



Mature minors and gender dysphoria: a matter for clinicians not courts

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doi:10.1136/medethics-2021-107924

Lord Scarman's judgment about when someone under the age of 16 years should have the right to make their own medical decisions emphasised the decision-making abilities of the particular child. He said:

...the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed (p188–189).¹

That created a duty on healthcare practitioners to assess whether a particular minor has decision-making abilities at a degree that would enable them to understand the decision to a high extent, sufficient hopefully that they would 'own' the decision. In December of 2020, the High Court considered whether young people with gender dysphoria (GD) and seeking access to puberty blocking (PB) therapy, were likely to pass Scarman's mature minor test and cast doubt on their ability to fully understand that decision, thereby making it less likely that a healthcare practitioner would decide they are a mature minor for that therapy. The High Court said:

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 (p151).²

Since then, the *Journal of Medical Ethics* has published papers about the ethical issues raised by that judgment. Beattie, writing at the time the judgment was made, disagreed with the High Court and claimed that the decision to take puberty blockers is no more complex than many of the other medical decisions that minors are assessed as being competent to make.³ Central to the High Court's decision was the claim that the decision to start PB therapy (the first stage of therapy for GD) is inextricably linked to the more permanent and significant, cross-sex hormone (CSH) therapy. That meant the abilities

required to fully understand what was proposed became very demanding because they would require someone who had not yet gone through puberty to know what a second round of treatment, that would result in permanent and complex changes, would mean for them. Beattie objects to that claim for several reasons including that '...high progression rates to CSH may merely represent successful identification of persistent GD, rather than PBs promoting persistence' (p4).

Giordano *et al* consider the possibility that consenting to PB might be more complex than other treatments a minor might consent to.⁴ They point out that many other medical decisions are similarly complex and emotionally involving, so PB should not be viewed differently from other decisions a minor might take.

The High Court's judgment was recently overturned by the Court of Appeal who criticised the judgment on a number of grounds, including the implications that it would have for those seeking therapy for GD.

Moreover, the effect of the guidance was to require applications to the court in circumstances where the Divisional Court itself had recognised that there was no legal obligation to do so. It placed patients, parents and clinicians in a very difficult position. In practice the guidance would have the effect of denying treatment in many circumstances for want of resources to make such an application coupled with inevitable delay through court involvement (p86).⁵

While some might read that as an ethical point about access to therapy, the Court of Appeal is making a legal point about when it is appropriate for the court to become involved and the costs of them doing so. That kind of concern continues where they object to the court making age-based recommendations about the likely ability of young people to consent.

We conclude that it was inappropriate for the Divisional Court to give the guidance concerning when a court application will be appropriate and to reach general age-related conclusions about the likelihood

or probability of different cohorts of children being capable of giving consent (p89).⁵

Predictably, the Court of Appeal judgment has been hailed as 'a positive step forwards for trans rights in the UK and around the world'.⁶ It is important to be clear, though, about exactly what was and what was not an issue here. The court was careful not to take a position on the debate about PBs. It recognised that this is an ongoing controversy. 'The present proceedings do not require the courts to determine whether the treatment for GD is a wise or unwise course'.⁵

Furthermore, there is nothing in the judgment about how often minors seeking access to PBs will be assessed as competent to make that decision, nor about what they will need to demonstrate in order to show that competence.

As we have already said, the principle enunciated in Gillick was that it was for clinicians rather than the court to decide on competence (p87).⁵

The point is precisely that it is not appropriate for courts to involve themselves in such matters. It will be for clinicians to make that determination. There is nothing inherent to the nature of PBs that set them apart from other healthcare decisions, nothing that justifies the court intruding on what is a well-recognised area of clinical expertise.

Certainly, it is not for the court to require that young people accept as matters of fact propositions that are currently factually contested or complex, such as the claim that PBs almost always serve as precursors to 'much greater medical interventions'. And it is not for the court to issue guidance, in general terms, about when capacity assessments should require judicial intervention.

There was a recognition here that this is a 'difficult and controversial area', where facts are contested and deep-seated values set in conflict. But as the court acknowledged, the concept of 'Gillick competence' arose in a context where that could also have been said of the provision of contraceptives to minors. Generalisations about capacity assessment

were no more appropriate here than they were back in that earlier context.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; internally peer reviewed.

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REFERENCES

- 1 1 AC 112. *Gillick v West Norfolk and Wisbech area health authority and another*, 1986.
- 2 EWHC 3274. *Bell v the Tavistock and Portman NHS Foundation trust*, 2020.
- 3 Beattie C. High Court should not restrict access to puberty blockers for minors. *J Med Ethics* 2021.

doi:10.1136/medethics-2020-107055. [Epub ahead of print: 16 Feb 2021].

- 4 Giordano S, Garland F, Holm S. Gender dysphoria in adolescents: can adolescents or parents give valid consent to puberty blockers? *J Med Ethics* 2021;47(5):324.
- 5 EWCA Civ 1363. *Bell v The Tavistock and Portman NHS Foundation trust*, 2021.
- 6 Liberty: court of appeal ruling step forwards for trans rights. Available: <https://www.libertyhumanrights.org.uk/issue/liberty-court-of-appeal-ruling-step-forwards-for-trans-rights/>