# From Clinical to Judicial Decision-Making, and Back Again in Bell v Tavistock? Preparing for the Legacy of Court Involvement in Gender Care for Minors

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## ABSTRACT

*Gender care for minors in England has recently been scrutinised by the courts and is currently undergoing significant transformation, shifting away from the long-standing centralised service provision model. Alongside this change, the World Professional Association for Transgender Health has recently published Version 8 of its Standard of Care, which introduces radical changes that shift away from age restrictions on medical interventions. This article considers what role judicial decision-making could, or should, play in this new era of healthcare provision for adolescent gender care, especially since Bell v Tavistock. Despite Bell seemingly returning decision-making to clinicians, patients and their families, we argue that the decision has left the door open in a way that threatens the autonomy and rights of gender diverse children. Through a comparative analysis with Australian case law, we demonstrate how and why uncertainties left by Bell may in fact lead to continued court involvement. Finally, we suggest several pragmatic responses that may mitigate the risk of unnecessary and time-consuming court involvement.*

## INTRODUCTION

Gender care for minors is undergoing significant transformation. In England, service provision is being radically overhauled, shifting from a singular centralised NHS service provider to a regional ‘hub’ model of care.[[1]](#footnote-1) At the same time, the World Professional Association for Transgender Health (WPATH) has recently published Version 8 of its Standard of Care (SOC8) setting out new clinical guidelines for the optimal management of adolescents with gender incongruence/dysphoria.[[2]](#footnote-2) The SOC8 has been described as ‘a watershed moment in trans healthcare’.[[3]](#footnote-3) It significantly alters the provision of gender care for minors, including the removal of age restrictions on medical interventions.[[4]](#footnote-4) Yet, medical assessment, diagnosis and interventions for gender diverse minors are subject to ongoing fraught, dichotomous socio-political debates. On one hand, paternalistic calls to protect gender diverse minors from seemingly harmful medical interventions frame such minors as an inherently vulnerable population incapable of consent and highly likely to regret decisions relating to their gender identity made in childhood.[[5]](#footnote-5) On the other hand, is the precarity of established rights for capacious minors to exercise autonomy over their bodies and identities. Given the intensifying socio-political scrutiny, this article focuses on legal oversight and critically considers the courts’ role in this area. This article’s central thesis is that it is fundamental for clinicians, service providers and users to gain a clearer understanding of the appropriate role of the courts in gender care for minors, to ensure optimal clinical care and support.

Until recently, the courts had not considered the provision of medical interventions for gender diverse minors. However, in 2020, the High Court (HC) handed down a controversial judgment in a judicial review application, *R (Bell) and A v Tavistock and Portman NHS Foundation Trust*[[6]](#footnote-6) (referred to as *Bell* HC), where it held that gender diverse minors were highly unlikely to be competent to give valid consent to puberty blockers (PBs).[[7]](#footnote-7) Supporting this decision, Lieven J reiterated and further emphasised the same concerns in the subsequent case *AB v CD*.[[8]](#footnote-8) However, less than ten months later, the Court of Appeal (CA) (referred to as *Bell* CA) overturned this decision,[[9]](#footnote-9) holding that the HC had ‘intruded into the realm of decisions agreed upon by doctors, patients and their parents, where the court had not previously gone”.[[10]](#footnote-10) This reversal has been heralded as a ‘resounding success’[[11]](#footnote-11) for reinstating ‘the proper distinction of responsibilities between doctors and the courts’.[[12]](#footnote-12) Despite the CA’s intervention, this article argues the judicial proceedings in *Bell* have not restored the status quo. Instead, *Bell* perpetuates the precarious nature of access to gender care for minors, in stark contrast to other, more accepted areas of adolescent healthcare. Specifically, *Bell* CA leaves a number of uncertainties for clinicians, patients and their families, making inappropriate court involvement in the gender care of minors likely to continue.

To demonstrate this concern, we turn to Australia’s experience of shifting from judicial decision-making back to clinical decision-making. The Australian Family Court experience suggests that even when the requirement for court authorisation is formally removed, residual and unnecessary court involvement in this area may remain.[[13]](#footnote-13) We argue that ongoing Australian court involvement has not been concerned about the rights of gender diverse children to make decisions regarding their bodies and identities, consistent with their evolving capacities. Rather, it has been motivated by paternalistic or defensive concerns regarding: (1) disputes over diagnosis, *Gillick* competence or proposed treatment; (2) framing medical interventions in gender care as experimental or novel; and (3) clinician anxiety regarding liability for failing to obtain informed consent. We argue that similar concerns exist in England post-*Bell.*

Notably, *Bell* CA held that, given the complexity of this area, *difficult* cases may necessitate court involvement ‘but it was not appropriate to give guidance as to when such circumstances might arise’.[[14]](#footnote-14) We argue this statement’s ambiguity may leave a legacy of defensive clinical practice. Moreover, the threshold of what is considered ‘difficult’ is likely to be low given the surrounding socio-political discomfort, leaving considerable uncertainty in gender care for minors. Accordingly, a more cautious interpretation of CA *Bell* is warranted. Learning from the Australian experience, we suggest several pragmatic responses that recognise the importance of the courts’ inherent jurisdiction in determining individual best interests yet aim to mitigate the risk of inappropriate court involvement. Given the planned NHS changes to gender care for minors, there is a timely opportunity for regulatory and professional authorities to respond to these concerns to better support clinical decision-making and the evolving autonomy of gender diverse minors.

We commence with a contextual overview of the precarity of accessing gender care for minors in the current socio-political climate. We then explain how socio-political anxieties have manifested judicially in *Bell* HC and CA*.* Next, we critically examine the gaps left by *Bell* CA, to demonstrate why ongoing paternalistic and arguably inappropriate court involvement is highly likely. From this we turn to our comparative analysis of the Australian experience and identify areas of ongoing court involvement, Finally, we consider pragmatic ways to minimise inappropriate court involvement, highlighting potential support for clinicians and gender diverse minors through clearer professional guidance and clinical guidelines by drawing on existing approaches to other seemingly controversial areas of healthcare.

## THE PRECARITY OF GENDER CARE FOR MINORS IN THE CONTEMPORARY SOCIO-POLITICAL CLIMATE

Gender care for minors exposes a conflict between ‘the right to bodily integrity and self-determination versus parents’ right to ensure that children are protected from harm and from making impetuous decisions inimical to their best interests’.[[15]](#footnote-15) Dworkin observed that ‘[o]ur self-esteem and sense of worth are bound up with the right to determine what shall be done to and with our bodies and minds’.[[16]](#footnote-16) Gender diverse children’s right to make decisions about medical treatment that so fundamentally affects their bodily autonomy and identity has been coloured not only by judicial involvement in recent years, but also by broader ‘moral and ethical issues, all of which are the subject of intense professional and public debate’.[[17]](#footnote-17) The polarity of these debates has importantly been recognised as a challenge for clinicians working in this area of care.[[18]](#footnote-18)

Prior to *Bell* HC, medical interventions available for gender diverse children through NHS England largely conformed with international guidelines.[[19]](#footnote-19) Decision-making was a clinical matter and gender care was not distinguished as a unique area of healthcare requiring court authorisation. The general use of court authorisation has only been sought in a narrow band of cases: where a minor’s refusal was not considered to be in their best interests;[[20]](#footnote-20) or where there was a dispute, for example, between doctors and parents or between the parents themselves; or in regards to controversial or non-therapeutic procedures which lack medical benefit for the child.[[21]](#footnote-21) This approach acknowledges the domestic and international legal recognition of children’s evolving capacities for decision-making, moving from participating in shared decision-making within healthcare to being autonomous decision-makers.[[22]](#footnote-22)

In practical terms, and prior to *Bell*, stage one interventions for gender dysphoria – puberty blockers (PBs) – were prescribed on the basis of the child’s physical development and psychological maturity, with a requirement that the child was *Gillick* competent and that clinicians had obtained parental consent (despite this having no legal basis if the child was *Gillick* competent).[[23]](#footnote-23) In 2014, the NHS lowered the age for prescription of PBs from 16 to 12 years, and also allowed PBs to be prescribed to children aged under 12 years where they were in Tanner Stage 2 of established puberty.[[24]](#footnote-24) The decision to prescribe PBs was made by the multidisciplinary clinical team with the young person and their parents/carers.[[25]](#footnote-25) Like international guidelines, the NHS Service Protocol placed significant emphasis on psychological and parental support for children who sought to access PBs.[[26]](#footnote-26) Second stage interventions –cross-sex (or ‘gender-affirming’) hormones– were not available until the child reached 16 years, at which age children have a statutory right to consent to treatment under English law.[[27]](#footnote-27) Stage three -surgical- interventions were not available until adulthood (eighteen).

