

***To treat or not to treat: legal responses to transgender young people***

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## Introduction

In 2013 the Full Court of the Family Court of Australia (Bryant CJ, Finn and Strickland JJ) handed down *Re: Jamie*,<sup>1</sup> the first ever appellate decision of the Court concerning whether court authorisation was required to treat children and adolescents with gender dysphoria. In that judgment, the Full Court considered the application of principles developed by the High Court of Australia in *Secretary, Department of Health and Community Services; JWB and SMB* (known as ‘*Marion’s Case*’ or ‘*Re: Marion*’),<sup>2</sup> a case which concerned the proposed sterilisation of an intellectually disabled young person, to treatment for gender dysphoria. The Full Court critically examined a 2004 decision of a former Chief Justice of the Court, Nicholson CJ, in *Re: Alex*,<sup>3</sup> where it was found that court authorisation for the condition was required, for both the reversible (Stage 1) and partly irreversible (Stage 2) stages of treatment. The Full Court also considered the issue of whether people under the age of 18 were able to give their own consent to medical treatment (the test of *Gillick* competency), and in what circumstances. Significantly, the Full Court departed from the earlier decision in *Re: Alex* in finding that court authorisation for Stage 1 treatment for gender dysphoria was not required.

This paper discusses the principles established by the High Court of Australia in *Re: Marion* concerning when court authorisation for medical treatment of young people is required, the decision in *Re: Alex*, the cases following *Re: Alex*, and the first instance and appellate decisions in *Re: Jamie*. It discusses how *Re: Jamie* departs from previous jurisprudence, its significance and what the implications of the decision might be.

The paper compares the legal position in Australia with that in certain Canadian provinces and American states and reflects on whether the outcome in *Re: Jamie* would have been different if Australia, like Canada and the United States, had a national Charter or Bill of Rights. Finally, the paper considers a range of issues that are likely to confront the Court as a result of the decision, including whether the Family Court will continue to have any role at all in authorising treatment for gender dysphoria.

## Setting the scene

### Cooperative federalism and jurisdiction

Australia is a federation, comprised of the federal parliament and state and territory parliaments. The federal (Commonwealth) government has specific powers under the Australian Constitution and the states and territories exercise residual powers.

The Commonwealth has constitutional responsibility for marriage, divorce and matrimonial causes, and parental rights and the custody and guardianship of children. The *Family Law Act 1975* (Cth) (“the Family Law Act”) is the primary piece of legislation that governs proceedings with respect to

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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.

± I wish to acknowledge the assistance of Kristen Murray, Senior Legal Research Adviser to the Hon. Diana Bryant AO, Chief Justice of the Family Court of Australia, in the preparation of this paper.

<sup>1</sup> [2013] FamCAFC 110.

<sup>2</sup> (1992) 175 CLR 218.

<sup>3</sup> (2004) FLC 93-175.

dissolution of marriage, arrangements for children post-separation, property proceedings, spousal maintenance and other matters, such as injunctive relief. The Family Court, a superior court of record, exercises this jurisdiction, largely concurrently with the lower court, the Federal Circuit Court of Australia. Part of the Court's jurisdiction includes what has been described as a 'welfare' jurisdiction with respect to children, based on the common law *parens patriae* power. The 'welfare' jurisdiction is found in section 67ZC of the Family Law Act. Certain medical procedures require the Family Court's authorisation under section 67ZC. As the Full Court of the Family Court found in *Re: Bernadette*,<sup>4</sup> the Court's powers under 67ZC are limited to making orders for people under the age of 18 years. As a matter of practice, applications for consent to authorise medical treatment are made to the Family Court rather than the Federal Circuit Court.

Australia has six states and two territories. States and territories have jurisdictional responsibility for child welfare and protection. State child welfare agencies are often invited to intervene in Family Court proceedings where the welfare of a child is in issue, including in applications for permission to authorise medical treatment for children. State Supreme Courts also have *parens patriae* jurisdiction at common law.

Two Australian states, namely New South Wales and South Australia, have consent to medical treatment legislation, which confers full capacity for decision making about medical treatment on persons aged 16 years and over.<sup>5</sup> 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.<sup>6</sup>

## Terminology

### *'Special medical procedures'*

Although the term "special medical procedures" has been used in most of the Family Court cases where consent for medical treatment has been sought, Finn J in *Re: Jamie* queried the usefulness of the term and observed that it did not appear in the High Court of Australia's decision in *Re: Marion* (discussed in more detail below), nor in Nicholson CJ's later decision at first instance in that case.<sup>7</sup> Finn J further noted that the relevant rules, namely the Family Law Rules 2004 (Cth) ("the Rules"), refer only to a "medical procedure". Finn J said that she preferred the expression "medical procedures requiring court authorisation" and that term will be used where possible.

### *Gender identity disorder/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 ("the DSM"). The DSM-IV was originally published in 1994 and an updated version, the DSM-IV-TR, was published in 2000. The DSM-IV-TR was superseded by the DSM-5, published in May 2013. The condition was described as "gender identity disorder" in the DSM-IV. It was renamed "gender dysphoria" after criticisms that the

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<sup>4</sup> (2011) FLC 93-463.

<sup>5</sup> *Minors (Property and Contracts) Act 1970* (NSW); *Consent to Medical Treatment and Palliative Care Act 1995* (SA).

<sup>6</sup> *Children and Young Persons (Care and Protection) Act 1998* (NSW), s 175.

<sup>7</sup> *In Re Marion (No 2)* (1994) FLC 92-448.

former term was stigmatizing. Subtyping by sexual orientation was deleted in the DSM-5, and the diagnosis for children was separated from that for adolescents and adults.<sup>8</sup>

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.

As far as treatment for gender dysphoria is concerned, Hewitt et al wrote:<sup>9</sup>

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.

Cross-sex hormone therapy is usually given from the age of 16 years. Surgery is not considered in patients less than 18 years of age. This process for psychological and medical treatment of children and adolescents with gender dysphoria accords with national and international guidelines.<sup>10</sup>

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.

The prevalence of the condition was evidenced in a study undertaken by a major treating hospital in Melbourne, Australia. Between 2003 and 2011, 39 children and adolescents were referred to the hospital's specialist treatment clinic for gender identity disorder. Of those, 21 adolescents were either approaching puberty or were pubertal, and were reviewed for consideration of hormone treatment. 11 had planned to make an application to the Family Court for permission to authorise hormone treatment.<sup>11</sup>

The Family Court decisions that have involved applications for treatment of gender dysphoria have used different terms to describe the condition. For example, in *Re: Alex*, Nicholson CJ said that he preferred the term "gender identity dysphoria" to "gender identity disorder", as he thought it questionable whether the condition was in fact a "disorder". The Full Court in *Re: Jamie* referred

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<sup>8</sup> American Psychiatric Association, DSM-5 fact sheets, *Gender Dysphoria*, <http://www.psychiatry.org/dsm5> (accessed 1 May 2014).

<sup>9</sup> Jacqueline Hewitt et al, 'Hormonal Treatment of Gender Identity Disorder in a Cohort of Children and Adolescents' (2012) *MIA* 578.

<sup>10</sup> Australasian Paediatric Endocrine Group Disorders of Sexual Development Working Group, *position statement and management guidelines*; World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Non-conforming People*.

<sup>11</sup> Above n 9.

to “childhood gender identity disorder”. At the time *Re: Jamie* was heard at first instance and on appeal, the relevant diagnostic psychiatric manual was the DSM-IV. Accordingly, the discussion of the decisions up to and including *Re: Jamie* will use the term “gender identity disorder”. For the discussion of developments following *Re: Jamie* and contemporary issues associated with the treatment of non-gender conforming conditions, the term “gender dysphoria” will be used.

## **Medical procedures which require Family Court authorisation**

As Dessau J observed in *Re: Jamie* at first instance:<sup>12</sup>

It is generally within the bounds of a parent’s responsibility to be able to consent to medical treatment for and on behalf of their child. There are however certain procedures, referred to in the authorities as “special medical procedures”, that fall beyond that responsibility and require determination by the court, as part of the court’s *parens patriae* or welfare jurisdiction... .

Following *Re: Marion*, and as part of extensive amendments to the Family Law Act made in 1995, a definition of parental responsibility was included in section 61B. It states that “parental responsibility” means “all the duties, powers, responsibilities and authority which, by law, parents have in relation to children.” Pursuant to section 61C, both parents have parental responsibility for a child, subject to court orders. Section 64B defines a “parenting order”, which pursuant to section 64B(2)(i) includes an order concerning any aspect of the care, welfare or development of a child or any other aspect of parental responsibility for a child.

Section 67ZC was inserted into the Act in 1995. 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 A A (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. According to Callinan J, a former judge of the High Court of Australia, the section “reproduce[s] the earlier welfare jurisdiction [recognised by the High Court of Australia in *Marion’s Case*], arguably in clearer terms ...”<sup>13</sup>

Sub-section 67ZC(2) confirms that, as with decision making about children generally, the child’s best interests is the paramount consideration in the exercise of the ‘welfare jurisdiction’. There is a list of factors that the Court must consider in determining what outcome is in a child’s best interests,

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<sup>12</sup> [2011] FamCA 248 at [33].

<sup>13</sup> *Minister for Immigration and Multicultural and Indigenous Affairs v B and Anor* (2004) 219 CLR 365 at [221].

divided into ‘primary’ and ‘additional’ considerations.<sup>14</sup> This includes any views expressed by the child and any factors (such as the child’s maturity and level of understanding) that the court thinks is relevant to the weight it should give to the child’s views.

