



Review Article

Reassessing Capacity Assessments in Adolescent Consent to Gender-Affirming Care

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ABSTRACT

Assessing whether an adolescent has the decision-making capacity to consent to gender-affirming care has become one of the most contested procedural questions in pediatric bioethics, yet the doctrine most jurisdictions rely on -- mature-minor or Gillick competence -- was developed for discrete, low-stakes interventions rather than staged, partially irreversible treatment pathways.

This review examines how capacity assessment is structured and practiced across informal clinical judgment, multidisciplinary assessment protocols, and the more centralized, gatekept model that followed the Cass Review in England, alongside the methodological controversy that review has generated.

It then considers the harder cases in which an adolescent judged competent and a skeptical parent reach opposite conclusions, and the structural gap in mature-minor doctrine that such disagreements expose.

We argue that much of the present conflict is fought on the wrong terrain, with disputes over the strength of the underlying clinical evidence and the appropriate scope of parental authority often presented as disputes about capacity itself.

We conclude that a more defensible process would require staged, intervention-specific assessment, transparency about clinicians' evidentiary assumptions, and an explicit, disclosed procedure for resolving adolescent-parent disagreement.

Keywords: *adolescent decision-making capacity; gender-affirming care; informed consent; Gillick competence; pediatric bioethics*

Citation: Nowak C, Toth L and Ferraro L (2026) Reassessing Capacity Assessments in Adolescent Consent to Gender-Affirming Care. *Bioethics*. 1(2):01-06.

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Article History: Received 27 June 2026 | Accepted 29 September 2026 | Published 27 December 2026

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INTRODUCTION

Whether an adolescent can meaningfully consent to

gender-affirming medical care has become one of the more contested questions in pediatric bioethics, and much of the disagreement traces back to a narrower,

more technical question: what does it actually mean to assess decision-making capacity in a minor facing this particular decision? Capacity assessment sits at the hinge between two positions that are each individually defensible but pull in opposite directions -- the conviction that adolescents can hold genuine, stable views about their own gender and bodies, and the caution that developmental immaturity, mental health comorbidity, and social pressure can all distort a young person's stated preferences without either the young person or the clinician noticing [1]. Neither position resolves the practical problem clinics face: some workable procedure has to exist for deciding, case by case, whether a particular fourteen- or sixteen-year-old understands enough, and is stable enough in that understanding, to make a decision with consequences that may extend across an entire lifetime.

The doctrinal starting point in most common-law jurisdictions is the "mature minor" or Gillick standard, under which a minor who demonstrates sufficient understanding and intelligence to comprehend a proposed treatment may consent to it without parental authorization [2]. That standard was developed for a paradigmatic case -- a general practitioner prescribing contraception to a minor -- and its extension to gender-affirming care asks it to do work it was never obviously designed for: assessing understanding not of a single reversible intervention but of a staged pathway that may include reversible social changes, partially reversible pubertal suppression, and treatments with effects that are difficult or impossible to fully undo [3]. Commentators have long noted that Gillick's abstract formula -- sufficient understanding and intelligence -- gives almost no operational guidance for how deep that understanding needs to be, or how a clinician is supposed to test for it under real time pressure [4].

This review examines how capacity assessment for adolescent gender-affirming care is actually practiced and contested: the legal and ethical scaffolding inherited from mature-minor doctrine, the assessment tools and multidisciplinary processes clinics have built on top of it, the evidentiary controversy sharpened by the Cass Review in England, and the harder cases where an adolescent's stated wishes and a parent's judgment diverge. Table 1 summarizes four broad approaches to structuring these assessments, and Figure 1 offers a schematic comparison of how much weight each places on adolescent self-report relative to external clinical oversight.

LEGAL AND ETHICAL FOUNDATIONS: GILLICK COMPETENCE AND ITS LIMITS

Gillick competence was framed as a case-by-case factual inquiry rather than an age threshold, which is precisely its appeal and its weakness: it avoids an arbitrary cutoff, but it also gives clinicians very little to hold onto beyond their own judgment of "sufficient understanding" [5]. Applied to contraception or straightforward acute treatment, that judgment is

comparatively tractable, since the clinician can explain a discrete intervention with a short time horizon and a well-characterized side-effect profile. Applied to a staged gender-affirming pathway, the same test has to somehow capture whether a fifteen-year-old grasps not just what pubertal suppression does in the near term, but how a decision made now interacts with fertility, sexual function, and an identity that may itself still be consolidating [6].