Despite established clinical practice, it is important to highlight the precarious nature of accessing gender care for minors. There is a tension in this area between protecting children and protecting children’s rights by supporting their autonomy and independence in decision-making.[[28]](#footnote-28) Those endorsing the need to ‘protect’ children from themselves frame gender diverse children as *uniquely* vulnerable and incompetent to consent to medical interventions. However, as Dimopoulos argues, defining those children *exclusively* by their vulnerabilities has had the effect of establishing ‘overly protectionist agendas’,[[29]](#footnote-29) which reinforce assumptions about children’s lack of capacity for rational decision-making.[[30]](#footnote-30) This paternalistic narrative fails to acknowledge gender diverse children as active, rights-bearing subjects with evolving capacities. It perpetuates the problematic view ‘that promoting and supporting children’s autonomy, and ‘protecting’ children, are mutually exclusive’.[[31]](#footnote-31)

The seeming need to ‘protect’ gender diverse children has gained significant social and political traction.[[32]](#footnote-32) In 2020, the UK’s former Prime Minister and Minister for Women and Equalities, Liz Truss expressed these paternalistic concerns:

Finally, which is not a direct issue concerning the Gender Recognition Act, but is relevant, making sure that the under 18s are protected from decisions that they could make, that are irreversible in the future. I believe strongly that adults should have the freedom to lead their lives as they see fit, but I think it’s very important that while people are still developing their decision-making capabilities that we protect them from making those irreversible decisions.[[33]](#footnote-33)

The narrative of ‘protection’ has gained further political prominence across the West. In January 2023, former US President Donald Trump promised to ‘stop’ gender affirming care of minors as part of his Presidential campaign. He equated such care to ‘child abuse’ and set out a ‘plan to stop the chemical, physical and emotional mutilation of our youth’.[[34]](#footnote-34) Trump also committed to punishing medical professionals involved in the provision of gender-affirming care if re-elected.[[35]](#footnote-35) This growing political paternalism significantly threatens the rights of gender diverse children, undermining their ability to make decisions regarding their own medical treatment, consistent with their evolving capacities.[[36]](#footnote-36) It also disregards their lived experiences, wishes and views. These children are singled-out and homogenised as particularly vulnerable on the basis of gender diversity, which is then used to justify restrictions on their ability to self-determine their identity. The decision-making process becomes, in essence, ‘about adult control over and regulation of [gender diverse] children’s bodies and identities’.[[37]](#footnote-37)

Furthermore, there is an obvious tension between the aforementioned socio-political views, the motives of gender care clinicians, and the basis of care provision. There are long-standing social and legal concerns about the primacy of medical decision-making without legal oversight.[[38]](#footnote-38) For example, in the context of intersex children, healthcare practitioners have been criticised for their justification for irreversible and harmful surgical interventions. Largely, without any legal oversight, practice has continued on the basis that clinicians are best placed to determine the best interests of intersex children, despite strong research pointing to the contrary.[[39]](#footnote-39) This article does not challenge broader critiques of such impermeable medical power/knowledge, but rather distinguishes gender care from other controversial debates like intersex interventions and male circumcision. In these contexts, socio-political ideologies are accused of influencing medical motivations typically when children are too young to consent.[[40]](#footnote-40) However, within gender care, medical interventions are by their very nature led by the lived gender experience of individual children and not broader socio-political narratives.[[41]](#footnote-41) Accordingly, deferring to healthcare professionals in gender care, through the development of clinical guidelines with professional and regulatory oversight (including an appropriate use of the courts, defined below) is not akin to reinforcing unquestionable medical authority. Rather, it prevents clinical practice from being influenced by unsubstantiated or heavily refuted socio-political concerns which infringe upon the rights of the child to self-determination and bodily integrity.

Such socio-political concerns also extend *beyond* medical interventions: even the legal recognition of transgender identities in minors has generated political instability in the UK. In early 2023, Scotland’s proposed Gender Recognition Reform (Scotland) Bill (SP Bill 13) sparked a constitutional debate going to the very heart of devolution. This Bill proposed significant changes to the way Gender Recognition Certificates were granted.[[42]](#footnote-42) Among other things, it shifted away from requiring medical evidence and allowed mature minors to have their experienced gender legally recognised from sixteen, rather than eighteen.[[43]](#footnote-43) The proposals caused media and political outrage, further framing gender diverse and transgender children as being ‘at risk’ of their own decision-making.[[44]](#footnote-44) The UK Government successfully prevented the Bill from receiving Royal Assent by enacting Section 35 of the Scotland Act 1996. The policy rationale cited by the UK Government for using this section – for the first time ever in its devolutionary history – refers to the perceived ‘adverse affects’ that this Bill could have on the rest of the UK, including on schools and education.[[45]](#footnote-45)

Given this growing ‘protective’ narrative, we now consider the impact and consequences of *Bell*. At the outset, we argue that *Bell* HC reflected paternalistic concerns uninformed by clinical guidelines and subsequently fuelled further marginalisation of gender diverse youth, delegitimising individual gender identity experience. We then explain why *Bell* CA does not mark a complete reversal of the HC’s judgment.

## BELL v. TAVISTOCK

### *The High Court*

*Bell* concerned a judicial review application evaluating the practice of prescribing PBs to gender-diverse children within the Gender Identity Development Service (GIDS). The applicants argued children under 18 were incapable of consenting to PBs because of their longer-term implications, which they were incapable of understanding. They sought a declaration that the decision-making practice was unlawful and that court authorisation was necessary prior to administering PBs. Finding in favour of the applicants, the HC concluded:

A child under 16 may only consent to the use of medication intended to suppress puberty where he or she is competent to understand the nature of the treatment. That includes an understanding of the immediate and long-term consequences of the treatment, the limited evidence available as to its efficacy or purpose, the fact that the vast majority of patients proceed to the use of cross-sex hormones, and its potential life changing consequences for a child. There will be enormous difficulties in a child under 16 understanding and weighing up this information and deciding whether to consent to the use of puberty blocking medication. It is highly unlikely that a child aged 13 or under would be competent to give consent to the administration of puberty blockers. It is doubtful that a child aged 14 or 15 could understand and weigh the long-term risks and consequences of the administration of puberty blockers.

In respect of young persons aged 16 and over, the legal position is that there is a presumption that they have the ability to consent to medical treatment. Given the long-term consequences of the clinical interventions at issue in this case, and given that the treatment is as yet innovative and experimental, we recognise that clinicians may well regard these as cases where the authorisation of the court should be sought prior to commencing the clinical treatment.’ [[46]](#footnote-46)

Controversially, this decision departed from established legal principles of consent for those under the age of majority. Adolescents aged 16 or 17 are considered competent to consent to medical treatment,[[47]](#footnote-47) while minors under 16 can consent to medical treatment providing they are *Gillick*-competent, that is, they demonstrate ‘sufficient understanding and intelligence to be capable of making up [their] own mind on the matter requiring decision …’.[[48]](#footnote-48) *Bell* HC offered a radically altered approach*.* First, it set out gender diverse minors as a separate and uniquely vulnerable group very unlikely to achieve *Gillick* competence, the bar of which is already recognised as being higher than that of adults.[[49]](#footnote-49) Not only does this potentially undermine the wider standing and application of Gillick,[[50]](#footnote-50) but *Bell* HC’s framing of gender diverse minors demonstrates judicial discomfort reflective of wider socio-political concerns. *Bell* HC directly challenged the rights to self-determination and to bodily integrity that are present in most other accepted areas of children’s health. Indeed, the Court took what Tobin has labelled an ‘invisible rights approach’,[[51]](#footnote-51) where it paid no attention to children’s rights or the rights of transgender children and further ignored the role of the child in medical decision-making.[[52]](#footnote-52)

Second, *Bell* HC implied that the courts’ role, through its inherent jurisdiction,[[53]](#footnote-53) was justified on the basis that PBs are ‘innovative’ and ‘experimental’, given the court’s perception that PBs lack a clear evidence-base as to the benefits or potential harm of treatment.[[54]](#footnote-54) This finding ignored the fact that PBs have been prescribed for gender diverse children for almost twenty years; and arguments that they are ‘experimental’ are contested because PBs cannot be viewed in the same way as other drugs in this context.[[55]](#footnote-55) Moreover PBs have been used to treat precocious puberty since the 1980s without such controversy.[[56]](#footnote-56) Nevertheless, the HC’s decision had an instant impact on clinical practice. GIDS immediately suspended all endocrine treatments for gender diverse minors until court authorisation was gained, despite the HC not setting this as a mandatory requirement. Several other jurisdictions followed suit.[[57]](#footnote-57) Although swift, in the months before *Bell* HC, GIDS had also been subject to concerning Care Quality Commission (CQC) reviews, highlighting the need for organisational changes,[[58]](#footnote-58) and a subsequent independent review led by Dr Hilary Cass. Whilst the CQC report highlighted issues within the service, the Cass Review, in the Interim Cass Report (ICR) situated itself as responding to increasing demand:

In recent years there has been a significant increase in the number of referrals to the Gender Identity Development Service, and this has occurred at a time when the service has moved from a psychosocial and psychotherapeutic model to one that also prescribes medical interventions by way of hormone drugs. This has contributed to growing interest in how the NHS should most appropriately assess, diagnose and care for children and young people who present with gender incongruence and gender identity issues.[[59]](#footnote-59)

Given such intense political and regulatory scrutiny of GIDS as the only service provider, it is unsurprising that the courts followed suit.

