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Building bridges: A Multidisciplinary Approach to Family Law

To Treat Or Not To Treat:

Legal Responses to Transgender Young People Revisited

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* The views expressed in this paper are my own and are personal to me. They do not represent those of the Family Court of Australia.

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Introduction

This paper updates a presentation made at the Association of Family and Conciliation Courts 51st annual conference in Toronto on 30 May 2014, and should be read in tandem with the paper accompanying that presentation.¹ The 2014 paper contained an overview of the development of the law in Australia governing medical treatment for young transgender people, compared the position in Australia with that in Canada, the United States and the United Kingdom, undertook a detailed examination of the Full Court of the Family Court's decision in *Re: Jamie*,² and identified particular issues that were suggested may be the subject of curial consideration in decisions following *Re: Jamie*. These issues were thought likely to include the types of applications being made to the court, the form of the relief sought, the approach to assessing a child's competency to consent to Stage 2 medical treatment for gender dysphoria, and the factors taken into account in arriving at a decision about whether a child is or is not *Gillick* competent.

Twelve months on from that presentation, and two years since the Full Court's decision in *Re: Jamie*, it is timely to consider whether and to what extent those predictions have been realised. This paper therefore explores whether the law surrounding consent to medical treatment has developed in a logical, structured and principled way following *Re: Jamie*, and whether any jurisprudential or procedural ambiguities are able to be discerned.

The primary contention is that although *Re: Jamie* was intended to provide clarity and certainty about the extent to which the Family Court needs to be involved in treatment decisions involving young transgender people, with few exceptions the decisions following *Re: Jamie* evince a degree of confusion about the limits of the law's operation. Accordingly, although the Family Court has laudably been engaging with stakeholders to develop a faster, cheaper and more streamlined approach to the task of

¹ The Hon. Justice Strickland, *To Treat or Not to Treat: Legal Responses to Transgender Young People*, Association of Family and Conciliation Courts 51st annual conference, *Navigating the Waters of Shared Parenting: Guidance from the Harbour*, Toronto, Canada, May 28-31, 2014

<<http://www.familycourt.gov.au/wps/wcm/connect/fcoaweb/reports-and-publications/speeches-conference-papers/2014/speech-strickland-transgender-youth>> (accessed 23 August 2015).

² (2013) FLC 93-547.

assessing the competency of young transgender people to consent to medical treatment, legislative intervention is now warranted.

Terminology

Gender dysphoria

People with gender dysphoria have a persistent and profound discomfort with their biological sex and a strong identification with the gender of the opposite sex. It is usually diagnosed by reference to the diagnostic criteria contained in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

For a child to be diagnosed with gender dysphoria, there must be a marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six identified criteria. These criteria must include "a strong desire to be of the other gender or an insistence that one is the other gender, or some alternative gender different from one's assigned gender". For adolescents, there must be a marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two identified criteria – no criterion is mandatory. For both, the condition must also be associated with clinically significant distress or impairment in social, school, occupational or other important areas of functioning.

Stage 1 and Stage 2 treatment for gender dysphoria

Treatment for gender dysphoria in children and adolescents has been described in the following terms:³

In addition to ongoing psychological support, peripubertal adolescents with persistent [gender dysphoria] may be given hormonal treatment using gonadotrophin releasing hormone (GnRH) analogue to suppress puberty once it has commenced, followed later by cross-sex hormone therapy to promote physical development in the affirmed gender.

³ Jacqueline Hewitt et al, 'Hormonal Treatment of Gender Identity Disorder in a Cohort of Children and Adolescents' (2012) *Medical Journal of Australia* 578 < <https://www.mja.com.au/journal/2012/196/9/hormone-treatment-gender-identity-disorder-cohort-children-and-adolescents> (accessed 3 September 2015).

Stage 1 of the treatment – the suppression of puberty – is fully reversible. Stage 2 of the treatment – the administration of testosterone or oestrogen – has irreversible features. For testosterone use in females transitioning to males, these include hair growth, voice deepening and muscle growth. There is also a risk of impaired liver function, polycystic ovaries and ovarian cancer. For oestrogen use in males transitioning to female, these include breast development, testicular shrinkage and growth height maturation. There is also a risk of impaired liver function and thromboembolism.

Gillick competence

The majority of the House of Lords in *Gillick v West Norfolk and Wisbech Health Authority* (*'Gillick'*)⁴ held that a child is capable of providing his or her own consent to medical treatment where he or she is found to be of sufficient intelligence and maturity to fully understand what is involved. This is what has been referred to in subsequent cases, including *Re: Jamie*, as *Gillick* competency. The High Court of Australia in *Secretary, Department of Health and Community Services; JWB and SMB* (known as *'Marion's Case'* or *'Re: Marion'*)⁵ confirmed that the House of Lords' decision forms part of the common law in Australia.

The relevant law

Part VII of the *Family Law Act 1975* (Cth) (“the FLA”) concerns children. Section 69H(1) of the FLA confers jurisdiction on the Family Court “in relation to matters arising under this Part.” In proceedings for a parenting order, the Court is empowered to make such parenting order as it considers proper.⁶ A parenting order can deal with a range of matters, as contained in section 64B(2). These include the allocation of parental responsibility for a child. Parental responsibility is defined in section 61B as “all the duties, powers, responsibilities and authority which, by law, parents have in relation to children.” In addition to allocating parental responsibility (and other

⁴ [1985] 3 All ER 402. It should be remembered however that the House of Lords in *Gillick* was concerned with assessing capacity of a child aged under 16, as children aged 16 years and over can give their own consent to medical treatment – see *Family Law Reform Act 1969* (UK), s 8.

⁵ (1992) 175 CLR 218.

⁶ *Family Law Act 1975* (Cth), s 65D.

matters such as with whom a child should live and who they should spend time with), a parenting order may also deal with “any aspect of the care, welfare or development of the child or any other aspect of parental responsibility for a child.”⁷ The best interests of the child is the paramount consideration when the Court is deciding what parenting order to make.⁸

Section 67ZC of the FLA confers additional jurisdiction on the Court. It states:

Orders relating to welfare of children

(1) In addition to the jurisdiction that a court has under this Part in relation to children, the court also has jurisdiction to make orders relating to the welfare of children.

Note: Division 4 of Part XIII AA (International protection of children) may affect the jurisdiction of a court to make an order relating to the welfare of a child.

(2) In deciding whether to make an order under subsection (1) in relation to a child, a court must regard the best interests of the child as the paramount consideration.

Note: Sections 60CB and 60CG deal with how a court determines a child’s best interests.