***How is the distinction drawn between procedures that require court authorisation, and procedures that do not? The High Court of Australia and ‘Re: Marion’***

No clear line is able to be drawn between the type of medical procedures that fall within the realm of parental responsibility and those which require court authorisation pursuant to section 67ZC. The principles for identifying the type of medical procedures requiring authorisation were pronounced by the High Court of Australia in *Re: Marion*. That case involved an appeal to the High Court of Australia from a decision of the Full Court of the Family Court that the parents of an intellectually disabled 13 year old girl could authorise her sterilisation without a court order. The High Court allowed the appeal.

In their joint judgment, Mason CJ, Dawson, Toohey and Gaudron JJ stated:<sup>15</sup>

There are, in our opinion, features of a sterilization procedure or, more accurately, factors involved in a decision to authorize sterilization of another person which indicate that, in order to ensure the best protection of the interests of a child, such a decision should not come within the ordinary scope of parental power to consent to medical treatment. Court authorization is necessary and is, in essence, a procedural safeguard. Our reasons for arriving at this conclusion, however, do not correspond precisely with any of the judgments considered. We shall, therefore, give our reasons. But first it is necessary to make clear that, in speaking of sterilization in this context, we are not referring to sterilization which is a by-product of surgery appropriately carried out to treat some malfunction or disease. We hesitate to use the expressions “therapeutic” and “non-therapeutic”, because of their uncertainty. But it is necessary to make the distinction, however unclear the dividing line may be.

As a starting point, sterilization requires invasive, irreversible and major surgery. But so do, for example, an appendectomy and some cosmetic surgery, both of which, in our opinion, come within the ordinary scope of a parent to consent to. However, other factors exist which have the combined effect of marking out the decision to authorize sterilization as a special case. Court authorization is required, first, because of the 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 secondly, because the consequences of a wrong decision are particularly grave.

As the Full Court said in *Re: Jamie*:<sup>16</sup>

An effective formulation of the ratio of Marion’s case is to be found Nicholson CJ’s decision in *Re: Alex* at [153]:

Marion’s case involved an application for the sterilisation of a 14-year-old teenager with a severe intellectual disability for the purpose of “preventing pregnancy and menstruation with its psychological and behavioural consequences”. The gravamen of the decision was that if a child or young person cannot consent her/himself to a medical procedure, parental consent (which for present purposes may be equated with that of a guardian) is ineffective where the proposed intervention is:

- invasive, permanent and irreversible; and

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<sup>14</sup> *Family Law Act 1975* (Cth), s 60CC.

<sup>15</sup> *Secretary, Department of Health and Community Services; JWB and SMB* (1992) 175 CLR 218 at 249-250.

<sup>16</sup> *Re: Jamie* [2013] FamCAFC 110 at [22].

- not for the purpose of curing a malfunction or disease.”

The majority in *Re: Marion* endorsed the decision of the House of Lords in *Gillick v West Norfolk and Wisbech Health Authority* (‘*Gillick*’)<sup>17</sup> 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 principles emerging from *Re: Marion* are therefore 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.

### **Examples of procedures which require court authorisation**

The following are examples of conditions where an application has been made to the Family Court for permission to undertake medical treatment. In some cases the Family Court held that its permission was not required, as consent to treatment fell within the realm of parental responsibility:<sup>18</sup>

- sterilisation of a young person with an intellectual disability<sup>19</sup>
- cardiac surgery on an infant without parental consent<sup>20</sup>
- administration of experimental non-approved drug treatment<sup>21</sup>
- bone marrow harvest<sup>22</sup>
- gonadectomies<sup>23</sup>
- treatment for people with disorders of sexual development<sup>24</sup>
- treatment for gender identity disorder<sup>25</sup>
- sex reassignment surgery<sup>26</sup>

<sup>17</sup> [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.

<sup>18</sup> Examples include *Re: Inaya* [2007] FamCA 658; *Re: Sean & Russell* [2010] FamCA 928; *Re: Sarah* [2014] FamCA 208.

<sup>19</sup> *Re: Marion* (1992) 175 CLR 218; *Re: Katie* (1996) FLC 92-659; *Re: Angela* [2010] FamCA 98.

<sup>20</sup> *Re: Michael* (1994) FLC 92-486.

<sup>21</sup> *Re: Baby A* [2008] FamCA 417.

<sup>22</sup> *Re: GWW and CMW* (1997) FLC 92-748; *Re: Inaya* [2007] FamCA 658.

<sup>23</sup> *Re: Sally* [2010] FamCA 237; *Re: Sean and Russell* [2010] FamCA 948; *Re: Sarah* [2014] FamCA 208.

<sup>24</sup> *Re: A (a child)* (1993) FLC 92-402; *Re: Sarah* [2014] FamCA 208.

<sup>25</sup> *Re: Alex* (2004) FLC 93-175; *Re: Brodie* [2008] FamCA 334; *Re: Bernadette* [2010] FamCA 94; *Re: O* [2010] FamCA 1153; *Re: Rosie* [2011] FamCA 63; *Re: Jamie* [2011] FamCA 248; *Re: Jodie* [2013] FamCA 62; *Re: Lucy* [2013] FamCA 518; *Re: Sam and Terry* [2013] FamCA 563.

<sup>26</sup> *Re: A (a child)* (1993) FLC 92-402; *Re: Alex* [2009] FamCA 1292.

## Procedure for applications for authorisation

Division 4.2.3 of the Rules sets out the procedure to be followed in applications requiring court authorisation of medical procedures. The Dictionary to the Rules define a “Medical Procedure Application” as:

...an Initiating Application (Family Law) seeking an order authorising a major medical procedure for a child that is not for the purpose of treating a bodily malfunction or disease.

### Example

An example of a major medical procedure for a child that is not for the purpose of treating a bodily malfunction or disease is a procedure for sterilising or removing the child’s reproductive organs.<sup>27</sup>

In *Re: Jamie*, Finn J expressed concern about the use of the word “bodily” in the definition, and the precision of the language in the example given in the Rules.<sup>28</sup>

Any medical procedure application and any document filed with it must be served on a prescribed child welfare authority, being state and territory child welfare departments.<sup>29</sup>

Sub-rule 4.09(1) provides that evidence must be given that satisfies the Court that the proposed medical procedure is in the best interests of the child. Pursuant to sub-rule 4.09(2) that must include evidence from a medical, psychological or other relevant expert witness that establishes the following matters:

- (a) the exact nature and purpose of the proposed medical procedure;
- (b) the particular condition of the child for which the procedure is required;
- (c) the likely long-term physical, social and psychological effects on the child:
  - (i) if the procedure is carried out; and
  - (ii) if the procedure is not carried out;
- (d) the nature and degree of any risk to the child from the procedure;
- (e) if alternative and less invasive treatment is available — the reason the procedure is recommended instead of the alternative treatments;
- (f) that the procedure is necessary for the welfare of the child;
- (g) if the child is capable of making an informed decision about the procedure — whether the child agrees to the procedure;
- (h) if the child is incapable of making an informed decision about the procedure — that the child:
  - (i) is currently incapable of making an informed decision; and
  - (ii) is unlikely to develop sufficiently to be able to make an informed decision within the time in which the procedure should be carried out, or within the foreseeable future;
- (i) whether the child’s parents or carer agree to the procedure.

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<sup>27</sup> The Dictionary to the Family Law Rules 2004 (Cth) forms part of the Rules (see Note 1 to the Dictionary).

<sup>28</sup> *Re: Jamie* [2013] FamCAFC 110 at [155].

<sup>29</sup> Family Law Rules 2004 (Cth), r 4.10.

Upon the commencement of the Rules in 2004, practice directions for medical procedure applications were issued for the Family Court's Victorian and Queensland registries.<sup>30</sup> The practice directions are designed to:

- (a) promote positive outcomes for children and young persons;
- (b) promote the care, welfare and development of children and young persons;
- (c) provide intending applicant/s and other interested parties with the opportunity to identify and discuss all relevant issues;
- (d) assist in identifying, where appropriate, alternative options and strategies;
- (e) encourage and support a co-operative and collaborative approach between the four participating organisations and medical and health professionals;
- (f) ensure consistent and timely management of applications for a medical procedure for a child;
- (g) ensure that a Court hearing is of 'last resort', after all other options have been tested or considered and failed to or been assessed as unable to produce a satisfactory outcome;
- (h) ensure that, if this matter proceeds to a court hearing, the Family Law Rules are followed and, in particular, all necessary evidence is available to the Court in compliance with Division 4.2.3 of the Rules.

An issue that became of some significance in the decision at first instance of *Re: Baby D*,<sup>31</sup> and before the Full Court in *Re: Jamie*, is that the practice directions require the relevant public authority to be served with an application for consent to authorise medical treatment for a child. As Young J pointed out in *Re: Baby D* however, that right is confined to service and does not confer any right to appear and be heard in the proceedings.