The shift ‘towards’ court involvement was inherently problematic. Commentators criticised *Bell* HC for overstepping boundaries by legally enshrining the need to ‘protect’ gender diverse children at the expense of their competence, autonomy and individual best interests.[[60]](#footnote-60) Concerns were voiced about the adverse implications for the physical and mental health and wellbeing of these children, as well as serious delays and even outright refusals from the courts.[[61]](#footnote-61) The risk of harm from such delays is exacerbated by the heightened risk of suicide and self-harm experienced by gender diverse children.[[62]](#footnote-62) A joint statement from international professional transgender health associations in response to *Bell* HC summarised these significant concerns:

although treatment for young transgender adolescents involves uncertainties, as is the case in many fields involving young people, several studies demonstrate the clear mental health benefit of gender-affirming medical treatment (including puberty blockers). Withholding such treatment is harmful and carries potential life-long social, psychological, and medical consequences[[63]](#footnote-63)

The resulting changes to clinical practice were likely to have intensified the psychological distress experienced by gender diverse children and adolescents, preventing much-needed time and space to meaningfully explore their experienced, developing gender identity.[[64]](#footnote-64) Such impact has been documented in the Australian context, where court authorisation for gender affirming treatment was required in some form for almost thirteen years.[[65]](#footnote-65) Through *Bell* HC, determining whether the provision of PBs was in the best interests of adolescents had seemingly become a judicial rather than a clinical decision, despite the concluding statements in *Bell* HC not being definitive. Concerningly, the Court uses language such as ‘highly unlikely’ and ‘doubtful’, with regards to gender diverse minors achieving *Gillick* competence. Such speculative language reflects concerns about not only homogenising gender diverse children, but *all* children as a collective. In the subsequent case *AB v CD* (which we return to below),[[66]](#footnote-66) the Court failed to consider these questions even when finding that parental consent for PBs would be lawful.

### *The Court of Appeal*

Given our above analysis, it is unsurprising that *Bell* CA was well-received for overturning the judgment, particularly given that the focus of the appeal was to restore the application of law in *Gillick.* The CA was clear that, ‘by making the declaration accompanied by guidance requiring (probably frequent) court intervention, the Divisional Court had placed an improper restriction on the *Gillick* test of competence’.[[67]](#footnote-67) *Bell* CA foremost reaffirmed the position of *Gillick* as it applied to the provision of PBs:

The *ratio decidendi* of *Gillick* was that it was for doctors and not judges to decide on the capacity of a person under 16 to consent to medical treatment. Nothing about the nature or implications of the treatment with puberty blockers allows for a real distinction to be made between the consideration of contraception in Gillick and of puberty blockers in this case bearing in mind that, when Gillick was decided 35 years ago, the issues it raised in respect of contraception for the under 16s were highly controversial in a way that is now hard to imagine.[[68]](#footnote-68)

In summary, *Bell* CA reaffirmed:

1. the decision to prescribe treatment for gender dysphoria remained a clinical rather than judicial matter.
2. the HC was wrong to generalise about the competency of children suffering from gender dysphoria; and
3. decisions regarding contentious areas of health, and which are subject to clinical and social controversies, should not be the remit of the courts.

The CA also set out a clear context in respect of this area of healthcare. Burnett LCJ explained:

The treatment of children for gender dysphoria is controversial. Medical opinion is far from unanimous about the wisdom of embarking on treatment before adulthood. The question raises not only clinical medical issues but also moral and ethical issues, all of which are the subject of intense professional and public debate. Such debate, when it spills into legal proceedings, is apt to obscure the role of the courts in deciding discrete legal issues. The present proceedings do not require the courts to determine whether the treatment for gender dysphoria is a wise or unwise course or whether it should be available through medical facilities in England and Wales. Such policy decisions are for the National Health Service, the medical profession and its regulators and Government and Parliament. The treatment of children for gender dysphoria is lawful in this jurisdiction.[[69]](#footnote-69)

Furthermore, in considering the HC’s broad generalised conclusions, the CA referred to Lieven J’s judgement in *AB v CD*,[[70]](#footnote-70) who had *‘*expressed herself wary of ‘becoming too involved in highly complex moral and ethical issues on a generalised, rather than case specific basis.’*[[71]](#footnote-71)* The CA held the HC was not equipped to make findings that PBs were ‘experimental’, nor that the vast majority of patients receiving PBs would be on a trajectory towards cross-sex hormones (CSHs) and then irreversible gender-affirming interventions.[[72]](#footnote-72) However, *Bell* CA empathised with the issues presented to the HC, highlighting that the cautionary approach was driven by ‘the very best of intentions’.[[73]](#footnote-73) This gave prominence to the concerning protective narrative towards gender diverse children, who were constructed as a vulnerable collective.[[74]](#footnote-74) The ‘restoration’ of *Gillick* by the CA arguably then reflects adherence to judicial precedent, rather than any commitment to uphold the rights of individual gender diverse children.

GIDS subsequently returned to the clinical practice protocols in place prior to *Bell* HC.[[75]](#footnote-75) However, we now explain our concern that, in light of the socio-political context and the redesign of clinical gender care services for children, inappropriate court involvement will likely continue.

### *Why Might Court Involvement Continue?*

Deeper analysis of CA *Bell* suggests that a return to clinical decision-making is not straightforward. The CA held: ‘…[it] is not to say that such an application will never be appropriate. There may be circumstances where there are disputes between one or more of clinicians, patients and parents where an application will be necessary’.[[76]](#footnote-76) The CA also held: *‘*applications to the court may well be appropriate in specific *difficult* cases, but it was not appropriate to give guidance as to when such circumstances might arise.*’*[[77]](#footnote-77) *Bell* CA thus seemingly anticipates further cases due to the complexity of this area, or because, as anticipated in *Gillick*, there may be disagreements in respect of diagnosis or treatment.

Whilst disagreements over a child’s best interests can rightly fall within the courts’ inherent jurisdiction,[[78]](#footnote-78) in our view, the wider socio-political concerns associated with gender diversity will mean that, following *Bell,* disagreements will arise not just in respect of *Gillick* competence, but in respect of the diagnosis and treatment of gender dysphoria. Ultimately, it is important that *Bell* CA’s ‘success’ is not taken for granted and perceived as a clear-cut reversal of *Bell* HC. Without clarity over the courts’ role in the medical decision-making process, there is a very real possibility that gender diverse minors will continue to be marginalised and their care subject to higher and more intrusive levels of legal and professional challenge than other, more accepted, areas of healthcare. To demonstrate this, we now turn to the Australian experience.

## THE AUSTRALIAN EXPERIENCE

### *Australian Law and Special Medical Procedures*

To fully understand the Australian experience, it is necessary to briefly set out the legislative basis for the Family Court of Australia to authorise medical treatment for gender diverse minors and trace the case law evolution.[[79]](#footnote-79) The *Family Law Act 1975* (Cth) (FLA) provides, subject to any court order in force, parents have ‘parental responsibility’: ‘[a]ll the duties, powers, responsibilities and authority which, by law, parents have in relation to children’.[[80]](#footnote-80) The ‘default position’ under Australian law is that parents can consent to medical treatment for their child who is not yet able to consent, ‘reflected through the prism of the child’s best interests’.[[81]](#footnote-81) However, some medical interventions –referred to as ‘special medical procedures’– lie beyond the scope of parental responsibility and must be authorised by the Family Court of Australia pursuant to its welfare jurisdiction.[[82]](#footnote-82) Furthermore, when deciding whether to make such an order, the court ‘must regard the best interests of the child as the paramount consideration’.[[83]](#footnote-83)

The requirement for court approval of ‘special medical procedures’ emerged from a decision of the High Court of Australia on the scope of the welfare jurisdiction. In *Secretary, Department of Health & Community Services v JWB & SMB* (*Marion’s Case*),[[84]](#footnote-84) the High Court held that the Family Court has jurisdiction to make decisions about a child’s proposed medical treatment where that treatment is ‘invasive’, ‘permanent’ and ‘irreversible’, and ‘non-therapeutic’ – that is, not carried out ‘to treat some malfunction or disease’.[[85]](#footnote-85) Other factors warranting court intervention were the ‘significant risk’ of making a wrong decision about the child’s current or future capacity to consent, or about the best interests of a non-*Gillick* competent child, and the ‘particularly grave’ consequences of such a decision.[[86]](#footnote-86)

### *Gender Dysphoria Treatment as a ‘Special Medical Procedure’*

In 2004, *Re Alex*[[87]](#footnote-87)broadened the category of special medical procedures to stage one (PBs) and stage two treatment (CSHs) for childhood gender dysphoria. Like *Bell* HC, the practical consequence of *Re Alex* was to require parents of gender diverse children to seek authorisation from the Family Court.

The Full Court of the Family Court of Australia, which hears appeals from the Family Court, has twice considered whether court authorisation of medical treatment for gender diverse children should be required, and whether the Court should be involved in determining a child’s *Gillick* competence in relation to that treatment.

