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Informed consent: the decision-making capacity of children in relation to gender-affirming treatment

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SUMMARY

When the High Court of Justice ruled in *Bell v Tavistock* that children under the age of 16 suffering from gender dysphoria most likely could not consent to being treated with puberty blockers or cross-sex hormones, the verdict told the story of a young girl who underwent gender-affirming treatment and later came to regret her decision.

This essay studied the decision-making capacity of children and their ability to consent to medical treatment and more specifically to gender-affirming treatment, examining first domestic provisions and subsequently the UN Convention on the Rights of the Child. It concludes that domestic statutory provisions are few and that the legal area is prone to uncertainty. This is largely because of a custom under which children have been granted far-reaching decision-making capacity and autonomy in medical matters, heavily dependent on individual assessments as a rule.

The parental right and duty to decide on behalf of the child in his or her personal matters is established in Chapter 6, Section 11 of the Parental Code and it persists until he or she turns 18 years old. Young children may receive treatment by parental proxy-consent as they have no decision-making capacity of their own. As the child matures, the capacity to make his or her own decisions progresses. This initially manifests as a negative decision-making capacity (the ability to decline treatment) and gradually expands to a positive decision-making capacity (the ability to accept or request treatment).

There are no legislative provisions concerning the administration of puberty blockers, cross-sex hormones, or the surgical procedures which the Gender Classification Act (1972:119) does not regulate. Treatment is instead administered according to recommendations issued by the National Board of Health and Welfare, currently under revision. These assert that the child may receive puberty blockers after having received appropriate and adequate degree of information according to the Patient's Act (2014:821), together with the parent(s) or legal guardian, jointly making the decision. When cross-sex hormones and surgery might come into question, the child is usually of an age where he or she is in possession of positive decision-making capacity, leaving the parents with less influence in the matter, if any at all. This development of maturity in relation to autonomy finds general support by the provisions of the UNCRC, which may or may not give a right to gender-affirming treatment. This increasingly observed issue is of a considerably private nature and constitutes a clash between the child, the parent, and the caregiver. It contains several ethical considerations for the legislator and society.

SAMMANFATTNING

När High Court of Justice avkunnade dom i målet *Bell v Tavistock* konstaterade domstolen att barn under 16 års ålder som lider av könsdysfori högst troligen inte kan ge ett giltigt samtycke till pubertetsbromsande hormonbehandling eller könskonträr hormonbehandling. Världen fick då ta del av berättelsen om en ung flicka som genomgått identitetsbekräftande vård och sedan ångrat sitt beslut.

Denna uppsats har undersökt barns medicinska självbestämmanderätt och mer specifikt dess förmåga att samtycka till de vårdinsatser som kan tänkas ingå i identitetsbekräftande vård, först enligt nationell rätt och därefter enligt Barnkonventionen. Det har funnits få nationella bestämmelser att luta sig på och rättsläget förefaller osäkert. Gällande rätt består till största del av principer som inte förekommer i lagstiftning och endast i svag utsträckning i praxis. Principerna innebär en långtgående självbestämmanderätt för barn i medicinska ärenden som enligt en huvudregel alltid ska avgöras genom individuell bedömning.

Barnets vårdnadshavare har både rätten och skyldigheten att bestämma i barnets personliga ärenden enligt 6 kap. 11 § FB tills han eller hon fyller 18 år. Små barn kan behandlas med en vårdinsats efter att proxy-samtycke ges av vårdnadshavarna. De har ingen egen självbestämmanderätt. Allt eftersom barnet mognar, ökar förmågan att fatta egna beslut. Först inträder negativ självbestämmanderätt (förmågan att avböja behandling) och successivt även positiv självbestämmanderätt (förmågan att godta eller söka behandling).

Det finns inga lagstadgade bestämmelser som reglerar hormonbehandling eller de ingrepp som inte behandlas i lagen (1972:119) om fastställande av könstillhörighet i vissa fall. I stället gäller Socialstyrelsens rekommendationer som för närvarande är under revidering. Efter att ha informerats i enlighet med Patientlagen (2014:821) och beslutat i samråd med vårdnadshavarna får barnet behandlas med pubertetsbromsande hormonbehandling. Då könskonträr hormonbehandling och kirurgi blir aktuellt har barnet ofta tillträtt en ålder i vilken han eller hon tillerkänns positiv självbestämmanderätt. Vårdnadshavarnas inflytande minskar väsentligt, om inte helt och hållet. Denna utveckling finner generellt stöd i Barnkonventionen, som möjligen eller möjligen inte ger barnet en rätt till identitetsbekräftande behandling. Denna alltmer uppmärksammade fråga är mycket privat till sin natur och innebär sammandrabbningar mellan barnet, vårdnadshavaren och vårdgivaren. Den innehåller flera etiska överväganden för lagstiftaren och samhället i stort.

ABBREVIATIONS

CSHs	cross sex hormones
DSM	Diagnostic and Statistical Manual of Mental Disorders
GCA	Gender Classification Act (1979:119)
GIDS	Gender Identity Development Service
HMSA	Health and Medical Services Act (2017:30)
HSAN	Hälso- och sjukvårdens ansvarsnämnd
JO	Justitieombudsmannen
NBHW	National Board of Health and Welfare
PA	Patient's Act (2014:821)
PBs	puberty blockers
SOU	Statens offentliga utredningar
SRS	sex reassignment surgery
SSA	Social Services Act (2001:453)
UNCRC	Convention on the Rights of the Child
WHO	World Health Organization

1. INTRODUCTION

Following the 2020 judgment by the Queen’s Bench Division of the High Court of Justice in *Bell v Tavistock*,¹ the question of gender-affirming health care in adolescents gained considerable attention.² The case concerned judicial review of the practice of the Tavistock and Portman NHS Foundation Trust which operated a Gender Identity Development Service (GIDS) through which children under the age of 18 experiencing gender dysphoria could be prescribed puberty suppressing drugs, also known as puberty blockers.³ One of the claimants, who was born female, had been prescribed PBs at the age of 15 in order to halt the development of female sex characteristics. Eventually, she was prescribed cross-sex hormones to further the development of male sex characteristics and underwent sex reassignment surgery (SRS). After receiving these fateful treatments, she came to realize that it had all been a mistake. In this case, the matter of legal interest and subsequent adjudication was the question of informed consent. The claimants argued that children under the age of 18 did in fact not have the ability to consent to being treated with puberty blockers, implying therefore that the GIDS-practice was unlawful. Dame Victoria Sharp P, Lord Justice Lewis, and Mrs. Justice Lieven concluded that it was highly unlikely that a child aged 13 years or under could be considered competent enough to consent to being treated with PBs. It was considered doubtful whether 14- to 15-year-olds could do so either, seeing as they were likely not able to understand or weigh the consequences of such treatment. The Court considered it enormously difficult for children under the age of 16 to understand the information in question and ultimately decide, rendering them unable to consent.⁴ In relation to children aged 16 and over, the Court concluded that prior authorisation of the Court should be attained, considering the long-term consequences of the treatment and its experimental nature at this moment in time.⁵

¹ R (on the application of) Quincy Bell and A -v- Tavistock and Portman NHS Trust and others. Delivered on December 1st, 2020.