Section 67ZC is the statutory basis for the Court’s jurisdiction to approve or refuse permission for medical procedures that fall outside the bounds of parental consent. Applications for permission undertake medical treatment for gender dysphoria have historically been heard and determined through an exercise of the Court’s ‘welfare’ jurisdiction pursuant to section 67ZC.

The Full Court of the Family Court’s decision in *Re: Jamie*

Re: Jamie involved an appeal from a decision in respect of an application by the parents of a child aged 10 years and 10 months at the date of hearing – March 2011 – for Stage 1 (fully reversible) and Stage 2 (partly irreversible) treatment for gender dysphoria. At first instance, Stage 1 treatment had been ordered by the trial judge but the judge was unable to make a determination that the second stage of treatment, which would not commence until 2016 or 2017, was in the child’s best interests. The major issue arising in the appeal was that the Family Court did not have jurisdiction to

⁷ Ibid para 64B(2)(i).

⁸ Ibid s 60CA.

authorise the child’s parents to consent to treatment, as it fell within the exercise of parental responsibility.

Re: Jamie was described in the 2014 paper in the following terms:

Re: Jamie was the first case where the Full Court of the Family Court had the opportunity to undertake a comprehensive analysis of earlier authorities, including that of the High Court of Australia in *Re: Marion* and Nicholson CJ in *Re: Alex*, in the context of an application for authorisation to undertake medical treatment for gender dysphoria. It is therefore a highly significant decision in the context of the limits of the Family Court’s welfare or supervisory jurisdiction.

As the High Court is at the apex of the Australian judicial system, its decisions, including that of *Re: Marion*, are binding on the Family Court in its exercise of original and appellate jurisdiction. In *Re: Marion*, the High Court essentially held that court authorisation to perform a medical procedure on a non-*Gillick* competent child is required where:

- the proposed procedure is invasive, permanent and irreversible;
- the proposed procedure is non-therapeutic, meaning it is not for the purpose of curing a malfunction or disease;
- there is a significant risk of making the wrong decision, either as to
 - a child’s present or future capacity to consent, or
 - about what are the best interests of a child who cannot consent; and
- the consequences of a wrong decision are particularly grave.

The Full Court of the Family Court, comprised of Bryant CJ, Finn J and Strickland J, explored how the *Re: Marion* principles applied to both stages of treatment for gender dysphoria. Although each member of the Full Court delivered a separate judgment, the Full Court agreed that, absent controversy, Stage 1 treatment for gender dysphoria did not require the Court’s consent as it “fell within the wide ambit of parental responsibility reposing in parents where a child is not yet able to make his or her own decisions about treatment”.⁹ However, when it came to Stage 2 treatment, the Full

⁹ At [108] per Bryant CJ.

Court was *ad idem* that the court's permission was required. This decision was arrived at following an application of the principles emerging from the High Court's decision in *Re: Marion*, which was binding on the Full Court. Therefore, and somewhat reluctantly, the Full Court held that the significant risk of making the wrong decision about treatment, or a child's capacity to consent to treatment, and the grave consequences of a wrong decision, meant that court authorisation was a precondition to undertaking Stage 2 treatment.

Bryant CJ summarised the decision she had reached in paragraph 140 of her reasons for judgment:

- Stage 1 of the treatment is not a medical procedure or a treatment which falls within the class of cases which attract the jurisdiction of the Family Court of Australia under s 67ZC of the Act and requires court authorisation.
- If there is a dispute about whether treatment should be provided (in respect of either Stage 1 or Stage 2), and what form treatment should take, it is appropriate for this to be determined by the court under s 67ZC. In relation to Stage 2 treatment, as it is presently described, court authorisation for parental consent will remain appropriate unless the child concerned is *Gillick* competent.
- If the child is *Gillick* competent, then the child can consent to the treatment and no court authorisation is required, absent any controversy.
- The question of whether a child is *Gillick* competent, even where the treating doctors and the parents agree, is a matter to be determined by the court.
- If there is a dispute between the parents, child and treating medical practitioners, or any of them, regarding the treatment and/or whether or not the child is *Gillick* competent, the court should make an assessment about whether to authorise Stage 2 having regard to the best interests of the child as the paramount consideration. In making this assessment, the court should give significant weight to the views of the child in accordance with his or her age or maturity.

According to Finn J, the task of balancing the benefit accruing from undertaking a medical procedure against the risk of a wrong decision and the consequences of that decision was an appropriate one for a court.

Finn J observed that *Re: Marion* could be distinguished from *Re: Jamie* because there was no prospect of the child in *Re: Marion* being able to consent to the procedure for which authorisation was sought. In *Re: Jamie*, Finn J said that the child may be able to consent. The question for Finn J then became whether it was for Jamie’s doctors and parents to decide as to *Gillick* competency, or whether it was a matter for the court.

After noting the relevant submissions before the Court that it is the court that should make the decision, and in light of what the High Court said about the risk of a wrong decision being made and grave consequences arising from a wrong decision, Finn J concluded that the question of a child’s capacity to consent to Stage 2 treatment “must remain a question for the court.”¹⁰

Strickland J delivered a short concurring judgment where he said that he agreed with the outcome and “generally” for the reasons expressed by both Bryant CJ and Finn J.¹¹

The 2014 paper identified what were considered to be the key principles to emerge from *Re: Jamie*. They are:

- Court authorisation for medical treatment of non-*Gillick* competent children and young people is required:
 - when the treatment is invasive, permanent and irreversible;
 - when the treatment is not for the purpose of curing a malfunction or disease;
 - where there is a significant risk of making a wrong decision; and
 - where the consequences of a wrong decision would be particularly grave.
- When deciding whether or not authorisation is required, the principle of proportionality should be invoked, such that the therapeutic benefit of the

¹⁰ At [180] to [188] per Finn J.

¹¹ At [192] to [196] per Strickland J.

proposed procedure should be weighed against the risk of making the wrong decision and the consequences of that decision.

- A “disease” or a “malfunction” includes psychological and psychiatric disorders.
- Authorisation for treatment for psychological and psychiatric conditions, including gender dysphoria, can fall within the exercise of parental responsibility.
- Stage 1 and Stage 2 treatment for gender dysphoria are part of the same treatment package but can be considered separately and distinctly.
- Stage 1 treatment for gender dysphoria is therapeutic in nature and is fully reversible. Court authorisation for Stage 1 treatment is not required unless:
 - the child is subject to a guardianship order, or similar; or
 - there is disagreement between the child, the child’s parents or the child’s doctors (or any of them) as to the need for, or the form of, Stage 1 treatment.
- Stage 2 treatment for gender dysphoria is therapeutic in nature but has irreversible features. Court authorisation for Stage 2 treatment is required.
- Court authorisation for Stage 2 treatment is not required where a child is *Gillick* competent (ie. the child understands the treatment and is able to give informed consent to it).
- It is the Family Court’s responsibility to assess whether a child is *Gillick* competent and therefore capable of consenting to Stage 2 treatment themselves.
- Even where a child is found to be *Gillick* competent, court authorisation is required for Stage 1 and Stage 2 treatment for gender dysphoria where there is a disagreement between the child, the child’s parents or the child’s doctors as to the need for, or the form of, treatment.
- Where court authorisation is sought, the best interests of the child is the paramount consideration in deciding whether or not to authorise the proposed procedure.

