Insights

UK: Court of Appeal overturns controversial finding that under-16s cannot give informed consent to treatment with puberty blockers for gender dysphoria; attempt to restrict the *Gillick* test by elucidating a clinical checklist for consent deemed "inappropriate"

The UK Court of Appeal[1] has overturned the controversial decision of *Bell v Tavistock*[2] in which the High Court (by its Divisional jurisdiction)[3] found that court approval was required for all young trans patients[4] prior to the commencement of treatment with puberty blockers[5] on the basis that it was "*very doubtful*"[6] that under-16s could understand, retain and weigh up[7] various factors[8] identified by the court as demonstrative of informed consent in circumstances where they deemed the treatment to be experimental, lifelong and lifechanging.[9]

The Appeal found that the *Gillick* test[10] had been improperly restricted[11] by the judicial declaration and guidance, which were themselves unwarranted and inappropriate having regard to the evidence and well-established legal principles and medical safeguards.

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[1] *Bell and another v Tavistock and Portman NHS Foundation Trust (University College London Hospitals NHS Foundation Trust and others intervening)* [2021] EWCA Civ 1363; [2021] All ER (D) 36 (Sep) *("Appeal")*.

[2] *Bell and another v Tavistock and Portman NHS Foundation Trust (University College London Hospitals NHS Foundation Trust and others intervening)* [2020] EWHC 3274 (Admin) [2021] PTSR 593, 177 BMLR 115; [2020] All ER (D) 30 (Dec) ("*Tavistock*").

[3] The Divisional Court refers to the constitution of the High Court when sitting with two or more judges.

[4] Reference to "young trans patients" refers to children and young persons under the age of 16, which is consistent with the interpretation in *Tavistock*, above n 2, at [11].

[5] Above n 2, at [145].

[6] Above n 2, at [145] [emphasis added].

[7] Above n 2, at [138].

[8] The "*Bell competency factors*" are those set out at para [138] of the *Tavistock* judgment, above n 2.

[9] Above n 2, at [134].

[10] *Gillick* competency refers to the precedential common law test elucidated by the House of Lords in *Gillick v West Norfolk & Wisbech Area Health Authority* [1986] AC 112; [1985] 3 All ER 402; [1985] 3 WLR 830 for assessing whether a child under 16 can legally consent to medical treatment, as accepted by the High Court of Australia in *Dept of Health and Community Services (NT) v JWB and SMB (Marion's case)* (1992) 175 CLR 218; (1992) 106 ALR 385; (1992) 15 Fam LR 392; (1992) FLC 92-293; [1992] HCA 15. Parental responsibility terminates when the child "*achieves sufficient understanding and intelligence to understand fully what is proposed",* citing Lord Scarman (at [1985] 3 All ER 402 at 423 [emphasis added]).

[11] Above n 1, at [9].

An appeal to the Supreme Court has been foreshadowed by Bell, one of the original claimants, alleging a fundamental fallacy of consent.

First instance decision[12]

Tavistock was a judicial review case brought by two claimants alleging (for different reasons), that the UK's only specialised gender clinic for children, the Gender Identify Development Service ("**GIDS**")[13] had failed to protect young patients who sought its services. That failure related to alleged unlawfulness in the practice of prescribing puberty suppressing medication to under-18s on the basis that valid consent could not be given to treatment and a court order was required in all circumstances.[14]

The first-instance decision sparked intense debate owing to its reversion of well-established rights for competent children to determine their own health care (in concert with their families and clinicians) in circumstances that openly discriminated against trans and non-binary children alone.

The Court of Appeal distilled the pertinent aspects of the judgment under review into three parts:

1. The Central Question — stated at para [6] of that judgment as: *"whether informed consent in the legal sense can be given by such children and young persons."*[15]
2. The Declaration — stated at para [138] of that judgment as:

> *to achieve Gillick competence . . . a child would have to understand, retain and weigh up . . . (i) the immediate consequences of the treatment in physical and psychological terms; (ii) the fact that the vast majority of patients taking [puberty blockers] go on to [cross-sex hormones] and therefore that s/he is on a pathway to much greater medical interventions; (iii) the relationship between taking [cross-sex hormones] and subsequent surgery, with the implications of such surgery; (iv) the fact that [cross-sex hormones] may well lead to a loss of fertility; (v) the impact of [cross-sex hormones] on sexual function; (vi) the impact that taking this step on this treatment pathway may have on future and life-long relationships; (vii) the unknown physical consequences of taking [puberty blockers]; and (viii) the fact that the evidence base for this treatment is as yet highly uncertain.*[16] [emphasis added]

3. The Guidance — stated at para [145] of that judgment as:

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[12] See earlier article for full discussion: L Biviano and A Saxton "*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" (2021) 29(2) *HLB* 22.