The first opportunity arose in 2013 in *Re Jamie*.[[88]](#footnote-88) The Court held that stage two – but not stage one – treatment required court authorisation, unless the child was *Gillick* competent.[[89]](#footnote-89) Importantly, the Court concluded that the nature of stage two treatment required the Family Court to determine the child’s *Gillick* competence.[[90]](#footnote-90) The Court conceded that ongoing court involvement was ‘harsh’, but considered itself ‘bound by the High Court’s reasoning in *Marion’s Case*’.[[91]](#footnote-91)

*Re Jamie* was the subject of vocal judicial discontent and criticism within legal and medical communities – akin to that which followed *Bell* HC.[[92]](#footnote-92) The Family Court asserted that the ‘mandatory ordeal’ which gender diverse children had to endure ‘seems to be anything but in their best interests’, and described the court authorisation process as ‘some dubious self-affirming rite of passage … plainly … of no benefit to the child, or anyone else’.[[93]](#footnote-93) As feared post-*Bell* HC, the court approval process in Australia delayed access to medical interventions and was criticised for imposing a harmful and unnecessary burden on children and their families.[[94]](#footnote-94)

Moreover, Kelly showed that court involvement in decision-making was often harmful to young people and their families.[[95]](#footnote-95) Medical specialists described court involvement as ‘an expensive, time consuming and ultimately unnecessary intrusion into the complex decision-making between the patient, their parents and the treating medical team’.[[96]](#footnote-96) Georgie Stone, sharing her own experience of requiring court authorisation, became an activist for the rights of gender diverse children, which she argued were ‘not being protected or upheld’.[[97]](#footnote-97) Georgie was adamant that ‘[t]he only people who should be part of this decision are the medical specialists, the parents and most importantly the teenager themselves’.[[98]](#footnote-98)

Although *Bell* CA seemingly returns decision-making to clinicians, patients and their families, we argue that the uncertainty left open by the CA would create similar harms. Stewart describes the process of laws that undermine the provision of healthcare and cause harm as *nomoigenesis*, that is, sickness generated by law.[[99]](#footnote-99) Whilst complex cases require resolution, the evidence of harm associated with the Australian Family Court authorisation process suggests that courts may not be an ideal forum for resolving such disputes. These concerns have also been raised in *Bell*.[[100]](#footnote-100)

### *Shifting Back from Court Involvement*

In 2017, the Full Court of the Family Court of Australia shifted back from the court-authorisation process*.* In *Re Kelvin,*[[101]](#footnote-101)the Court held that, where a child diagnosed with gender dysphoria consents to stage two treatment (CSHs); the child’s treating medical practitioners agree the child is *Gillick* competent; and the parents do not object to treatment, court authorisation was no longer required.[[102]](#footnote-102) However, the judgment did not remove the courts from the decision-making process entirely. Echoing the references to ‘difficult cases’ in *Bell* CA, *Re Kelvin* held that court involvement was necessary where there is ‘a genuine dispute or controversy as to whether the treatment should be administered, for example, if parents, or medical professionals are unable to agree’.[[103]](#footnote-103) The majority of the Court observed that in no stage two cases had ‘contradictory evidence been forthcoming … to challenge the desirability of the relevant treatment’.[[104]](#footnote-104) The majority added:

… some of the parties in this case use that fact to argue that court proceedings, with the attendant stress and expense, have no practical utility and suggest that this, of itself, is a significant pointer to this Court holding that there is no role for courts in the process, absent a dispute between parents or between parents and doctors.[[105]](#footnote-105)

The majority countered this argument by noting that court authorisation might have served as a ‘filter’ for cases in which treatment was recommended and undertaken.[[106]](#footnote-106) However, contradictory evidence manifested in *Re Imogen* *(No 6)*.[[107]](#footnote-107) The *Re Imogen* proceedings were controversial, as Imogen’s mother disputed her daughter’s diagnosis and the finding of *Gillick* competence, and did not consent to Imogen commencing stage two treatment.

*Re Imogen* set out that if a parent or a medical practitioner of a child diagnosed with gender dysphoria disputes the child’s *Gillick* competence, the diagnosis, or the proposed treatment, then court authorisation is mandatory.[[108]](#footnote-108) Once an application is made, the Court should make a finding about *Gillick* competence. A declaration of *Gillick* competence determines the dispute and the child can make a decision about treatment without court authorisation.[[109]](#footnote-109) Yet where the dispute concerns diagnosis or treatment (notwithstanding a finding of *Gillick* competence), the Court concluded that *it* should determine the diagnosis; determine whether treatment is appropriate, following a best interests assessment; and make an order pursuant to its welfare jurisdiction..[[110]](#footnote-110) Thisdecision has reignited the debate in Australia about the appropriateness of court involvement in this area, and whether the views and wishes of a *Gillick* competent child should be respected in circumstances of dispute or controversy over diagnosis or treatment.[[111]](#footnote-111)

The next section explores how Australian case law has left the door open for ongoing court involvement in cases involving medical treatment for gender diverse children, without providing clear guidance as to when this should occur. We then consider the implications of the Australian situation for England and Wales. There are, of course, significant differences between the domestic contexts in these two jurisdictions. Much of the later Australian case law, for example, concerned stage two treatment and an emphasis on disputes arising between parents and clinicians. In comparison, *Bell* CA spoke more broadly of *difficult* cases arising from complex moral and ethical issues and other ‘particular circumstances’. However, we argue that, given the recent consideration by the English courts of medical interventions for gender diverse minors, Australian case law warrants serious consideration for both the courts’ role and the impact of potential court oversight on clinical practice and children’s rights.[[112]](#footnote-112)

## WHY ARE THE AUSTRALIAN COURTS STILL INVOLVED?

There are three categories of case heard in the Australian courts since the shift away from court involvement, which highlight potential areas for future litigation in England and Wales: circumstances of dispute over the diagnosis of or treatment for gender dysphoria, or an adolescent’s capacity to consent to treatment; the perceived ‘experimental’ or ‘novel’ nature of gender dysphoria treatment; and the scope for civil liability of clinicians in relation to the assessment of *Gillick* competence. We address each of these in turn.

### *Disputes over Diagnosis, Treatment or Gillick Competence*

In Australia, *Re Kelvin* suggested court authorisation may be needed for gender dysphoria treatment in two circumstances:

Any court authorisation for that treatment is a departure from the exercise of a right and responsibility ordinarily vested in parents. Of course, routine treatments for everyday medical conditions embrace that parental right and responsibility and do not require court authorisation. However, other circumstances may dictate the need for court intervention. For example, **disputes between parents** or **experimental or novel treatment** or treatment for unusual or novel conditions can present difficulties; those circumstances may require a determination by a court of the best interests of the relevant child, in other words by a source other than those who would usually be regarded as being “in the best position to act in the best interests of the child.[[113]](#footnote-113)

In *Re Imogen*, discussed above, Watts J emphasised how ‘disputes between parents’ warranted involvement of the Family Court.[[114]](#footnote-114) This case involved parents in ‘warring camps’,[[115]](#footnote-115) and Watts J sought to resolve a ‘controversy’ about what the leading cases of *Re Jamie* and *Re Kelvin* decided about ‘cases where there is dispute about consent or treatment’.[[116]](#footnote-116) Watts J further reflected that these such disputes present dangers to the welfare of the child.[[117]](#footnote-117)

Applications to the Family Court have continued to emerge following *Re Kelvin*, as they fall beyond the scope of the decision. While some cases have involved a dispute between parents, or between parents and clinicians in relation to diagnosis, *Gillick* competence or the proposed treatment,[[118]](#footnote-118) others raise the question of whether ‘disputes’ as envisaged in *Re Kelvin* capture situations where one parent refuses to give consent for treatment to commence;[[119]](#footnote-119) or is unavailable to provide consent.[[120]](#footnote-120) The unfortunate practical result for gender diverse minors is that their access to treatment ‘is contingent upon alignment between the views of their parents and their treating medical practitioners’.[[121]](#footnote-121)

Similarly, *Bell* CA acknowledged that whilst the HC was wrong to give guidance on when court involvement was necessary, it did not mean that such an application will never be appropriate ‘where there are disputes between one or more of clinicians, patients and parents.’[[122]](#footnote-122) Without clarification on what a ‘dispute’ relates to - just that one may arise between these parties - similar applications to those in Australia may arise. Moreover, in the current socio-political climate, the English courts may very well take a sceptical approach to the validity of the treatment in such disputes, particularly given Lieven J’s reasoning in *AB*,[[123]](#footnote-123) heard in the Family Courts in England and Wales in between *Bell* HC and CA. The key issue in *AB* was, following *Bell* HC, whether parents of a 15-year-old minor could consent to PBs or whether court authorisation was required. Commenting on potential disagreements between clinicians themselves, Lieven J (who notably presided over *Bell* HC) stated:[[124]](#footnote-124)

… it may be that clinical difference and disagreement will not necessarily be fully exposed. The taking of strong, and perhaps fixed, positions as to the appropriateness of the use of PBs may make it difficult for a parent to be given a truly independent second opinion.[[125]](#footnote-125)

Lieven J further stated that parents were unlikely to disagree, given the ‘pressure’ they may feel from the child to consent.[[126]](#footnote-126) Although Lieven J ultimately believed that safeguarding against these issues was a matter for regulatory bodies,[[127]](#footnote-127) the pressure this places on individual clinicians to ascertain ‘real’ consent from parents heightens the likelihood of future court intervention. Such pressure is intensified by the vagueness in Tavistock’s current service specification.[[128]](#footnote-128) The specification simply states that, as part of GIDS’ criteria for considering the administration of PBs for those under 16, minors require support from the family/carers.[[129]](#footnote-129) Yet, there is little detail about what such support should look like and whether it is required from both parents.[[130]](#footnote-130) Questions of dispute and support become even more complex in cases involving complicated parental arrangements, for example children in care.[[131]](#footnote-131)