Individuals who and organisations which are not parties to the proceedings can make an application to intervene. State child welfare authorities have notice of the application as a requirement of the Rules. Other bodies that potentially have an interest in the proceedings may be invited by the court to intervene. These are often the Australian Human Rights Commission ("AHRC") and public authorities, such as state public advocates, who can be appointed as guardians for people with disabilities. On occasion, Commonwealth and state Attorneys-General have been invited to intervene. In *Re: Jamie*, the Full Court was required to deliver judgment in respect of an application by a public authority to intervene. The Full Court granted the application on a limited basis.<sup>32</sup>

It is common, but not a legal requirement, for an independent children's lawyer to be appointed. The role of an independent children's lawyer is to form an independent view, based on the evidence available to the independent children's lawyer, of what is in the best interests of the child; and to act

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<sup>30</sup> *Victorian and Queensland Registries – Medical Procedure Applications*, Family Court of Australia, Practice Direction No. 9 of 2004, 17 March 2004.

<sup>31</sup> [2011] FamCA 14.

<sup>32</sup> *Re: Jamie* [2012] FamCAFC 8.

in relation to the proceedings in what the independent children's lawyer believes to be in the best interests of the child.<sup>33</sup>

The Family Court also has the power to order a family report to be prepared and admitted in evidence in applications for authorisation of medical treatment. A family report is a professional appraisal of the family from a non-legal and non-partisan perspective, independent of the case presented by either party to a dispute. Family reports are prepared by family consultants, who are specialist social workers or psychologists employed by the Family Court, or by external officers with appropriate qualifications.

## **The road to *Re: Jamie***

As earlier discussed, *Re: Jamie* is a landmark appellate decision. In it, the Full Court found that treatment for Stage 1 of gender dysphoria was therapeutic, that there was no significant risk of making the wrong decision, and that the consequences of making a wrong decision were not particularly grave. The Full Court found that treatment for gender dysphoria was divisible, and that court authorisation for Stage 1 of the treatment program was not required. In so doing, the Full Court departed from earlier authorities, including *Re: Alex*, which held that court authorisation for both stages of treatment was necessary. The Family Court's journey from *Re: Alex* to *Re: Jamie* and beyond is discussed below.

## **The decision in *Re: Alex* (2004) FLC 93-175**

### ***Introduction***

*Re: Alex* was the first case in which the Family Court of Australia was asked to provide authorisation for treatment for a young person who was biologically one sex (female) but who identified as another (male).

### ***Background***

Alex's legal guardian brought an application in 2003, when Alex was aged 13 years, for treatment of the condition Nicholson CJ described as "gender identity dysphoria". The treatment sought was in two stages: the administration of oestrogen and progestogen until Alex turned 16 years old, the effect of which would be to suppress Alex's menses, and the administration of a luteinizing hormone releasing hormone (LHRH) analogue and testosterone after Alex turned 16 years old, for the purpose of beginning the process of masculinisation. No surgical intervention was sought until Alex turned 18 years old. The respondents to the application were Alex's mother, from whom he was estranged, and Alex's aunt, with whom he lived. An independent children's lawyer was appointed to assist the court in determining whether the orders sought would be in Alex's best interests. The Human Rights and Equal Opportunity Commission ("HREOC") (now the AHRC) intervened without objection, in order to make submissions on the human rights principles applicable in the case. All parties to the proceedings supported the orders sought and thus there was no contradictor to the application.

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<sup>33</sup> *Family Law Act 1975* (Cth), sub-s 65LA(2).

### ***Evidence before the court***

The Court had before it what Nicholson CJ described as an “impressive array” of medical expert opinion, evidence from Alex’s case worker and school principals, and a family report. Most of the evidence was in affidavit form. Nicholson CJ also acceded to a request from Alex to meet him in private, which was not objected to by any of the parties.

The evidence before the Court was that Alex had a “long-standing, unwavering and present identification as a male”,<sup>34</sup> dating back to his childhood. Alex dressed in male clothing, asked to be addressed by the male pronoun and refused to use the female toilets; wearing nappies to school instead until he was permitted to use a disabled toilet. Alex was said to have responded with anger when attempts were made to reinforce his gender as female. According to notes kept by the government department appointed as Alex’s legal guardian, Alex asked to see a doctor to confirm that he was a boy. The notes indicated that Alex told the doctor that he knew he was a girl but wanted to be a boy.

The report of one of the medical experts, Professor P, stated that Alex found menstruation “extremely distressing” and that he was frightened of continued breast development. Alex told Professor P that he was “angry with God” for trapping him in the wrong body.<sup>35</sup> Professor P described Alex as distressed and as being “very sad” and “miserable” with his situation for a long time, and that he wanted to die. All expert witnesses agreed that Alex exhibited classic symptoms of gender identity disorder.<sup>36</sup>

### ***Reasons for the decision***

#### **Jurisdiction**

In considering whether to make the orders sought, Nicholson CJ said that he must be firmly satisfied upon clear and convincing evidence that the proposed treatment was in Alex’s best interests. On the question of the Court’s jurisdiction to hear the application pursuant to section 67ZC of the Family Law Act, Nicholson CJ said he was satisfied that two considerations going to jurisdiction justified the Court’s involvement in hearing the application. Those considerations were:

- whether Alex could give effective consent to the proposed procedure; and
- the nature of the proposed procedure.

#### **Gillick competence**

Nicholson CJ then considered whether Alex was *Gillick* competent. On the issue of Alex’s capacity to himself consent to the procedure, Nicholson CJ said that as a result of the High Court of Australia’s pronouncement on *Gillick* competence in *Re: Marion*, he was required to consider whether Alex had achieved “a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.”

Nicholson CJ referred to the medical evidence directed towards Alex’s understanding of the proposed procedure and to the submissions of HREOC. Nicholson CJ concluded that the evidence

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<sup>34</sup> At [180].

<sup>35</sup> At [95].

<sup>36</sup> See discussion in Eithne Mills ‘*Re Alex: Adolescent Gender Identity Disorder and the Family Court of Australia*’ (2004) 9 *Deakin Law Review* 365 at 372.

did not establish that Alex had the capacity to decide for himself whether to consent to the proposed treatment. He said “[i]t is one thing for a child or young person to have a general understanding of what is proposed and its effect but it is quite another to conclude that he/she has sufficient maturity to fully understand the grave nature and effects of the proposed treatment.”<sup>37</sup> Nicholson CJ distinguished the subject matter of the application in *Gillick*; namely, the use of oral contraceptives, from that which was before him, and concluded that “[i]t is highly questionable whether a 13 year old could ever be regarded as having the capacity” to consent to a procedure which would change his sex.<sup>38</sup> Ultimately however Nicholson CJ found that the issue of *Gillick* competency was “academic”, because it would only arise were the court to refuse to provide authorisation for the procedure and there was “uncontroverted evidence” before the court that the orders sought were entirely consistent with Alex’s wishes and in his best interests.

In what was clearly *obiter dicta*, given that Nicholson CJ found that he did not need to make a determination as to the jurisdiction of the court to override a *Gillick* competent minor’s decision to either receive or refuse medical treatment, Nicholson CJ said that he doubted the correctness of the submission put to him by HREOC that a court has no power to override the informed consent or informed refusal of a competent child to medical treatment or, if it did, it should only be exercised in extreme circumstances.

#### **The nature of the proposed procedure – is court authorisation required?**

Nicholson CJ then turned to the nature of the proposed procedure and specifically whether it was one that required court authorisation. If not, Alex’s legal guardian was able to consent to the course of treatment. Nicholson CJ referred to Hannon J’s decision in *Re GWW and CMW* in affirming that the court’s permission is required in circumstances where there is a significant risk of making the wrong decision and where the consequences of making a wrong decision are particularly grave. Nicholson CJ agreed with Hannon J’s finding that the High Court of Australia in *Re: Marion* was not confining procedures that required court authorisation to sterilisation alone, and indeed only to surgical procedures. Nicholson CJ recorded that he had raised with the parties at any early stage of the proceedings whether court authorisation was required, given that the first stage of treatment (the suppression of puberty) was entirely reversible. Significantly, Nicholson CJ said that it was “common ground” between the parties that the “staged clinical program” proposed for Alex should be seen as one single treatment package. Nicholson CJ said:<sup>39</sup>

It is respectful of the assessment of Alex that emerges from the expert evidence and my own interview with him. He is adamant in his deep and long held desire to suppress his biological development as a female and to induce the presence of male characteristics. Compartmentalising the stages of treatment for the purposes of these proceedings would have an air of unreality about it.

Nicholson CJ went on to say:

I think it would have been detrimental to Alex’s best interests for the Applicant to have viewed the reversible treatment as within its authority as a guardian and only approached the Court when the second stage was imminent.

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<sup>37</sup> *Re Alex* (2004) FLC 93-175 at [168].

<sup>38</sup> At [173].

<sup>39</sup> At [188].

In conclusion, Nicholson CJ said that it would be “prudent” for an application to be made pursuant to section 67ZC at the outset of a clinical intervention, where the first stage of the treatment plan is reversible but is nevertheless being undertaken in anticipation of commencing a further stage that has irreversible features.