Legal scholars analyzing the broader mature-minor jurisprudence have pointed out that courts and legislatures have never settled whether the underlying rationale is really about a minor's cognitive capacity at all, or whether it is a proxy for something else -- confidence that the minor's expressed preference will hold up over time, or comfort with the particular treatment being requested [7]. That ambiguity becomes consequential in gender-affirming care because critics and supporters alike tend to smuggle their substantive views about the treatment into what is nominally a procedural test of capacity: a clinician who is skeptical of an intervention's long-term evidence base may set the bar for "sufficient understanding" higher than one who is not, even while both describe themselves as applying the same neutral standard [8]. Legal analyses of the field describe this drift explicitly, arguing that the "transgender child" has been partly constituted as a legal category through litigation and guidance documents that were themselves shaped by contested clinical opinion, rather than emerging from a stable, pre-existing legal test [9]. A related line of scholarship situates gender-affirming decisions for minors within a wider category of adolescent body-modification requests, arguing that whatever standard applies should be at least broadly consistent with how the law treats other significant, identity-related decisions adolescents make about their own bodies [10]. Comparative legal analysis of gender-related treatment more broadly has likewise noted that jurisdictions rarely built a purpose-specific consent framework for gender-affirming care from scratch; instead they extended doctrines developed for other medico-legal disputes, sometimes awkwardly, and the resulting patchwork of standards varies considerably even among otherwise similar legal systems [11]. Early Australian commentary tracking the shift from court-authorization models toward clinician- and family-led decision-making captured this evolution directly, describing a landscape that was already changing faster than the legal doctrine meant to govern it [12].

CAPACITY ASSESSMENT IN PRACTICE: TOOLS, STANDARDS, AND GAPS

In practice, most specialized gender clinics do not rely on an unstructured clinical impression of "sufficient understanding." They have built multidisciplinary assessment processes involving mental health clinicians, endocrinologists, and sometimes

bioethicists, intended to probe an adolescent's understanding of the specific treatment being requested, screen for co-occurring mental health conditions that might complicate the picture, and document that understanding over more than a single visit [13]. A recent scoping review of the capacity literature found that, despite this apparent structure, there is no validated, gender-affirming-care-specific capacity instrument in wide use; clinics largely adapt general pediatric capacity frameworks or rely on locally developed checklists, which makes it difficult to compare practice across institutions or to know whether any given process reliably distinguishes adolescents who understand the decision from those who do not [1].

Table 1. Four broad models used to structure capacity assessment for adolescent gender-affirming care, compared by locus of assessment, role of parents, and main critique.

Model	Locus of assessment	Role of parents	Main critique
Informal mature-minor judgment	Single treating clinician, one or few visits	Informed but not required to agree	Highly variable; understanding poorly documented
Structured multidisciplinary assessment	Mental health clinician, endocrinologist, and care team jointly, over multiple visits	Actively involved; disagreement usually delays but does not automatically block	No validated, condition-specific capacity instrument in wide use
Centralized gatekept model (post-Cass)	Regional specialist service with extended psychosocial assessment before referral	Involved throughout an extended assessment period	Longer waits; critics dispute the evidence base motivating the extra caution
Shared decision-making framework	Adolescent and family jointly with clinical team, capacity treated as necessary but not sufficient	Effectively co-decision-makers, not just informants	No settled process when an assessed-competent adolescent and parent disagree

Figure 1. Schematic comparison of the relative weight given to adolescent self-report versus external clinical/institutional oversight across the four capacity assessment models in Table 1. Illustrative only, based on qualitative reading of the literature discussed in this review, not derived from a single empirical study or quantitative scale.

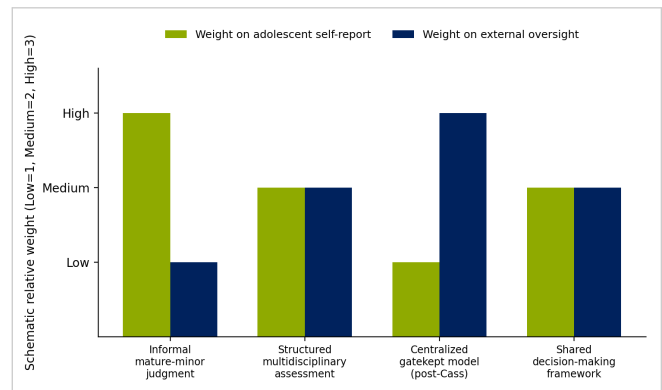


Table 1 lays out four broad models that have emerged in different jurisdictions and institutional settings: an informal mature-minor clinical judgment, a structured multidisciplinary assessment along the lines recommended in professional guidelines, the more centralized, gatekept model that followed the Cass Review's recommendations in England, and a shared decision-making framework that treats capacity as necessary but not sufficient, requiring family agreement wherever practicable. None of the four is uncontested. The most detailed empirical account of adolescents' own reasoning process, an interview study with youth who had already undergone hormone therapy, found that participants described their decisions as carefully considered rather than impulsive, drawing on information gathered well before their clinical appointments -- evidence that at least some adolescents bring a level of deliberation to the decision that a brief clinical encounter might fail to detect [14]. That same study, however, was necessarily retrospective and drawn from adolescents who had already been approved for treatment, which limits what it can say about the assessment process's ability to identify the minority of adolescents whose understanding or stability might genuinely be in question.