Given that *Bell* HC heard evidence about regret, allegations of improper decision-making processes, and the potential for civil or regulatory actions, a further concern is that clinicians will more cautiously approach these decisions. Consequently, even where there is agreement between clinicians, patients and their parents, clinicians may still defer to the courts to ensure this decision is assessed outside of the clinical team (potential reasons for this are discussed below). As aforementioned, the English courts even suggested that parental agreement may be more aligned to acquiescence; Lieven J in *AB* expressed concern that the absence of *any* court referral in cases as complex as the administration of PBs was enough to raise concerns about the safeguards currently in place to allow parents to voice any disagreements.[[132]](#footnote-132) These concerns echo *Bell* HC’s reasoning, which is unsurprising given that Lieven J presided over both judgements. However, despite overturning the HC, *Bell* CA did not overturn or challenge Lieven’s reasoning in *AB*,and instead drew from that reasoning to support its conclusions. Thus, Lieven J’s comments in *AB*, whilst predominantly made in obiter, retain ongoing significance in the Family Courts. It remains entirely possible, and even likely, that the Family Court of England and Wales will adopt a narrow approach towards such disputes and the concept of ‘family support’, given Lieven J’s scepticism regarding the ability of children and parents to provide informed consent to PBs*.*

### *Concerns about the ‘Experimental’ and ‘Novel’ Nature of Medical Treatment*

The second area for ongoing court involvement suggested by the Australian Full Court in *Re Kelvin* relates to the nature of gender dysphoria treatment itself. There is a thread of ‘judicial discomfort’ woven through case law involving gender diverse children consenting to treatment that the Family Court of Australia perceives to be ‘innovative’.[[133]](#footnote-133) While the term ‘innovative treatment’ has not been used explicitly in these cases, the Court has referred variously to ‘experimental’ or ‘novel’ treatment,[[134]](#footnote-134) medical evidence that is not ‘clear cut’,[[135]](#footnote-135) and ‘evolving medical science, which, notoriously, occurs at a very rapid pace’.[[136]](#footnote-136) The notion of ‘innovation’ appears to relate to treatment that lacks a clear or consistent line of medical authority, and for which minimal longitudinal data exist to support long-term efficacy.[[137]](#footnote-137)

The Family Court of Australia has identified ‘uncertainties surrounding…treatment’[[138]](#footnote-138) and ‘significant controversy within the scientific community’[[139]](#footnote-139) regarding the risks and potentially adverse effects of gender affirming hormone treatment that ‘is not well-understood’.[[140]](#footnote-140) The Court has noted ‘limited longitudinal research on the impact of long term cross hormone treatment’,[[141]](#footnote-141) and observed that ‘the long-term effects of the proposed treatment are still being studied’.[[142]](#footnote-142) *Re Jamie* found the *nature* of stage two treatment for gender dysphoria required the court to determine the child’s *Gillick* competence.[[143]](#footnote-143) The majority in *Re Kelvin* held: ‘if…the nature of the treatment no longer justifies court authorisation, and the concerns do not apply, then there is also no longer a basis for the Court to determine *Gillick* competence’.[[144]](#footnote-144) The majority also observed:

treatment that might not meet the description of having ‘grave or irreversible consequences’ might nevertheless fall outside of the scope of parental authority because of its novelty, or its experimental nature, or its place outside of accepted medical science…[[145]](#footnote-145)

In *Re Imogen*, the Family Court emphasised ‘the emergence of alternative thinking’ about treatment for gender dysphoria in adolescents.[[146]](#footnote-146) The Court noted that research literature in transgender health had ‘expanded rapidly’ in the last decade, particularly since *Re Kelvin*.[[147]](#footnote-147) The Family Court’s anxiety about ‘emerging debate’ within the medical community,[[148]](#footnote-148) and research gaps; including lack of engagement with longer term follow up, an exponential increase in gender dysphoria cases, regret and de-transitioning, and the surge in adolescents identifying as transgender without a reported childhood history;[[149]](#footnote-149) arguably prompted the conclusion in *Re Imogen* that a finding of *Gillick* competence is not determinative if there is a dispute about treatment.

A question then arises as to whether the courts in Australia and England and Wales are, *or could be*,stretching the scope of their welfare jurisdiction in these cases, to address their discomfort around what they view as ‘innovative treatment’ for minors. This raises a further question about what constitutes ‘innovative treatment’ and whether it is distinct from ‘special medical procedures’ warranting specific attention by the courts. As noted above, the Australian courts seem to evade the concept of ‘innovative treatment’ in gender dysphoria cases. However, this concept was more squarely raised by *Bell* HC, which focused on ‘the highly complex and unusual nature of [puberty blocker] treatment and the great difficulty there is in fully understanding its implications for the individual young person’.[[150]](#footnote-150)

In *AB*,[[151]](#footnote-151) the Court noted that PBs have life-changing and life-long consequences, the implications of which are not fully understood, and clinical and ethical views on their use differ significantly. However, the Court concluded that, although the experimental nature of PBs was significant and should give parents ‘pause for thought … parents can and do routinely consent on their child’s behalf to experimental treatment, sometimes with considerable, including life-changing, potential side-effects’.[[152]](#footnote-152) Moreover, *Bell* CAheld that finding PBs to be experimental went far beyond the expertise and remit of the HC.[[153]](#footnote-153)

We do not seek here to outline why PBs should not be considered ‘experimental’, rather, we acknowledge that medical opinion is likely to remain divided because establishing an evidence-base for these interventions is difficult for several reasons. These include: the way drugs are licensed, the way PBs are prescribed, the inability to conduct randomized control trials and the difficulties associated with long-term outcome data.[[154]](#footnote-154) However, as medical interventions inevitably evolve, clinical evidence will emerge and medical opinion is likely to differ or even change.

Yet, scientific data may not be the only influence. Indeed, the historic centrality of GIDS within England may have exacerbated the likelihood of this treatment being perceived as ‘experimental’ or ‘novel’. As a solitary provider, GIDS has likely been subjected to far more focused social and political scrutiny than had it been one of many service providers specialising in this area. First, this form of organisation and management of gender identity services sends out important messages about service users and broader community needs. Adopting a centralised model suggests that this form of healthcare requires a more specialised approach than other areas of healthcare. It also raises concerns about matters relating to medical authority and power, such as access, gate-keeping and the monopolisation of care.[[155]](#footnote-155) It is entirely appropriate and necessary to challenge the basis of medical authority to prevent poor practise or gatekeeping. However, in the area of gender care, speculative concerns carry greater significance, depicting patient needs as requiring heightened specialist care also suggests to non-clinicians and potentially the judiciary that the field is, as Lieven J describes, ‘particular and unusual’.[[156]](#footnote-156) This accordingly provides greater space for the courts to perpetuate the belief that such treatment is ‘novel’ or ‘experimental’.

Second, centralisation presents greater opportunity for concerns about the impartiality of the clinicians involved. Again, drawing upon *AB* (which provides a window into how the Family Court in England and Wales may perceive court referrals regarding gender care), Lieven J stated that the likelihood of doctors or the clinical ethical committee referring gender care matters to the courts is hindered by the ‘unanimity’ present within the team:

… Mr Lock also points to the ability of a doctor to refer matters of concern to an appropriate clinical ethics committee, or to apply to the Court if they are concerned about the treatment being proposed. I place limited weight on these safeguards given the risk of a unanimity of view within the clinical group in this very particular and unusual field, leading to no reference being made.[[157]](#footnote-157)

Lieven J called for increased regulation to ensure that concerns about the administration of treatment are brought to the judicial realm. In doing so, she implicitly suggests that healthcare providers are too readily allowing children access to medical interventions. The narrative of protection surrounding healthcare for gender diverse minors, discussed earlier, has manifested culturally in mainstream media and political discourse.[[158]](#footnote-158) By reporting these issues as contentious, Slothouber argues that news articles are not simply ‘exposing a contentious issue, but also producing the issues as being contentious.’[[159]](#footnote-159) Lieven J’s judgment in *AB* arguably creates a similar effect: it critiques the decision-making model adopted by GIDS, whilst ignoring the fact that not only are these medical professionals subject to regulatory oversight, but that the lack of court referrals may be the product of heightened and effective safeguarding measures. However, given its centrality and historic single service provision, there is a seemingly increased marginalisation of the clinicians within GIDS. Although Lieven J in *AB* noted that safeguarding is a matter for the regulatory body, her extensive comments suggest law is the appropriate mechanism through which to deal with clinical issues within an organisation. This position is troubling, given the concerns raised within this article and in particular the *appropriate* role of the courts.