- The wishes of the child should be given considerable weight in deciding whether or not to authorise medical treatment, and on what conditions, commensurate with their age and maturity.

Anticipated issues emerging

The members of the Full Court were clear that Stage 1 treatment for gender dysphoria is not a procedure for which the consent of the Court is required, unless there is disagreement about the form and nature of such treatment. Bryant CJ, Finn J and Strickland J were also unanimous in finding that the starting point in considering whether court authorisation for Stage 2 treatment is required is for the Court to assess whether or not the young person has the capacity to consent to that form of treatment themselves.

It could rightly have been anticipated therefore that the process for assessing competence to consent to Stage 2 treatment, the jurisdiction and power to be invoked when competency assessments are being undertaken, the form of relief sought, and allied matters such as the limits of *Gillick* competency, would assume prominence in the post *Re: Jamie* decisions. The primary task of this paper is to review the post *Re: Jamie* decisions in order to determine whether those issues have in fact arisen and how they have been addressed.

An allied purpose is to consider the extent to which criticisms of *Re: Jamie* can properly be sustained. Commentators such as Bell¹² and Wallbank¹³ have effectively described *Re: Jamie* as a “lost opportunity”. Bell, for example, states that the decision in *Re: Jamie* is a step in the right direction but contends that growing medical consensus, the absence of alternative viewpoints and evidence in the reported cases, and the established serious risks of harm to children who are not able to access treatment, militate against the court continuing to play any role in determining whether treatment can proceed. Wallbank maintains that the Full Court established a

¹² Felicity Bell, ‘Children with Gender Dysphoria and the Jurisdiction of the Family Court’ (2015) 38 *University of New South Wales Law Journal* 426.

¹³ Rachel Wallbank, ‘A Critique of *Re: Jamie* and the Role of the Family Court in Determining the Access to Medical Treatment of Young Australians Living with Transsexualism’ (Paper presented at the Queensland Law Society Family Law Residential, Gold Coast, Queensland, 17 July 2015).

new and distinctive interpretation of the ratio of the High Court’s decision in *Re: Marion* that elevates the risk and gravity of diagnosis and treatment error over that of the therapeutic nature of the procedure, with gravity being conflated with reversibility.

The analysis of the post *Re: Jamie* decisions will therefore also have regard to whether those complaints about *Re: Jamie* have legitimate foundation.

Overview of the post *Re: Jamie* cases

Since the Full Court delivered its reasons in *Re: Jamie* on 31 July 2013, and to 31 July 2015, there have been 15 judgments delivered in respect of applications for treatment for gender dysphoria. Consistent with the Full Court’s determination that Stage 1 treatment does not require court authorisation (absent conflict), all applications concerned Stage 2 treatment. There was also one judgment delivered in respect of an application for treatment of an intersex condition and, as the treatment sought was the same as that for Stage 2 treatment for gender dysphoria, that decision has also been included. Accordingly, 16 judgments in total have been taken into account.

The names and citations of the cases follow:

Re: Shane (Gender Dysphoria) [2013] FamCA 864

Re: Spencer [2014] FamCA 310

Re: Colin (Gender Dysphoria) [2014] FamCA 449

Re: Dylan [2014] FamCA 969¹⁴

Re Isaac [2014] FamCA 1134

Re: Leo [2015] FamCA 50

Re: Xanthe [2015] FamCA 116

Re: Jordan [2015] FamCA 175

¹⁴ This case involved an application for authorisation to consent to Stage 2 hormonal treatment for an intersex condition.

Re: Ashley [2015] FamCA 373

Re: Darcey [2015] FamCA 409

Re: Christopher [2015] FamCA 454

Re: Jamie [2015] FamCA 455

Re: Dale [2015] FamCA 473

Re: Janson [2015] FamCA 499

Re: Julian [2015] FamCA 562

Re: Flynn [2015] FamCA 629

Of the 15 applications which sought orders about treatment for gender dysphoria, 12 concerned young people born biologically female but identifying as male, and three concerned young people born biologically male but identifying as female. The case involving an intersex person concerned someone appearing as male but born biologically female.

The young people who were the subject of an application ranged in age between 15 years, and 17 years and seven months old. Three were in the age group 15 to 16 years, seven were in the age group 16 to 17 years and five were in the age group 17 to 18 years. In countries like the United Kingdom and New Zealand, the age at which young people can consent to their own medical treatment is 16 years. If 16 had been adopted as the age of consent in Australia therefore, only three of the 15 applications would have needed to be made.

Consistent with Full Court authority in *Re: Jamie*, in each of the 15 gender dysphoria cases, no issue was taken with the categorisation of gender dysphoria as a ‘disease’ or ‘disorder’. Diagnostic reliance was placed upon the inclusion of gender dysphoria as a psychiatric condition in the American Medical Association’s Diagnostic and Statistical Manual of Mental Disorders, fifth edition, in each case.

The orders sought in the applications varied. In the cases decided soon after *Re: Jamie*, court authorisation for a parent or parents to consent to Stage 2 treatment for gender dysphoria (and in one case, for Stage 2 treatment for an intersex condition) was common. However, the relief sought gradually gave way to a declaration that a child was competent to consent to their own medical treatment, either as a stand alone order or in combination with an application for authorisation to consent to medical treatment in the alternative.

The applicants were most commonly a parent or parents, although in one case a maternal grandmother sought a declaration (*Re: Ashley*) and in another, the child themselves was the applicant (*Re Isaac*).

In each case there was affidavit evidence from treating medical practitioners before the court and in general there was also an affidavit from the parent, parents or legal guardian. Less often, the child who was the subject of the application was granted permission to swear an affidavit in the proceeding (*Re: Shane, Re: Dylan*). In at least one decision, that of *Re Leo*, the experts also gave oral evidence.

In terms of outcomes, the Court either gave permission to a child's parents to consent to Stage 2 medical treatment, or declared or found that the child was themselves capable of consenting to Stage 2 treatment on their own behalf. In no case was Stage 2 treatment for gender dysphoria, or an intersex condition, denied. In one case, that permission extended to both hormonal therapy and reconstructive chest surgery (*Re: Leo*).

