IN THE MATTER OF:

KEIRA BELL (1)
TRANSGENDER TREND (2)

ADVICE IN RESPECT OF PROPOSED LEGISLATION ON "CONVERSION THERAPY"

Introduction

1. I am asked by Keira Bell, and Transgender Trend to advise on whether a proposed legislative prohibition of "conversion therapy" for gender identity is likely to be unlawful specifically in terms of :

    (i) The provision of treatment for children by fettering the ability of clinicians to provide appropriate therapeutic input;
    (ii) The ability of parents to help their children navigate the development of their personal identity;
    (iii) The rights of children to be protected from inadequate therapeutic services and experimental medical treatment;

Summary of Advice

2. For the reasons set out below, it is my view that any proposed UK legislation which seeks to ban conversion therapy in respect of children **and** gender identity is likely to give rise to a substantial risk of unlawfulness because of incompatibility with rights protected under Article 8, 9, 10, 11 and possibly also Article 2 of the First Protocol on the European Convention on Human Rights.

3. The risk of unlawfulness may be mitigated by exceptions or exemptions from the ban, but in general terms any proposed legislation that includes a proscription of any attempt to cancel, change or suppress '*gender identity*' in terms similar to that proposed, in say, the Australian Capital Territory definition below, is likely to be unlawful since it would deny to a cohort of consenting patients treatments such as

"*watch and wait*" aimed at allowing the natural pubertal process in children to take effect and allow natural desistance of the underlying condition.

4. Moreover, from what I have seen from my instructions it is far from clear that such a wide proscription has any firm scientific or evidential basis such that any such legislation would be justified as proportionate in meeting a pressing social need. There is a justifiable concern that the motivation for the inclusion of 'gender identity' in both the MOU 2017 and the proposed draft legislation is grounded in a political viewpoint of gender identity not on scientific evidence of harm caused by such therapy.

Background to the concerns

5. Keira Bell is one of the two Claimants in the current litigation against the Tavistock clinic. She underwent gender reassignment treatment at the Tavistock but has subsequently regretted undergoing such treatment and brought proceedings in the High Court to ventilate her concerns. These cover the manner in which she was treated, in particular concerns over the reliance on her 'consent' while she was still at a vulnerable and impressionable age and suffering not simply from gender dysphoria but other co-morbid conditions as well which she says were never fully explored.

6. Transgender Trend is a UK organisation advocating for evidence-based care of gender dysphoric children and science-based teaching in schools. It is an interested party in those proceedings.

7. A summary of the concerns raised by those instructing are that:-
    (i) there is an inadequate evidence base from which to ban conversion therapy;
    (ii) a ban would be more harmful than the problem it seeks to remedy

(iii) there is no agreed approach to gender identity *per se*, with many people disavowing they have one.

(iv) there is dispute within both the Royal College of Psychiatrists and the British Psychological Society over the definition of conversion therapy. In particular, the inclusion of "gender identity" in any definition.

Proposed legislation to ban conversion therapy

8. I have been provided for the purpose of this advice with a table of actual or proposed legislation in other jurisdictions where "bans" on CT have been sought to be imposed. This legislation varies, both in its definition of CT and the extent to which exemptions are made to the ban. I do not go through each and every one of those definitions but identify four for the purposes of this advice, which show how, through a process of definition, scope of application and exceptions or exemptions the proposed or actual ban is achieved.

Australian Capital Territory

9. The **Australian Capital Territory** definition is as follows:

> *"In this Act: sexuality or gender identity conversion practice means a treatment or other practice the purpose, or purported purpose, of which is to change a person's sexuality or gender identity"*

10. The exceptions:

> *"However, sexuality or gender identity conversion practice does not include a practice the purpose of which is to—*
> *(a) assist a person who is undergoing a gender transition; or*
> *(b) assist a person who is considering undergoing a gender transition; or*
> *(c) assist a person to express their gender identity; or*
> *(d) provide acceptance, support or understanding of a person; or (e) facilitate a person's coping skills, social support or identity exploration and development"*

11. I understand this legislation to be of broad application, including whether or not the recipient consents to the practice.

Queensland Australia

12. The **Queensland Australia** definition is:

> *"Conversion therapy is a treatment or other practice that attempts to change or suppress a person's sexual orientation or gender identity."*
>
> *Examples—*
> *• conditioning techniques such as aversion therapy, psychoanalysis and hypnotherapy that aim to change or suppress a person's sexual orientation or gender identity*
> *• other clinical interventions, including counselling, that encourage a person to change or suppress the person's sexual orientation or gender identity*
> *• group activities that aim to change or suppress a person's sexual orientation or gender identity*

13. Exceptions to that definition are:

> *"Conversion therapy does not include a practice that:*
> *(a) assists a person who is undergoing a gender transition; or*
> *(b) assists a person who is considering undergoing a gender transition; or*
> *(c) assists a person to express their gender identity; or*
> *(d) provides acceptance, support and understanding of a person; or*
> *(e) facilitates a person's coping skills, social support and identity exploration and development.*
> *Also, conversion therapy does not include a practice by a health service provider that, in the provider's reasonable professional judgment, is necessary to—*
> *(a) provide a health service in a manner that is safe and appropriate; or*
> *(b) comply with the provider's legal or professional obligations."*

14. My understanding is that the scope of the legislation limits the application to health service providers only.

Canada Nova Scotia

15. In **Canada Nova Scotia,** the term "change effort" rather than conversation therapy is is used, thus:

> *"The purpose of this Act is to protect Nova Scotia youth from damaging efforts to change their sexual orientation or gender identity.*
> *In this Act, (a) "change effort" means any counselling, behaviour modification techniques, administration or prescription of medication or any other purported*

treatment, service or tactic used with the objective of changing a person's sexual orientation or gender identity;

16. The relevant exceptions to that legislation read:-

> *"Subsection (1) does not apply where the person receiving the services is over the age of sixteen years, capable of consenting to the services and consents to the services. [...] For greater certainty, the services and change efforts referred to in Sections 4 and 5, subsection 6(1) and subsection 7(1) do not include (a) services that provide acceptance, support or understanding of a resident or the facilitation of a resident's coping, social support or identity exploration or development; and (b) gender-confirming surgery or any services related to gender-confirming surgery*

17. It may be noted that the Nova Scotia legislation only applies to minors (I presume because they not able to consent) and in terms of scope it applies to regulated health professionals or anyone '*in a position of trust or authority towards a young person"*.