Despite the upcoming changes away from a centralised service provider, Lieven J’s comments are inextricably linked to broader social concerns regarding misdiagnosis and irreversible care pathways. This, Slothouber notes, is a narrative commonly employed ‘to question gender-affirming medical care for trans people and support heightened psychiatric gatekeeping and medical regulation of trans-related healthcare.’[[160]](#footnote-160) This unfortunate result may be avoided, given the restructuring announced by NHS England following the ICR.[[161]](#footnote-161) The report echoed Lieven J’s concerns that a single specialist service provider is not a ‘safe or viable long-term option.’ It instead suggested that a regional network of hubs would have the following benefits:

* creating networks within each area to improve early access and support;
* reducing waiting times for specialist care;
* building capacity and training opportunities within the workforce;
* developing a specialist network to ensure peer review and shared standards of care; and
* providing opportunities to establish a more formalised service improvement strategy.[[162]](#footnote-162)

NHS England has since supported this recommendation with plans to close Tavistock and open regional centres in London and the North West by 2023.[[163]](#footnote-163) This plan, although not yet in effect, may counter the heightened specialism narrative found within a central service provider. However, we must wait and see how this regional network develops in practice. If development stalls at two regional centres rather than multiple centres, similar concerns to above may reappear. Moreover, decentralisation will not entirely tackle issues relating to decision-making, and specifically the *nature* of the treatment itself. Indeed, Australia’s multiple service model has still led to litigation based on the perception that gender affirming care is ‘innovative’ or ‘experimental’.[[164]](#footnote-164)

### *Scope for Clinician Liability*

The third area of uncertainty emerging from Australian case law is potential civil liability for clinicians. This concern is heightened in light of our above discussion regarding parental disputes. In *Re Imogen*, the Family Court explained that:

… there is a basis in proper medical practice for requiring an application to the court if a dispute cannot otherwise be resolved:

1. Without such a determination, a medical practitioner may run the risk of being criminally or civilly liable in the event that, notwithstanding the practitioner’s assessment that the child is *Gillick* competent, that is not in fact the case. That risk may be heightened in circumstances where there is a dispute between the parents as to the appropriate treatment, and one of the parents does not consent to the treatment.
2. Without such a determination, a medical practitioner may run the risk of effectively giving preference to one *parent’s* view over that of the other in circumstances where, if the child is not Gillick competent, each parent with parental responsibility has power to consent (or not consent) on behalf of the child (s 61C of the Act). If parents disagree, it is invidious for medical practitioners to be required to give preference to the views of one parent rather than the other.[[165]](#footnote-165)

One concern is that the Australian case law in this area suggests that *Gillick* competence may require a higher level of decision-making capacity from minors than required under the general test for legal capacity for adults.[[166]](#footnote-166) According to White et al., the *Gillick* test ‘requires not merely an understanding of the decision in question, but a *full* understanding of the decision and its effects’.[[167]](#footnote-167) As identified in *Re Imogen*, concern has emerged about clinicians’ potential liability in negligence for failing to obtain valid consent to gender dysphoria treatment.[[168]](#footnote-168) These concerns have begun to manifest in the form of litigation against treating doctors, in both Australia and the UK.[[169]](#footnote-169) Such fears can only be intensified internationally by Trump’s recent promise that if re-elected, he will ‘support the creation of a private right of action for victims to sue doctors who have unforgivably performed these procedures on minor children.’[[170]](#footnote-170)

Particularly noteworthy are two Australian cases in which a declaration of *Gillick* competence for stage two treatment was sought by parents in light of changes to a health service’s pathway to gender-affirming treatment.[[171]](#footnote-171) Relevantly, the health service in each case referred to the *Bell* proceedings and submitted that:

Given the fact of the *Bell* dispute …, the absence of any legislative framework, and the clear position that the question of *Gillick* competency and whether there is an adequate understanding of the consequences of the treatment in question are in effect value judgments of the clinicians in question, the [health service’s] position is that it considers it appropriate for this Court to exercise its welfare jurisdiction.[[172]](#footnote-172)

A court declaration of an adolescent’s *Gillick* competence transfers the responsibility for risk from the clinician to the adolescent, and thus staves off any challenge that the clinician had not obtained effective consent to the treatment.[[173]](#footnote-173) The Family Court of Australia in *Re Sean* recognised that clinicians may seek ‘apparent certainty provided by a court decision authorising a procedure in circumstances where doubt might otherwise attend the capacity to consent’.[[174]](#footnote-174) However, the Court added that it could potentially be an abuse of process if authorisation was sought for treatment plainly within the bounds of parental responsibility ‘where the sole purpose of such an application was as a protection against the prospect of future litigation’.[[175]](#footnote-175) Following *Re Imogen*, the Supreme Court of Queensland in *Re a Declaration Regarding Medical Treatment for ‘A’*[[176]](#footnote-176) exercised its welfare jurisdiction to authorise stage one treatment for an almost 13-year-old adolescent. While this case did not involve a dispute, the Supreme Court noted that medical practitioners ‘have concerns as to whether they can commence treatment which is urgently required without the specific consent of [the adolescent’s] father – hence this application to the court’.[[177]](#footnote-177)

*Bell* CA also highlighted the vulnerability of clinicians to liability for failure to obtain informed consent,[[178]](#footnote-178) and further acknowledged the standards expected from clinicians in England and Wales:

We should not finish this judgment without recognising the difficulties and complexities associated with the question of whether children are competent to consent to the prescription of puberty blockers and cross-sex hormones. They raise all the deep issues identified in *Gillick*, and more. Clinicians will inevitably take great care before recommending treatment to a child and be astute to ensure that the consent obtained from both child and parents is properly informed by the advantages and disadvantages of the proposed course of treatment and in the light of evolving research and understanding of the implications and long-term consequences of such treatment. Great care is needed to ensure that the necessary consents are properly obtained. As *Gillick* itself made clear, clinicians will be alive to the possibility of regulatory or civil action where, in individual cases, the issue can be tested. [[179]](#footnote-179)

While clinician liability in the context of gender care provision has only recently become the subject of litigation in Australia, NHS clinicians may feel greater scrutiny of their decision-making arising from the legacy of Tavistock and a lack of an explicit assessment frameworks[[180]](#footnote-180) in tandem with the emphasis in *Bell* CA on gender diverse adolescents not being a homogenous population.[[181]](#footnote-181)

Clinical deferral to the courts also becomes more likely in an era of increasing defensive practice within healthcare. As O’Dowd notes, there are ongoing academic and professional concerns from regulators such as the General Medical Council (GMC) in the UK that ‘Doctors are becoming more cautious and are practising ‘defensive’ medicine to prevent litigation after treating patients and to avoid investigation’.[[182]](#footnote-182) Ries and Jansen argue these anxieties are changing how doctors practise medicine, leaning towards risk-averse or ‘hedging-type’ defensive practices to avoid complaints, litigation and even negative publicity.[[183]](#footnote-183) For Leask, ‘the court’s opinion will be increasingly sought as parents’ expectations increase and doctors fear litigation.’[[184]](#footnote-184) In Autumn 2022, it was announced that Tavistock is potentially facing 1000 clinical negligence claims on the basis of misdiagnosis and negligent administration of PBs.[[185]](#footnote-185) This trend, combined with ongoing social and institutional scrutiny of treatment provision, makes it likely that clinicians may *want* court approval to avoid the ramifications of potential disputes. Deference to judicial decision-making may become a ‘hedging-type’ practice. Of course, the reverse is also possible: the courts may actually become a more proactive authorising body because clinicians are apprehensive about the provision of treatment.

## HOW MIGHT COURT INVOLVEMENT BE MINIMISED?

This article has demonstrated the difficulty of returning to clinical decision-making. Careful thought is required as to how clinical services and regulatory bodies can better support clinicians, avoiding inappropriate court involvement. We now make three pragmatic suggestions to ensure an appropriate use of the courts’ inherent jurisdiction: improved integration of gender care services within child and adolescent healthcare provision; subsequent development of national guidelines and decision-making protocols for clinicians; and greater clarity as to when court oversight is required.

### *Improved Integration of Gender Care*

Much concern expressed in the ICR related to the volume of referrals, as well as clinical and organisational practice within GIDS.[[186]](#footnote-186) Rather than just focussing on decision-making practice, the ICR highlights the importance of child and adolescent gender care being provided in the same way as any other aspect of healthcare:

A fundamentally different service model is needed which is more in line with other paediatric provision, to provide timely and appropriate care for children and young people needing support around their gender identity. This must include support for any other clinical presentations that they may have.[[187]](#footnote-187)

Furthermore, the benefits of increased gender identity service provision for children and adolescents are proposed in the ICR, not only to ensure access to timely specialist healthcare, but to develop improved evidence-based care:

There needs to be agreement and guidance about the appropriate clinical assessment process that should take place at primary, secondary and tertiary level, underpinned by better data and evidence. Addressing the challenges will require service transformation, with support offered at different levels of the health service.[[188]](#footnote-188)

Gender care for children and adolescents is seemingly ill-suited to a centralised model of service provision, therefore service design and individual access must reflect this.[[189]](#footnote-189) The planned change in NHS England service provision will, at the very least, shift the focus away from singular organisational clinical practice analysis by the courts. However, the Australian experience demonstrates that even with better-integrated and decentralised service provision, there remains some court oversight. Consequently, while multiple providers of gender identity services may challenge the view that treatment is ‘experimental’, clinical decision-making guidelines and frameworks are needed to fully address the concerns expressed in *Bell* and *AB* to avoid defensive practice.