Themes emerging from the post *Re: Jamie* cases

Numerous themes can be discerned from the post *Re: Jamie* cases, the most significant of which are discussed below.

What relief is being sought?

Bryant CJ in *Re: Jamie* clearly contemplated that future applications would be for an assessment of whether the child was competent to consent themselves to Stage 2 treatment for gender dysphoria. Bryant CJ said:

[138] It seems harsh to require parents to be subject to the expense of making application to the court with the attendant expense, stress and possible delay when the doctors and parents are in agreement but I consider myself to be bound by what the High Court said in *Marion's case*.

[139] That application however would only need to address the question of *Gillick* competence and once established the court would have no further role. The material in support of such an application, whilst needing to address the proposed treatment and its effects, and the child's capacity to make an informed decision, would not need to be as extensive as an application for the court to authorise treatment and I can see no reason why any other party need be involved, absent some controversy. It would be an issue of fact to be determined by the court on the material presented.

In fact, the type of orders that have been sought following *Re: Jamie* range from applications for court authorisation to consent to Stage 2 medical treatment, to declarations of competency for a child to consent to Stage 2 treatment, to both in the alternative. Judges have variously authorised Stage 2 treatment in circumstances where the evidence before the court was that the child was not *Gillick* competent (*Re: Shane, Re: Dylan*), declared that a child is competent to consent to their own medical treatment (*Re: Xanthe, Re: Colin, Re: Darcey, Re: Janson, Re: Leo*), or declined to make a declaration and instead made a finding that the child is competent to consent to medical treatment and then authorised the child to make his or her own decision in relation to that treatment (*Re: Ashley, Re: Jamie, Re: Christopher, Re: Dale, Re: Julian*). In the most recent decision, namely that of *Re: Flynn*, Berman J made orders in terms of being satisfied that the child was competent to consent to oestrogen treatment and was able to make her own decisions in respect of that treatment. Notably, the trial judge did not appear to consider it necessary to make an order authorising the child to make her own decision in respect of medical treatment.

It can reasonably be assumed that in cases such as *Re: Ashley*, where a declaration was sought but the Court instead made a finding of competency and authorised the child to

make their own decision about medical treatment, that approach was adopted because of the caution sounded by Finn J in *Re: Jamie* about the availability of declaratory relief. There, Finn J said:

[190] In my view, it would not be in accord with the reasons of this court, **or indeed within any power contained in the Act**, for it to make the declaration sought by the parents in their amended notice of appeal. Nor would the order which they seek in the alternative to the declaration be in accord with the reasons of any member of this court. (emphasis added)

In *Re: Sarah*,¹⁵ Macmillan J made a declaration that treatment for an intersex condition known as 45X/46XY Turner Syndrome was not a medical procedure requiring court authorisation pursuant to section 67ZC of the FLA. In considering whether she had power to grant the declaration sought, Macmillan J recited the comments of Finn J and proceeded to consider decisions of single judges, the Full Court of the Family Court and the High Court concerning the power of the Family Court to make declarations in the absence of a specific statutory conferral of power. Macmillan J was ultimately satisfied that the power to grant the declaration sought was found in either section 64B(2)(i) of the FLA or section 67ZC of the FLA.

However, in *Re: Flynn*, Berman J declined to grant the declaratory relief sought by the applicant parents. At paragraph 72 Berman J said that he did so because “I am not satisfied that the power exists to make a declaration and in any event do not consider that it is necessary to do so.”

Cronin J took a very different approach in *Re Isaac*. Although a declaration of ‘*Gillick* competency’ was sought by Isaac as to his own decision making capacity about undertaking Stage 2 treatment for gender dysphoria, Cronin J ultimately made orders in reliance on section 64B(2)(c) of the FLA that Isaac have sole parental responsibility for all medical decisions concerning himself.

¹⁵ [2014] FamCA 208.

Cronin J reviewed the evidence before the court as to Isaac's competence to make a decision about his own medical treatment, which Cronin J described as being unanimous in supporting a finding of *Gillick* competence. Cronin J found that the source of power to make an order about competence lies in both section 64B(2) and section 67ZC of the FLA because the issue of competence has to be judged against the issue that the child is wanting to decide. Cronin J accepted that the court has power to give parental responsibility for a particular issue to any person, including persons other than parents. Therefore, Cronin J found that it must follow that in respect of certain issues, the court has the power to give parental responsibility to the child him or herself.

Cronin J said that although Isaac had sought a declaration of competency, his view was that an order for sole parental responsibility would suffice. He found that there was no reason why that responsibility could not be given to a capable child, which he found Isaac to be.

Cronin J's approach has not been adopted in any other application for a declaration or finding of competency.

Where does the jurisdiction to make the orders sought derive from?

It can be observed that the post *Re: Jamie* cases do not tend to make explicit the jurisdiction that is being exercised in making the orders sought, or orders in the alternative to that which were sought (as occurred in *Re: Ashley* and *Re: Jamie*, where declaratory relief was sought but not granted).

As Thornton J recited in identical terms in *Re: Ashley*, *Re: Jamie*, *Re: Dale* and *Re: Julian*, section 69H(1) of the FLA provides that jurisdiction is conferred on the Family Court in relation to matters arising under Part VII of that Act. That includes making a parenting order dealing with "any aspect of the care, welfare or development of a child", pursuant to section 64B(2)(i). Additional jurisdiction is conferred by section 67ZC to make orders relating to the welfare of children. It is the jurisdiction conferred by section 67ZC that has been invoked to make orders with respect to medical treatment for children that falls outside of the confines of an exercise of

parental responsibility. The Full Court found in *Re: Jamie* that an application for Stage 2 treatment for gender dysphoria fell to be determined under section 67ZC.

However, most of the applications that have come before the court following *Re: Jamie* have not been for court authorisation for Stage 2 medical treatment for gender dysphoria. Instead, the applications have been directed towards a declaration or finding of competency for a child to provide their own consent to Stage 2 treatment.

As previously discussed, the issue of jurisdiction has been adverted to in the context of the power to grant declaratory relief. It otherwise has not been directly engaged with in the post *Re: Jamie* decisions. A survey of the decisions reveals that the jurisdiction being invoked when the court makes an order authorising a child to consent to medical treatment on their own behalf has not been clearly articulated. It is not readily apparent whether it is section 69H, or section 67ZC, which provides the source of jurisdiction to make a order concerning a child's capacity to consent to medical treatment.

The reliance in many of the decided cases on Division 4.2.3 of the *Family Law Rules 2004* (Cth) ("the Rules"), which concern a "medical procedure application", is suggestive of section 67ZC being the source of jurisdiction to make orders about the competency of minors to consent to their own medical treatment.