² The Economist et al. reported on the judgment in their December 12th issue (2020): Volume 437 Number 9224. “Trans Rights: Boys and Girls”, p. 53.

³ *Bell v Tavistock*, point 2.

⁴ *Bell v Tavistock*, point 151.

⁵ *Bell v Tavistock*, point 152.

1.1 Aims

Considering the above, it is the aim of this essay to provide a comprehensive account of the current approach of applicable law to the decision-making capacity of children and their ability to give valid consent to medical treatment. This will provide ground for the specific example of gender-affirming treatments, all of which call for legal evaluations especially if the patient is a child. This essay will attempt to do so by considering relevant domestic provisions and the Convention for the Rights of the Child (UNCRC). The latter allows for an international perspective to be assumed in relation to the findings upon conclusion.

1.2 Questions and delimitations

The questions posed to cover these objectives thus follow:

1. What does the principle of informed consent mean in the context of gender-affirming treatment, if the patient is a child?
2. What provisions of the Convention on the Rights of the Child are actualized in relation to gender-affirming treatment and informed consent?
 - a. Does the child have a right to gender-affirming treatment under the Convention?

The inquiry has been limited to review the circumstances under which children may undergo certain medical treatment. Part of this discussion is the possibility of *authorising* treatment for themselves, excluding the circumstances under which children may *decline* medical treatment. closely related legal matters which are not included in the scope of this essay are cases of negligence in medical practice (perhaps due to invalid consent), subsequent liability, issues between parents and children relating to medical confidentiality, consent coercion or the nature of the consent per se (duration, form, hypothetical consent or negotiorum gestio e.g.). Presumably, a larger comparative approach to medical interventions in children with atypical sex development, also known as intersex children, would have

been immensely fruitful. However, due to the imposed limitations on time and space, the issue has not been subject to comparison.

1.3 Method and material

At the foundation of my course of action lies the legal-dogmatic method. Guided by the stipulated research questions, this form of inquiry reviews the current and widely accepted sources of positive law in legislation, case law, preparatory works and doctrine in the attempt of answering them according to applicable law.⁶ Importantly, statements which correspond to *de lege legata*-type of arguments (what the law is) must be distinguished from *de lege ferenda*-type of arguments (what the law ought to be).⁷ The research questions of this essay prescribe the use of the former type in order to be accurately answered.

On the one hand, there are the domestic legal provisions. Relevant acts of legislation are initially concerned as are the cases in which they have been applied and interpreted, mainly by JO and HSN. Where statutory provisions and cases have been few, this essay has considered official sources such as preparatory works, government reports, reports of recommendation and statements from the Legislative Council. Legislation and case law have equally been reviewed in legal literature and scholarly output which offer essential elaborations in relation to the research questions of this essay.

On the other hand, there are the international provisions, mainly adhering to the Convention on the Rights of the Child which is first and foremost an international treaty. The essay has considered the Convention text, the ready-made interpretations by the monitoring Committee on the Rights of the Child, established under the Convention⁸ and interpretations in literature. Lastly, the mentioned judgment by the High Court of Justice is not studied but merely recounted at certain points.

⁶ Kleineman, Jan (2013) "Rättsdogmatisk metod" *Juridisk metodlära*, p. 21 ff.

⁷ Kleineman, p. 36.

⁸ Sandberg, Kirsten (2015) "The Rights of LGBTI Children under the Convention on the Rights of the Child" *Nordic Journal of Human Rights*, volume 33, issue 4, p. 62.

1.4 Current research

Medical law has a broad adjoining field of jurisprudence that has grown over the four past decades and continues to do so.⁹ Swedish jurists have not taken the same interest to informed consent as has been the case in many countries¹⁰ but the larger issue of medical consent was investigated thoroughly by the acclaimed Elisabeth Rynning in her doctoral thesis.¹¹ The medico-legal problem of childrens' decision-making capacity and consent has been investigated only to a very limited extent in doctrine. Gustav Svensson and Kirsten Sandberg have notably provided immensely helpful output on the matter and for the essay in its entirety.

1.5 The decision-making capacity of children: based on competence, needs or both?

When examining the decision-making capacity of children in a medical context, one might consider two respective approaches for a theoretical framework in relation to the findings.¹²

- a. The competence-based approach views the child as a competent individual who can express his or her own wishes and needs. It asserts that the expressed will of the child shall be the determining factor for a decision, since what the child wishes for is also what is best for him- or herself.
- b. The needs-based approach views the child as having needs and wishes which should be protected, safeguarded, and realized by adults in the child's surrounding environment. An adult will consider the needs and wishes when ultimately deciding on the child's behalf.

⁹ Vansweevelt, Thierry and Glover-Thomas, Nicola (2020) "A general introduction" *Informed Consent and Health: A Global Analysis*, p. 1.

¹⁰ Rynning, Elisabeth (1993) "Consent to Medical Care and Treatment — Legal Relevance in Sweden" *Patient's Rights*, p. 323.

¹¹ Rynning, Elisabeth (1994) *Samtycke till medicinsk vård och behandling: en rättsvetenskaplig studie*. Uppsala: Iustus.

¹² Svensson, Gustav (2007) gives a comprehensive account of these in *Barns rätt i hälso- och sjukvård*, pp. 158–162.