[13] 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 2, at [13]–[17] for further information as to the relationship and purpose of each body. If appropriate, GIDS on-refers the young patient to one of two separate endocrine services for treatment, both being NHS Trusts ("treatment Trusts"). For the purpose of this article, the author collectively refers to these separate but linked treatment services as "*The Service*".

[14] Above n 1, at [14].

[15] Above n 2 [emphasis added].

[16] Above n 2.

> *[t]he conclusion we have reached is that it is highly unlikely that a child aged 13 or under would ever be Gillick competent to give consent to being treated with [puberty blockers]. In respect of children aged 14 or 15 we are also very doubtful that a child of this age could understand the long-term risks and consequences of treatment in such a way as to have sufficient understanding to give consent.*[17] [emphasis added]

Appeal

The Service appealed the primary decision and elucidated eight grounds of appeal. A number of those submissions focused on the Declaration and Guidance as being wrong in law, specifically that the Divisional Court had misapplied the law in *Gillick* and the statutory presumption of competence for minors over 16 years.

Further, it was submitted that the Divisional Court had relied on contradictory evidence to resolve clinical differences of opinion, which is outside the bounds of the judicial remit generally. It was further alleged that the primary outcome was discriminatory and in breach of Human Rights Conventions.[18]

The evidence

The Appeal Court found that unsupported factual conclusions[19] had been made as to the experimental nature and permanency of treatment based on evidence that was procedurally defective and controversial, not only in its content (which was argumentative and adversarial)[20] but because it directly contradicted the evidence of a public authority[21] and did not comply with the rules relating to expert evidence.[22]

Despite the Divisional Court recognising that it was not their role to "determine clinical disagreements between experts about the efficacy of a treatment"[23] or make conclusions about the short- or long-term benefits or disbenefits of such treatment[24] to this specific cohort of children, the Divisional Court indulged in conclusions based on "*strong impressions*"[25], resulting in affirmative statements of fact including that:

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[17] Above n 2.

[18] Above n 1, at [12], noting that the Court of Appeal did not deal with the issue of discrimination on the basis that it found the Declaration and Guidance to be inappropriate—see above n 2, at [90].

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

[20] Above n 1, at [38].

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

[22] Above n 1, at [38].

[23] Above n 1, at [31], citing above n 2, at [9], [70] and [74].

[24] Above n 1, at [32], citing above n 2, at [9].

[25] Above n 1, at [33] [emphasis added].

> practically all children/young people who start [puberty blockers] . . . in statistical terms . . . are on a very clear clinical pathway to [cross-sex hormones][26]

the former being "a very unusual treatment"[27] and may be "supporting the persistence of [gender dysphoria]".[28]

In contrast, the Service produced evidence that puberty blockers were safe, internationally endorsed, reversible and subject to a rigorous assessment process at each stage.[29] Statistically, only 16% of all referrals to the Service were treated with puberty blockers, and of that cohort only 55% progressed to cross-sex hormones.[30] Further, it was accepted by the Divisional Court — and not challenged on appeal — that the policies and practices of the Service were not unlawful, and the information provided by the Service was not misleading.[31]

The Court of Appeal concluded that the Divisional Court erred in admitting and relying on evidence adduced by the claimants, which erroneously bolstered the Divisional Court into making the Declaration and Guidance in circumstances where they were ill-equipped[32] to grapple with the real issues. This led them into the great danger of enunciating principles that have the effect of confusing those who are obliged to implement those principles, or be affected by their application, in a practical sense.[33]

The Declaration

Declarations are themselves legal remedies used in the resolution of disputes of considerable public importance on the basis that it pronounces the legality of a future situation and so avoids unlawful actions before they are taken, or repeated, on a systemic level.[34] *Gillick* is a good example, and one that is referred to by the Appeal Court for obvious reason. The Declaration made in this instance however is fundamentally different as it turns expressions of judicial opinion into a statement of law itself. In addition, it states facts as law which are both controversial and capable of change.[35]

Succinctly stated, the Court of Appeal recognised that the Declaration:

> not only states the law but also identifies an exhaustive list of the factual circumstances that must be evaluated in seeking consent from a child and specifies some matters as conclusive facts. It comes

[26] Above n 1, at [34].