Those rules are referred to in *Re: Ashley*, *Re: Leo*, *Re: Dale*, *Re: Jamie*, *Re: Janson* and *Re: Julian* as variously providing standing to a parent to bring an application (*Re: Jamie* and *Re: Julian*), a grandparent to bring the application (*Re: Ashley*), requiring service of the application on the relevant child welfare authority (*Re: Janson*, *Re: Christopher*), making orders dispensing with the requirement for service on the child welfare authority (*Re: Dale*, *Re: Spencer*), and the matters to which evidence should be directed (*Re: Leo*).

However, on one view, reliance on section 67ZC may be, and Division 4.2.3 of the Rules certainly is, misconceived. This is because an application for an assessment of competency is quantifiably different from an application to authorise medical treatment. That much is implicit in the comments made by Bryant CJ in *Re: Jamie*

distinguishing between an application for a competency assessment and an application for authorisation of medical treatment; the former being described by Bryant CJ as not needing to be as “extensive” as the latter.

In the reasons for judgment in *Re: Ashley*, *Re: Jamie* and *Re: Dale*, Thornton J described the application before the court as “essentially an application for determination by the Court as to whether [the child] is competent to consent to [his or her] own stage two medical treatment for gender dysphoria.” In those three cases, and in *Re: Julian*, Thornton J found that it was unnecessary to make an order under section 67ZC authorising medical treatment because she was satisfied that in each instance, the child was competent to make their own decision about medical treatment.

In *Re: Janson*, Austin J had an application for consent orders before him. The orders jointly sought by the child’s parents were that “the Court declare their child has sufficient competence to consent to further treatment for the diagnosed condition I have already described” (the condition in question being gender dysphoria). This, according to Austin J, was “an order relating to a medical procedure” which engaged Division 4.2.3 of the Rules and which in turn required service on the relevant government department. However, by reference to the Rules, that description is contestable.

Division 4.2.3 of the Rules concern a “medical procedure application”. A medical procedure application is defined in the dictionary to the Rules, which forms part of the Rules, as an initiating application “seeking an order authorising a major medical procedure for a child that is not for the purpose of treating a bodily malfunction or disease.” Leaving aside the issue of whether gender dysphoria is a “bodily malfunction” or “disease”, which was discussed by Bryant CJ in *Re: Jamie*,¹⁶ an application where orders are sought (rightly or wrongly) for a declaration that a child is competent to consent to Stage 2 treatment for gender dysphoria, is clearly not an application seeking an order “authorising a major medical procedure”. It is instead, to use the words of Lord Scarman in *Gillick*, a matter of assessing whether the child has

¹⁶ See [66] to [74].

achieved sufficient understanding and intelligence to enable [him or her] to fully understand what is proposed.

The distinction is significant, not least because of the High Court's decision in *Minister for Immigration and Multicultural and Indigenous Affairs v B and Anor*.¹⁷ In that case the High Court read down section 67ZC of the FLA so that it must attach to a "matter" within the meaning of sections 75 and 76 of the Constitution. Important jurisdictional issues are therefore likely to arise where a subject child is not a "child of the marriage", or where it is a person other than a parent seeking orders in respect of the child, particularly where the child is subject to a guardianship order. The decisions of Carter J in *Re: Brodie (Special Medical Procedures: Jurisdiction)*¹⁸ and Murphy J in *Re: Lucy (Gender Dysphoria)*¹⁹ lay bare the complexities arising in resolving threshold jurisdictional issues when section 67ZC is sought to be relied upon. The same issues do not arise when making a parenting order pursuant to section 64B(2)(i) in the exercise of the Court's jurisdiction under section 69H. Accordingly, it is unfortunate that the decisions handed down after *Re: Jamie*, save for that of *Re Isaac* and arguably *Re: Flynn*, are not explicit as to matters of jurisdiction and power. That is particularly so in cases like *Re: Ashley*, where the applicant was not the child's parent.

Parenting orders and consideration of best interests

Whether an order is being made under section 64B(2)(c) or (i) in the exercise of jurisdiction under section 69H, or in the exercise of the 'welfare jurisdiction' in section 67ZC, the best interests of the child is the paramount consideration. Sections 60CA and 67ZC(2) make that abundantly clear. Accordingly, the 'best interests factors' found in section 60CB to section 60CG of the FLA should be engaged in arriving at a decision about whether to authorise Stage 2 medical treatment, or in deciding whether or not a child is competent to make decisions about their own treatment.

¹⁷ (2004) 219 CLR 365.

¹⁸ [2007] FamCA 776.

¹⁹ [2013] FamCA 518.

Yet, the post *Re: Jamie* decisions expose a limited consideration of best interests, both as the paramount consideration and by reference to the enumerated statutory factors. A seeming lack of regard for following the ‘best interests’ pathway can also be discerned. Of the 15 published judgments, only four – *Re: Shane*, *Re: Isaac*, *Re: Jordan* and *Re: Flynn* – explore best interests in any detail, and two of those involved applications for authorisation of medical treatment where the evidence was that the child was not competent to consent to their own treatment.

The two decisions in which a lack of *Gillick* competency was conceded and therefore the question before the court was whether or not to authorise Stage 2 treatment are *Re: Shane* and *Re: Jordan*. In both cases Murphy J and Kent J respectively identified best interests as the paramount consideration. They then discussed the nature of the condition and of Stage 2 treatment, the evidence before the court, and proceeded to identify what the evidence revealed about why Stage 2 treatment may or may not be in the child’s best interests. Overwhelmingly, the evidence in both cases supported a finding that Stage 2 treatment was in the child’s best interests. Matters that Murphy J and Kent J took into account included:

- unanimity between treating professionals as to the child’s diagnosis
- the child having identified as their affirmed sex and living as that sex
- the unlikelihood of the child changing his mind
- the child’s understanding, appreciation of and insight into his condition, despite not being competent to the *Gillick* standard
- the child’s parents’ genuine wish to act in the child’s best interests and their support of Stage 2 treatment
- the availability of support networks
- the lack of alternative treatment
- the risks to the child if treatment was not provided, including mental health issues and self-harm

Again in both cases Murphy J and Kent J detailed the risks associated with Stage 2 treatment, including irreversible effects on appearance, reduced fertility and an

increased likelihood of developing serious medical conditions. They respectively found that although the risks could not be eliminated, they could be monitored, and on balance the evidence supported a finding that authorising Stage 2 treatment would be in the child's best interests.