Various claims and arguments for the sake of each approach may be presented. One might argue for the competence-based approach on the grounds that it teaches the child to take responsibility and advances the transition from childhood into adulthood. Arguments against this approach might hold that it puts the child in a very difficult situation if he or she is to decide and decide alone on all matters. Naturally, the two approaches are put against each other to determine which is most preferable. This might not be necessary: Svensson¹³ refers to Professor Michael Freeman who in *The Moral Status of Children* (1997) presents the idea that protecting either children or their right to autonomy is a false dichotomy. On the one hand, a fundamentally competence-based approach which does not offer adequate protection will not enable the child to exercise self-determination. On the other hand, a fundamentally needs-based approach might be counterproductive in the sense that it reduces the child to an object of intervention.

1.6 Disposition

This essay will take its starting point in a domestic setting by reviewing the status of children in relation to their decision-making capacity and ability to give medical consent. Next comes the practical example of gender-affirming treatment which will be defined and examined according to relevant guiding provisions. Section 3 will examine these matters under UNCRC provisions. Finally, the results will be analysed in a conclusionary segment.

¹³ p. 161.

2. THE DECISION-MAKING CAPACITY OF CHILDREN

2.1 Defining the child

Most simply, we can decide on who counts as a child using numerical standards. Article 1 of the Convention on the Rights of the Child states that all persons under the age of 18 are considered children unless the age of majority is reached earlier according to applicable law. There has historically been no such general definition in Swedish law, outside the UNCRC, which significantly was enacted as part of domestic law in its entirety on January 1st, 2020.¹⁴ Specific acts such as the SSA include a definition for the sake of clarity.¹⁵ In this case, the act applies to all individuals under the age of 18.¹⁶ A numerical definition can be applied conveniently; it makes the case of who counts as a child considerably easy to argue.¹⁷ The case cannot with ease be rested here. Age assessments will often refer to the maturity and/or development of the individual which consequently calls for definitions of these terms. Development relates to mental capacity and the ability to think in abstract terms and conduct logical reasoning, i.e., psychological development, whereas maturity covers the process in which the individual's characteristics become functional. The notion is not consistent, however. A child may be mature in one respect but not another.¹⁸

2.2 Custody of the child

Chapter 6 of the Parental Code¹⁹ contains provisions on what parental responsibilities are actualised as a result of having a child in one's custody. Section 2 states that a child remains under the custody of both parents or one of them until it reaches the age of 18. The parent (s) or legal guardian is responsible for the child's personal matters and shall provide for the child according to its needs. It shall also supervise

¹⁴ Lag (2018:1197) om Förenta nationernas konvention om barnets rättigheter, Chapter 1, Section 1.

¹⁵ Svensson, p. 64.

¹⁶ Socialtjänstlag (2001:453) Chapter 1, Section 2, para 1.

¹⁷ Svensson, p. 61.

¹⁸ Svensson, p. 62.

¹⁹ Föräldrabalk (1949:381).

the child insofar as it is required in relation to his or her age, development, and other circumstances.²⁰ The notion of custody is to be understood as the responsibility for the legal matters of the child.²¹ Section 11 clarifies how this custody should be exercised by the parent, who obtains both the right and the responsibility to decide on behalf of the child in his or her personal matters. Section 11 was enacted as part of a measure to strengthen the legal position of the child and can be said to complement the parental responsibility with the child's opinions and wishes.²² The preparatory works make reference to the "nature of things" when explaining how the holder of custody must be able to decide on behalf of the child²³ but not in order to exercise behavioural control over the child, rather, the participation of the child in decision making is held as important for the child's own personal development. As soon as it is possible, the parent should consult with the child when deciding on his or her personal matters.²⁴

2.3 Children as patients

The fundamental Health and Medical Services Act²⁵ and Patient's Act²⁶ both contain provisions relating to the facilitation and safeguarding of the patient's status within the healthcare system. There are several acts to consider when looking at health law provisions which are spread out and often regulated twice.²⁷ Patients under the age of 18 are regarded as minor patients and pose a particular challenge for medical staff in some situations when it is unclear how to view the need for consent prior to treating the patient. The legal provision which has come to determine the outcome of these situations is the previously reviewed Chapter 6, Section 11 of the Parental Code, leaving the responsibility to decide on the child's behalf in medical matters with the parent. The opinions and wishes of the child are to be given due regard as he or she grows older and develops.²⁸

²⁰ Parental Code: Chapter 6, Section 2, para 2.

²¹ Oldenstedt, Boel. Parental Code (1949:381), Chapter 6 Section 2, Note 155 (JUNO).

²² Svensson, p. 75.

²³ Prop 1981/82:168, p. 23.

²⁴ Prop 1981/82:168 p. 24.

²⁵ (2017:30) Hälso- och sjukvårdslag.

²⁶ (2014:821) Patientlag.

²⁷ Rönnberg, Lena (2020) *Hälso- och sjukvårdsrätt*, p. 99.

²⁸ Rönnberg, p. 135.

2.3.1 Informed consent

The functions of the principle of informed consent vary depending on the medical context.²⁹ The Patient's Act³⁰ states that a patient cannot undergo medical treatment unless he or she has consented to the treatment. Prior to consenting, the patient must be informed according to the provisions of the Act's third chapter. Chapter 3, Section 1, points 1-8 of the Patient's Act states that information shall be provided concerning et al. the health status of the patient and methods for treatment. This includes the possible benefits of the treatment but also the risks, most importantly.³¹ These should be interpreted as the non-negligible risks. Nonetheless, the duty to inform does not encompass all possible risks and complications that might arise as a result of the treatment, but it should correspond reasonably to the treatment in question.³² Individual accommodation is crucial for the validation of consent.³³ Providers are obliged to make sure, as far as it is possible, that the patient has accurately understood the information.³⁴ These wide efforts to inform the patient and subsequently secure valid consent are part of consultation measures with the larger aim of facilitating the patient's self-determination.³⁵

Normally, the patient takes on two roles: he or she is both the recipient of the information and the person who subsequently gives consent.³⁶ However, there is no explicit rule on who is to give consent for a minor patient, but it must be investigated as far as possible what he or she feels toward the treatment, considered in relation to his or her age and development.³⁷ Parents are entitled to receive information necessary to consent, as is the child, adjusted to his or her age and maturity.³⁸

²⁹ Vansweevelt & Glover-Thomas, "A general introduction" p. 3.

³⁰ PA Chapter 4, Section 2, para 1.

³¹ Rönnberg, p. 140.

³² Lönnheim, Charlotte. Patient's Act (2014:821), Chapter 4, Section 3, Note 17 (JUNO).