Malta

18. The Maltese definition (proposed) is as follows

> *"In this Act, unless the context otherwise requires: "conversion practices" refers to any treatment, practice or sustained effort that aims to change, repress and, or eliminate a person's sexual orientation, gender identity and, or gender expression; "*

19. The exceptions are:

> *"Such practices do not include –*
> *(a) any services and, or interventions related to the exploration and, or free development of a person and, or affirmation of one's identity with regard to one or more of the characteristics being affirmed by this Act, through counselling, psychotherapeutic services and, or similar services; or*
> *(b) any healthcare service related to the free development and, or affirmation of one's gender identity and, or gender expression of a person; and, or*
> *(c) any healthcare service related to the treatment of a mental disorder;*

20. In terms of scope the prohibition applies to 'professionals' - broadly defined to include counsellors, medical practitioners, youth workers, etc. conducting conversion therapy, regardless of whether the services are paid for or not. It only applies to

vulnerable individuals (including minors) or where someone has been coerced. There is a prohibition of advertising conversion therapy practices.

General observations on actual or proposed legislation

21. In general terms the common features of the proposed or actual legislation summarised above are:

    (a) a definition of "conversion therapy" or 'change effort' which includes gender identity as well as sexual orientation. Indeed a common general definition would appear to be on the following lines: *"conversion therapy means any treatment or practice that seeks to change or suppress a person's sexual orientation or gender identity"*.

    b) limitations on scope, which can include a limitation to vulnerable persons or minors only – the rationale being presumably that over 16's and non-vulnerable persons have the capacity to consent to treatment or therapy of their choosing and should not have it prohibited by legislation.

    (c) while prohibiting therapy which attempts to change, suppress or repress a person's gender, any therapy or surgery which *confirms* self-identified gender, (e.g. affirmation, social transition, puberty blockers, cross sex hormones, gender reassignment surgery) is excepted from the prohibition.

Background to Conversion Therapy

22. In order to understand these definitions when applied to the UK context, I set out briefly below what I understand to be the background to the proposed ban.

23. "Conversion Therapy" at least in its initial use, refers to scientific / pseudoscientific practices that are deployed to attempt to change and individual's sexual orientation –

historically from homosexuality or bisexuality to heterosexuality using psychological, physical or spiritual interventions. Invasive techniques that have been historically associated with CT include ice-pick lobotomies; chemical castration alongside hormonal treatment and clinically aversive treatments such as 'electro-shock therapy'. The term 'reparative therapy' is sometimes deployed as a synonym.

24. More recently the phrase has come to be used to apply to practices concerning Gender Identity although the evidence of what such practices consist in is sparse.

25. In particular, within the UK, a Memorandum of Understanding (MOU) (Version 2 – 2017) exists that has been signed by the NHS, regulatory bodies and counselling associations stating that '*conversion therapy in relation to* ***gender identity and sexual orientation*** *(including asexuality) is unethical and potentially harmful*'. The relevant introductory text to the Memorandum seeks to explain the terms it uses to make this wide-ranging statement as follows:-

"**Purpose and Overarching Position:**

1 *The primary purpose of this Memorandum of Understanding (MoU) is the protection of the public through a commitment to ending the practice of 'conversion therapy' in the UK.*

2 For the purposes of this document 'conversion therapy' is an umbrella term for a therapeutic approach, or any model or individual viewpoint that demonstrates an assumption that any sexual orientation or gender identity is inherently preferable to any other, and which attempts to bring about a change of sexual orientation or gender identity, or seeks to suppress an individual's expression of sexual orientation or gender identity on that basis. These efforts are sometimes referred to by terms including, but not limited to, 'reparative therapy', 'gay cure therapy', or 'sexual orientation and gender identity change efforts', and sometimes may be covertly practised under the guise of mainstream practice without being named.

> *i) For the purpose of this document, sexual orientation refers to the sexual or romantic attraction someone feels to people of the same sex, opposite sex, more than one sex, or to experience no attraction.*
>
> *ii) For the purposes of this document, gender identity is interpreted broadly to include all varieties of binary (male or female), nonbinary and gender fluid identities.*

3. Signatory organisations agree that the practice of conversion therapy, whether in relation to sexual orientation or gender identity, is unethical and potentially harmful.

…
6…
…For people who are unhappy about their sexual orientation or their gender identity, there may be grounds for exploring therapeutic options to help them live more comfortably with it, reduce their distress and reach a greater degree of self-acceptance. Some people may benefit from the support of psychotherapy and counselling to help them manage unhappiness and to clarify their sense of themselves. Clients make healthy choices when they understand themselves better.

26. This 2017 MOU may usefully be compared with the previous 2015 version which referred only to '**sexual orientation'** and did not include any reference to gender identity. The relevant similar text without the addition of "*or gender identity*" (only six years old) read as follows:-

" There has been a long history of medical and psychological professions seeing homosexuality as a form of arrested sexual development. Up until 1974 the American Psychiatric Association classified homosexuality as a mental illness. In 1992 the World Health Organisation declassified homosexuality as a mental disorder.
Awareness of the prevalence of conversion therapy in the UK grew following the publication of research in 2009 which revealed that 1 in 6 psychological therapists had engaged clients in efforts to change their sexual orientation.
Several professional bodies have reviewed the evidence around conversion therapy and concluded there is no good evidence that it works, while there is evidence that it has the potential to cause harm.

