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## Trans\* identity does not limit children's capacity: *Gillick* competence applies to decisions concerning access to puberty blockers too!

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In *Bell & Anor v The Tavistock and Portman NHS Foundation Trust* [2021] EWCA Civ 1363 the Court of Appeal overturned the decision of the High Court in *Bell & Anor v The Tavistock and Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin) concerning the judicial review of the policies and practice of the Tavistock and Portman NHS Trust ('Tavistock'), through its Gender Identity Development Service (GIDS) of prescribing puberty blockers to children and young people below the age of 18. The facts of the case are as follows.

The original case was filed by Keira Bell, a former patient of the Tavistock, and Mrs A, the mother of a child on the waiting list for treatment. Keira Bell was assigned female at birth, and was treated with puberty blockers at the age of 16. She was then treated with cross-sex hormones and underwent surgical intervention to transition fully from female to male. After taking testosterone for three years, she began to have doubts about the transition, but nevertheless when she was 20, she had a double mastectomy. She later regretted her decision to transition and from January 2019 she stopped taking testosterone, and now identifies as a woman. The main issue in the claim was to determine whether children below the age of 18 are competent to give consent to puberty blockers. The claimants argued that children below the age of 18 are not competent and therefore require the consent of the court every time puberty blockers are prescribed. In addition, a further claim concerned the lawfulness of the policies and practice provided by Tavistock.

In its decision, the High Court did not declare the practice and policies of Tavistock as unlawful, and concluded that children under 16 may only consent if *Gillick* competent. However, the Court added that it was 'highly unlikely' that a child aged 13 or under would be *Gillick* competent to give consent and that it was 'very doubtful' that a child of 14 or 15 would understand fully the long-term implications of the treatment [HC, para 145]. Further the High Court gave a point of guidance for clinicians to follow in ascertaining the competency of children below the age of 16. The court held that in order for a child to be *Gillick* competent to give valid consent the child would have to understand, retain and weigh the following information: (i) the immediate consequences of the treatment in physical and psychological terms; (ii) the fact that the vast majority of

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patients taking puberty blocking drugs proceed to taking cross-sex hormones and is, therefore, a pathway to much greater medical interventions; (iii) the relationship between taking cross-sex hormones and subsequent surgery, with the implications of such surgery; (iv) the fact that cross-sex hormones may well lead to a loss of fertility; (v) the impact of cross-sex hormones on sexual function; (vi) the impact that taking this step on this treatment pathway may have on future and life-long relationships; (vii) the unknown physical consequences of taking puberty blocking drugs; and (viii) the fact that the evidence base for this treatment is as yet highly uncertain [HC, para 138].

The statutory presumption of capacity in section 8 of the Family Law Reform Act 1969 applies to young persons aged 16 and over. However, the High Court held that it would be appropriate for clinicians to involve the court in any case where there may be any doubts' about the impact of the treatment [HC, para 147]. The intervention of the court is required because of the nature of the treatment as considered innovative and experimental, and its long-term psychological and physical consequences not yet fully understood [HC, para 148].

The Tavistock appealed. The issues before the Court of Appeal were whether the High Court had approached the evidence appropriately, and whether it was right to have made the declaration and its accompanying guidance. The Court of Appeal allowed the appeal, maintained that it was not for the Court in judicial review to decide upon contested evidence, set aside the declaration and held that it was inappropriate for the High Court to provide such guidance [CoA, para 91]. Thus, it affirmed that the original *Gillick* competence applies also to children below the age of 16 who ask for puberty blockers, and that it is for the clinicians – and not for the court – to determine whether the child has the required maturity. Unlike the High Court, the Court of Appeal recognised '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' [CoA, para 76] and therefore did not justify modification of the test.

At first sight, the decision of the Court of Appeal seems to make the case less about the alleged specific controversial context – access to puberty blockers – and more about the general principles applicable to medical decision making. Indeed, the Court of Appeal stated that once the High Court did not declare the practice and policy of Tavistock to be illegal, the focus of the appeal was 'squarely on *Gillick*' [CoA, para 94]. However, a comparative reading of the two decisions shows that there is more than a different application of *Gillick*. The two decisions differ significantly on the manner in which they conceptualise/construct trans children. Such different approaches explain how the two courts have valued trans children's voices and capacity, how the two courts have interpreted *Gillick* differently, and reached divergent conclusions.

The High Court proceeded by homogenising trans children and generalising the impact of gender dysphoria as essentially making children vulnerable and incapable of understanding the consequences of taking puberty blockers; limits to capacity that, according to the Court, cannot be fulfilled by offering adequate information about puberty blockers and their effects [HC, para 144].

This assumption about the capacity of trans children is mirrored in the guidance to ascertaining competency, and in the weight the High Court gave to the evidence submitted to it. In fact, the Court had evidence from self-identified trans children and young people who explained how having access to puberty blockers was beneficial for

their well-being. The Court, however, neglected those voices, and instead made factual findings on the basis of other disputed evidence, and statistics. As suggested by Merry (2016), statistics are seductive but can only work if accompanied by contextualised qualitative accounts of local knowledge. Thus, prioritising disputed evidence over the voice of children has bluntly denied the meaningful agency of those voices and, more generally, those of trans children. Further, the High Court conceptualised trans children and young people essentially in terms of protection, and never as individuals with their own rights and capacity to express themselves. It is through the protection lens, intertwined with the view that access to puberty blockers represents a special category of medical intervention, that the High Court felt the need to restrict the *Gillick* test, and to suggest the intervention of the court when puberty blockers are to be prescribed.

Conversely, the Court Appeal has departed from a stage-based developmental conception of childhood. Its decision conveys the view that trans identity *per se* does not influence the competence of children required for the *Gillick* test. The court acknowledged the difficulties surrounding the issues discussed, but in drawing upon *AB v CD* [2021] EWHC 741 (Fam) it accepted that puberty blockers do not represent a particular category of medical intervention and do not deprive children of the capacity to consent. The court also maintained that giving guidance was inappropriate and that the High Court ‘was not in a position to generalise about the capability of persons of different ages to understand what is necessary for them to be competent to consent to the administration of puberty blockers’ [CoA, para 85]. In doing so, the Court of Appeal departed from sterile generalisations about trans children, recognised trans children’s agency, and encouraged respectful attention for each trans child requiring access to puberty blockers. Further, it removed courts from the decision-making process concerning access to puberty blockers, and neatly reinstated the distinction of responsibilities and roles that judges and clinicians have. Decision making concerning health issues is often difficult, but the declaration of the High Court ‘turns expressions of judicial opinion into a statement of law itself’ [CoA, para 80] and was based on factual findings that the Court ‘was not equipped to make’ [CoA, para 65], whereas the clinicians, given their expertise and professional regulations, could decide whether a child is *Gillick* competent.

Both gender identity and child autonomy are aspects of life that mirror systemic inequalities and power imbalances. They raise ethical and moral issues that both Courts recognised. Yet, both Courts did not engage with children’s rights discourse and did not acknowledge that the one to identity is indeed a child right. Thus, this case reveals both the need to employ rights and protection discourses in proactive terms to overcome systemic inequalities and power imbalances, and to conduct further research involving trans children avoiding the influence of sterile debates that use biology and protection discourses as tools to suppress their voices and agency.

### Disclosure statement

No potential conflict of interest was reported by the author(s).

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