[27] Above n 1, at [35].

[28] Above n 1, at [36].

[29] Above n 1, at [75].

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

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

[32] Above n 1, at [65].

[33] Above n 1, at [77].

[34] Above n 1, at [68].

[35] Above n 1, at [80].

> close to providing a checklist or script that clinicians are required to adopt for the indefinite future. . .[36]

and

> would require the clinicians to suspend or at least to temper their clinical judgement and defer to what amounts to the clinical judgement of the court on which key features should inform an assessment of Gillick competence. . .[37]

The fundamental inconsistency is striking. *Gillick* itself stands for the principle that it is a "matter of clinical judgement, tailored to the patient in question, how to explain matters to ensure that the giving or refusal of consent is properly informed."[38] Enunciation of specific judicial observations into formal declarations would have been inappropriate[39] and inconsistent with the *ratio* that clinicians must be trusted to make the decisions, themselves being vulnerable to disciplinary sanction if not properly obtained,[40] for the court to effectively give them a manual about how to do so.[41]

Unsurprisingly, the Court of Appeal ruled that the Declaration should not have been granted.[42]

The Guidance

The effect of the Guidance was to establish a new norm[43] requiring court approval in all cases of a young trans person seeking access to puberty blockers despite the Divisional Court recognising that there was no legal obligation to do so.[44]

On Appeal, it was found that the Divisional Court erred by not taking into account binding precedent that a minor's capacity to make autonomous decisions as to his or her own health care depends on the individual's understanding and intelligence and is not to be determined by reference to judicially fixed age limit.[45] Any rigid demarcation necessary to achieve certainty is a matter for parliament and legislation.[46]

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[36] Above n 1, at [70].

[37] Above n 1, at [75].

[38] Above n 1, at [81].

[39] Above n 1, at [81].

[40] Above n 1, at [80].

[41] Above n 1, at [80].

[42] Above n 1, at [84].

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

[44] Above n 1, at [86].

[45] Above n 1, at [88], citing Lord Scarman's dictum in *Gillick* at 188B.

[46] Above n 1, at [88], citing Lord Scarman's dictum in *Gillick* at 186C.

The Court of Appeal concluded that it was inappropriate for the Divisional Court to give the Guidance concerning when a court application will be appropriate and to reach general age-related conclusions about the likelihood or probability of different cohorts of children being capable of giving consent.[47]

That is not to say an application will never be appropriate.[48] It is recognised that treatment of children for gender dysphoria is controversial and the subject of intense professional and public debate over medical, moral and ethical issues.[49] It is not unfathomable that instances of disagreement may arise by or within families and/or the treating clinicians. In those circumstances, a "best interests" application is warranted, and consistent with related doctrines including parental consent.

Parental responsibility and consent

Interestingly, the Divisional Court largely dismissed any substantive discussion of parental consent on the basis that the Service's policy required consent of the child themselves before any treatment would be instituted or continued. In this way, the judgment was insufficiently sensitive to the role of parents in giving consent.[50]

The original decision caused great difficulty for young trans people suffering gender dysphoria, their parents, and clinicians.[51] This in turn led to the related proceedings of *AB v CD and others*[52] which is cited in the Appeal judgment.[53] That decision acknowledged the established principles of parental responsibility and found no reason in law why that doctrine could or should not apply to treatment with puberty blockers, especially in cases where the child, their parents, and clinicians agree that treatment is in the best interests of the child.[54]

Fallacy of consent

Kiera Bell, claimant turned gender activist, has written[55] insightfully about her experience and the difficulties of accepting that a young person struggling with gender incongruence can give informed consent to treatment, often when they are at the height of their physiological and psychological distress. Now in her

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

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

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

[50] Above n 1, at [88].

[51] Above n 1, at [86].

[52] [2021] EWHC 741 (Fam); 179 BMLR 139.

