

---

**What about parental consent in the treatment of trans children and young people? – a view of the *Bell v Tavistock* case.**

---

The decision of the High Court in [\*Bell v Tavistock\* \[2020\] EWHC 3274 \(Admin\)](#) handed down on 1 December 2020 has generated much media comment. Perhaps now a little breath can be drawn and the case looked at with a more neutral eye.

We respect the judgment of the High Court. The Court had to work hard with the material in front of it. There are serious questions to be asked about the increasing number of female to male transitioner candidates who have come forward in recent years. Why this change? Is it just that they were always there all along? Or is there something about our still too patriarchal society. Similar questions exist about the increasing alignment of autism and trans in those presenting with apparent gender dysphoria in recent years. Are the assessment processes rigorous enough to stand the best chance of identifying those who may later suffer transition regret?

Other legitimate questions apply to the long-term risks of using puberty blockers. There is evidence that they will, for some, have an effect on adult bone density and questions have been raised about their effect on teenage brain development. And are they truly a ‘pause for thought’ or do they set vulnerable young people and children on an inevitable path to gender transition? What is the real instance of ‘transition regret’ and ‘detransition’?

To ask these questions is not to deny the experience of any individual trans person. But they need to be asked. Some questions may be hard to answer as double-blind studies allowing some gender-dysphoric children to experience puberty as a ‘control’ group might be thought to be barbaric.

But NOT to have asked the questions appears to be a serious failure on the part of the relevant clinicians. It should not have been a surprise that the High Court was unimpressed that ready answers were not available or at least being sought.

All the above need to be balanced against the relief from the terrible distress some young people face in experiencing what they perceive as the ‘wrong’ puberty, and the positive benefit of avoiding teenage secondary sex characteristic development for those who are to transition. Arguably the Court’s decision did not look sufficiently at this distress and the physical and psychological consequences of requiring a child to go through the “wrong” puberty and possibly undergo more intrusive and less successful gender reassignment medical treatment in later life.

Indeed, the voices of those assisted by transition appears strangely muted in the judgment.

Courts have been able to understand the difficulties that trans people face, shown perhaps most clearly by the opening statement made by Lady Hale in *Baroness Hale in R (C) v Work and Pensions Secretary* [2017] 1 WLR 4127 at para 1:

*“Those of us who, whatever our occasional frustrations with the expectations of society or our own biology, are nevertheless quite secure in the gender identities with which we were born, can scarcely begin to understand how it must be to grow up in the wrong body and then to go through the long and complex process of adapting that body to match the real self. But it does not take much imagination to understand that this is a deeply personal and private matter; that a person who has undergone gender reassignment will need the whole world to recognise and relate to her or to him in the reassigned gender; and will want to keep to an absolute minimum any unwanted disclosure of the history. This is not only because other people can be insensitive and even cruel; the evidence is that transphobic incidents are increasing and that transgender people experience high levels of anxiety about this. It is also because of their deep need to live successfully and peacefully in their reassigned gender, something which non-transgender people can take for granted.”*

It could be argued that to *deny* puberty blocking treatment is to force some children or young persons to experience a puberty they face with dread and for those ready for cross-sex hormones to take away from the teenage years they should enjoy as their true selves.

The lacuna created by the judgment

A major difficulty with the judgment is that, whilst accepting that it was, rightly, not being asked to give a view about the rights and wrongs of treating under 16s with puberty blockers, there is no guidance or consideration given in the judgement as to how consent might lawfully be given in such a situation. If it is accepted that there are situations in which such treatment is in the best interests of the child, how should consent be obtained?

This question is far from theoretical in a situation where waiting lists are already long and the potential for adverse mental health consequences, including the very real possibility of suicide, or the obtaining of medication without medical supervision, is very real.

Consent in other situations

The decision of the Gender Identity Service (‘GIDS’) - also known colloquially as ‘the Tavistock’ after its London location - to deal with consent purely based almon upon consent by the child is inconsistent with guidelines developed elsewhere. The NHS website is states clearly:

**People aged 16 or over are entitled to consent to their own treatment. This can only be overruled in exceptional circumstances.**

Like adults, young people (aged 16 or 17) are presumed to have sufficient capacity to decide on their own medical treatment, unless there's significant evidence to suggest otherwise.

Children under the age of 16 can consent to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment. This is known as being Gillick competent.

Otherwise, someone with parental responsibility can consent for them.

This could be:

- The child's mother or father
- The child's legally appointed guardian
- A person with a residence order concerning the child
- A local authority designated to care for the child
- A local authority or person with an emergency protection order for the child

The General Medical Council document '*0-18 Years: guidance for doctors*' issued in 2018 states at paragraph 27:

*27 If a child lacks the capacity to consent, you should ask for their parent's consent. It is usually sufficient to have consent from one parent. If parents cannot agree and disputes cannot be resolved informally, you should seek legal advice about whether you should apply to the court.*

And has the sensible and helpful statement at para 26:

*26 It is important that you assess maturity and understanding on an individual basis and with regard to the complexity and importance of the decision to be made. You should remember that a young person who has the capacity to consent to straightforward, relatively risk-free treatment may not necessarily have the capacity to consent to complex treatment involving high risks or serious consequences. The capacity to consent can also be affected by their physical and emotional development and by changes in their health and treatment.*

The similarities between paragraph 26 and the High Court's judgment in *Bell v Tavistock* are notable.

This different approach may well have led to the result in *Bell v Tavistock*. This may be explained by the need in Gender Dysphoria to focus on the mind of the child that is not present in some other areas of medicine. Indeed, the Tavistock's stated position in the litigation that they cannot conceive of a situation where it would be appropriate to administer blockers on a patient without their consent must be right.

But that is the wrong question.

What is the right question and what is the solution?

The question is what to do when the Tavistock has concluded that it has the consent of the child to the standard it requires but not to a standard that would satisfy the usual standards for consent, as set out in *Bell v Tavistock*.

Surely the solution then is to seek parental consent in the normal way. The Tavistock say that they do not want to remove control from the child but they also state that they would equally never want to go against parental opinion. This suggests that in reality they are already getting parental consent, or at least approval. It does not seem therefore such a big step to obtain parental consent in the normal way or indeed court approval in extreme cases, however much all the parties would want to avoid such a situation.

We believe that the Tavistock should, with immediate effect and NHS support, announce that it respects the decision of the Divisional Court and adopt the same consent regime which applies to the whole of the rest of children's services in the NHS.

If parents can take decisions about forms of cancer treatment which may have long term consequences on health and sexual function, who better to decide on gender treatment for trans children where such children have already satisfied the Tavistock of their views? And where normal parental consent is not available, or where there is disagreement between parents and child, there are well established mechanisms, including where necessary court intervention, to fill the gap.

There would then needs to be a rapid re-consenting of treatment, *with a full explanation of the risks and unknowns of the treatment proposed*. Where the parents, clinicians and child agree, problem solved. Where there is any disagreement, a 'best interests' court hearing would be required but, given that the number is likely to be a small sub-set of the approximately 170 children we are told find themselves in this position, no doubt they could be accommodated as urgent hearings. This would have the advantage of ending the present litigation and creating a renewed focus on the needs of the children concerned.

There are very real children at the heart of this. Their voices must not be forgotten but in hearing their voices the normal rules for consent must also be adhered to.

**Nicola Newbegin and Robin Moira White**

**Old Square Chambers**

**20.12.20**