A parallel debate concerns puberty suppression specifically, which is often described to patients and families as fully reversible. Ethicists working through individual pediatric cases have argued that this framing understates the decision's stakes, since halting puberty is not ethically neutral even where its physiological effects can be reversed -- it forecloses the lived experience of endogenous puberty and narrows, at least temporarily, the range of futures still open to the adolescent, a consideration relevant to capacity assessment because it changes what "sufficient understanding" would need to include [3]. The most extensively documented individual case in the pediatric ethics literature, a nonbinary adolescent on extended puberty suppression, illustrates how

capacity assessment in practice often becomes an ongoing process of re-evaluation rather than a single determination made at one point in time [15].

THE EMPIRICAL AND EVIDENTIARY CONTROVERSY

Capacity assessment cannot be separated from the underlying evidence base for the treatments being assessed, because how confidently a clinician can describe risks, benefits, and alternatives to an adolescent depends on how well those things are actually known. This is precisely where the field's most consequential recent controversy sits. The Cass Review, an independent review of gender identity services for children and young people in England, concluded that the evidence supporting several interventions was weaker than commonly represented and recommended a more cautious, centralized model of care with more extensive psychosocial assessment before medical treatment [16]. Its author has argued that the review's recommendations were misread by some critics as a wholesale rejection of gender-affirming care, when they were intended narrowly as a call for better evidence generation and more consistent assessment practice [16].

That framing has not settled the argument. Critics have published detailed methodological critiques arguing that the review's evidence synthesis applied inconsistent standards, disproportionately excluded observational studies supportive of gender-affirming approaches, and understated the clinical consensus in specialist practice elsewhere [17]. Others analyzing the review's aftermath from a health-policy and legal perspective have argued that its findings and the litigation and legislative responses that followed illustrate a deeper structural problem: courts and legislatures import clinical evidentiary disputes into legal standards not well-suited to resolving them, producing capacity and consent frameworks that shift with each new evidence review rather than resting on a stable underlying principle [18]. Jurisdictions outside England have had to decide how much weight to give the review's conclusions in their own policy, with at least one analysis concluding that wholesale adoption without independent evidence review risks importing the review's own contested methodological choices into a different health system [19]. Population-level Finnish data, drawn from specialized gender identity services, have been cited on multiple sides of this debate: one register study found substantially elevated all-cause and suicide mortality among adolescents and young adults who had contacted such services relative to the general population, a finding its authors caution should not be read as evidence about the effects of gender-affirming treatment itself, since the cohort includes people at very different stages of assessment and treatment, but which nonetheless underscores the clinical stakes attached to getting assessment and referral processes right [20].

WHEN ADOLESCENTS AND PARENTS DISAGREE

A capacity assessment that concludes an adolescent understands a proposed treatment does not, on its own, settle whether that adolescent should receive it, because most clinical pathways also expect meaningful parental involvement, and Gillick-style doctrine deliberately leaves the relationship between a minor's own competence and a parent's authority somewhat unresolved. That ambiguity becomes acute in the minority of cases where an assessed-as-competent adolescent and a parent land on opposite conclusions. An analysis of pediatric cases involving exactly this kind of disagreement found that clinical teams had no settled algorithm for resolving it, relying instead on extended discussion, delay, and case-by-case ethics consultation, an approach defensible in individual cases but difficult to generalize into a transparent standard that families can anticipate in advance [21].

The stakes of getting the parent-adolescent relationship wrong differ depending on which party's concerns are overridden. Overriding a competent adolescent's stated wish in deference to a reluctant parent risks the same paternalism mature-minor doctrine was designed to prevent, treating a documented capacity finding as advisory rather than determinative. Overriding a parent's serious, evidence-engaged reservations in deference to an adolescent's stated preference risks treating capacity assessment as a formality that rubber-stamps a predetermined outcome rather than a genuine safeguard, a concern that runs through much of the Cass-adjacent critique described above [18]. Broader scholarship on adolescent consent and refusal has described this asymmetry as a structural feature of most mature-minor frameworks, not a defect specific to gender-affirming care: the same doctrine that lets a competent minor consent to treatment often does far less work when a minor wants to refuse it, or when a parent disagrees with a minor's considered choice, because refusal and parental override trigger separate legal and clinical safeguards that consent alone does not [8].