Nicholson CJ then turned to the issue of whether the proposed treatment was for the purpose of ‘curing a disease’ or ‘correcting a malfunction’. Were it found to be so, the court’s jurisdiction pursuant to section 67ZC would not be invoked. Nicholson CJ said that the current state of knowledge would not enable a finding to be made that the procedure was clearly one directed towards curing a ‘disease’. His Honour found that the High Court of Australia in *Re: Marion* sought to distinguish medical treatment that seeks to address disease in or malfunctioning of organs from sterilisation, in circumstances where there is no abnormality or underlying pathology. Nicholson CJ found that the application before him, and the issues raised by it, did not lend itself to such a comparison. Ultimately, Nicholson CJ held that the Family Court’s authorisation was required because of the “significant risks attendant to embarking on a process that will alter a child or young person who presents as physically of one sex in the direction of the opposite sex, even where the Court is not asked to authorise surgery.”<sup>40</sup>

### **The best interests of the child**

Lastly, Nicholson CJ had regard to whether the orders sought would be in Alex’s best interests. In so doing, Nicholson CJ placed “considerable weight” on Alex’s wish to undertake medical treatment and the risks to him that might occur if authorisation was not granted. An additional matter to which Nicholson CJ had regard to was the submissions of HREOC that article 8(1) of the United Nations Convention on the Rights of the Child (“UNCROC”), which concerns children’s right to preserve their identity, arguably included sexual and gender identity. Nicholson CJ agreed with the submission as a matter of general principle and found that it weighed in favour of authorisation being in Alex’s best interests. For the reasons contained in the judgment, Nicholson CJ expressed himself as being satisfied to the requisite standard that he should make a declaration authorising the administration of hormonal treatment. Orders in those terms, and ancillary orders concerning Alex’s public identity, were duly made.

### **Responses to *Re: Alex***

Nicholson CJ’s decision has been described by North American academics Hazel Beh and Milton Diamond as “important” and “noteworthy”; one which they contended offered international guidance as to how to approach treatment issues and to serve a child’s best interests.<sup>41</sup> In a similar vein, Australian academics Eithne Mills<sup>42</sup> and Kim Atkins<sup>43</sup> wrote that the decision was one that demonstrates the deployment of a practical and discursive conception of identity, rather than an essentialist view according to which gender identity is regarded as a direct expression of bodily sex<sup>44</sup> and which sought to “bring Alex peace with regard to the incongruence between his phenotype and male identity.”<sup>45</sup>

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<sup>40</sup> At [196].

<sup>41</sup> Hazel Beh and Milton Diamond, ‘Ethical Concerns Related to Treating Gender Nonconformity in Childhood and Adolescence: Lessons from the Family Court of Australia’ (2005) 15 *Health Matrix* 239 at 271.

<sup>42</sup> Mills, above n 35.

<sup>43</sup> Kim Atkins, ‘*Re Alex*: Narrative Identity and Gender Identity Dysphoria’ (2005) 14 *Griffith Law Review* 1.

<sup>44</sup> *Ibid.*

<sup>45</sup> Mills, above n 35, 373.

However, the decision was not without its detractors. Lawyer Rachael Wallbank, who subsequently represented the parents of transgender young people in applications for permission for treatment, described the decision as one that gave rise to “considerable concern” as a result of its reasoning and its legal and public policy ramifications.<sup>46</sup> In particular, Wallbank contended that:

- the expert opinion in *Re: Alex* was limited to psychiatric opinion which adhered to the “anachronistic” psychiatric/disorder model of transsexualism;
- Nicholson CJ wrongly applied the principles of *Re: Marion* and *Gillick* in finding that Alex was not competent to consent to the proposed procedure in his own right, insofar as Nicholson CJ transformed the personal nature of the assessment to one applicable to any and all children and young people in respect of the medical treatment of transsexualism;
- Nicholson CJ erred in finding that the treatment proposed for Alex’s transsexualism was not for the purpose of curing a ‘malfunction’ or a ‘disease’ and was therefore not therapeutic in nature; and
- Nicholson CJ failed to take account of the financial, emotional and child welfare implications of the decision on the parents of children with transsexualism, and upon the children themselves, in limiting and delaying access to treatment.

In essence, Wallbank argued that decisions about treatment for transsexualism should be made privately and without “ongoing intrusion” by courts exercising a welfare jurisdiction. She stated:<sup>47</sup>

I submit that it is neither good medical practice, humane (to the child and his or her family) nor good public policy that the medical treatment of each such child or young person be subject to the delay, worry and cost of obtaining the approval of the Family Court of Australia. The additional financial and other impositions involved in the process of court approval are likely to result in further professional reluctance to diagnose, and further parental resistance to both diagnosis and treatment.

Wallbank was at pains however to emphasise that Nicholson CJ approached the matter with “fundamental goodwill and open-mindedness”, which she described as “the distinguishing characteristic of our Australian justice system which enables it to deal so well with diversity and which provides its capacity to facilitate cultural maturation.”<sup>48</sup>

### **Decisions subsequent to *Re: Alex***

There have been a number of decisions subsequent to *Re: Alex* in which the Family Court’s permission has been sought to perform a medical procedure. Most of these have been for the treatment of gender identity disorder. An overview of the cases follows.

#### ***Re: Brodie (Special Medical Procedures: Jurisdiction) [2007] FamCA 776;* *Re Brodie (Special Medical Procedure) [2008] FamCA 334***

*Re: Brodie* concerned an application by the mother of an 11 year old child, Brodie, who was born biologically female but who identified as male. The child’s mother sought the Family Court’s authorisation to undertake Stage 1 treatment in the form of administration of a gonadotrophin releasing hormone analogue to suppress puberty. No orders were intended to be sought with respect to Stage 2 treatment until Brodie turned 16 years old. The application was resisted by

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<sup>46</sup> Rachel Wallbank, ‘*Re: Kevin* in Perspective’ (2004) *Deakin Law Review* 1.

<sup>47</sup> *Ibid* 30.

<sup>48</sup> *Ibid* 33.

Brodie's father, although he did not participate in the substantive hearing. The Court was assisted by the Victorian Office of the Public Advocate, which appeared as *amicus curie* ("friend of the court"), by an independent children's lawyer, and by a family report which the court ordered to be prepared. Following the High Court of Australia's decision in *Minister for Immigration and Multicultural Affairs and Immigration v B*,<sup>49</sup> delivered subsequent to *Re: Alex*, the Court had to consider the threshold issue of jurisdiction. This was because Brodie's parents were unmarried and therefore, as Brodie was not a "child of a marriage", the question of whether there was a provision in Part VII of the Family Law Act that would create a Constitutional "matter", to which the Court's jurisdiction under section 67ZC would attach, arose. Carter J found that the authorisation for Stage 1 treatment fell within the realm of parental responsibility for Brodie and that the exercise of parental responsibility was the relevant Constitutional "matter". Brodie's mother was therefore found to have standing to bring the application and the Court had the jurisdiction and power to hear and determine the application pursuant to section 67ZC.

In a separate judgment, Carter J delivered her reasons for authorising Stage 1 treatment for Brodie. Carter J accepted the unanimous evidence from the conference of expert witnesses that for as long as Brodie needed to "battle" to obtain treatment, he would be focussed on the "battle" and not on tackling issues associated with his gender identity. Carter J took into account the submissions of the independent children's lawyer, which were that Brodie was adamant that he wanted to live his life as male. Carter J accepted medical evidence that Brodie's conception of adulthood was of being a man with a wife and children, which Carter J found to be "mature concepts" and thoughts. When considering the issue of the likely effect of change on Brodie, Carter J accepted the independent children's lawyer's submission that Brodie was at risk of self-harm if the court's authorisation of Stage 1 treatment was not forthcoming. On the issue of whether the proposed procedure was one intended to correct a 'disease' or 'malfunction', Carter J said "I am not satisfied that the treatment plan is a procedure "for the purpose of treating a bodily malfunction or disease"."<sup>50</sup>

Carter J took into account the impact of oestrogen suppression on Brodie's bone density and that Brodie's growth would be affected, such that he would be small in stature as a male. Nevertheless, in consideration of the constellation of 'best interest' factors, Carter J found that authorising treatment would be in Brodie's best interests and that, conversely, his best interests would be jeopardised if authority was withheld.

### ***Re Inaya (Special Medical Procedure) (2007) 38 Fam LR 546***

*Re Inaya* concerned an application by the parents of a one year old child for a bone marrow transplant to be performed to assist her baby cousin, who suffered from infantile osteopetrosis. The evidence was that the child would likely die without the transplant being performed. In departing from Hannon J's earlier decision in *GWW & CMW*, Cronin J found that court authorisation was not required to undertake the procedure. Cronin J considered the High Court of Australia's decision in *Re: Marion* and distinguished bone marrow harvest from non-therapeutic sterilisation on the basis that a marrow transplant was not irreversible and, although it required a general anaesthetic, it was not considered major surgery. Cronin J found that the medical evidence demonstrated that the procedure was a routine operation with minimal risks and commonly

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<sup>49</sup> (2004) 219 CLR 365.

<sup>50</sup> *Re Brodie (Special Medical Procedure)* [2008] FamCA 334 at [41].

performed on young children. Cronin J nevertheless went on to make orders authorising the procedure to be performed, such orders being necessary because of a conflict between federal and state laws. In arriving at a determination that the procedure was in the child's best interests, despite the subject of the application not being the recipient of the bone marrow harvest, Cronin J gave considerable weight to evidence as to the psychological impact on the child if she learned that her cousin had perished because of her non-involvement in a procedure that could have potentially saved her cousin's life.

***Re: Alex (2009) 42 Fam LR 645***

*Re: Alex* was the second occasion upon which an application was made to the Family Court for medical treatment for Alex, related to his gender identity. The application was made by Alex's legal guardian and was for a double mastectomy. Alex was close to 17 years old at the time the application was made and had progressed to taking testosterone following his 16<sup>th</sup> birthday. Bryant CJ made the orders authorising the double mastectomy to be performed at the conclusion of the hearing in October 2007 and reserved her judgment, with reasons being delivered in 2009.