'Conversion therapy' is the umbrella term for a type of talking therapy or activity ***which attempts to change sexual orientation or reduce attraction to others of the same sex****. It is also sometimes called 'reparative' or 'gay cure' therapy.*

The purpose of this memorandum of understanding (MoU) is to set out an agreed framework for activities by the parties concerned to help address the issues raised by the practice of conversion therapy in the UK. ***The MoU is informed by a position that efforts to try to change or alter sexual orientation through psychological therapies are unethical and potentially harmful****. This position is not intended to discourage clients with conflicted feelings around sexuality seeking help. Psychological therapists routinely work with people who are struggling with inner conflict. '****For people who are unhappy about their sexual orientation – whether heterosexual, homosexual or bisexual – there may be grounds for exploring therapeutic options to help them live more comfortably with it, reduce their distress and reach a greater degree of acceptance of their sexual orientation****".*

27. The inclusion of "*gender identity*" as being a concept comparable to '*sexual orientation*" and deserving of an equivalent approach in respect of prohibiting "*conversion therapy*" in the 2017 MOU and more widely, was and remains highly controversial –

especially in light of the decision in *R(Bell) and another v Tavistock*. [2012] PTSR 593 which underscores that children under 16 are unlikely to be able to understand the ramifications of some gender conversion procedures, such as puberty blockers followed by cross sex hormones. This is particularly important as can be seen from the above examples of actual or proposed legislation in other jurisdictions where the focus of a ban is directed at the treatment of minors, or vulnerable persons. The implication of the Divisional Court's ruling is that persons under 16, are unlikely to be able to give consent to change effort/conversion therapy which confirms self-identified gender where that does not correspond with their biological sex because of the life-long consequences and the experimental nature of the treatment.

28. The depth of the controversy may be seen from a letter written in June 2020, by a number of eminent psychologists written to the Chief Executive of the British Psychological Society about the Guidelines for Psychologists Working with Gender Sexuality and Relationship Diversity (which are expressly referred to and required to be read alongside the 2017 MOU[1]) making the points that:-

(i) the Guidelines/MOU only represents a trans-affirmative ideological position and does not rehearse competing views from, for example, gender critical feminism[2] or versions of scientific realism;

(ii) the singular focus on gender affirmation implies that psychologists disagreeing with it are in some way ethically deficient in their practice

(iii) the document is dominated by assertion and moral injunction but does not address the evidence for (or its lack) for gender affirmative practices

(iv) It is not clear why gender, sexuality and relationship diversity are being discussed together when they are separate concepts with no self-evident connection from a psychological perspective.

(v) the guidance may inhibit psychologists from raising concerns and giving appropriate treatment tailored to the individual.

[1] See Clause 17 of the 2017 MOU

[2] Feminists holding a gender critical position: i.e. that sex is a material reality which should not be conflated with gender or gender identity. Being female is an immutable biological fact not a feeling or identity. … and sex matters. Gender does not trump sex and therefore transwomen are not women – see e.g. *Forstater.*

29. All these criticisms apply equally to a definition of conversion therapy which is to be found in the Royal College of Psychiatrists Position Statement: *Supporting Transgender and Gender-Diverse People* as follows:-

"The term 'conversion therapy' has also been used to describe treatments for transgender people that aim to suppress or divert their gender identity – i.e. to make them cisgender – that is exclusively identified with the sex assigned to them at birth. Conversion therapies may draw from treatment principles established for other purposes, for example psychoanalytic or behaviour therapy. They may include barriers to gender-affirming medical and psychological treatments. There is no scientific support for use of treatments in such a way and such applications are widely regarded as unacceptable."

30. More fundamentally there is a very real concern expressed by those instructing as to meaning and scope of the concept of '*gender identity*'. It is not defined in the MOU 2017. Rather it is simply stated that there should be broad interpretation of the concept.

31. In understanding its meaning, some light is shone on the meaning of gender identity by first looking at the condition of gender dysphoria, and then on how gender identity has been dealt with by the courts.

Gender Dysphoria

32. Closely connected to the concept of gender identity is the condition of gender dysphoria. Gender dysphoria was, but is no longer recognised as a mental illness. Rather it is defined as follows in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) which provides for one overarching diagnosis of gender dysphoria with separate specific criteria for children and for adolescents and adults:

> *"In adolescents and adults gender dysphoria diagnosis involves a difference between one's experienced gender and assigned gender, and significant distress or problems functioning. It lasts at least six months and is shown by at least two of the following:*
>
> *1. A marked incongruence between one's experienced / expressed gender and primary and / or secondary sex characteristics*
>
> *2. A strong desire to be rid of one's primary and / or secondary sex characteristics*

3. A strong desire for the primary and / or secondary sex characteristics of the other gender

4. A strong desire to be of the other gender

5. A strong desire to be treated as the other gender

6. A strong conviction that one has the typical feelings and reactions of the other gender.

In children, gender dysphoria diagnosis involves at least six of the following and an associated significant distress or impairment in function, lasting at least six months:

1. A strong desire to be of the other gender or an insistence that one is the other gender

2. A strong preference for wearing clothes typical of the other gender

3. A strong preference for cross-gender roles in make-believe play or fantasy play

4. A strong preference for toys, games or activities stereotypically used or engaged in by the other gender

5. A strong preference for playmates of the other gender

6. A strong rejection of toys, games and activities typical of one's assigned gender

7. A strong dislike of one's sexual anatomy

8. A strong desire for the physical sex characteristics that match one's experienced gender."

33. It may be seen that in this definition of gender dysphoria, gender identity is expressed in binary terms e.g. "*the other gender*", and is explained by a comparison between '*experienced gender*' (a subjective and personal experience) and biological primary or secondary characteristics.

34. But even this understanding of gender dysphoria itself is far from uncontroversial. As was pointed out by one of the Claimants' key witnesses in the Tavistock case, Professor Levine, there are at least three very different ways of understanding gender dysphoria:

    a. A curable illness that causes suffering, to be treated through medical intervention. The difficulty with this conceptualisation is there is no known biological cause of gender dysphoria and so it is a psychiatric rather than a physical condition. This means that "*since doctors gave up performing lobotomies to treat psychiatric disorders many decades ago, gender dysphoria is the only psychiatric condition that doctors ultimately treat by surgery."*

b. A developmental paradigm, in which gender dysphoria is a manifestation of various underlying issues and events in the child's life, to be treated primarily through psychological therapy.

c. An issue of sexual minority rights, where if a child claims to 'be' the opposite gender to their birth sex, any response other than agreement and affirmation by society and medical professionals is a violation of the individual's civil right to self-expression. The difficulty with this conceptualisation for the purposes of evidence-based medicine is that it is not a medical or scientific understanding at all, but a political one.