In *Re Isaac*, Cronin J recorded that in deciding whether or not to make a particular parenting order in respect of a child, the court must regard the child's best interests as paramount. Cronin J found that all of the factors in section 60CC which were determinative of the best interests of the child were not helpful, but went on to state that the court was still left with the fact that it must make a parenting order based on the child's best interests anyway. Cronin J said it was clear on the evidence that the best interests of the child would be served by making a parenting order limited to that contemplated in section 64B(2)(c) of the FLA. Cronin J then turned to the presumption of equal shared parental responsibility. He recorded that the parents did not appear, despite being aware of the application. Cronin J found that Isaac was capable of making medical decisions, and that it was in his best interests to do so. Accordingly, the presumption in section 61DA(4) was rebutted.

Berman J's decision in *Re: Flynn*, delivered on 31 July 2015, is notable for the rigour with which best interests considerations are engaged with in the context of an application for a declaration of *Gillick* competency. 'Best interests' appears as a discrete sub-heading in the reasons for decision, sections 60CC(2) (paramount considerations) and 60CC(3) (additional considerations) are recorded, and Berman J notes that not all the provisions of section 60CC are of assistance in determining appropriate orders. In this respect the decision can be contrasted with that of Cronin J, who found that none of the section 60CC factors were of assistance. Those which Berman J considered to be of particular significance were the views of the child, to which he gave "significant and substantial weight" and, notably, the "substantial and potentially grave" risk to the child of denying commencement of oestrogen treatment, which included episodes of depression, social anxiety, self-loathing and an elevated risk of self-harm.

The remainder of the decisions either state that best interests is the paramount consideration but do not make a finding that the order ultimately made is in the child's best interests, or do not refer to the 'paramount consideration' at all.

An example of the former can be found in *Re: Christopher*. There, in a section entitled 'legal principles', Johns J recited that best interests was the paramount consideration pursuant to section 60CA and section 67ZC(2). Further, Johns J, despite hearing an application for a declaration of competency, recorded that rule 4.09(1) of the Rules provided that medical evidence must be given that satisfied the court that the proposed medical procedure was in the best interest of the child. Johns J then quoted from the evidence of one expert where that expert stated that it was in the child's best interests to commence testosterone treatment. Johns J relied upon the "unchallenged evidence" of the experts as to the child's competence and on the basis of that evidence, found that the child was able to consent to his own medical treatment and authorised him to do so. Best interests was not referred to by Johns J in reaching her conclusion, in making a finding of competency, or in authorising the child to consent to Stage 2 treatment.

In *Re: Leo*, the only reference to 'best interests' that can be found is in a paragraph quoted from Bryant CJ's judgment in *Re: Jamie*. Rees J in that case nevertheless went on to make both an order for Stage 2 treatment and an order for reconstructive chest surgery. Those orders appear to be made on the basis of the evidence set out in her reasons, which was also silent on the issue of the child's best interests.

In *Re: Xanthe*, the term 'best interests' was entirely absent and there was no 'best interests' analysis. Johnston J recorded that the child informed her mother and her father that she wanted to receive gender therapy and transition from female to male as a way of feeling at home in her body. There was otherwise no independent reference to the wishes or views of the child, as provided for in section 60CC(3)(a) of the FLA. This is particularly significant given that the child was five months from his age of majority.

In *Re: Darcey*, discussion of best interests was limited to the application to change the child's name. There was no reference to the 'paramourty principle' in that part of the judgment dealing with the child's capacity to consent to Stage 2 treatment for gender dysphoria. Consequentially there was no exploration of any of the best interests factors and nor was the evidence before the court interrogated from a 'best interests' perspective in a Stage 2 treatment context.

What is particularly notable about this case is that the father, who may or may not have been served with the initiating application, is recorded as having terminated all contact with the mother in 2013. 2013 was also the year in which an older brother of the child transitioned from male to female and apparently the year in which the child commenced seeing a paediatric endocrinologist. In such circumstances, the adoption of a best interests analytical framework may have resulted in closer scrutiny of the strength and durability of the child's gender identification in the task of assessing competency to consent to Stage 2 treatment, as well as a consideration of the risk of the child changing her mind about her self-conception as female. At it stands however, any discussion of those issues is entirely absent.

Finally, with the exception of *Re Isaac*, none of the decisions discuss the application or rebuttal of the presumption of equal shared parental responsibility.

Consent, conflict and the limits of *Gillick* competence

Ultimately, none of the 15 post *Re: Jamie* decisions gender dysphoria decisions, and the one intersex decision, involved an active contradictor.²⁰ As a result, one of the matters anticipated to be the subject of judicial pronouncement – namely, whether and to what extent the presence of disagreement between a child, their parents or guardian, and the treating medical professionals as to Stage 2 treatment determines how an application is to be dealt with – is uncertain.

In *Re: Jamie*, Bryant CJ²¹ posed the question of whether, if a child is found to be *Gillick* competent, there remains any role for the court at all. Bryant CJ said "In my

²⁰ It is not clear from the reasons for judgment in *Re: Darcey* whether the child's father knew of the application.

²¹ At [129].

view there does not.” However, Bryant CJ said went on to say “If the child is *Gillick* competent, then the child can consent to the treatment and no court authorisation is required, absent any controversy”.²² Bryant CJ then stated:²³

If there is a dispute between the parents, child and treating medical practitioners, or any of them, regarding the treatment and/or whether or not the child is *Gillick* competent, the court should make an assessment about whether to authorise stage two having regard to the best interests of the child as the paramount consideration.

Finn J said “If the court was completely satisfied of the child’s capacity to consent to stage two treatment, it would be unnecessary for it to have to authorise the treatment.”²⁴

Strickland J said “Whether the child is able to fully understand and give informed consent to stage two treatment, and thus court authorisation is not required, is a threshold issue that the court must decide.”²⁵ As mentioned earlier, Strickland J agreed with the outcomes proposed by Bryant CJ and Finn J, “generally” for the reasons set out by each of them.

On one view therefore, the Full Court was saying that a finding of *Gillick* competence is determinative and that once that finding has been made, court authorisation for Stage 2 treatment is not required, even where there is disagreement about the nature and form of treatment. On another view, the presence of conflict over treatment for gender dysphoria, even in circumstances where a child has been found to be competent to consent to their own treatment, requires the intercession of the court.

The role of conflict and the limits of *Gillick* competence has not loomed large in the post *Re: Jamie* decisions. Rees J in *Re: Leo* said that the members of the Full Court in *Re: Jamie* “held unanimously that in the event that the Court finds that child is *Gillick* competent then the authority of the Court is not required to authorise the treatment.”

This passage from *Re: Leo* was quoted by Foster J in *Re: Darcey*. However, Austin J in *Re: Janson* highlighted the absence of controversy about the status of the medical evidence as a factor to be considered in the orders that the court should make, which

²² At [140(d)].

²³ At [140(e)].

²⁴ At [188].