After discussion with Alex's independent children's lawyer, Bryant CJ identified the three issues upon which expert evidence was required as:

- why surgical intervention was being proposed, given that Alex was less than 18 years of age but could make his own decision without needing the consent of the Court upon turning 18;
- the urgency associated with the proposed surgical procedure; and
- Alex's views and level of understanding about the nature and effect of the proposed procedure.

Concurrent expert evidence was given in respect of those three issues. That evidence, which was not contradicted, was that Alex had experienced some breast development in the interregnum between the onset of puberty and his guardian being authorised to consent to treatment for gender identity dysphoria. Alex found the presence of female breasts to be a "major and distressing preoccupation", which he sought to address by wearing a compression garment and by lifting weights so as to minimise their appearance. One medical expert described Alex as feeling that his life was "extremely inhibited" by his breasts, in that he could not go swimming or play sport because of them and that his social life was restricted. Alex was described as having been "persistent and consistent" in his wish over previous years to have his breasts removed. The Court was told that the benefits Alex thought would accrue to him as a result of having the surgery performed were:

- improved socialisation with his peers, to allow him to feel less self conscious about his appearance and affirm his male identity;
- being able to wear his school uniform without undergarments and in greater comfort;
- playing sport and participating in school athletics carnivals and inter-school sporting competitions;
- participating comfortably in school social events;
- interacting with girls in a developmentally and age appropriate way, such as engaging in hugging; and

- managing the adjustment to the next stage in his gender change process within existing and familiar support structures.

Bryant CJ first considered the issue of whether Alex had the capacity to consent to the surgery himself. Bryant CJ said that this was an issue of “special importance in the circumstances of this case and in light of Alex’s age, the strength of his views and the greater recognition that is being accorded in the international law community to the right of children to exercise agency in decisions affecting them.” Bryant CJ noted that no submissions were directed towards the issue of Alex’s *Gillick* competence. Bryant CJ said:<sup>51</sup>

In my view it is abundantly clear that Alex is an extremely mature and considered young man, with the capacity for sophisticated reflection upon the implications of undertaking chest surgery. The evidence of the medical witnesses is that Alex has a good understanding of the process of bilateral mastectomy and the advantages and disadvantages of the procedure. Alex has shown initiative in undertaking independent research into the procedure and into gender reassignment/sex affirmation surgery more broadly and, as he has told me through the independent children’s lawyer, Alex will continue to research his condition.

Bryant CJ summarised the position as follows:<sup>52</sup>

[S]ince mid-2004, when hormone therapy commenced, the development of secondary female characteristics in Alex has been suppressed. This year Alex commenced taking testosterone and that has caused the development of male physical features. Essentially therefore, Alex has lived as a male for three and a half years. The evidence is that there have been significant improvements in major facets of Alex’s life following the commencement of hormonal treatment and that Alex has responded positively to the physical changes arising from the administration of testosterone. Alex has neither exhibited nor verbalised anything other than an enduring wish to continue to live as a man. Alex believes, fervently, that breast surgery will be of great assistance to him in achieving this end. Alex is an intelligent, thoughtful, reflective and creative young person with well developed adaptive skills.

Bryant CJ concluded:<sup>53</sup>

Taking all of these matters into account, I am not satisfied that Alex is not *Gillick* competent and therefore unable to himself consent to the surgery. However, as the parties, the ICL [independent children’s lawyer] and the intervenor have not led evidence nor made submissions on this matter, I am reluctant to make a positive finding to that effect. The most appropriate course of action, it seems to me, is for me to adopt the same approach as that of Nicholson CJ in the earlier proceedings, which is to take the view that the issue of *Gillick* competence is academic unless I intend to make orders not permitting the procedure. Alex’s maturity and likely *Gillick* competence however provide further support for the orders I made.

Bryant CJ agreed with Nicholson CJ that the treatment regime proposed for Alex, which included bilateral mastectomies to remove excess breast tissue, should be viewed as part of one ‘package’. Bryant CJ said that in light of the fact that submissions were made to Nicholson CJ that Alex would not undergo surgery prior to turning 18 years of age, the interventionist nature of the procedure, its irreversibility, and the risks that attend any form of surgery, it was appropriate for the Court’s permission to be sought.

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<sup>51</sup> At [143].

<sup>52</sup> At [146].

<sup>53</sup> At [147].

In considering whether the procedure would be in Alex's best interests, Bryant CJ found that Alex's wishes were a "very important factor" in the application, and found that Alex had "consistently, firmly and unwaveringly expressed the view that he wishes a bilateral mastectomy to be performed and indeed the application for permission for surgery to be undertaken was made to give effect to Alex's wishes."<sup>54</sup> On the issue of the likely change in Alex's circumstances upon undergoing surgery, Bryant CJ found that the procedure was likely to have a positive psychological effect on Alex. In all the circumstances, Bryant CJ had no hesitation in finding that authorising Alex to undergo breast reduction surgery would be in his best interests.

Bryant CJ devoted the concluding part of her judgment to consideration of human rights law, including the provisions of the International Covenant on Civil and Political Rights with particular relevance to sex and gender diverse people, and those provisions of UNCROC with particular relevance to transgender young people. Bryant CJ, assisted by HREOC's *Sex and Gender Diversity Issues Paper*, also referred to the *Yogyakarta Principles*. These principles were developed by a group of human rights experts in 2006 and addressed a broad range of human rights standards and their application to issues of sexual orientation and gender identity. Bryant CJ stated that although no submissions were addressed to her specifically on the issue of the relevance of international human rights law to the application before her (HREOC having been granted permission to withdraw from the proceedings), the decision she had arrived at was consistent with international human rights instruments.

***Re: Bernadette [2010] FamCA 94;***  
***Re: Bernadette (2011) FLC 93-463***

In *Re: Bernadette*, an application was made by the parents of a 15 year old child who was born biologically male for her to undergo Stage 1 and Stage 2 hormonal treatment, commencing after she turned 16 years old, to assist her in living in her affirmed sex as female. Bernadette had identified as female since the age of three years, where she consistently demonstrated what Collier J described as female behaviour, preferences and traits. Since 2004, Bernadette had lived as a female in her family, and publically. There was evidence before the Court from Bernadette's treating child and adolescent psychiatrist that Bernadette met the DSM-IV diagnostic criteria for Gender Identity Disorder (Childhood). An independent children's lawyer had been appointed for Bernadette and the Director-General of the Department of Human Services and HREOC had been given permission to intervene in the proceedings, without objection. Collier J made orders, by consent, authorising Bernadette to receive hormonal treatment as sought by her parents at the conclusion of the hearing, and otherwise reserved his decision. It was not argued by the applicants that Bernadette was competent to consent to her own treatment.

Collier J commenced by recording the issues he was required to determine. By way of a minute of order handed up by counsel for the applicants, these included important questions of law. In effect, the applicants submitted that the 2004 decision of *Re: Alex* was wrongly decided and, if Nicholson CJ had the evidence before him that Collier J had in *Re: Bernadette*, he would not have found that there was a requirement to obtain court authorisation to commence hormonal treatment for gender identity disorder. The applicants formulated a number of questions for determination by the Court, which included the following:

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<sup>54</sup> At [167].

- Does the parent of an adolescent minor and/or such minor (provided that such minor has a sufficient understanding and intelligence to enable him or her to understand fully what is proposed) have the authority to lawfully authorise medical treatment of that adolescent minor to arrest the onset of the minor’s puberty (“Phase 1 Treatment”)<sup>55</sup> in the course of the medical treatment of the condition of transsexualism (also called gender identity disorder) without an Order of a Court?
- Does the parent of an adolescent minor and/or such minor (provided that the adolescent minor has a sufficient understanding and intelligence to enable him or her to understand fully what is proposed) have the authority to lawfully authorise hormonal medical treatment for the adolescent minor to induce the secondary sexual characteristics of the adolescent minor’s affirmed sex (“Phase 2 Treatment”) in the course of the medical treatment of the condition of transsexualism (also called gender identity disorder) without an Order of a Court?

In response, the Director-General submitted that the questions should be limited to Bernadette and not be responded to as matters of general application. The Director-General argued that both questions should be answered in the negative. HREOC submitted that the issues before the court were “Is transsexualism a condition that requires treatment (as so referred to by the majority [in *Re: Marion*] as ‘malfunction or disease’)? If so, is the proposed treatment in this case appropriately carried out to treat the condition?”

HREOC submitted that both questions should be answered in the affirmative, with the effect that Bernadette’s parents would be lawfully able to consent to treatment without an order of the court. The independent children’s lawyer adopted in part the submissions of the Director-General as to the issues to be determined.

Although Collier J accepted that there were issues arising in the case which may well be matters of general interest and concern, he was of the view that it would be unsafe to determine the questions raised as matters of general or theoretical application, as the evidence that his Honour had before him was particular to the case.

Collier J said:<sup>56</sup>

To find as an apparent matter of general application that it was or was not a matter for parental responsibility could be to do a disservice to other persons contemplating treatment. To say as a rule of general application that parents could or could not authorise such treatment could mean that parents without the full understanding, that the parents in this case clearly have, could make a decision which was ill informed and may well have a disastrous long term affect [sic] on a child, either by permitting or denying the child access to treatment.

Collier J then turned to consider the following issues:

**The condition of the child**

The applicants contended that transsexualism was not a malfunction or a disease but a natural variation to be found in human beings where brain sex and genitalia are different. Collier J found that the state of the evidence before him was not such that he could say precisely what caused transsexualism or gender identity dysphoria. However, he accepted that the ‘Dutch material’ before

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<sup>55</sup> “Phase 1” and “Phase 2” treatment are the same as “Stage 1” and “Stage 2” treatment.