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35. An additional feature of the scientific evidence in relation to gender dysphoria is evidence as to its persistence and that in the majority of cases gender dysphoria desists over time and particularly during puberty. According to DSM5: "*in natal males, persistence of [gender dysphoria] has ranged from 2.2% to 30%. In natal females, persistence has ranged from 12% to 50%.*"

36. Thus it is a natural feature of the condition of gender dysphoria that it may desist over time. There is a concern that treatment such as GnRHa (puberty blockers) may in fact increase persistence rather than allow the natural pubertal process to cause the gender dysphoria to alleviate. The point is made by the authors *Brik et al* : Archives of Sexual Behavior (2020) 49:2611-2618 as follows:-

> "*Some state that adolescents may be unable to make far-reaching decisions at a young age, especially in the presence of comorbid psychiatric conditions, which are common among youth with gender dysphoria (Korte et al., 2008; Laidlaw et al., 2019; Vrouenraets et al., 2015). Furthermore, gender identity develops and may change during adolescence.* ***Concerns have been raised that the use of GnRHa may infuence this process and might increase the likelihood of persistence of gender dysphoria*** *(Korte et al., 2008; Laidlaw et al., 2019; Richards et al., 2019; Stein, 2012; Vrouenraets et al., 2015). It is unknown if the use of GnRHa prevents resolution of gender dysphoria (Korte et al., 2008).* ***Many prepubertal children with gender dysphoria no longer experience gender dysphoria in adolescence, and the experience of romantic and sexual attraction is thought to play an important role in this process (****Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011). Some may come to understand themselves as homosexual or bisexual (Steensma et al., 2011).* ***GnRHa, by blocking sexual***

development, might interfere with this process *(Korte et al., 2008).* ***Another concern is that although GnRHa treatment is to be used as an extended diagnostic phase, the start of it may lead the adolescents and parents to assume that transgender outcome is the only possible outcome which may prevent exploration of other possibilities*** *(Leibowitz & de Vries, 2016)"*

(emphasis emboldened)

Gender Identity in law

37. Against this backdrop I turn to how the concept of gender identity is most commonly used in the UK and Strasbourg Jurisprudence. Essentially, it is used as a relational concept which describes an individual's self-perception in relation to society. It relates to the *social* attributes of sex, or those social characteristics generally associated with being female or male[3]. A helpful explanation of Gender Identity used in this sense is given at first instance in *Elan- Cane* by Jeremy Baker J.

> *96. Although at one time the terms "sex" and "gender" were used interchangeably, (and confusingly still are on occasions), due to an increased understanding of the importance of psychological factors, (albeit these may be due to differences in the brain's anatomy), sex is now more properly understood to refer to an individual's physical characteristics, including chromosomal, gonadal and genital features, whereas gender is used to refer to the individual's self-perception.*
>
> *97. The established concepts of both sex and gender are based upon a binary differentiation between male and female. Certainly, as the defendant points out, this is the basis for current UK legislation relating to gender, hence the effect of a recognition certificate under the Gender Recognition Act 2004 enables the individual to acquire for all purposes either the male or female gender.*
>
> *98. Of course, the notion of an individual not conforming exclusively to one or other of the binary categories of male or female is of ancient lineage, going back at least to the Greeks and the figure of Hermaphroditus; albeit this was based upon incongruency between the individual's physical sexual characteristics, which is now normally referred to as "intersex". More recently however, since the recognition of the importance of psychological factors influencing gender, it has become clear that there may also be incongruency between an individual's physical characteristics and their psychological ones.*

[3] As some commentators have pointed out, there is a real danger that when gender identity is stripped of its natural association with biological sex, it is very uncertain of meaning other that by resort to gender- stereotypes in assessing what the social attributes of a man or woman are: wearing make up, a preference for pink rather than blue, etc. All seem a very imprecise way of identifying a persons gender identity.

> 99. *The most common and certainly well-known form of this latter type of incongruency has become known as transsexuality or transgenderism, where the individual's physical sexual characteristics oppose that of their psychological ones; for which medical assistance has been available for some time, and in respect of which there is now the ability to obtain full legal recognition under the Gender Recognition Act 2004. Although this has largely resolved the legal difficulties faced by this group, it is still based upon the binary concept of gender, with the individual becoming recognised as being either male or female, usually in accordance with their psychological gender identity.*

38. Thus whatever its precise description (i.e. whether viewed in a binary sense, or a wider, more fluid sense) gender identity is undoubtedly an aspect of personal identity and as such is protected by Article 8 of the ECHR. As the Court of Appeal in *Elan-Cane* held:

> *"There can be little more central to a citizen's private life than gender, whatever that gender may or may not be. No-one has suggested (nor could they) that the Appellant has no right to live as a non-binary, or more particularly as a non-gendered, person. Indeed, a gender identity chosen as it has been here, achieved or realised through successive episodes of major surgery and lived through decades of scepticism, indifference and sometimes hostility must be taken to be absolutely central to the person's private life. It is the distinguishing feature of this Appellant's private life."*

39. Thus in legal terms, the safeguarding and preservation of gender identity and the ability of the individual to understand and determine that identity are fundamental aspects of private life, and Article 8 protects against interferences by the state with aspects of personal identity. These include for example, an individual's right to determine his or her dress or appearance: *McFeeley v United Kingdom* (1980) 30 EHRR 161, ECtHR; *Sutter v Switzerland* (1984) 6 EHRR 272, ECtHR. Being a qualified right the State has a margin of appreciation in respect to restrictions on such a right which are deemed to be necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.

40. Examples from the European Court of Human Rights are cases where the Court has held that failing to provide for the full recognition of post-operative reassigned gender identity is a breach of Article 8 and has emphasised the relationship between identity dignity, autonomy and privacy: *Goodwin v United Kingdom* (2002) 35 EHRR 447, 13 BHRC 120, ECtHR; *I v United Kingdom* (2002) 36 EHRR 967, [2002] 2 FCR 613, ECtHR. See also *Bellinger v Bellinger* [2003] UKHL 21, [2003] 2 AC 467, [2003] 2 All ER 593 (declaration of incompatibility re. the Matrimonial Causes Act 1973 s 11(c) (repealed) preventing transsexuals from marrying).

Framework for considering whether a ban is compatible with human rights.

41. By Section 6(1) of the HRA it is unlawful for a public authority to act in a way which is incompatible with an ECHR right. Section 4 of the HRA gives the court power to make a declaration of incompatibility.

42. As noted above, the right which is most obviously engaged by parents and children in relation to a ban on conversion therapy is Article 8, although it is also likely that, Article 9 (Freedom of thought, conscience and religion); Article 10 (Freedom of expression)[4]; Article 11 (freedom of peaceful assembly and freedom of association with others) may apply to specific groups or in particular circumstances, and Article 2 of the First Protocol with respect to the right of education and the right that a child's upbringing be in accordance with a parents religious and philosophical convictions.