³³ Axelsson, Ewa (2011) *Patientsäkerhet och kvalitetssäkring i svensk hälso-och sjukvård: en medicinrättslig studie*, p. 262.

³⁴ PA Chapter 3, Section 7.

³⁵ Rönnberg, p. 142.

³⁶ Hartlev, Mette (2020) "Informed consent in the Nordic countries" *Informed Consent and Health: a Global Analysis* p. 168.

³⁷ PA Chapter 4, Section 3.

³⁸ Hartlev, p. 169.

2.3.2 Decision-making capacity

Young children

The right and responsibility of a parent(s) or legal guardian to decide on personal matters on behalf of the child applies in every case to young children, who are not capable of decision-making in a medical setting. This puts the parent in possession of the negative decision-making capacity (the capacity to veto or decline treatment) and the positive decision-making capacity (the capacity to authorise treatment).³⁹ In JO 1995/96 s. 89, the Prosecutor-General considered parental consent necessary for the physical examination of younger children⁴⁰ but that the child would be able to consent on his or her own upon reaching twelve years of age.⁴¹ While the child remains young, the general rule asserts that the responsibility to authorise medical treatment lies with the parents by proxy consent.⁴²

Teenagers

As we climb up the ages, it seems as if this general rule becomes its opposite. Older teenagers can and do normally decide on their own what medical treatment to undergo, if he or she can interpret the information and assess the consequences of his or her decision.⁴³ This principle is significant yet not reflected to a great extent in case law.⁴⁴ In JO 1975/76 p. 244 it was suggested that the legal validity of a declaration of intent concerning a personal matter should be assessed with a starting point in the legal act which is sought. It was also claimed to be a legal principle, that decisions relating to the personal affairs of a child at least 15 years old who was also capable of reasonably assessing the meaning of the consent and its consequences, could not be affirmed only in case the parent or guardian had consented.⁴⁵ In HSAN 2747/00, parental consent was considered unnecessary after the administration of addictive drugs to a 17-year old due to the fact that it had occurred upon request from the patient, affirming the

³⁹ Svensson, p. 140.

⁴⁰ JO 1995/96 p. 96.

⁴¹ JO 1995/96 p. 97.

⁴² Hartlev, p. 169.

⁴³ Lönnheim, Charlotte. Patient's Act (2014:821), Chapter 4, Section 3, Note 41 (JUNO).

⁴⁴ Svensson, p. 111.

⁴⁵ JO 1975/76 p. 251.

notion that older teenagers have positive decision-making capacity. The capacity which older teenagers seem to hold may also be enjoyed by younger teenagers (12-14 years old) to a similar extent.⁴⁶ Whereas the negative decision-making capacity is unquestionable in older teenagers, the positive decision-making capacity is acquired gradually. If a certain form of treatment is considered high risk and the possible benefits are not clear, e.g. plastic surgery, it cannot be excluded that the parent might rightfully veto the treatment.⁴⁷ It would require a considerable degree of maturity for a child to consent to a procedure which is particularly significant or invasive.⁴⁸ There is, however, no legal guidance to support any claim on the matter in general health law.⁴⁹ The situation is different when specialised legislation applies and enforces numerical age restrictions in e.g. the acts on sterilisation,⁵⁰ male circumcision,⁵¹ clinical drug trials,⁵² and research.⁵³ General principles are often vague which calls into question their validity and strength. Despite this, they correspond to a competence-based approach which can be observed in current international developments.⁵⁴ All in all, what seems to befall children is a *relative* decision-making capacity and non-capacity. If the child possesses maturity to a degree which enables him or her to interpret information and ponder the consequences, the decision-making capacity will most likely be the child's alone.⁵⁵ In the cases where the child can be considered capable of declining treatment but not consent to it, it seems a joint child-parent might come into question.⁵⁶ Regardless of what prior evaluations in case law tell us, the need for an individual assessment of maturity and the nature of the treatment remains crucial.⁵⁷

⁴⁶ Svensson, p. 147.

⁴⁷ Svensson, p. 144.

⁴⁸ Lönnheim, Charlotte. Patient's Act (2014:821), Chapter 4, Section 3, Note 41 (JUNO) 20121-05-15.

⁴⁹ Svensson, p. 144.

⁵⁰ Steriliseringslag (1975:580).

⁵¹ Lag (2001:499) om manlig omskärelse.

⁵² Läkemedelslag (2015:315) Chapter 7.

⁵³ Lag (2003:460) om etikprövning av forskning som avser människor.

⁵⁴ Svensson, p. 157.

⁵⁵ Rynning, *Samtycke till medicinsk vård och behandling*, p. 286.

⁵⁶ Rynning, *Samtycke till medicinsk vård och behandling*, p. 287.

⁵⁷ Lönnheim, Charlotte. Patient's Act (2014:821), Chapter 4, Section 3, Note 41 (JUNO).

2.3.3 Gender-affirming healthcare

To align physical sex characteristics with gender identity, an individual may seek gender-affirming treatment. This usually consists of hormonal therapy and sex reassignment surgery in some cases.⁵⁸ Medical procedures for treating gender dysphoria can be traced back to at least the 1920s.⁵⁹ Today's diagnostic criteria for gender dysphoria in children is provided by DSM-5⁶⁰ and is defined as “a marked incongruence between one's experienced/expressed gender and assigned gender”.

PBs and CSHs

In the absence of specific statutory provisions, the medical treatment of dysphoric children is based on a report of recommendations issued in 2014 by the National Board of Health and Welfare. The administration of PBs to children with gender dysphoria is a Dutch medical custom centered mainly around the relieving of suffering associated with the outset of puberty and improving mental health. A precondition for administration is the notion that the treatment is reversible. Older children may be prescribed CSHs to further the development of sex characteristics which correspond to his or her gender identity.⁶¹ The report recommends that health care facilities ought to provide dysphoric children the treatment of PBs and CSHs on a psychiatrist's initiative.⁶² It asserts that the child and his or her parents shall receive information on the possible risks associated with PBs since treatment is most effective if started early on. They shall jointly decide to begin treatment.⁶³ Regarding CSH, it holds that the administration of these is a crucial part of treatment. Whereas PBs are beneficial in terms of improving mental health, CSHs are beneficial in terms of relieving feelings of dysphoria.⁶⁴ It recommends the administration of CSHs to dysphoric children if the child in question displays “mental maturity” and knowledge about what results can be expected, possible medical and social risks and possibilities as a

⁵⁸ Sandberg, p. 68.