<sup>56</sup> *Re: Bernadette* [2010] FamCA 94 at [68].

him appeared to clearly indicate that a person's sexually identity was determined by their "brain sex" and not by their genitalia or other aspects of their physical appearance or presentation.

#### **The nature of the procedure or treatment**

Collier J said he was satisfied that Stage 1 and Stage 2 treatment were part of a single treatment package for transsexualism. He found that Stage 1 treatment was reversible and that Stage 2 was reversible to the extent that if both stages had been entered, it would still be possible for Bernadette to retain male characteristics. That Bernadette could cease or decline treatment at any time was a matter Collier J said was of "some significance". On the evidence, his Honour did not view Bernadette's loss of capacity to be a biological parent as something that diminished her wish to be female.

#### **The reason for which is it proposed that the treatment or procedure be carried out**

Collier J found that the reasons for treatment were clear, and they were to enable Bernadette to live her life "in that which she is absolutely positive is her true sex".

#### **The alternative course of treatment**

Collier J was satisfied there was no proper and viable alternative course of treatment.

In addition to the concern his Honour had that other parents contemplating treatment for childhood or adolescent transsexualism may not have the same depth of information and expert evidence that Bernadette's parents had, Collier J was also concerned about situations where there was a lack of agreement between parents or guardians as to the proposed treatment. Accordingly, he found that the principles developed by the High Court of Australia and pronounced in *Re: Marion* had application in the case. Collier J said he was "satisfied that the majority judgment of the High Court made it clear that the child's best interests is itself a limit of parental power."

In discussing the distinction between therapeutic and non-therapeutic treatment, Collier J reiterated that the evidence was unclear as to the cause of transsexualism. His Honour said there were two opposing views: that transsexualism has a biological basis, or that it results from mental illness. According to his Honour, there was expert opinion that the actual cause remains uncertain. His Honour went on to record that there was criticism of attempts to treat transsexualism as a mental illness and that "in this case none of the experts expressed a view that mental illness was a satisfactory explanation."<sup>57</sup>

Collier J then considered the various primary and additional 'best interests' factors. As judges had before him, his Honour said he was satisfied that the child's view should be given "serious weight" and "taken into account appropriately". Those views, Collier J found, were that Bernadette wished to commence treatment. His Honour described those views as "well formed" and having been strongly held over an extensive period of time.

Collier J then asked whether it was a case where he should permit the parents to authorise the treatment for a child, with there being no need for the court to be in any way involved in the decision.

Collier J said:<sup>58</sup>

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<sup>57</sup> Ibid [114].

<sup>58</sup> Ibid [123].

I am not satisfied that the evidence before me establishes that there has been such a change in the state of medical knowledge that I should find that I am able to disregard the views of the Stage 1 or indeed of the former Chief Justice in *Re: Alex*. My concern is as to making the wrong decision as was referred to by his Honour in *Alex*. The risk of making a wrong decision was a primary factor influencing their Honours of the Stage 1 in Marion's case.

His Honour went on to opine:<sup>59</sup>

I am satisfied there still remains grave dispute within the medical community as to the best treatment that can be offered. I am satisfied that until there is a clear cut line of authority within the medical profession, it would be difficult for parents to reach an informed conclusion in every case.

In conclusion Collier J said:<sup>60</sup>

...in all the circumstances in this case I am unable to say that the medical evidence presented to me has demonstrated conclusively the cause of transsexualism so as to enable me to find that it is a normally occurring factor of human development. I am thus not satisfied that on that test, that transsexualism is a condition that falls within the range of matters that can be addressed and seen as falling within the parameters of normal parental responsibility to authorise treatment.

Principally for that reason, his Honour decided that he would have to answer “no” to each of the questions posed by the applicants.

Collier J's decision was appealed to the Full Court of the Family Court of Australia.<sup>61</sup> The orders themselves were not appealed, given that they had been sought by the applicants and made by consent. It was the finding of the trial judge that the court's consent to treatment for Bernadette was required, rather than treatment related decisions being within the purview of Bernadette's parents as part of their exercise of parental responsibility, that was the primary issue agitated on appeal. Bernadette, who had turned 18 years of age prior to the Notice of Appeal being filed, was granted permission to intervene in the appeal. The New South Wales Director-General applied to have the appeal dismissed on the basis that Bernadette had turned 18 and the court therefore did not have jurisdiction to entertain the appeal, by reference to the terms of placitum (xxii) of section 51 of the Australian Constitution, which refers to “infants”. At the invitation of the Court, the New South Wales Attorney-General intervened in the proceedings to make submissions addressed to that issue.

The Full Court found that there was a lack of any indication that the welfare power contained in section 67ZC of the Family Law Act was to be exercised in a different manner from every other aspect of the Court's powers in relation to children, the effect of which was to confine the capacity of the Court to make parenting orders to children under the age of 18 years. The Full Court found that the appeal was incompetent and granted the application for its dismissal.

***Re: Sally (Special Medical Procedure) [2010] FamCA 237***

*Re: Sally* involved an application by a hospital to perform a gonadectomy on a 14 and a half year old adolescent. At birth, Sally appeared to be a healthy baby girl and she was raised as female. When she was 11, Sally detected lumps in her groin. Some years later, tests revealed that Sally had an XY genotype, did not have a uterus, and had gonads present in her pelvis. Sally was diagnosed with 5-alpha-reductase deficiency. Sally, despite identifying as a female for the whole of her life,

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<sup>59</sup> Ibid [124].

<sup>60</sup> Ibid [125].

<sup>61</sup> *Re: Bernadette* (2011) FLC 93-463 per Bryant CJ, O’Ryan and Strickland JJ.

was therefore genetically male. Sally and her parents supported the hospital's application to remove her gonads and thus all traces of what Murphy J described as her "maleness". The Department of Communities of the relevant state appeared at the hearing as *amicus curiae*. No independent children's lawyer was appointed. However, the hospital was granted leave to rely upon an affidavit deposed to by Sally herself and it was through these means that Sally's views were brought to the attention of the Court.

Murphy J said that an important issue for the Court was for it to be satisfied that Sally was not suffering from a gender identity disorder as that term was described in the DSM-IV. Murphy J said that "[t]he reason for that is that, if such a condition was present in Sally, the underlying issue for her would be one of psychology, as distinct from, perhaps, a condition involving [an] invasive and irreversible medical procedure."<sup>62</sup> The Court accepted expert evidence that Sally was not suffering from that condition and that she had a clear identity as female.

Murphy J went on to consider whether the procedure was "necessary", as understood by reference to Nicholson CJ's decision in *Re: Alex*. Murphy J found that Sally was a "thoughtful and mature" young woman who understood the reasons why the procedure was recommended and also understood that there might be risks associated with it, in both the physical and psychological sense. Murphy J did not however find that Sally was competent to consent to the surgery herself. In making that finding Murphy J agreed with the submission made by counsel for the Department that, notwithstanding the findings of the court with respect to Sally's maturity and understanding, the Court would require a "very firm foundation" before arriving at the conclusion that a 14 and a half year old child would be competent to consent to undergoing a procedure Murphy J described as "as significant as this". Murphy J said:<sup>63</sup>

When the ramifications of the procedure are taken into account, including, of course, its irreversibility in particular, and the potential ramifications which it might have on Sally's psychological health, both currently and in the future, I would be extremely reluctant to proceed on the basis that she is *Gillick* competent.

Murphy J considered alternatives to surgery, such as its postponement until Sally turned 18 years old. Murphy J relied upon medical evidence about the benefit to Sally's physical and emotional welfare to have her gonads removed and said that any delay in surgery would cause him to have significant concerns.

In considering the 'best interests' factors, Murphy J opined that:<sup>64</sup>

Plainly enough, the surgery will involve significant changes of one sort or another. I have earlier outlined the possible benefits and detriments of those changes as referred to by the treating medical practitioners and I have concluded that the likely effect of the changes brought about by the prospective surgery are more likely to be in Sally's best interests than if the surgery does not occur.

Murphy J said in conclusion, in referring to the court's jurisdiction and discretion:<sup>65</sup>

Despite the fact that all parties are in agreement about a proposed course of action, and those who agree include the child, the parents and the relevant medical agency, this court nevertheless retains

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<sup>62</sup> *Re: Sally (Special Medical Procedure)* [2010] FamCA 237 at [36].

<sup>63</sup> *Ibid* [52].

<sup>64</sup> *Ibid* [68].

<sup>65</sup> *Ibid* [71]-[72].

an independent obligation to consider all of the matters directly relevant to Sally's best interests in arriving at a conclusion about whether this invasive and irreversible procedure ought be permitted.

In my view, all of the evidence points clearly and unequivocally to a conclusion that Sally being permitted to undergo that procedure is in her best interests and I propose to so order.

***Re: Sean & Russell (Special Medical Procedures) (2010) 44 Fam LR 210***

*Re: Sean & Russell* was also an application before Murphy J; in this instance to perform a gonadectomy on two young children from two different families, both of whom suffered from a rare medical condition known as Denys-Drash Syndrome. The syndrome was associated with a high risk of bilateral Wilm's tumours (cancer of the kidneys), a risk of germ cell tumours (i.e. cancer) of the testes, and kidney problems, including the likelihood of complete renal failure by the age of four years. Genetic males with abnormal and intra-abdominal gonads, as both Sean and Russell were, were at the highest risk of malignancy. As Murphy J described it, "the essential proposition in respect of each child is that the development of the cancers, considered highly probable by reason of the syndrome, can be prevented by the surgical removal of both kidneys and both testes."