[53] Above n 1, at [47]–[51].

[54] See earlier article for full discussion: L Biviano and A Saxton "UK: Winding back *Bell v Tavistock*; High Court affirms that parents can consent to puberty blockers on behalf of their children, which are not (of themselves) part of any 'special category' of treatment requiring court approval" (2021) 29(4) *HLB* 54.

[55] "Kiera Bell: My Story", *Persuasion Community*, published 7 April 2021 online at: www.persuasion.community/p/keira-bell-my-story. (NB – check font style and size – inconsistent with other footnotes)

early 20s, Bell is de-transitioning to her natal sex and regrets the choices she made at 16 years when confronted with her diagnosis and the "gender affirmative care" model employed by the Service, and generally gaining uptake internationally.[56]

As reported by BBC News on 1 March 2020, Bell believed that the Service should have "challenged her more on the things she was saying," but instead she was "allowed to run with this idea that (she) had, almost like a fantasy, as a teenager . . . and it has affected (her) in the long run as an adult". Bell feverishly voiced her dissatisfaction at the outcome of the appeal and has foreshadowed a last-ditch application to the Supreme Court stating that "it is a fantasy and deeply concerning that any doctor could believe a 10-year-old could consent to the loss of their fertility."

"Consent" itself is a legal term that focuses on an intellectual process rather than the merits of a decision. To anchor one's view on moral or ethical arguments as to whether a child *should* be able to consent to treatment misses the point. The relevant question is can they make decision for their own body in a legal sense.

As with the Declaration and Guidance, conclusive statements such Ms Bell's are apt to simplify complex issues to a degree that exposes the vulnerability of a static perspective. Both the Divisional Court and Bell fail to acknowledge that trans children do not make decisions in isolation, but rather as one part in a chain of consent. That chain starts and ends with the child but is linked by their caregivers and clinicians.

One thing that Ms Bell cannot be challenged on is the fact that "a global conversation has begun and has been shaped by this case. There is more to be done". [57]

Developments in Australia for young trans patients

That conversation is ardent in Australia given the growing global awareness and politicisation of the trans experience, including in respect of healthcare. It is a hotly contentious topic and one that has not always been correctly resolved. Only two years ago, Prime Minister Scott Morrison dismissed the worrying trend of suicide in trans and gender diverse young people as suffering the "pressures of identity politics,"[58] which was reported internationally[59] and only increased the debate globally about a lack of understanding and empathy for trans issues.

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[56] Including in the provision of paediatric care in America in accordance with the Policy Statement of the American Academy of Paediatrics: *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, online, 1 October 2018, accessed on 10 Dec 2021 at: https://publications.aap.org/pediatrics/article/142/4/e20182162/37381/Ensuring-Comprehensive-Care-and-Support-for.

[57] The Guardian "Appeal court overturns UK puberty blockers ruling for under-16s: Tavistock and Portman NHS foundation trust wins challenge over case brought by Keira Bell last year", published 18 September 2021, accessed online on 9 Dec 2021 at: www.theguardian.com/society/2021/sep/17/appeal-court-overturns-uk-puberty-blockers-ruling-for-under-16s-tavistock-keira-bell.

[58] "Identity Politics" is defined (by Merriam-Webster Dictionary) as a politic movement in which groups of people having a particular racial, religious, ethnic, social, or cultural identity tend to promote their own specific interests or concerns without regard to the interests or concerns of any larger political group.

[59] The Guardian "Scott Morrison criticised after saying transgender teens pressured by 'identity politics': Prime minister's comments described as 'inaccurate, dismissive and patronising", published 9 October 2019, accessed online on 10 Dec 2021 at:

Medical recognition

It is well recognised that the trans and gender diverse population are at an increased risk of harm because of discrimination, social exclusion, bullying, physical assault and even homicide.[60] Serious psychiatric morbidity is seen in children and adolescents with a recent study suggesting that more than 70% of Australian trans adolescents suffer depression and/or anxiety, and close to 80% have engaged in self-harm.[61] Often their symptomology is exacerbated by unequal access to health care, including mental health services.