43. Article 8 provides:-

Article 8

1. Everyone has the right to respect for his private and family life, his home and his correspondence.

[4] See in particular with respect to counselling: ***Open Door and Dublin Well Woman v Ireland*** (App. 14234/88) 29 October 1992, where the Strasbourg Court held that a law prohibiting pregnancy counsellors from providing information about the availability of abortion in Great Britain was an unlawful interference with the rights of the counselling groups and those receiving the counselling

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."

44. As already explained rights protected by Article 8 (and 9, 10, 11) are qualified rights, This means that a public authority (e.g. through legislation) may interfere with them in certain circumstances. But any interference must be:-

(a) prescribed by law;

(b) pursue a legitimate aim; and

(c) be necessary in a democratic society.

Prescribed by law

45. "Prescribed by law" is helpfully explained in: ***R (Bridges) v Chief Constable of South Wales Police*** [2020] 1 WLR 5037, where the Court of Appeal approved the following summary of the relevant legal principles on this issue (§55):

(1) The measure in question (a) must have 'some basis in domestic law' and (b) must be 'compatible with the rule of law', which means that it should comply with the twin requirements of 'accessibility' and 'foreseeability': Sunday Times v United Kingdom (1979) 2 EHRR 245 ; Silver v United Kingdom (1983) 5 EHRR 347 ; and Malone v United Kingdom (1984) 7 EHRR 14 .

(2) The legal basis must be 'accessible' to the person concerned, meaning that it must be published and comprehensible, and it must be possible to discover what its provisions are. The measure must also be 'foreseeable' meaning that it must be possible for a person to foresee its consequences for them and it should not 'confer a discretion so broad that its scope is in practice dependent on the will of those who apply it, rather than on the law itself': Lord Sumption JSC in P [2019] 2 WLR 509 , para 17.

(3) Related to (2), the law must 'afford adequate legal protection against arbitrariness and accordingly indicate with sufficient clarity the scope of discretion conferred on the competent authorities and the manner of its exercise': S v United Kingdom, 48 EHRR 50, paras 95 and 99.

(4) Where the impugned measure is a discretionary power, (a) what is not required is 'an over-rigid regime which does not contain the flexibility which is needed to avoid an unjustified interference with a fundamental right' and (b) what is required is that

'safeguards should be present in order to guard against overbroad discretion resulting in arbitrary, and thus disproportionate, interference with Convention rights': per Lord Hughes JSC in Beghal v Director of Public Prosecutions [2016] AC 88 , paras 31 and 32. Any exercise of power that is unrestrained by law is not 'in accordance with the law'.

(5) The rules governing the scope and application of measures need not be statutory, provided that they operate within a framework of law and that there are effective means of enforcing them: per Lord Sumption JSC in Catt at para 11.

(6) The requirement for reasonable predictability does not mean that the law has to codify answers to every possible issue: per Lord Sumption JSC in Catt at para 11."

Legitimate aim

46. In the present context a likely legitimate aim of any proposed legislation is likely to be said to be the protection of health and the protection of the rights and freedoms of others.

Necessary in a democratic society

47. A key issue will be whether any interference by way of legislation with the rights of parents or children with respect to the therapy they may wish to receive is whether the measure (in our situation a legislative ban) is *"necessary in a democratic society"*. It will only be so if it responds to a "pressing social need"[5] and if it is proportionate, having regard to the aims pursued.

48. In considering whether an interference is proportionate the court will usually apply *Bank Mellat v HMT (No.2)* [2014] AC 700 (§74) criteria:

    a. Whether the objective of the measure is sufficiently important to justify the limitation of a protected right;

    b. Whether the measure is rationally connected to the objective;

    c. Whether a less intrusive measure could have been used without unacceptably compromising the achievement of the objective;

[5] See e.g. *R v Shayler* [2003] 1 AC 247, Lord Bingham at §23

d. Whether, balancing the severity of the measure's effects on the rights of the persons to whom it applies against the importance of the objective, to the extent that the measure will contribute to its achievement, the former outweighs the latter. In essence, this question asks whether the impact of the rights infringement is disproportionate to the likely benefit of the impugned measure.

49. The context of any proposed legislation would need to have regard to the established law on medical treatment and consent. I therefore summarise this briefly below.

Consent to medical treatment

50. For treatment to be given lawfully by a doctor, two things must be satisfied in all cases:
    i. The treatment must be determined by the doctor to be in the best interests of the patient (or at least not harmful to the patient); and
    ii. Unless the patient is incapacitated, the doctor must receive effective legal consent to the treatment.

51. Children aged 16 and 17 years old are presumed to have capacity to consent. Section 8(1) of the Family Law Reform Act 1969 provides:

    "*The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.*"

52. Children under the age of 16 can only lawfully consent to treatment if they are considered *Gillick* competent: the judge-made test which requires that the child:

    (i) Understands the nature of their medical condition and the proposed treatment;

    (ii) Understands the moral and family issues involved;

(iii) Possesses the necessary 'experiences of life';

(iv) Is not fluctuating between a state of competence and incompetence; and

(v) Can weigh the information appropriately to be able to reach a decision.

53. As explained by Lord Scarman at p189:

> "*It is not enough that she should understand the nature of the advice which is being given: she must also have a sufficient maturity to understand what is involved*."

54. In *Re R (a minor) (wardship: consent and treatment)* [1992] Fam 11 at p26 the Court of Appeal emphasised the need for full understanding of the treatment in question:

> *"What is involved is not merely an ability to understand the nature of the treatment… but a full understanding and appreciation of the consequences both of the treatment in terms of intended and possible side effects and, equally important, the anticipated consequences of failure to treat"*

Legal analysis and summary

55. I specifically now consider the questions in the request for advice and seek to give a legal analysis of the relevant issues.

56. First, it is necessary to appreciate that Gender identity is not identified as a protected characteristic in the Equality Act 2010. Gender identity (whatever its precise meaning) is conceptually different from both "sex" and "sexual orientation" which are protected characteristics.