The applicant was the hospital seeking to perform the surgery, the respondents were Sean and Russell's parents, and the Department of Communities participated in the proceedings as *amicus curiae*. There was no independent children's lawyer appointed.

The specialist medical opinion was that the procedure should be performed. However, a by-product of the procedure would be to render both children infertile. Murphy J quoted from the High Court of Australia's decision in *Re: Marion* that "... the decision to sterilise a child [is] a special case requiring authorisation from a source other than the child's parents". Murphy J summarised the position at law following *Re: Marion* as being that an appropriate party could seek orders in respect of guardianship by reference to the jurisdiction and power of the Court to make orders in respect of that matter. If the matter related to a medical procedure involving sterilisation of a non-*Gillick* competent child, jurisdiction was found within the "welfare jurisdiction" of the court, similar to the *parens patriae* jurisdiction of the courts of common law.

Turning then to amendments to the Family Law Act following the decision in *Re: Marion*,<sup>66</sup> Murphy J posed the following questions:

- Do the subsequent legislative amendments and the current Act alter the requirement for some medical procedures to be authorised by a court?
- If so, does this court have jurisdiction to grant any such application and does that jurisdiction have any relevant limits?
- Where is that jurisdiction to be found?

After reviewing the relevant statutory amendments, Murphy J found that "in my view, the words of the High Court in *Marion's Case* remain the law; namely that the decision to sterilise a child is a special case requiring authorisation from a source other than the child's parents."

Murphy J confirmed that it was recognised in *Marion's Case* that there is an "unclear dividing line" between cases which must be authorised by a court and those which may not. Murphy J said "[i]t is by no means fanciful that parents may seek to have the court give approval (or disapproval) to a

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<sup>66</sup> *Family Law Reform Act 1995* (Cth), *Family Law Amendment (Shared Parental Responsibility) Act 2006* (Cth).

decision which falls within the limits of their parental responsibility but over which they have agonised and may be ambivalent.” As Murphy J also observed, doctors can legitimately claim to need certainty when the consequences of proceeding in the absence of proper authority are potentially very severe.

Murphy J provided an overview of the matters that in his view were dictated by legislation and principle. They were:

- parents (or guardians) do not have, as an incident of their parental responsibilities, the power to authorise or give consent on behalf of their non-*Gillick* competent children to medical procedures or treatment of a type analogous to that in *Marion’s Case*;
- for children (or others) who are not “*Gillick* competent”, it remains the law that court authorisation is required in respect of medical procedures or treatment that can be properly so categorised;
- the Family Court has jurisdiction to hear such an application and the jurisdiction is to be found in section 67ZC;
- for children, or others who are not “*Gillick* competent”, medical procedures or treatment not analogous to that in *Marion’s Case* – even those involving serious and irreversible consequences including sterilisation – can, and in most cases should, be authorised by parents (or guardians) as part of their “parental responsibilities”;
- the Family Court has jurisdiction (found in Part VII) and power (also found in Part VII) to make “parenting orders” in respect of any such issues, because they deal with “any other aspect of parental responsibility” and do not seek to enlarge powers which those with parental responsibility otherwise have by law; and
- the power to make parenting orders of that type includes the power to make orders akin to declarations, including where no inter-parties dispute exists between parents or guardians.

Murphy J then sounded a cautionary note about the limits of the Family Court’s role in making decisions about medical treatment for non-*Gillick* competent children. Murphy J said:<sup>67</sup>

Where parents are properly and appropriately exercising parental responsibility as the Act and the law contemplate that they will and should; where there is no disagreement between them and where there is no “solely therapeutic” element to the proposed procedure, the dilemmas and decisions for parents and doctors alike are predominantly medical (true though it is that those medical decisions are likely to also involve difficult moral and ethical and parental considerations).

In my view, the law should tread very lightly in seeking to intrude in, or impose itself upon, those decisions. It would in my respectful view be sad indeed if the courtroom was to replace a caring, holistic environment within which approach by parents and doctors alike could deal with the (admittedly extremely difficult) medical and other decisions that need to be made.

Murphy J went on to consider whether the procedure required court authorisation. His Honour found that the proposed surgery was to treat a bodily malfunction or disease and was essential from a medical point of view. Murphy J said that the surgery could “not remotely” be considered “therapeutic” in the sense used in *Re: Marion*; nor could he discern any conflict between the parents’ intentions and those of the children, should they reach an age and state of maturity sufficient to constitute *Gillick* competence.

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<sup>67</sup> *Re: Sean & Russell (Special Medical Procedures)* (2010) 44 Fam LR 210 at [90]-[91].

Murphy J ultimately found that a decision about surgical intervention fell within the scope of parental powers and thus court authorisation was not required. However, as an application had been brought, Murphy J said that if the Court's jurisdiction was properly invoked and the orders sought were within power, the Court should go on to decide whether the orders should be made, with the best interests of the children as the determinant.

Murphy J then considered what orders would be in the best interests of Sean and in the best interests of Russell. Murphy J found that, on balance, the proposed treatment was more consistent with securing Sean's best long term outcomes, both physically and psychologically, than any of the alternatives. Murphy J reached the same conclusion with respect to Russell, who unlike Sean had not experienced renal failure.

***Re: O [2010] FamCA 1153***<sup>68</sup>

*Re: O* involved an application by parents of a 16 year old adolescent who was born genetically male but who wished to receive treatment to assist his transition to his affirmed sex as female. The application was brought jointly with O's treating hospital. The Victorian Office of the Public Advocate accepted the court's invitation to intervene but the Department of Human Services did not. The court appointed an independent children's lawyer to assist it in determining what orders, if any, would be in O's best interests. The court also ordered that a family report be prepared.

The orders sought in the application were four-fold:

- (a) O to undergo a procedure known as "electro-ejaculation", for the purpose of collecting his semen for storage;
- (b) O to be administered implants of a drug to effectively suppress continuing male pubescent development;
- (c) subsequent oral application of oestrogen, to develop secondary female characteristics; and
- (d) any other hormonal and/or psychiatric or psychological treatment recommended by O's treating endocrinologist and psychiatrist.

Dessau J took what she described as the "unusual step" of announcing her decision at the conclusion of the hearing without providing reasons or formally pronouncing orders. Dessau J did so in light of the urgency for O to know the outcome and as a compassionate measure for his parents.

O's developmental issues did not present themselves until mid-primary school and he was subsequently diagnosed with Autism Spectrum Disorder at the age of 12. Some two years later, O was seen by his mother dressing in his sister's clothes. He also confessed to accessing information on "cross-dressing boys" on the internet. At the age of 15, O informed his parents that he had had an "epiphany" and wanted to become female. His pubertal development as male, which was advanced, was causing him significant distress and he began articulating suicidal thoughts. O was subsequently found to meet the diagnostic criteria for gender identity disorder as contained in the DSM-IV. O's consultant child and adolescent psychiatrist described O's condition as one which

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<sup>68</sup> Dessau J's reasons for decision use the male pronoun and thus references to "he" rather than "she" appear in this discussion.

caused clinically significant distress and impairment in his social, emotional and other areas of functioning.

Dessau J then turned to the nature and purpose of the proposed treatment. Her Honour observed that “[i]t is important to note that although the medical practitioners referred to the two-stage process, they were clear that it is part of one package of treatment.”<sup>69</sup> In discussing the reversibility of the procedure, Dessau J noted that Stage 1 was fully reversible whereas Stage 2 involved the development of female breasts, which would only be reversible upon a mastectomy being performed.

The nature and degree of risk to O of having medical procedures performed was described by Dessau J as being “at the heart of the case”. Dessau J found that O’s mental health would be placed at serious risk if he did not receive the two-stage treatment for which the Court’s approval had been sought. Dessau J said that she was satisfied that the risks facing O, in the event that the treatment did not proceed, had been properly weighed by the experts against any risks arising from treatment. Dessau J then discussed, in considerable detail, whether O was capable of giving informed consent to the proposed two-stage procedure. Dessau J found:<sup>70</sup>

Despite the combined complexities of O’s youth, the depression and anxiety that he has suffered, and the symptoms of Asperger’s syndrome, the consensus amongst all the professionals was that he is capable of making and has made an informed decision about the procedures. That accords with his parents’ assessment.

In conclusion, Dessau J said:<sup>71</sup>

The responsibility of decision-making in parenting cases, requiring the Court to project a child’s best interests into the future, always weighs heavily, but never more heavily than when considering a special medical procedure, part of which will ultimately be irreversible or at least, difficult to reverse.

In this case, the heavy onus is lightened in some respects. I have the uncontradicted evidence of a range of experts, recognised at the top of their respective fields. There is a thorough assessment by an experienced Family Consultant who has been able to confirm that these exquisitely difficult decisions about O are being made by two loving parents in a close and caring family. Finally, all the evidence points to O himself being a bright and resourceful young person, considered and determined in articulating his steadfast desire to live a fulfilling life as a female, and suffering terribly and at serious risk unless that can be achieved.

I am satisfied that the orders sought by the applicants are the orders that will promote O’s best interests.

***Re: Rosie [2011] FamCA 63***<sup>72</sup>

*Re: Rosie* involved an application by the parents of a young person born biologically female who sought Stage 2 treatment (by way of short and long acting testosterone drugs) for gender identity disorder, to enable her to live in her affirmed sex as male. Rosie was aged almost 17 years at the time the application was brought.