The *Australian Standards of Care and Treatment Guidelines for trans and gender diverse children and adolescents* (2020)[62] recognises that supportive, gender affirmative care can ameliorate harms and significantly improve mental harm outcomes for young trans patients.[63]

That approach is endorsed[64] by Australia's peak professional body for Trans Health (**AusPATH**) and is described as:

> a non-judgemental, respectful, shared-decision making model to support a person in their gender in a way that is tailored to their individual needs. Shared-decision making draws on and respects the ability and agency of most clients, including many trans youth, to provide informed consent for their healthcare.[65]

It is further acknowledged that despite widespread professional and scientific consensus on gender affirming healthcare, accessible multi-disciplinary services for trans youth in Australia is sparse, and there remains a dearth of gender affirming GPs in the primary care system.[66]

Despite that veiled criticism, general practitioners do not typically receive education regarding gender diversity despite the increasing number of trans and gender diverse patients presenting to general practices.[67] GPs represent the first point of entry into the healthcare system and have a vital role to play in reducing

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www.theguardian.com/society/2019/oct/09/scott-morrison-criticised-after-saying-transgender-teens-pressured-by-identity-politics.

[60] M Telfer et al, *Australian Standards of Care and Treatment Guidelines for trans and gender diverse children and adolescents*, Version 1.3, Melbourne: The Royal Children's Hospital; 2020, 2 accessed 9 Dec 2021 at www.rch.org.au/uploadedFiles/Main/Content/adolescent-edicine/australian-standards-of-care-and-treatment-guidelines-for-trans-and-gender-diverse-children-and-adolescents.pdf.

[61] Above n 60.

[62] Above n 60.

[63] Above n 60.

[64] "AusPATH: Public Statement on Gender Affirming Healthcare, including for Trans Youth" published 26 June 2021, accessed 9 Dec 2021 at: https://auspath.org.au/2021/06/26/auspath-public-statement-on-gender-affirming-healthcare-including-for-trans-youth/.

[65] Above.

[66] Above.

[67] Either during medical study or offered as Continuing Development modules.

barriers to health care and supporting patients on their gender journey.[68] However, there exists a competing risk that unsympathetic care — such as misgendering a patient— may deter them from seeking follow-up care[69] and thus strengthen the existing barriers.

It is not the case that the gender affirming model facilitates easier access to treatment, or that the assertions as to gender distress are treated as conclusive of a diagnosis and requiring of treatment. Rather, a recent Position Statement[70] published by The Royal Australian and New Zealand College of Psychiatrists (**RANZCP**) recognises the ethical and medicolegal dilemmas in relation to medical and surgical treatment of people experiencing gender dysphoria, the diagnostic research of which is still emerging. Further, there is a need for better evidence in relation to outcomes for children and young people, including further research into the long-term effects of medical and surgical affirming treatment. Such research is supported by the College and is critical for ensuring safe access to evidence-based therapies.

Legal landscape

Gillick is good law is Australia and applies to all forms of medical treatment.[71] Consistent with the international approach, treatment for gender dysphoria in Australia occurs in three stages, each progressively more invasive and irreversible.[72]

Current law in Australia requires the medical practitioner to ascertain whether the parent or guardian consents to treatment before an adolescent can access either puberty blockers[73] or hormone therapy.[74] Where there is no disagreement as to competency, diagnosis or treatment between the parents, the adolescent or the medical practitioner, the clinician can proceed based on the child's consent (if deemed *Gillick* competent) or parental consent.[75] If there is a dispute as to either competence, diagnosis or treatment, it must go to the Family Court prior to commencement of any treatment.[76]

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[68] M Liotta "Healthcare barriers a 'peak risk' for transgender people", *News GP*, published 7April 2021, accessed 10 Dec 2021 at: www.racgp.org.au/newsgp/clinical/barriers-to-accessing-care-peak-risk-times-for-tra.

[69] P Strauss et al "Supporting the health of trans patients in the context of Australian general practice" (2020) 49(7) *Australian Journal of General Practice* 401, accessed 10 Dec 2021 at: www.racgp.org.au/ajgp/2020/july/supporting-the-health-of-trans-patients-in-the-con.

[70] RANZCP, "Recognising and addressing the mental health needs of people experiencing Gender Dysphoria/Gender Incongruence" (Position Statement 103,August 2021), accessed 10 Dec 2021 at: www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/gender-dysphoria.

[71] Above n 1, at [57].