²⁵ At [196].

suggests that Austin J did not consider *Gillick* competence to be determinative. In *Re: Flynn*, Berman J observed that the child's history was not in conflict with the expert medical evidence before the court but did not go on to speculate as to the consequences flowing from there being a conflict in existence, as it was not necessary for him to do so.

The only decision in which conflict or disputation arose was in that of *Re: Leo*. There, Rees J considered the issue of whether there was any dispute between Leo's treating doctors as to him undertaking chest surgery. The matter came to the Court's attention as a result of a letter from Leo's former psychiatrist to his treating general practitioner, tendered by counsel for the independent children's lawyer. In that letter the psychiatrist expressed doubt that performing chest surgery on Leo before he turned 18 was in his best interests. The psychiatrist, who had seen Leo on four occasions and who had retired at the time of hearing, declined to participate in the proceedings. Rees J observed that the psychiatrist was not currently treating Leo and there was consequentially no disagreement between the members of Leo's treatment team. Therefore, and somewhat curiously given her earlier statement about the Full Court's decision in *Re: Jamie* concerning *Gillick* competence, Rees J said that she did not consider there was any "dispute" about treatment within the terms of Bryant CJ's judgment in *Re: Jamie*. However, Rees J said that if she was wrong about that, the dispute would be resolved by accepting the evidence of the experts who prepared reports and gave evidence under oath over the psychiatrist's opinion.

It can be observed in passing however that the evidence preferred by Rees J appears to have been directed to the orders sought on the application, namely a declaration of competency. The issue of whether the Court should authorise treatment, which on one view is what Bryant CJ said is the controversy to be determined when there is evidence of disagreement about treatment, was not before the Court.

If the presence of disagreement or conflict overrides *Gillick* competence, then it would be necessary for the court to be satisfied that the child, the child's parents (or guardian) and the child's treating medical professionals were in agreement about the treatment proposed and the orders sought on the application. That in turn would seem

to render evidence of service imperative. However, in at least one decision, *Re: Darcey*, it cannot be ascertained from the reasons whether the father had been served with the application or whether an order dispensing with service had been made. That contrasts with the approach adopted by Cronin J in *Re Isaac* in satisfying himself that Isaac's parents had been afforded procedural fairness before deciding to treat the application as undefended.

Concluding observations

It appears that where an application for a finding or declaration of competency for a child to consent to Stage 2 medical treatment for gender dysphoria has been sought, it is being treated as a medical procedure application, despite the fact that authorisation to perform a medical procedure is not being applied for.

As per *Re: Jamie*, jurisdiction to hear and determine medical procedure applications of a type requiring court authorisation falls under section 67ZC. It cannot be readily discerned from the decisions whether that jurisdiction is also being invoked for the purpose of undertaking a competency assessment and, if so, why. Accordingly, the jurisdictional foundation for being able to entertain such applications remains obscure.

Assuming it is section 67ZC that is being relied upon, the post *Re: Jamie* cases do not identify the constitutional 'matter' to which the jurisdiction attaches to enable it to be invoked, even when the person seeking a competency finding is not a child's parent.

The only post *Re: Jamie* decision involving a competency assessment that is explicit as to jurisdiction and power is *Re Isaac*. The approach adopted in that decision – namely, to vest parental responsibility in the child themselves – has not been followed subsequently. In saying that however, it can be observed that Berman J in *Re: Flynn* quoted from both the Full Court in *Re: Jamie*, where it was said that a determination as to Stage 1 and Stage 2 treatment could be made pursuant to section 67ZC, and from Cronin J in *Re Isaac* as to reliance on section 64B(2)(i), without then going on to identify the power he was invoking in finding that the child was competent to consent to hormone therapy.

The post *Re: Jamie* decisions also do not uniformly identify the best interests of the child as the paramount consideration, which it patently is under both section 60CA and 67ZC. It is notable that in the two decisions involving court authorisation for Stage 2 treatment, as opposed to findings or declarations of competency, the reasons are clearly directed towards the application of the paramountcy principle. Similarly, those ‘authorisation’ cases display an robust engagement with the expert evidence within a best interests framework. That too is true of Berman J’s decision in *Re: Flynn*, which appears to be the only ‘competency’ decision that squarely acknowledges and addresses the best interests of the child.

In general, it seems that the approach taken in the cases involving applications for declarations or findings of competency has been to merely to summarise the evidence, make a finding as to whether the child is *Gillick* competent or not, and make an order permitting the child to consent to Stage 2 treatment on their own behalf. As such, despite what that which was anticipated in 2014, there has been little jurisprudential development in the area of how the ‘best interests’ factors apply to an application for a finding of competency to consent to Stage 2 treatment for gender dysphoria. Nor is it clear which, if any, of the best interests factors should be given specific consideration in a competency assessment, what “other fact or circumstance” might be relevant, and whether it is necessary to consider the presumption of equal shared parental responsibility prior to making an order.

However, in so saying, the most recent decision, namely that of Berman J in *Re: Flynn*, should be distinguished. It is apparent from the reasons that Berman J placed considerable weight on both the views of the child and the risk to the child (which was recorded as including the child’s death by her own hand) if access to Stage 2 treatment was delayed or denied.

The issue of whether a finding of *Gillick* competence is determinative, even in the face of disagreement or conflict, similarly has yet to be grappled with.

Given what the Full Court in *Re: Jamie* said about the grave consequences that potentially attend treatment decisions for gender dysphoria, and particularly the

irreversible or partly irreversible nature of Stage 2 treatment, the somewhat cursory approach to the disposal of such applications is troubling, particularly as they are overwhelmingly without a contradictor.

The analytical process engaged in by Berman J in *Re: Flynn* is however heartening, as it brings rigour and principle to the process of deciding whether or not a child is competent to consent to Stage 2 treatment for gender dysphoria.

On a positive note though, in light of what the Full Court said in *Re: Jamie* about its concerns as to cost associated with imposing a requirement to seek court authorisation, it is encouraging that applications appear to be being dealt with with less formality than was previously the case. That includes matters such as the appointment of independent children’s lawyers, the intervention of state child welfare departments, and the way in which evidence is tendered.

As to the issue of delay allegedly occasioned by the requirement to issue proceedings in the Family Court, it need only be observed that in *Re: Flynn*, the application was filed on 23 July 2015, it came before a judge on 28 July 2015, where it proceeded as a full hearing, and orders were made on 31 July 2015. Clearly, the Family Court is able to accommodate the need for children experiencing gender dysphoria to receive treatment on an urgent basis.