⁵⁹ Combs, Ryan (2018) “Health Care Policy” *The Remarkable Rise of Transgender Rights*, p. 248.

⁶⁰ DSM-5 (2013) 302.6. (F64.2) p. 452.

⁶¹ Socialstyrelsen (2014) *God vård av barn och ungdomar med könsdysfori - Nationellt Kunskapsstöd*, p. 27.

⁶² Socialstyrelsen, *God vård av barn och ungdomar med könsdysfori*, p. 52.

⁶³ Socialstyrelsen, *God vård av barn och ungdomar med könsdysfori*, p. 55.

⁶⁴ Socialstyrelsen, *God vård av barn och ungdomar med könsdysfori*, p. 58.

result of treatment.⁶⁵ The report specifically stipulates that a child usually embodies this maturity at age 16. However, this maturity may be embodied sooner or later than that.⁶⁶ The child and his or her parents shall jointly be informed about the procedure and its effects, the fact that treatment is carried on into adulthood and the possible consequences regarding fertility.⁶⁷ There is no stipulation on the decision-making related to the initiation of treatment.

On May 7th, 2021, the Astrid Lindgren Children's Hospital in Stockholm announced that they would arrest the administration of PBs and CSHs to dysphoric children under the age of 16 due to an inadequate scientific basis and uncertain assessments of post-treatment beneficial effects. Rather than waiting for the new NBHW report, which is expected this year, the decision was made with urgency. A thorough study was requested before the facility would consider resuming the administration to not compromise the health of any children. Interestingly, the announcement also referenced the *Bell v Tavistock* judgment as a basis for their decision, in which under 16-year-olds were deemed incapable of consenting to hormone treatment.⁶⁸

Sex-reassignment surgery

When Sweden enacted the Gender Classification Act of 1972⁶⁹ it became the first country in Europe to legislate on the change of legal gender.⁷⁰ Changes of registered gender were statutorily integrated with medical care, explained partly by the universal health care system.⁷¹ Under section 1 and 5 of the GCA, an individual over the age of 18 may apply for a change of registered gender and in association with this application also receive permission from the Legal Advisory Board of the NBHW to undergo SRS of

⁶⁵ Socialstyrelsen, *God vård av barn och ungdomar med könsdysfori*, p. 63.

⁶⁶ Socialstyrelsen, *God vård av barn och ungdomar med könsdysfori*, p. 62.

⁶⁷ Socialstyrelsen, *God vård av barn och ungdomar med könsdysfori*, p. 59.

⁶⁸ Trysell, Katrin (2021) *Karolinska sätter stopp för hormonbehandling vid könsdysfori*.

<<https://lakartidningen.se/aktuellt/nyheter/2021/05/karolinska-satter-stopp-for-hormonbehandling-vid-konsdysfori/>>

⁶⁹ Lag (1972:119) om fastställande av könstillhörighet i vissa fall.

⁷⁰ Scherpe, Jens M. (2015) "The legal status of transsexual and transgender persons- an introduction" *The Legal Status of Transsexual and Transgender Persons*, p. 3.

⁷¹ Garland, Jameson (2015) "The legal status of transsexual and transgender persons in Sweden" *The Legal Status of Transsexual and Transgender Persons*, p. 282.

the primary sex characteristics and removal of the gonads. This act does not regulate SRS of the secondary sex characteristics (e.g. mastectomy, facial feminisation surgery etc.) which are consequently not subject to numerical age restrictions, as is also the case with hormonal treatment.⁷² Secondary-SRS is recommended if the child's dysphoria is well documented, if he or she has reached full physical maturity and again, facilities should first consider psychological and medical issues of the patients and conclude that they do not constitute a problem in terms of treatment.⁷³ Additional specific recommendations follow for each of the various procedures. The patient must be informed on surgical techniques, their respective pros and cons, typical risks and he or she must understand the information. He or she should also be shown images of successful and not-so-successful outcomes of previous procedures. Importantly, the time to decide should be considered enough for the child to reflect on what he or she has been told.⁷⁴ In 2012, the Government suggested that the numerical age restriction in the GCA should be revised.⁷⁵ An investigation was launched with the objective of determining the consequences of the age restriction for the child, his or her parents and whether it ought to be changed.⁷⁶ It suggested that the age restriction regarding primary SRS be lowered from 18 to 15. The necessary prerequisites for an approval of SRS-application as proposed by the investigation included the consent of both parents and sufficient maturity of the child to consent to treatment.⁷⁷ A subsequent effort with the purpose of complementing the 2014 investigation also proposed that individuals under the age of 18 who suffered from gender dysphoria could be granted permission to undergo primary SRS if exceptional reasons were present in the case. Applications, as proposed, could concern children under the age of 15, by parent-application. Children aged 15 and over were given the right to apply on their own. If primary SRS could relieve the suffering associated with gender dysphoria, it became significant for the 15-year-old, who should be given the greatest influence in the decision-making, rather than the parents.⁷⁸ The Council on Legislation advised against the proposal having concluded that the decision-

⁷² Socialstyrelsen, *God vård av barn och ungdomar med könsdysfori*, p. 20.

⁷³ Socialstyrelsen, *God vård av barn och ungdomar med könsdysfori*, p. 66.

⁷⁴ Socialstyrelsen, *God vård av barn och ungdomar med könsdysfori*, p. 67.

⁷⁵ Prop. 2011/12:142, p. 56.

⁷⁶ Dir 2014:20 *Åldersgränsen för fastställande av ändrad könstillhörighet*, p. 4.

⁷⁷ SOU 2014:91 *Juridiskt kön och medicinsk könskorrigering*, p. 24.

⁷⁸ Ds 2018:11 *Vissa kirurgiska ingrepp i könsorganen*, p. 75.

making capacity as suggested would interfere with the parents' responsibility and duty as part of their custody. It also asserted that it was challenging to accommodate the changes with the best interests of the child according to the UNCRC.⁷⁹ Similarly, after first having supported the proposal, the NBHW withdrew their approval and concluded that today's scientific basis and proven knowledge did not sufficiently show the benefits or risks associated with primary SRS in minors.⁸⁰

⁷⁹ Lagrådet (2018) *Utdrag ur protokoll vid sammanträde 2018-10-23*, p. 2.