### *National Gender Care Decision-Making Guidelines for All Service Providers*

The historical centralised model has meant that no standardised formal guidelines exist for the management of gender dysphoria in children and adolescents in the NHS. Instead, GIDS has a service specification for children and adolescents.[[190]](#footnote-190) We argue that national guidelines must be developed and implemented, as they are for most conditions. National clinical guidelines are important because they are based on current evidence and expert opinion, providing a ‘robust management strategy for patients and maintenance of consistency and quality in healthcare.’[[191]](#footnote-191) In the case of gender dysphoria these are largely drawn from the Endocrine Society and WPATH, and could be standardised by the National Institute for Health and Care Excellence (NICE). Whilst international clinical guidelines were evidenced within *Bell* HC,and *Bell* CA even described the service specification and SOC as ‘providing much guidance to the multi-disciplinary teams of clinicians’,[[192]](#footnote-192) uniform national guidelines are required. Our concerns have been exacerbated by the proposed Interim Service Specification, which reflects the recommendation from the ICR that PBs are prescribed only within the confines of a long-term clinical study.[[193]](#footnote-193) This recommendation raises ethical concerns regarding compulsory participation in clinical research, despite the most recent SOC8 reflecting the use of PBs as accepted practice. Given that the terms ‘novel’ and ‘experimental’ hold significant weight in the provision of medical interventions, the development of national guidelines must address the issue of whether gender care should be categorised as such, in light of international guidelines and beyond the ICR findings,

Moreover, as *Bell* focused significantly on decision-making, a specific decision-making framework within gender care, clearly explaining the application of *Gillick* competence, would further support clinicians. It is important here to explain that by ‘decision-making guidelines’, we do not mean an ‘improper restriction’ of the *Gillick* criterion, as wrongly set out by *Bell* HC.[[194]](#footnote-194) Rather, we draw from a framework that promotes the primacy of *Gillick* alongside the well-established shared decision-making approach for healthcare decisions between children and their families/carers (in so far as is possible). As highlighted earlier, two of the authors of this paper have proposed a framework that places the *Gillick* competent decision as being determinative so far as possible through engagement and partnership with family and clinicians.[[195]](#footnote-195) However, in the event of disagreement, the framework advocates for improved access to early mediation and engagement with a multidisciplinary team of specialists, including clinical bioethicists, to support young people, their families and clinicians.[[196]](#footnote-196)

### *Professional Clarity as to the Role of the Courts*

Given the potential for ongoing court engagement in the area of gender care for minors, as evidenced by the Australian experience, we finally suggest that clearer guidance on when to seek court authorisation is required for clinicians. There are well-established general principles as to the courts’ role, either set out under s 1(1) of the Children Act 1989, specifically regarding the child’s welfare, or through the court’s inherent jurisdiction to determine a child’s best interests.[[197]](#footnote-197) While academic debate more generally challenges when the court should become involved in decision-making,[[198]](#footnote-198) we do not seek to minimise the importance of the court in settling complex and emotionally fraught disputes between doctors and parents. For example, Auckland and Goold[[199]](#footnote-199) identify a number of scenarios that warrant judicial intervention, particularly when parents disagree with clinicians’ assessment of best interests on the basis of: factual error on behalf of the parent; bias; a sheer inability to decide between options; a conflict of interest;[[200]](#footnote-200) and/or values or beliefs.[[201]](#footnote-201) The court thus retains a necessary oversight role in settling disputes over treatment options and ensuring the paramountcy of the child’s best interests. As Wheeler states, ‘In the correct circumstances, [court declarations] may facilitate clinical management and provide a valuable adjunct to paediatric practice.’[[202]](#footnote-202),

While the courts can play an important role where there is a genuine dispute, it is fundamental that any such intervention does not overstep the boundaries of judicial knowledge and expertise. The courts’ primary concern should be the child’s best interests where this is disputed. Where there is disagreement as to the *nature*, that is the validity, of medical treatment, it should be accepted that clinicians and relevant medical authorities remain best placed to examine and develop effective decision-making and treatment pathways. As Chau notes, it is important that medical professional norms are ‘responsive to emerging scientific evidence in this field, not fixed by the courts on the basis of untested expert evidence.’[[203]](#footnote-203) While this was acknowledged by *Bell* CA*,*[[204]](#footnote-204) the increased likelihood of defensive practice in this area necessitates robust guidelines setting out when court involvement should be sought to ensure consistency and clarity in decision-making practice. Therefore, guidance from the medical regulatory body, the GMC in the UK, or from professional associations, such as the British Medical Association (BMA), would further support clinicians.

Decision-making guidance is not unusual or outside of the remit of these regulatory or professional bodies. For example, both the GMC and the BMA have general guidance regarding children and adolescents,[[205]](#footnote-205) and also procedure-specific guidance for doctors, an example being non-therapeutic male circumcision.[[206]](#footnote-206) This guideline sets out key judgements in this area and issues affecting consent and how best interests are to be weighed. It also sets out when and how court involvement should take place. Principally it states:

You should get the child’s consent if they have the maturity and understanding to give it. If not, you should get consent from all those with parental responsibility. If you cannot get consent for a procedure, for example, because the parents cannot agree and disputes cannot be resolved informally, you should:

– inform the child’s parents that you cannot provide the service unless you have authorisation from the court

– advise the child’s parents to seek legal advice on applying to the court[[207]](#footnote-207)

The guideline also details that where there is a dispute, and only after exhausting all other forms of communication (including potentially second opinions), a court referral may be necessary to resolve the case: ‘The law can provide a protective role for both patients and the health care team where there is disagreement that cannot be resolved.’[[208]](#footnote-208)

We do not claim the non-therapeutic male circumcision guidelines are a suitable model, as there are many core legal and clinical differences between this and gender care which require distinction. Moreover, our reference to male circumcision guidelines should not be taken as a statement of our views regarding its practice. Indeed, the practice is increasingly controversial and there is a growing body of scholarship in law and bioethics that interrogates the legal and clinical position.[[209]](#footnote-209) Accordingly, there are ostensible limits to the utility of this specific guidance for ensuring appropriate use of best interests assessments in the male circumcision context.[[210]](#footnote-210) However, given the vastly different nature of gender care for minors which is, first and foremost, necessitated by the individual experience of the child rather than parental wishes or expectations,[[211]](#footnote-211) there is value in developing a similar style of guidance to better support clinicians in understanding the specific ethico-legal and clinical issues within this area of care and, importantly, to highlight appropriate use of the courts.[[212]](#footnote-212)

We also note that the male circumcision guidance has been criticised for being impractical, this is largely because of the tension between doctors and parents determining the child’s best interests, alongside NHS services not providing non-therapeutic circumcision.[[213]](#footnote-213) Comparatively, gender care may benefit from intervention-specific guidance because of the child’s ability and evolving capacity to engage with decision-making. Notably, guidelines could help reinforce the validity of consent from the competent minor and set out clear processes for doctors to manage disputes before court applications are made. Therefore, it is possible to produce guidance on the interface between clinicians facing disputes and the role the courts should take, which supports our argument that all attempts must be made to minimise judicial intervention. In the context of gender care for adolescents, international clinical guidelines include decision-making approaches, but these cannot provide guidance on the domestic courts’ role. Therefore, if guidelines are developed and supplemented by guidance from the GMC or the BMA, these would better align to the professional standards of practice within the domestic legal framework.

## CONCLUSIONS

*Bell* CA has been heralded as reversing the earlier, damaging HC decision that effectively prevented gender diverse adolescents from accessing PBs without court authorisation. However, this paper has argued that *Bell* CA is unlikely to be the end of inappropriate court involvement without clarification over the boundaries of clinical decision-making. Currently, the lack of explanation as to what might constitute a *difficult* case and the way disputes may be conceptualised leave the legal position vague. The Australian experience highlights three areas in which continued court oversight may be likely: diagnosis or treatment disputes between patients, their parents or carers and clinicians; problematically conceptualising medical interventions as ‘experimental’ or ‘innovative’; and clinicians utilising the courts as a form of defensive practice. Lessons from Australia demonstrate that such judicial interference can disrupt the process of clinical decision-making, cause harm to patients and their families, and deny the rights of gender diverse children and adolescents. We suggest that the planned changes to NHS service provision need to go further in integrating gender care as part of child and adolescent care, to change the narrative of gender diversity and improve access to care. Alongside this should be the development of clearer national clinical guidelines to minimise the need for court involvement. Finally, carefully drafted decision-making guidelines from professional and regulatory bodies could better support clinicians and patients and ultimately minimise the need for court involvement.

The legacy of *Bell* is likely to be ongoing. Any continued inappropriate court oversight could be detrimental to patient care for a vulnerable population subject to socio-political and potentially inappropriate legal scrutiny. Resultantly, greater guidance and clarity is needed on the interface between clinical and patient decision-making and the courts. In light of the Australian experience, we believe more is needed to tackle issues left unresolved by *Bell*, so that the bodily autonomy and identity rights of gender diverse minors are not undermined.