On balance therefore, it must be acknowledged that there may be some validity in the criticisms of the Full Court’s judgment in *Re: Jamie*, and that there are a number of important issues – the limits of *Gillick* competency being one example – that require resolution. However, given the foregoing analysis, the suggestion that the continued role of the Family Court in treatment decisions around gender dysphoria is one that is “causing further distress and harm” is open to challenge.

Future directions

Re: Jamie was intended to clarify the application of legal principles that had been developed by the High Court in the context of sterilisation of an intellectually disabled child to the authorisation of treatment for gender dysphoria, and to provide appellate

guidance as to the limits of the court's jurisdiction in such cases. It is reasonable to suggest that that objective has been achieved as far as Stage 1 treatment is concerned, at least in cases where the child, his or her parents, and the treating medical professionals agree on diagnosis and treatment.

However, the position is less clear in respect of Stage 2 applications, particularly those in which a finding that a child is competent to consent to Stage 2 treatment on their own behalf is sought.

Although many of the decisions following *Re: Jamie* are less considered than might have been expected, given the significance of the matter that falls to be determined, it is clear that judges who are tasked with assessing a young person's competency to consent to Stage 2 medical treatment, or with deciding whether to authorise such treatment, are taking a practical and sensitive approach.

Applications for competency assessment are being brought on, and determined, quickly. The appointment of an independent children's lawyer is the exception rather than the rule. Intervention by a state child welfare authority or human rights body is unlikely to be sought. Judges are acceding to applications on behalf of young people for whom Stage 2 treatment is being sought, or where it is contended they are competent to consent to their own medical treatment, to file an affidavit and/or be present in the court during the hearing of the application. For example, in *Re: Jamie*, when the matter came back before the court for a decision about Stage 2 treatment, Thornton J permitted Jamie to tender an open letter to the Court. The letter reportedly said:

I am a normal, cheerful, confident girl and I know who I am. It's just that my exterior doesn't mirror my interior... and I want my body to match who I really am, a girl...²⁶

Although the best interests of the child is not always specifically referred to in the judgments arising from applications for a finding of competency, it is nevertheless clear from a reading of those decisions that judges are deeply concerned to ensure that they make orders which are compassionate and empathetic, and which accord with

²⁶ Kate Legge, 'Boys Will be Girls' *The Weekend Australian Magazine*, 18-19 July 2015, p. 16.

expert opinion and the child's expressed views and wishes. Decisions like *Re: Shane* and *Re: Flynn*, being the first decision following *Re: Jamie* and the last, display an acute awareness of the potentially fatal consequences of denying young people with gender dysphoria timely access to cross-hormone therapy.

The issue of the time and expense involved in being required to seek court approval for Stage 2 treatment, not to mention the effect on individual families, is one of obvious concern to the Court. That much is evident from the Full Court's decision in *Re: Jamie* and those judgments delivered subsequent to it.

It is apparent that the Family Court is giving appropriate priority to applications concerning young people with gender dysphoria and dealing with them expeditiously. However, there is perhaps more that can be done.

In her judgment in *Re: Jamie*, Bryant CJ envisaged that a faster, cheaper and less formal process for assessing children's competency to consent to their own medical treatment could be developed. In furtherance of this objective, the Chief Justice has been engaging with major treating hospitals with a view to developing a discrete application to be used when an assessment of competency to consent to medical treatment is being sought. The Chief Justice established a small working group for that purpose. The draft application is well advanced and is the subject of further consultation, both internally with the Court's Rules Committee, and externally.

Conclusion

Family Court judges, faced with an increased number of applications involving young people with gender dysphoria, are operating as best they can within the strictures of the Full Court's decision in *Re: Jamie* and the High Court's decision in *Re: Marion*. It was suggested in the 2014 paper that the limits of the Family Court's role in authorising Stage 2 treatment for gender dysphoria, and indeed whether the Family Court would have any role at all, would be the subject of further litigation. That has not been the case. In applications such as these, where there is no contradictor and where the relief sought has, without exception, been granted, it must therefore be concluded that the prospect of another Full Court appeal being instituted is remote.

Despite what was postulated in 2014 therefore, it must be concluded that pace of appellate jurisprudential development will be leisurely.

This leads inexorably to the view that legislative intervention in the arena of young people's consent to medical treatment is required. That could take the form of a national 'consent to medical treatment' statute, although there would be Constitutional hurdles to overcome as there is no obvious head of power under which such a statute could be enacted. For a national statute to have Constitutional validity, an appropriately framed referral of powers from the states and territories would be required. Alternatively, the states and territories could enact their own statutes, ideally in similar terms. In saying that, it should be noted that two Australian states, namely New South Wales and South Australia, have enacted consent to medical treatment legislation, which confers full capacity for decision making about medical treatment on persons aged 16 years and over.²⁷ New South Wales also has legislation in place governing the performance of "special medical procedures", which provides that the New South Wales Civil and Administrative Tribunal is responsible for deciding whether special medical treatment should be provided to a person aged under 16 years.²⁸

As recently as July 2015, in a feature article in *The Weekend Australian*, the requirement to obtain Court approval for Stage 2 treatment for gender dysphoria was described by a doctor at the Royal Children's Hospital in Melbourne as "very pathologising, very invasive and potentially very costly."²⁹ Although that characterisation of the prevailing legal climate can be disputed, it nevertheless is the current state of the law. In the absence of legislation or intervention by the Full Court of the Family Court or by the High Court, so it shall remain.

It is therefore respectfully suggested that it would be more constructive for those who advocate for the Court to have no role in making treatment decisions for young people with gender dysphoria to direct their attention towards advocating for statutory

²⁷ *Minors (Property and Contracts) Act 1970* (NSW); *Consent to Medical Treatment and Palliative Care Act 1995* (SA).

²⁸ *Children and Young Persons (Care and Protection) Act 1998* (NSW), s 175.

²⁹ Above n 26.

reform. As a starting point, that could proceed by being placed on the agenda of the Law, Crime and Community Safety Council or it could be the subject of terms of reference to a federal joint investigatory parliamentary committee.

It is demonstrably true that the Full Court of the Family Court has been unable to consider and resolve the myriad complex issues surrounding medical treatment for young people with gender dysphoria. In defence of the Full Court, that is not its role. The Full Court in *Re: Jamie* was asked to decide whether or not a particular judge, in a particular case, fell into appealable error. In answering that question, the bench found themselves bound by High Court authority that necessitated the Court retaining jurisdiction over Stage 2 treatment decisions. It is a decision that was made at a particular point in time and at a particular stage in the development of legal principle and medical science, and must be recognised as such.

The task of regulating treatment decisions now falls to others. In the face of increasing numbers of young people identifying as gender diverse, and demanding treatment services, it is time that the legislature took responsibility for developing a sensitive, humane and practical system for decision making around their access to potentially life-saving medical treatment.