57. Second, in law, "sex" does not mean or include self-identified sex or gender identity. Sex in legislation such as the Census Act 1920, or the Gender Recognition Act 2004, or the Equality Act 2010 means legal sex: that is to say, birth sex, or by reason of the operation of section 9 of the Gender Recognition Act, the sex one becomes as a result of being issued with a Gender Recognition Certification.

58. Sex in law is a binary and (save for legal mechanism of s.9 of the Gender Recognition Act[6] which treats a person with a gender recognition certificate in law as possessing the sex of the acquired gender[7]) a biological concept, there is a male and a female sex and no in between. Which side of the binary division one falls on is determined by *"[one's] individual's physical characteristics, including chromosomal, gonadal and genital features" (R (Elan-Cane) v Secretary of State for the Home Department* [2018] EWHC 1530 (Admin); [2018] 1 WLR 5119 [96]; see further *Corbett v Corbett* [1971] P 83)."[8]

59. Sexual orientation is a relational concept by definition in s.12 of the Equality Act 2010 and is a protected characteristic. i.e. discrimination on grounds of sexual orientation is unlawful. It is defined by reference to sexual orientation or attraction to another person's sex (i.e. male or female) not gender. It is possible to be sexually orientated to both males and females and this is reflected in terms of the Act. There are thus only three possible answers to the question: what is your sexual orientation (to what sex are you attracted)?: male, female or both.

60. By contrast "Gender Identity" is much wider relational concept than sexual orientation. For those whose identity aligns with their biological sex, a person's gender identity will be the same as their biological sex, e.g. male or female (sometimes called cis-gender). For those whose gender identity is wholly that of the sex opposite to their biological sex, they may be described as transgender or trans. But there are other gender identities which do not fit into this binary divide. Gender

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[6] Section 9 GRA 2004 provides

9 General

(1) Where a full gender recognition certificate is issued to a person, the person's gender becomes for all purposes the acquired gender (so that, if the acquired gender is the male gender, the person's sex becomes that of a man and, if it is the female gender, the person's sex becomes that of a woman).

[7] Note. The language in the Gender Recognition Act 2004 is agreed by many commentators to be muddled as it repeatedly conflates gender and sex

[8] See Karon Monaghan QC: the *Forstater* Employment Tribunal judgment: a critical appraisal in light of Miller .

identity is capable of encompassing non-binary, gender-fluid, genderqueer, pangender, and other identities.

Application to children and conflict with parental rights and responsibility

61. Whether gender identity, as an aspect of personal identity, is protected under Article 8 (an aspect of private and family life) or the other potentially relevant qualified[9] rights, the application of such rights to children and the conflicting rights of parents with parental responsibility is complex.

62. The *Tavistock* case itself has considered the question of the extent to which children, some aged as young as 10, can lawfully give consent to medical intervention aimed at blocking puberty and changing the physiological characteristics of their biological sex. Applying *Gillick* to the facts of the instant case the Divisional Court has held that most children under 16 are unlikely to be capable of giving consent to such treatment.

63. In the course of argument in that case, the scope of parental responsibility with regards to the growing autonomy of the child was considered, particularly by reference to the cases of *Gillick* itself, and *Hewer v Bryant*, and Lord Denning's dictum (approved by the majority in *Gillick*) to the effect that:-

> *" the legal right of a parent to the custody of a child ends at the eighteenth birthday; and even up till then, it is a dwindling right which the courts will hesitate to enforce against the wishes of the child, the older he is. It starts with a right of control and ends with little more than advice."*

64. It is therefore an open question and likely to be child-specific and decision specific, at what age a child has sufficient autonomy to determine their own gender identity under Article 8 for any particular purpose. That said, some general statements may be capable of being made. Ordinarily one would not expect a five-year old's assertion (however naïvely or sophisticatedly expressed) that their physical sexual

[9] i.e. a right subject to limitations prescribed by law which are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others

characteristics were in opposition to, or incongruent with, that of their psychological identity, to be determinative of that child's gender identity at any given time. On the contrary it is the very nature of gender identity that it may be fluid and liable to change over time particularly though the process of puberty.

65. Yet is clear from DSM V, and the facts of the Tavistock case that certainly for children as young as 9 or 10, clinicians have taken the view that expressions of gender identity by such young children are sufficiently permanent (i.e. lasting at least 6 months) that a diagnosis of gender dysphoria is appropriate and even that treatment for such dysphoria by means of puberty blockers may be given based on that child's consent to treatment.

66. For reasons examined in the Tavistock case, treatment given on such a basis to young children is highly controversial particularly because of the irreversible effects of cross sex hormones which the vast majority of children who commence puberty blockers go on to take.

67. If it is accepted that children of such a young age do not have capacity to determine their own gender identity for specific decisions, then the responsibility for those decisions falls within the sphere of parental responsibility[10]. Indeed a parent of a child, just as much as the child, has a right under Article 8 to respect for private and family life home and correspondence and sometimes those rights may be in conflict. Generally speaking it is usual (and lawful) to accept a parent's consent for decisions with regard to medical intervention for children who are not *Gillick* competent to make the decision for themselves. In such circumstances the parent will be exercising both a right and a duty as a parent.". This provision is a reflection of the view that parents do have protection of rights with respect to how their children are brought up and educated. Those qualified rights should not be interfered with unless the interference is necessary in a democratic society in the interests of public safety,

[10] I do not here discuss the controversial decision of *AB* which suggests that parental responsibility and a child's ability to consent co-exist so long as the parent and child agree.

for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.

68. These general concerns therefore inform the approach to the question of whether a prohibition on 'conversion therapy' as it has variously been described is likely to be lawful, or in fact conflict with, the rights of others, including parents, exercising the rights and duties of parental responsibility over their children.

Answers to specific questions

(1**) Is there is an inadequate evidence base from which to ban conversion therapy;**

69. It may be seen from the above range of definitions that "conversion" therapy may be cast extremely widely and includes any intervention which seeks to change the sexual orientation or *gender identity* of a person. It may include all adults and children, or be restricted to children under 16 and vulnerable persons. But clearly the wider the scope for the ban, the more pressing must be the social need and the more robust the evidence must be to justify it as proportionate.

70. Against that backdrop, it is entirely unclear what the evidence base is said to be to support the prohibition of therapy designed to cancel or suppress *gender identity*. On the contrary, as DSM V makes clear, desistence of gender dysphoria (incongruence of gender identity with biological sex) through puberty is a natural phenomenon which occurs in the majority of cases. Can it really be the intention of legislation to prohibit and render unlawful the natural pubertal process which has the effect of suppressing the perceived gender incongruence? Yet that is what "*watch and wait*" therapy, (an entirely respectable and evidence based psychological therapy) is intended to achieve.