⁸⁰ Socialstyrelsen (2020) *Åldersgräns för vissa kirurgiska ingrepp i könsorganen och socialnämndens roll vid ändring av det kön som framgår av folkbokföringen*, p. 7.

3. INTERNATIONAL PROVISIONS

3.1 The UN Convention on the Rights of the Child

Adopted in 1989, the United Nations Convention on the Rights of the Child (UNCRC) remains the most widely ratified human rights instrument to date. Whereas traditional human rights law is constructed and practiced from an adult perspective, the UNCRC advances the perspective of the child.⁸¹ In addition to being an internationally binding instrument, the Convention has, as previously mentioned, been enacted as part of domestic law in its entirety.

3.1.1 Article 8 and the right to identity

In General Comment No 4 (2003), the Committee remarks that dealing with one's own identity is one of the challenges of adolescence.⁸² Children have the right to preserve their identity as recognized by law under article 8 (1) CRC; beyond the child's nationality, name and family relations, the provision is often understood more broadly as concerning all components of the child's sense of self and what might distinguish him or her from others. Although not explicitly mentioned, the gender identity of the child could be included as such a component, entailing a right to self-determination for dysphoric children in relation to their gender identity.⁸³ When describing what elements to consider when assessing the best interests of the child under article 3, the Committee concludes that the notion of identity encompasses sex and sexual orientation.⁸⁴ Gender identity is not specifically mentioned but both have been suggested in literature to enjoy cover. Article 8 of the UNCRC seemingly allows for an interpretation which gives a right to legal recognition of one's gender in relation to children. It remains to be known whether the right to preservation of one's identity contrarily implies a right to have one's physical expression altered. Such an interpretation is possible if physical change is regarded as necessary to confirm the mental

⁸¹ Sandberg, p. 62.

⁸² General Comment No 4 (2003) *Adolescent health and development in the context of the Convention on the Rights of the Child*, 1 July 2003, CRC/GC/2003/4, para 2.

⁸³ Sandberg, p. 67.

⁸⁴ General Comment No 14 (2013) *on the right of the child to have his or her best interests taken as a primary consideration*, 29 May 2013, CRC/C/GC/14, para 55.

gender identity of the child and thereby also preserve it.⁸⁵ Søndrup suggests that a dynamic interpretation of the child's right to identity might imply a right to hormonal treatment while the actual form of treatment is determined by article 24.⁸⁶

3.1.2 Article 24 and the right to health

Children have the right to enjoy the highest attainable standard of health, treatment of illness and rehabilitation of health under article 24(1). The Committee adheres to the definition of *health* provided by the Constitution of the WHO wherein health equals a state of complete physical, mental, and social well-being.⁸⁷ The Committee attaches a set of freedoms and entitlements to the child's right to health. The freedoms include the control of one's health and body ("sexual and reproductive freedom to make responsible choices") whereas the entitlements include access to a range of facilities, goods, services and conditions that provide equality of opportunity for every child to enjoy the highest attainable standard of health.⁸⁸ As far as medical treatments relate to gender affirmation, they belong to the secondary and tertiary levels of care⁸⁹ which should be made available to the extent that is possible.⁹⁰ Article 4 requires parties to undertake measures to implement the rights of the Convention to the maximum extent of their available resources which entails that States are also expected to provide children with health care to the maximum extent of their available resources. The bar of requirements is consequently set lower for developing countries with fewer resources. Where States have established and recognised gender-affirming treatments to offer via the health service, these treatments are also part of the notion of highest attainable standard.⁹¹ Consent to these types of treatments is absolutely necessary and as part of parental responsibility, it is both the parents' right and duty to decide on behalf of the child which cannot yet,

⁸⁵ Sandberg, p. 67.

⁸⁶ Søndrup, Anders Skjellerudsveen (2015) *Har barnet en rett til rett kjønn? En vurdering av hvorvidt barnet har krav på pubertetsutsettende og femininiserende eller maskuliniserende hormonbehandling ved kjønnsinkongruens*, p. 39.

⁸⁷ General Comment No 15 (2013) *on the right of the child to the enjoyment of the highest attainable standard of health*, 17 April 2013, CRC/C/GC/15.

⁸⁸ General Comment No 15, para 24.

⁸⁹ Sandberg, p. 69.

⁹⁰ General Comment No 15, para 25.

⁹¹ Sandberg, p. 70.

due to a young age or insufficient maturity, decide for himself or herself.⁹² However, the child has a right to express his or her views and to have them given due weight in accordance with age and maturity under article 12 of the Convention. The starting assumption can consequently not be that children are incapable of expressing their views but rather that they are and must be heard.⁹³ The question is then if a child, who wishes to undergo gender-affirming treatment, can consent on his or her own without additional parental consent. Article 5 establishes the duty of State Parties to respect the responsibilities, rights and duties of parents or the extended family et al. to provide appropriate direction and guidance in the exercise of the Convention rights in a manner consistent with the evolving capacities of the child.⁹⁴ At the very least, children ought to be able to consent to medical treatments and interventions without parental permission that concern HIV-testing and other services related to sexual and reproductive health.⁹⁵ The stance taken by the Committee does most likely not include gender-affirming treatment as part of services that can be administered by the child's consent alone.⁹⁶ However, the Committee importantly writes that State parties need to ensure that specific legal provisions are guaranteed under domestic law, including provisions which establish a minimum age for [...] and the possibility of receiving medical treatment without parental consent.⁹⁷

⁹² Sandberg, p. 70.

⁹³ General Comment No 12 (2009) *on the right of the child to be heard*, 20 July 2009, CRC/C/GC/12, para. 20.

⁹⁴ Sandberg, p. 70.

⁹⁵ General Comment No 15, para 31.

⁹⁶ Sandberg, p. 71.

⁹⁷ General Comment No 4, para 5.