[72] Above n 1, at [16].

[73] *Jamie, Re* (2013) 278 FLR 155; (2013) 50 Fam LR 369; [2013] FamCAFC 110; BC201350653.

[74] *Kelvin, Re* (2017) 351 ALR 329; (2017) 327 FLR 15; (2017) 57 Fam LR 503; (2017) FLC ¶93-809; [2017] FamCAFC 258; BC201750980.

[75] *Imogen (No 6), Re* (2020) 61 Fam LR 344; [2020] FamCA 761; BC202050852.

[76] Above n 73, confirming *Re Jamie* and *Re Kevin*. Noting that since 1 Sept 2021 the Family Court of Australia is now titled Federal Circuit and Family Court of Australia. See generally, www.fcfcoa.gov.au/fl/pd/fam-medical.

Most recently, the Family Court has confirmed that where parents disagree (as between themselves) as to treatment for gender dysphoria, one parent can effectively withdraw their parental rights and so vest those rights exclusively in a single parent on a continuing basis enabling them to consent to multi-stage treatment for gender dysphoria on behalf of their child. The case of *Re Jesse*[77] arose in circumstances where *Gillick* competency was not in question, but the child's father did not consent to stage 1 (puberty blockers) and stage 2 (cross-sex hormones) treatment and otherwise did not engage with the court authorisation process. The Family Court found that the best interests of the child were promoted by allocating sole parental responsibility to the mother, which permits her to authorise treatment in accordance with prior case law.

Concluding comment

Medical practitioners ought to be aware of the constant state of flux of emerging research as to the efficacy of treatment and are encouraged to keep up to date with scientific and social developments to provide supportive care to the gender diverse cohort. Both medical and legal practitioners will continue to look to *Gillick* competency as the required standard, knowing that it too operates as part of a chain linked by parental rights and the threat of regulatory or civil sanction.

There is more to be done. There is no easy answer. One thing that has the potential to positively impact the journey of trans youth is for the judiciary to refrain from overreaching into the realm of clinical and regulatory decision making. However well intentioned,[78] the Divisional Court failed to heed historical warnings that "uncertainty is the price which has to be paid to keep the law in line with social experience".[79]

Such unnecessary overreach has the potential to damage and devalue judicial commentary by fuelling the gender panic[80] and giving purported strength to the wrongful impression that rigorous criteria were needed to avoid children coming home with puberty blockers like they would bring candy from the corner store. That is simply not the case. There remain uneasy scientific, clinical, legal, moral and ethical issues at play, which are incapable of being resolved definitively and will continue to change as society does. While some see progress, others will see regress.

Just as the primary decision could be seen to embody the stereotypical narrative that children don't know what they want and need protecting, it could also be seen to confirm the oft-cited criticism that the judiciary is merely a panel of white-haired men (and women) who, by virtue of their privilege, are out of touch with general society[81]. Enter the cool aunt from side stage, Courtney Apeel,[82] who breezes into the party and

[77] [2021] FedCFamC1F 42; BC202110232

[78] Above n 1, at [94].

[79] Above n 1, at [57] citing Lord Scarman in *Gillick*

[80] The term "gender panic" was originally used by Laurel Westbrook and Karen Schilt in 2014 to refer to situations where people react to disruptions to biology-based gender ideology by frantically reasserting the naturalness of a male-female binary.

[81] The Hon Justice Michael Kirby AC CMG, "Attacks on Judges — a Universal Phenomenon", American Bar Association section of Litigation Winter Leadership Meeting (Maui, Hawaii 5 January 1998) accessed 10 Dec 2021 at www.hcourt.gov.au/assets/publications/speeches/former-justices/kirbyj/kirbyj_maui.htm.

[82] It's a bad pun.

changes the music to that song that everyone loves to hate . . . *Baby, I'm just gonna shake, shake, shake, shake, shake, I shake it off, I shake it off (Whoo-hoo-hoo)*.[83]

Suddenly all is right with the world, if only for a minute. . .

This article was written by Associate, Lauren Biviano and originally published in January 2022, by Australian Health Law Bulletin in January 2022. Please contact Lauren if you have any questions or would like more information.

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[83] Lyrics from Taylor Swift, "Shake it off". From the album *1989* (Big Machine Records, 2014).