71. Moreover as noted above, the literature reports that:-

    (i) Many prepubertal children with gender dysphoria no longer experience gender dysphoria in adolescence, and the experience of romantic and

sexual attraction is thought to play an important role in this process (Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011).

(ii) Some may come to understand themselves as homosexual or bisexual (Steensma et al., 2011). This is extremely important. It may be that by prohibiting "conversion therapy" as so defined with only the exception for treatment directed at achieving gender transition (e.g. puberty blockers and cross sex hormones) that children growing up are actively prevented from developing into homosexuals or bisexuals.

(iii) GnRHa, by blocking sexual development, might interfere with this process (Korte et al., 2008).

(iv) Another concern is that although GnRHa treatment is to be used as an extended diagnostic phase, the start of it may lead the adolescents and parents to assume that transgender outcome is the only possible outcome which may prevent exploration of other possibilities (Leibowitz & de Vries, 2016)

72. It is difficult therefore to accept that there is a sufficient evidence base to justify a widely drawn prohibition of gender identity conversion therapy as a pressing social need. Such legislation is likely to prohibit treatment which is clinically indicated and appropriate and which the child (or parent on her behalf if not Gillick competent) may wish to undergo voluntarily and without coercion. If the concern of those who put forward the legislation is to prohibit coercive, unethical inhumane practices, wording which is unnecessarily wide and liable to result in treatment being prohibited which is entirely appropriate and lawful is clearly inappropriate. It is not easy to see how this problem is overcome by the kind of exceptions listed in say, the Canada Nova Scotia example, since even if limited to children under 16, the issue in relation to parental rights and treatment and upbringing in accordance with parental religious and philosophical convictions remains.

(2) there is no agreed approach to gender identity per se, with many people disavowing they have one.

73. The second point to make is that a definition of gender identity would be required. While not insurmountable, a problem is that once gender identity is not seen as a binary concept but as an expression of a person's social relations and self-perception, it is very difficult to be precise as to what conversion therapy in such context might include, rendering such a provision void for uncertainty, or not "*in accordance with law*". Equally how permanent or otherwise such gender identity must be before it must not be subject to conversion therapy, is open-ended. That too is a recipe for confusion and runs the risk of criminalizing or rendering unlawful the provision of therapies that are designed to ameliorate suffering in the individual, and reconcile them to their biological sex.

(3) whether a ban would be more harmful than the problem it seeks to remedy

74. If the ban is as wide as the Australian Capital Territory definition, then no proper account is given of consent. As summarised above, for treatment to be given lawfully by a doctor or other care-giver, two things must be satisfied in all cases:
    i. The treatment must be determined by the doctor/care-giver to be in the best interests of the patient (or at least not harmful to the patient); and
    ii. Unless incapacitated, the doctor must receive effective legal consent to the treatment – either from the patient, or if a child, his/her parent.

75. It is not usual for the law to trespass into the sphere of medical judgment as to what treatments are or are not in a patient's best interests in the specific circumstances of the case. This is usually best left to the medical profession and the appropriate professional regulatory bodies. There is, so far as I am aware no credible evidence that the absence of legislation governing the use of medical treatment for gender dysphoria, has resulted in improper 'conversion' treatment being given against any patient's consent, save for the facts of the Tavistock case itself where the Tavistock have relied on the supposed consent of a children as young as 10 for the administration of highly potent medication by way of puberty blocker treatment later to be followed by cross sex hormones which are irreversible in their effects. I

have been shown a copy of the controversial "2020 'Conversion Therapy' and Gender Identity Survey ' recently published by GIRES, the LGBT Foundation, Mermaids, the Ozanne Foundation and Stonewall. The survey says that it contains "ground breaking data on the effects of Gender Identity Conversion Therapy in the UK", however, I understand serious concerns have been raised about its methodological reliability and conclusions. A letter from Professor Michael Biggs raising these concerns is attached to this Opinion.

76. The law's usual approach to treatment which is of a highly invasive nature, or may be required compulsorily is to regulate such treatment by stipulating age requirements, making capacity to consent mandatory, and requiring an independent second opinion. A good example is Electro Convulsive Therapy, in the mental health context. There the law provides protections to ensure that if the treatment is provided it is done so in the patient's best interest and on the advice of at least two qualified professionals. It is instructive to look at the wording of the Mental Health Act 1983, in particular s.58A and to note that key components of the relevant legislation require the patient (i) to be suffering from a mental disorder; (ii) be of a particular age (18); (iii) have of a level of understanding in respect of the treatment; and (iv) a second opinion from an appointed independent doctor that such treatment is in best interests.

77. There must be a real risk that by imposing a blanket ban on conversion, children and adults may be improperly deprived of treatment which:-

    (i) is likely to be in their best interests

    (ii) is a medically respectable intervention

    (iii) is a treatment which they wish to receive and give consent to.

The most obvious example would be a person who voluntarily wishes to receive treatment from a doctor or therapist to help them reconcile their individual perception of gender with their biological sex. It is clear, even from the MOU 2017, that this cannot be intended:-

> *" For people who are unhappy about their sexual orientation or their gender identity, there may be grounds for exploring therapeutic options to help them live more*

comfortably with it, reduce their distress and reach a greater degree of self-acceptance. Some people may benefit from the support of psychotherapy and counselling to help them manage unhappiness and to clarify their sense of themselves. Clients make healthy choices when they understand themselves better".

78. Yet a ban on conversion therapy as so defined would prohibit or deter such treatment being accessed by individuals.

(4) there is dispute within both the Royal College of Psychiatrists and the British Psychological Society over the definition of conversion therapy. In particular, the inclusion of "gender identity" in any definition.

79. I have alluded to this concern above. The concern is that the inclusion of '*gender identity*' in the any legislation in respect of conversion therapy is highly controversial and not evidence-based. The justification for its inclusion does not seem to be based on empirical evidence, but is the product of a political viewpoint. .

Summary

80. I therefore summarise my conclusions on unlawfulness of a proposed ban on conversion therapy along the lines of comparable legislation in other jurisdictions. I do so in the context of the legal framework identified above, namely would it be compatible with convention rights, by being in accordance with law, introduced for a legitimate aim, proportionate and necessary in a democratic society.