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 The NHS is planning to move away from a centralised model currently delivered by the Gender Identity Development Service (GIDS) within the Tavistock and Portman NHS Foundation Trust through an interim service specification, in favour of a regional network with an amended service specification. See J. Andersson and A. Rhoden-Paul, ‘NHS to close Tavistock child gender identity clinic’ *BBC*, 28 July 2022, http://www.bbc.co.uk/news/uk-62335665?at\_medium=RSS&at\_campaign=KARANGA accessed 15/09/2022. [↑](#footnote-ref-1)
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79. In 2021, the Family Court of Australia and the Federal Circuit Court of Australia combined to become the Federal Circuit and Family Court of Australia. This paper refers to the Family Court, as the court that heard and determined gender dysphoria proceedings. [↑](#footnote-ref-79)
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108. Op. cit., [35(a)]. [↑](#footnote-ref-108)
109. Op. cit., [35(b)]. [↑](#footnote-ref-109)
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118. See *Re Imogen*; *Re Ash* [2021] FedCFamC1F 100; *Re Max* [2021] FamCA 290. [↑](#footnote-ref-118)
119. *Re John* [2021] FedCFamC1F 169; *Re Jesse* [2021] FedCFamC1F 42. [↑](#footnote-ref-119)
120. *Re G4* [2021] FCWA 102; *Re Addison [No 3]* [2021] FamCA 232. [↑](#footnote-ref-120)
121. Dimopoulos, *Decisional Privacy,* 169. [↑](#footnote-ref-121)
122. *Bell* CA, [89]. [↑](#footnote-ref-122)
123. *AB v CD*, op. cit., n. 34. [↑](#footnote-ref-123)
124. Specifically, regarding the context of Respondent 2, the Tavistock clinic and Respondent 3, the University College London Hospital NHS Trust which works with GIDS to provide paediatric and adolescent endocrinology services to treat patients with Gender Dysphoria. [↑](#footnote-ref-124)
125. *AB v CD*, [123]. [↑](#footnote-ref-125)
126. Op. cit. [↑](#footnote-ref-126)
127. Op. cit., [124]. [↑](#footnote-ref-127)
128. Although, as noted below, there are planned changes to Gender Identity Service provision in England and Wales. As yet, however, these proposed changes appear structural rather than substantive. [↑](#footnote-ref-128)
129. NHS England, ‘Gender identity development service for children and adolescent service specification’ (2020) p.3.4.4., http://gender-development-service-children-adolescents.pdf (England.nhs.uk) accessed 15 Oct 2023. [↑](#footnote-ref-129)
130. Op. cit. Although the service specification states for those over 15, support of one or both parents is needed. [↑](#footnote-ref-130)
131. See e.g. T. Matthews, V. Holt, S. Sahin, A. Taylor and D. Griksaitis, ‘Gender Dysphoria in looked-after and adopted young people in a gender identity development service’, *Clinical Child Psychology and Psychiatry* 24(1) (2019), pp.112–128. [↑](#footnote-ref-131)
132. *AB v CD*, [110]. [↑](#footnote-ref-132)
133. Taylor-Sands and Dimopoulos, ‘Judicial Discomfort’. [↑](#footnote-ref-133)
134. *Re Kelvin*, [124] and [13]. [↑](#footnote-ref-134)
135. *Re Bernadette* (2010) 244 FLR 242, [79] and [124]. [↑](#footnote-ref-135)
136. *Re Kelvin*, [139]. [↑](#footnote-ref-136)
137. See Taylor-Sands and Dimopoulos, ‘Judicial Discomfort’, 479. [↑](#footnote-ref-137)
138. *Re Rae* [2017] FamCA 958, [63]. See also *Re Emery* [2016] FamCA 240, [54]. [↑](#footnote-ref-138)
139. *Re Rae*, [57]-[58]. [↑](#footnote-ref-139)
140. *Re Christopher* [2015] FamCA 454, [23]. [↑](#footnote-ref-140)
141. *Re Rae*, [70]. [↑](#footnote-ref-141)
142. *Re Christopher*, [23]. See also *Re a Declaration Regarding Medical Treatment for ‘A’* [2020] QSC 389, [37(d)], [32]; *Re Brodie (Special Medical Procedure)* [2008] FamCA 334, [220], [223]; *Re Rae*, [70]. [↑](#footnote-ref-142)
143. *Re Jamie*, [136]-[138] (Bryant CJ); [185]-[186] (Finn J). [↑](#footnote-ref-143)
144. *Re Kelvin*, [182]. [↑](#footnote-ref-144)
145. Op. cit., [134]. [↑](#footnote-ref-145)
146. *Re Imogen*, op. cit., n.70, [57]. [↑](#footnote-ref-146)
147. Op. cit., [138]. [↑](#footnote-ref-147)
148. Op. cit., [5]. [↑](#footnote-ref-148)
149. Op. cit., [139]. [↑](#footnote-ref-149)
150. *Bell* HC, [65], [77]. [↑](#footnote-ref-150)
151. *AB v CD*. [↑](#footnote-ref-151)
152. Op. cit.,[121]. [↑](#footnote-ref-152)
153. *Bell* CA, [65]. [↑](#footnote-ref-153)
154. For an analysis of why PBs should not be viewed as experimental, see: Giordano, ‘Puberty Delay’, 113. [↑](#footnote-ref-154)
155. See S. Giordano, *Children with Gender Identity Disorder: A Clinical, Ethical, and Legal Analysis* (Routledge, 2012), ch. 6 - 7.; and C. Dietz, ‘Jurisdiction in Trans Health,’ *Journal of Law and Society*, 47(1) (2020), pp.60–86. [↑](#footnote-ref-155)
156. *AB v CD*, [110]. [↑](#footnote-ref-156)
157. Op. cit., 89. [↑](#footnote-ref-157)
158. V. Slothouber, ‘(De)trans visibility: moral panic in mainstream media reports on de/retransition’ (2020) 24(1) *European Journal of English Studies,* 24(1) (2020), pp.89-99, 92. [↑](#footnote-ref-158)
159. Op. cit. [↑](#footnote-ref-159)
160. Op. cit., 93. [↑](#footnote-ref-160)
161. The Cass Review ‘Interim Report’. [↑](#footnote-ref-161)
162. The Cass Review ‘Interim Report’, 69. [↑](#footnote-ref-162)
163. #  Andersson, ‘Tavistock’.

 [↑](#footnote-ref-163)
164. See Taylor-Sands and Dimopoulos, ‘Judicial Discomfort’, 479. [↑](#footnote-ref-164)
165. *Re Imogen* op. cit., [39]. [↑](#footnote-ref-165)
166. B. White, F. McDonald, L. Willmott, *Health Law in Australia* (Thomas Reuters, 2018, 3rd edn), 194. [↑](#footnote-ref-166)
167. Op. cit. [↑](#footnote-ref-167)
168. See e.g., T. Keren-Paz, T. Cockburn and A. El Haj, ‘Regulating Innovative Treatments: Information, Risk Allocation and Redress’, *Law, Innovation and Technology,* 11(1) (2019), pp.1 - 16 and references cited therein. See also M. O’Connor and B. Madden, ‘In the Footsteps of Teiresias: Treatment for Gender Dysphoria in Children and the Role of the Courts’, *Journal of Law and Medicine,* 27(1) (2019), pp.149-163. [↑](#footnote-ref-168)
169. In Australia: https://www.theage.com.au/national/absolutely-devastating-woman-sues-psychiatrist-over-gender-transition-20220823-p5bbyr.html. In England and Wales: C. Dyer, ‘Tavistock to face possible clinical negligence claims over gender identity service,’ *British Medical Journal*, (2022), p.378. [↑](#footnote-ref-169)
170. Trump, ‘Plans to Protect’, https://www.donaldjtrump.com/videos/president-trumps-plan-to-protect-children-from-left-wing-gender-insanity [↑](#footnote-ref-170)
171. *Re G2* [2021] FCWA 98; *Re G3* [2021] FCWA 99. [↑](#footnote-ref-171)
172. *Re G2*, [25]; *Re G3*, [24]. [↑](#footnote-ref-172)
173. *Re Alex*, [155]; *Re Imogen*, [39] and [238]. [↑](#footnote-ref-173)
174. *Re Sean* (2010) 258 FLR 192*,* [88]. [↑](#footnote-ref-174)
175. Op. cit., [93]. [↑](#footnote-ref-175)
176. [2020] QSC 389. [↑](#footnote-ref-176)
177. Op. cit., [36]. [↑](#footnote-ref-177)
178. For discussion of this point, see Dimopoulos, *Decisional Privacy*,183-185. [↑](#footnote-ref-178)
179. *Bell* CA, [92]. [↑](#footnote-ref-179)
180. The Cass Review ‘Interim Report’, 17. [↑](#footnote-ref-180)
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193. See https://www.engage.england.nhs.uk/specialised-commissioning/gender-dysphoria-services/ [↑](#footnote-ref-193)
194. *Bell* CA [94]. [↑](#footnote-ref-194)
195. Dimopoulos and Taylor-Sands, ‘*Re Imogen*’, 42-66. [↑](#footnote-ref-195)
196. Op. cit. [↑](#footnote-ref-196)
197. See n. 53. [↑](#footnote-ref-197)
198. See for example C. Auckland and I. Goold, ‘Parental Rights, Best Interests and Significant Harms: Who Should Have the Final Say Over a Child’s Medical Care?’, *Cambridge Law Journal* 78(2) (2019), pp.287-323 for an interesting discussion about the role of the courts. [↑](#footnote-ref-198)
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210. For more detailed analysis of best interests and male circumcision see: K. Möller, ‘Male and female genital cutting: between the best interest of the child and genital mutilation’, *Oxford Journal of Legal Studies* 40(3) (2020), pp.508-532. [↑](#footnote-ref-210)
211. Male circumcision typically happens in infancy or early childhood at the request of the parents. See BMA Guidance ‘Non-Therapeutic Male Circumcision’, op. cit. [↑](#footnote-ref-211)
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