4. CONCLUSION

4.1 Children, capacity, and consent

In most instances of child assessment, numerical standards are naturally useful to begin with. Other means of assessment which relate to maturity and development become necessary as the circumstances in relation to the child grow more specific. This essay has not encountered any difficulties in relation to the question as to what constitutes a child. The internationally and nationally binding provision found in article 1 of the UNCRC makes the case certain. Another certain starting point is that the custody of the child, held by the parents or legal guardians, remains until the child turns 18. Chapter 6, Section 11 of the Parental Code declares that custody entails both the right and duty for the parent to make decisions on the child's behalf in his or her personal matters, including medical matters. This authority is not without its limits. The parent must, as soon as it is possible, consult with the child and increasingly consider his or her opinions and wishes in decision-making. Consent is necessary to undergo medical treatment. For consent to be valid, the patient must be given prior information about et al. the treatment in question and the risks associated with it, hence the notion of *informed consent*. When the patient is a child, the parents usually consent on behalf of the child by proxy. Parents are thus entitled to receive the information, as is the child, adjusted to his or her age and maturity.

What is less certain in statutory terms, is how the parental responsibility relates to the ever more capable and mature child as time goes on. A case may rightfully be made that the issue is clear in principal terms based on case law, in which children have been given a far-reaching decision-making capacity. Younger teenagers first acquire negative decision-making capacity, giving them the right to decline medical treatment. It is not clear when they also acquire positive decision-making capacity but the fact that they do receive it gradually from as early as age 12 is undisputed among authors. When the child has positive decision-making capacity, parental consent is generally not needed unless the capacity ought to be limited in some way. The parent is likely to have a right to veto a high-risk treatment of which the benefits are not clear. The more invasive a procedure, the higher the degree of maturity is needed from

the child. It should be noted, again, that these principles in the general field of health law relating to children, do not follow from regulations but rather from custom. This is not the case with specialised legislation where numerical age restrictions apply. Children have what might be designated a relative decision-making capacity and non-capacity. When the negative capacity is clear but not the positive capacity, this most likely calls for a joint parent-child decision. Regardless, it is essential that these evaluations be made individually.

4.2 Gender-affirming treatment

Needless to say, this issue is of an interdisciplinary and abundantly private nature and must always be thought of as such. The administration of PBs and CSHs is based on a report of recommendations issued by the National Board of Health and Welfare in 2014, since there is no guiding legislation. Considering that the treatment of PBs is most effective when started early on, the report asserts that the child and his or her parents shall receive information on the treatment with PBs and risks associated with it. Thereby, it signals that this is a case of a joint parent-child consent, wherein the child is considered old enough to have negative, but not positive decision-making capacity on his or her own. Informed consent thus consists of the approving decision made jointly by the child and parents after having received sufficient information. This is also the case regarding CSHs. However, the child has at this point entered puberty and might have positive decision-making capacity. The report does not stipulate, as it did in relation to PBs, that the decision to undergo treatment should be made jointly with the parents. It does, however, stipulate that children usually reach the maturity which is necessary for treatment at age 16. A child almost certainly has positive decision-making capacity at this point. Still, the individual assessment remains the crucial element, in all cases. The recent announcement from the prominent children's hospital in Stockholm raises concern over the scientific basis and uncertain assessment of post-treatment benefits behind the administration of PBs and CSHs. Seemingly, the facility does not want to risk causing any children harm. Yet, it references *Bell v Tavistock*, which concerned the circumstances under which children could lawfully consent to these treatments. It is not known what legal assessment was made by the facility, or to what extent it considers the *Bell v Tavistock* judgment to not be in accordance

with the NBHW- recommendations. Regarding SRS, statutory provisions offer considerably more ground to stand on. Whereas primary SRS and removal of the gonads is regulated in the GCA and cannot lawfully be offered to those under the age of 18, secondary SRS is regulated by several acts of health law and alike hormone treatment, administered according to the NBWH report of recommendations. The child, now presumed to have positive decision-making capacity, must be informed on the surgical techniques, pros and cons, typical risks and he or she must understand the information. The report does not describe the extent to which parents ought to be informed or be involved in the decision-making process. It can therefore be assumed that the child has a right to decide on his or her own regarding CSHs and secondary SRS. However, when considering the possibility that the parent(s) may equally have a right to veto in case a procedure is too invasive, no general answers can be given other than what is concluded inside the setting of the individual assessment.

4.3 UN Convention on the Rights of the Child

On an international note, the UN Convention on the Rights of the Child is a binding treaty. It is also enacted as part of domestic legislation. Article 8 and the right to identity is the first most relevant provision in relation to gender-affirming treatment. Gender identity is not explicitly mentioned but has been interpreted to enjoy cover in literature based on a Committee comment. Whether or not the article, which gives the child a right to preserve his or her identity, contrarily gives a right to alter his or her physical appearance, rests on the assertion that gender-affirming is necessary to affirm the mental gender identity of the child. Seemingly, it is a very dynamic and perhaps unlikely interpretation to suggest that article 8 gives a right to gender-affirming treatment. Rather, the second most relevant provision in article 24 might hold this assertion, most likely in countries where the treatments in question are offered as part of the health service, as they are consequently part of the notion of highest attainable standard of health. Further clarification from the Committee is needed to conclude this. If one assumes this interpretation is correct: as in domestic law, the starting point seems to be that the right and duty to consent to medical treatment on behalf of the child lies with the parent. At the same time, the starting point is that the child has a right under article 12 to have his or her views be given due weight in accordance with age and

maturity. The Committee has stipulated the need for parties to ensure the enactment of specific legal provisions under domestic law which set a minimum age for et al. the possibility of medical treatment without parental consent. Considering that there exists no such provision, this should appropriately become a domestic priority for the domestic legislature in the years to come.

4.4 Competence-based or needs-based approach?

In attempting to answer questions on what lies in the best interests of the child, recent efforts to effectively lower the age restriction for primary SRS from 18 to 15 on the one hand clearly reflect a competence-based approach. Children are increasingly viewed as capable of making decisions that concern their personal matters on their own behalf. In addition, the domestic attitudes match the current international trend already as it is. On the other hand, the legislative efforts are yet to succeed and have been subject to much criticism. The Council on Legislation seemingly took on a needs-based approach, emphasising that the proposed legislation would interfere with the parental responsibility and the best interests of the child according to the UNCRC. The current provisions offer a far-reaching decision-making capacity to children through unwritten rules that can be described as ambiguous at most; the defining factor is the individual assessment which can take on the approach of competence, needs or both at any given moment. Without statutory guidance, it seems it is likely that competence on the one hand and needs on the other is indeed a false dichotomy. This is both a strength and weakness. It will continue to apply unless the matter is legislated or ruled on in a higher court. It is not at all impossible to assume a case like *Bell v Tavistock* unfolding domestically. A revised NBHW report of recommendations will soon see the light of day, but it remains to be known what modifications might be made. If the problem turns out to not be scientific in nature, but legal, then it is not entirely unthinkable that legislators will face calls for statutory affirmation of the circumstances under which children may consent to what kind of medical treatment. It remains to be known if others will follow, but at least one healthcare provider has now told us the following: *primum, non nocere*. Or, first, do no harm.