(i) Does it risk denying provision of appropriate treatment for children by fettering the ability of clinicians to provide appropriate therapeutic input;

81. Clearly yes. To legislate to ban any treatment designed to change, cancel, convert or suppress gender identity would clearly prohibit or deter such treatment being given by clinicians and care-givers even though such treatment e.g. watch and wait, talking therapy etc. is ethically based, supported by respectable medical literature and the child or adult is willing to receive it. Legislation which prohibits such treatment may well be unlawful/declared incompatible, because it is a disproportionate and interference with the Article 8 (or related) rights of the individual patient who may otherwise be entitled to seek and obtain such treatment or counselling. There is also

a real question whether the evidence base for the ban (concerning gender identity in particular) would be sufficiently cogent for such a ban to be in accordance with law.

(2) The ability of parents to help their children navigate the development of their personal identity;

82. Again the answer is a clear yes. A prohibition in the terms of the proposed legislation would hinder the ability of parents to navigate the development of their child's personal identity. Even though it may be a 'dwindling right' as the child grows to maturity, no one could deny that parents have rights and responsibilities towards their children as they grow up. Legislation in the terms proposed would inhibit parents from seeking to assist their children from navigating the discovery of their personal identity as they grow up through puberty. This is a real rather than fanciful concern. A legislative provision drafted in the terms suggested would have a chilling effect on the ability of parents to discharge their responsibilities for fear of being referred to social services or even the police for indulging in "conversion therapy" as so widely defined. It would be an unjustifiable interference with the private and family life of the parents and their relationship with their children. It is hard to see how even the exceptions in the example legislation cited above overcome this problem.

(3) The rights of children to be protected from inadequate therapeutic services and experimental medical treatment;

83. This concern is the very concern identified by one of the key proponents of puberty blocking and cross sex hormones Dr Annelou De Vries, in the *De Vries and Leibowitz* article mentioned above.

84. GnRHa treatment (puberty blocking) is used as an extended diagnostic phase. The phrase used by the Tavistock GIDS service is "time to think". It is experimental and controversial. The start of it may lead the adolescents and parents to assume that transgender outcome is the only possible outcome which may prevent exploration of

other possibilities (Leibowitz & de Vries, 2016). It may result in the individual subjected to such treatment to commence a course of treatment at an early stage (perhaps as young as 10) and persist with such treatment (the evidence is that very nearly all who commence puberty blockers go on to take (irreversible) cross sex hormones). As the Divisional Court in the *Tavistock* case concluded, it is unrealistic to consider that children as young as 10 or even of 15, are likely to be *Gillick* competent to take such life changing decisions particularly when the treatment is experimental, the evidence of effectiveness is almost non-existent, and the long term outcomes unknown. Yet it is this treatment that is exempted from prohibition in all the example legislative texts provided.

Conclusion

85. It is my view that the any proposed UK legislation in respect of conversion therapy in respect of children, particularly as it concerns gender identity, is likely to give rise to a substantial risk of unlawfulness because of incompatibility with rights protected under Article 8, 9, 10, 11 and possibly also Article 2 of the First Protocol on the European Convention on Human Rights. Even if exceptions are created such as those in the Canadian and Queensland example, (for example that the proscription should apply to minors only) it is my view that the use of a definition of "*conversion therapy*" which includes a proscription of any attempt to cancel, change or suppress '*gender identity'* in terms similar to that proposed, is likely to be unlawful because it is simply too wide, is not based on any reliable scientific evidence, is uncertain, and denies appropriate treatment (such as watch and wait) to children for whom such treatment (assuming they do not have capacity) may be in their best interests, or if they do have capacity, wish to receive. It would deny proper ethical treatment to those (children and parents) who may wish to receive it or give consent to it as being concordant with their wishes, or philosophical or religious beliefs.

86. It is a stark fact that the prime example of conversion therapy with the potential for irreversible harm in the context of gender identity, particularly in respect of children is the highly controversial treatment with puberty blocking medication and cross sex

hormones for children. Such treatment is designed to affirm and reinforce a child's perception of his or her gender identity. As the Divisional Court in the Tavistock observed:-

"the combination here of lifelong and life changing treatment being given to children, with very limited knowledge of the degree to which it will or will not benefit them, is one that gives significant grounds for concern."

87. Yet it is this treatment which is exempted the legislation examples given, along with only such treatment that "*assists a person to express their gender identity; or (d) provides acceptance, support and understanding of a person; or (e) facilitates a person's coping skills, social support and identity exploration and development".* In other words the only treatment that is exempted is that which accepts and affirms the self-identified gender, with the consequence that any therapy that questions the person's gender identity or seeks to reconcile that identity with the person's biological sex is rendered unlawful even if the individual consents to such treatment. That is a clear denial of the autonomy of the individual's (and where relevant, parent's) right to choose what treatments (from amongst those which are clinically indicated)[11] they wish to receive and would need cogent justification. On the evidence I have seen, there is none.

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[11] In *Burke* [2005] EWCA Civ 1003, the Court endorsed the following propositions from the GMC as to the right of the patient to select the treatment he will receive:

i) The doctor, exercising his professional clinical judgment, decides what treatment options are clinically indicated (i.e. will provide overall clinical benefit) for his patient.

ii) He then offers those treatment options to the patient in the course of which he explains to him/her the risks, benefits, side effects, etc involved in each of the treatment options.

iii) The patient then decides whether he wishes to accept any of those treatment options and, if so, which one. In the vast majority of cases he will, of course, decide which treatment option he considers to be in his best interests and, in doing so, he will or may take into account other, non clinical, factors. However, he can, if he wishes, decide to accept (or refuse) the treatment option on the basis of reasons which are irrational or for no reasons at all.

iv) If he chooses one of the treatment options offered to him, the doctor will then proceed to provide it.

v) If, however, he refuses all of the treatment options offered to him and instead informs the doctor that he wants a form of treatment which the doctor has not offered him, the doctor will, no doubt, discuss that form of treatment with him (assuming that it is a form of treatment known to him) but if the doctor concludes that this

treatment is not clinically indicated he is not required (i.e. he is under no legal obligation) to provide it to the patient although he should offer to arrange a second opinion.