Older legal commentary on this same asymmetry, written before gender-affirming care had reached its current prominence, warned that a legal system quick to extend adult-style refusal rights to minors while slow to extend the corresponding consent rights would leave adolescents with a right that functions mainly on paper -- an observation that reads as prescient given how much of the present dispute concerns exactly that gap [22].

Comparative work on adolescent self-consent in other domains offers a partial, if imperfect, benchmark. Programs allowing adolescents to independently consent to school-based vaccination, for instance, have been evaluated for both uptake and acceptability,

and found broadly workable when paired with accessible information and a genuine, low-friction opt-out [23]. That precedent is limited -- vaccination is a single-encounter, low-stakes, population-level intervention very unlike a staged, partially irreversible gender-affirming pathway -- but it illustrates that adolescent self-consent frameworks can be operationalized carefully in other clinical contexts, which is at least suggestive evidence against the claim that adolescent decision-making about medical care is inherently too unreliable to build a defensible process around.

TOWARD MORE DEFENSIBLE CAPACITY ASSESSMENT PRACTICE

Reviewing this literature suggests three principles that a defensible capacity assessment process for gender-affirming care would need to satisfy, none of which is fully met by current practice. First, the assessment needs to be genuinely staged and intervention-specific rather than a single global judgment, since the understanding required for a reversible social step is not the same as the understanding required for an intervention with lasting physiological effects [3]. Second, it needs to be conducted by clinicians whose evidentiary starting assumptions about the treatment are transparent, precisely because the Cass Review controversy shows how easily contested evidence claims can be smuggled into an ostensibly neutral capacity determination [17]. Third, it needs an explicit, disclosed procedure for the disagreement cases -- adolescent versus parent, or adolescent versus clinical team -- rather than leaving that resolution to ad hoc ethics consultation each time it arises [21]. Systematic reviews of the broader research ethics literature on trans and gender-diverse youth reach a compatible conclusion from a different angle, arguing that meaningful participatory engagement with young people themselves, not just retrospective interview studies, should inform how these processes are designed in the first place rather than being treated as a nice-to-have after the fact [24].

None of this resolves the underlying disagreement about how much weight capacity assessment can bear in a field where the treatment evidence itself remains genuinely contested. But it does suggest that much of the present conflict is being fought on the wrong terrain: participants on both sides describe themselves as defending "capacity assessment" while sometimes really disputing the underlying evidence base for the treatments being assessed, or the appropriate degree of parental authority, questions capacity doctrine alone was never built to answer [7].

CONCLUSION

Capacity assessment in adolescent gender-affirming care sits under more weight than the doctrine it draws on -- Gillick competence -- was designed to carry, and

much of the current controversy reflects that mismatch rather than a simple disagreement about where to set the bar. The mature-minor standard offers a case-by-case test of understanding but little guidance on how deep that understanding must go for a staged, partially irreversible treatment pathway, and clinics have filled that gap with a patchwork of locally developed, largely unvalidated assessment processes. The Cass Review and the methodological disputes it triggered have made unmistakably clear that capacity assessment cannot be evaluated apart from the strength of the underlying clinical evidence, since a clinician's account of risks and benefits is only as reliable as the evidence informing it. And the hardest cases, where an assessed-as-competent adolescent and a skeptical parent disagree, expose a structural gap in mature-minor doctrine that predates gender-affirming care but is now most visible within it. A more defensible path forward likely requires staged, intervention-specific assessment, transparency about the evidentiary assumptions clinicians bring into the room, and an explicit, disclosed process for resolving disagreement, rather than continuing to ask a single, decades-old competence test to settle a set of questions it was never designed to answer alone.

DECLARATIONS

Acknowledgements

The authors thank colleagues at their respective bioethics and clinical ethics centres for helpful discussion during the drafting of this review.

Funding

This review received no external funding.

Conflict of Interest

The authors declare no conflicts of interest relevant to this work.

Author Contributions

Chiara Nowak conceived the review, coordinated the literature synthesis, and drafted the initial manuscript. Lieve Toth contributed the sections on capacity assessment tools and the Cass Review controversy and critically revised the manuscript. Laura Ferraro contributed the philosophical analysis of Gillick competence and parent-adolescent disagreement and provided final approval of the submitted version. All authors read and approved the final manuscript.

Ethics Statement

As a literature review synthesizing previously published, publicly available research, legal analysis, and policy documents, this article did not involve new data collection from human participants and did not require institutional ethics committee approval.

Data Availability

No new data were generated or analyzed for this review. All sources discussed are cited in the

reference list and are publicly available through their respective publishers.

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