REFERENCES

PRINTED SOURCES

Official materials

Sweden

Reports

Dir. 2014:20 Åldersgränsen för fastställande av ändrad könstillhörighet

Ds 2018:11 Vissa kirurgiska ingrepp i könsorganen

SOU 2014: 91 Juridiskt kön och medicinsk könskorrigering

Propositions

Prop. 1981/82:168 Vårdnad och umgänge m.m

Prop. 2011/12:142 Ändrad könstillhörighet

Other parliament materials

JO 1975/76 p. 244

JO 1995/96 s. 89

Lagrådet (2018) Utdrag ur protokoll vid sammanträde 2018-10-23

National Board for Health and Welfare

Socialstyrelsen (2015) God vård av barn och ungdomar med könsdysfori - Nationellt Kunskapsstöd

Socialstyrelsen (2020) Åldersgräns för vissa kirurgiska ingrepp i könsorganen och socialnämndens roll vid ändring av det kön som framgår av folkbokföringen: Redovisning av regeringsuppdrag

Cases etc.

Sweden

HSAN 2747/00

England and Wales

Bell v Tavistock R (on the application of) Quincy Bell and A -v- Tavistock and Portman NHS Trust and others.

ELECTRONIC SOURCES

Diagnostics and Statistical Manual of Mental Disorders (DSM-5) 2013. <<https://cdn.website-editor.net/30f11123991548a0af708722d458e476/files/uploaded/DSM%2520V.pdf>> 2021-05-10.

Søndrup, Anders Skjellerudsveen. "Har barnet en rett til rett kjønn? En vurdering av hvorvidt barnet har krav på pubertetsutsettende og femininiserende eller maskuliniserende hormonbehandling ved kjønnsinkongruens". 2015-06-01.

<<https://www.duo.uio.no/bitstream/handle/10852/45651/232.pdf?sequence=1&isAllowed=y>> 2021-04-21.

Trysell, Katrin. "Karolinska sätter stopp för hormonbehandling vid könsdysfori" Läkartidningen. 2021-05-07. <<https://lakartidningen.se/aktuellt/nyheter/2021/05/karolinska-satter-stopp-for-hormonbehandling-vid-konsdysfori/>> 2021-05-07.

GENERAL COMMENTS

The Committee on The Rights of the Child

General Comment No 4 *Adolescent health and development in the context of the Convention on the Rights of the Child*, 1 July 2003, CRC/GC/2003/4. 2003.

General Comment No 12 *on the right of the child to be heard*, 20 July 2009, CRC/C/GC/12. 2009.

General Comment No 14 *on the right of the child to have his or her best interests taken as a primary consideration*, 29 May 2013, CRC/C/GC/14. 2013.

General Comment No 15 *on the right of the child to the enjoyment of the highest attainable standard of health*, 17 April 2013, CRC/C/GC/15. 2013.

LITERATURE

Axelsson, Ewa. *Patientsäkerhet och kvalitetssäkring i svensk hälso- och sjukvård: en medicinrättslig studie*. Uppsala: Iustus. 2011.

Combs, Ryan. "Health Care Policy" *The Remarkable Rise of Transgender Rights*. pp: 246- 259.
Taylor, Jami K, Daniel, Lewis C. and Haider-Markel, Donald P. (Eds) Ann Arbor: University of Michigan Press. 2018.

Garland, Jameson. "The Legal Status of Transsexual and Transgender Persons in Sweden" *The Legal Status of Transsexual and Transgender Persons*. pp. 281-311. Scherpe, Jens M. (Ed.) Cambridge: Intersentia. 2015.

Hartlev, Mette. "Informed consent in the Nordic countries" *Informed Consent and Health: a Global Analysis*. pp. 163-182. Vansweevelt, Thierry and Glover-Thomas, Nicola Cheltenham (Eds) Cheltenham: Elgar. 2020.

Kleineman, Jan. "Rättsdogmatisk metod" *Juridisk metodlära*. pp. 21-45. 1:3 ed. Korling, Fredric and Zamboni, Mauro (Eds). Lund: Studentlitteratur. 2013.

Lönnheim, Charlotte. Patient's Act (2014:821), Chapter 4, Section 3, Not 17 (JUNO) 2021-05-15.

Lönnheim, Charlotte. Patient's Act (2014:821), Chapter 4, Section 3, Note 41 (JUNO) 2021-05-15.

Oldenstedt, Boel. Parental Code (1949:381), Chapter 2, Section 6, Note 155 (JUNO) 2021-05-15.

Rynning, Elisabeth. "Consent to Medical Care and Treatment — Legal Relevance in Sweden" *Patient's Rights*. pp. 321-364. Westerhäll, Lotta and Phillips, Charles (Eds) Stockholm: Nerenius & Santérus. 1993.

Rynning, Elisabeth. *Samtycke till medicinsk vård och behandling*. Uppsala: Iustus. 1994.

Rönneberg, Lena. *Hälso- och sjukvårdsrätt*. 5 ed. Lund: Studentlitteratur. 2020.

Sandberg, Kirsten. "The Rights of LGBTI Children under the Convention on the Rights of the Child" *Nordic Journal of Human Rights*, volume 33, issue 4. pp. 337-352. 2015.

Scherpe, Jens M. "The Legal Status of Transsexual and Transgender Persons- an Introduction" *The Legal Status of Transsexual and Transgender Persons*. pp. 1-6. Scherpe, Jens M. (Ed.) Cambridge: Intersentia. 2015.

Svensson, Gustav. *Barns rätt i hälso- och sjukvård*. Lund: Studentlitteratur: 2007.

Vansweevelt, Thierry and Glover-Thomas, Nicola. "A general introduction" *Informed Consent and Health: A Global Analysis*. pp. 1-4. Vansweevelt, Thierry and Glover-Thomas, Nicola (Eds) Cheltenham: Elgar. 2020.

Articles

The Economist. "Trans Rights: Boys and Girls" *Volume 437 Number 9224*. December 12th, 2020. Pp. 53-55.