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<sup>69</sup> *Re: O* [2010] FamCA 1153 at [54].

<sup>70</sup> *Ibid* [77].

<sup>71</sup> *Ibid* [108]-[110].

<sup>72</sup> Dessau J’s reasons for decision use the female pronoun and thus references to “she” rather than “he” appear in this discussion.

Rosie had been diagnosed with gender identity disorder, as defined in the DSM-IV, of “significant severity”. Rosie’s treating psychiatrists, her endocrinologist, the family report writer and the independent children’s lawyer all supported treatment for Rosie to induce masculine development.

Dessau J recorded that, at the age of two years, Rosie had asked her father whether she could have an operation to give her a penis. From the age of three Rosie insisted upon being called by a male name and wore only boys’ clothing. Dessau J’s judgment documents Rosie’s “distress and discomfort” at having to identify as female or expose her body. This became acute when Rosie commenced puberty. Rosie ceased attending school because she could no longer stand being in an environment in which she felt “alienated, uncomfortable and left out from the other boys.” Rosie ultimately was referred to a specialist psychiatrist with whom she could discuss her gender identity issues.

Medical evidence before the court was that, in line with the United States Endocrine Society’s treatment guidelines, it would be appropriate to administer cross-sex hormones to Rosie because of her age, thereby bypassing Stage 1 of the treatment regime. Short and long acting injections of a testosterone drug were recommended in order to minimise potential side-effects. The evidence was that hormone treatment would cease Rosie’s ovulation and menses, but the effect on the ovaries would be fully reversible if treatment was stopped. Rosie’s fertility would be temporarily impaired, but in a fully reversible way. The Court was told that some irreversible effects of cross-sex hormone treatment included the growth of facial and body hair, deepening of Rosie’s voice and increased muscular development.

Dessau J accepted the experts’ unanimous opinion that Rosie’s psychological health and general wellbeing were at risk without the treatment. The evidence of one expert, which was accepted by the court, was that the benefits of the proposed treatment for Rosie would make her feel that she was being taken seriously and supported in her desire to live as a male. She would also experience satisfaction from undergoing male sex development. Rosie told the expert that she would have increased ambition and “a greater will to live” after receiving treatment. The family report writer said that Rosie would be unlikely to receive any benefit from refusing or delaying hormonal treatment, particularly given the “excruciating psychological pain” she had faced over her gender issues.

Dessau J then considered whether Rosie was competent to provide her own consent for the administration of cross-sex hormones. Dessau J said that Rosie not only agreed to the treatment, but she had researched it and was “ardently” seeking it. Dessau J found that Rosie’s parents and all the experts agreed that she was capable of making an informed decision about it. Dessau J noted the evidence of Rosie’s gynaecologist that Rosie appeared to be “*Gillick* competent” and able to make an informed decision. The family report writer considered that although Rosie had significant psychological issues, that did not impair her ability to make her own decision about the proposed course of treatment. In summary, Dessau J found that Rosie was capable of making an informed decision about the proposed treatment.

Dessau J said in conclusion:<sup>73</sup>

Every decision about a child carries a heavy weight of responsibility with it. An order that will result in a young person living in one gender when born into another carries a particular onus. That

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<sup>73</sup> *Re: Rosie* [2011] FamCA 63 at [110].

onus is considerably lightened in this case, by the level of expertise in those treating Rosie, the cautious approach towards treatment that they propose, the reversible nature of much of the treatment, Rosie's unwavering views and her age, and the support of her parents who have exhibited a laudable capacity to put her interests ahead of their own.

Dessau J made the orders as sought by Rosie's parents.

***Re: Jodie [2013] FamCA 62***

*Re: Jodie* involved an application by the mother of a 12 year old child born biologically male for authorisation to consent to Stage 1 treatment for gender identity disorder on an interim basis, which would have the effect of suppressing puberty. As part of the final orders sought, Jodie's mother applied for a declaration that "Gender Identity Disorder (including but not limited to all hormone and other treatment known as "Stage 1 Treatment" and/or "Stage 2 Treatment") is not a "special medical procedure"." The father was a respondent to the application but did not appear at the hearing. The Minister, Families South Australia, was invited to participate in the proceedings but advised the Court that he did not intend to object or appear. An independent children's lawyer was appointed and both Jodie's mother and the independent children's lawyer appeared at the hearing of the interim application for the administration of Stage 1 treatment.

Jodie was diagnosed with gender identity disorder (transsexual type, male to female) when she was eight years old. Her family, friends, educators and professionals had referred to her by a female pronoun since she was seven years old. When she was ten, Jodie enrolled in a new school where she was known exclusively as female. The evidence before the court was that Jodie showed signs of anxiety and depression upon the commencement of puberty, and, according to one expert report, she would "become at major risk of developing distress, depression and self-loathing should she have to experience a body becoming more masculine." She was considered to be at "significant risk" of self harm. The medical experts recommended the immediate administration of puberty suppressing medication, with treatment to continue until Jodie was aged 16 years, when it was considered she could decide whether she wished to undertake more "definitive" treatment.

Dawe J noted that the expert evidence was that Stage 1 was a fully reversible treatment. With respect to the orders sought for Stage 1 treatment on an interim basis (it being contended on a final basis that neither Stages 1 or 2 were procedures which attracted the "special" jurisdiction of the Court), Dawe J said:<sup>74</sup>

Because Stage 1 (seen without the proposed Stage 2) could be seen as outside the type of treatment which would require the special medical procedures approval by this Court, an interim order may be made simply confirming that the mother, having sole parental responsibility of the child, is authorised to make that decision. The alternative is that the Court finds that it is a special medical procedure which requires the Court to give approval to the mother having such authority.

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Jurisdiction exists to make the interim order, whether it is considered to be an order which confirms that the mother has such parental responsibility, or whether it is an order which falls within the special medical procedure requirements and thus specifically authorises the mother to consent to the procedure.

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<sup>74</sup> *Re: Jodie* [2013] FamCA 63 at [96], [98].

Dawe J found that the medical evidence emphasised the benefit to the child of the commencement of treatment and the significant disadvantage and risk to the child if the treatment is not carried out. The evidence of one medical expert was that “...without puberty suppression treatment [Jodie] will look more and more masculine and this will increase the sense of feeling different, isolated and disconnected from her peers.”

On the issue of whether Jodie was capable of making an informed decision about her treatment, Dawe J said that “[t]he evidence from the mother and the reports of the experts consulted provide strong evidence that the child “demonstrates an understanding of the broad nature of the treatment proposed.””<sup>75</sup> Dawe J concluded with the observation that “[t]he evidence strongly supports the finding that the child has expressed strong views that she wishes to proceed with treatment as soon as possible.”<sup>76</sup>

Dawe J found that there was “compelling evidence” before the court that it was necessary for Jodie’s psychological and emotional health that Stage 1 treatment commence immediately. Dawe J made the interim orders sought by the mother.

### ***Re: Lucy [2013] FamCA 518***

*Re: Lucy* involved an application by a government department, which was Lucy’s legal guardian, for authorisation for Lucy to commence Stage 1 treatment for gender identity disorder. Lucy, who was aged 13 years at the time the application was heard, was born genetically and biologically male but identified as female. The expert evidence was unanimous that Lucy met the criteria for gender identity disorder contained in the DSM-IV. As Lucy had no living parents, there was no respondent to the application. Murphy J did not appoint an independent children’s lawyer but granted a lawyer leave to be heard on Lucy’s behalf.

Lucy had entered puberty at the time the application was brought and the treatment proposed was said to be urgent in order to prevent bodily changes that would be so significant as to require surgery to reverse. Murphy J observed that an effect of the treatment would be to postpone any more extensive treatment, and particularly that with reversible features, until Lucy was *Gillick* competent. Murphy J recorded that all parties, including Lucy’s lawyer, accepted that although Lucy had age-appropriate intelligence, she was not competent to consent to Stage 2 treatment on her own behalf.

Murphy J distinguished the comments made by Nicholson CJ in *Re: Alex* pertaining to the need for court authorisation in circumstances where a child wished to embark on a process “that will alter a child or young person who presents as physically of one sex in the direction of the opposite sex” from the case before him, because it was only Stage 1 treatment for which authorisation was being sought and that was entirely reversible. Further, Murphy J said:<sup>77</sup>

I consider, respectfully, that the passages referred to present too narrow a picture of ordinary treatments and procedures which fall outside of the narrow band of “special cases” to which the High Court of Australia in *Marion’s Case* refer. The passages to which I have earlier referred from the judgment of Brennan J, his Honour’s judgment read as a whole, and a reading of the plurality’s judgment as a whole present, in my view, a much wider ambit for ordinary parental/guardian consent

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<sup>75</sup> *Ibid* at [122].

<sup>76</sup> *Ibid* at [128].

<sup>77</sup> *Re: Lucy* [2013] FamCA 518 at [94].

than that which can be given for treatment solely to address “disease” or to correct some “malfunction” (albeit that those expressions are used within the judgments in *Marion’s Case*). The ambit might also become wider as a result of, as Nicholson CJ said, “... the march of science overtak[ing] the perimeters of the settled law.

Murphy J had regard to the comments made by Brennan J in *Re: Marion* that treatment “...administered for the chief purpose of preventing, removing or ameliorating ... a psychiatric disorder” fell within the ordinary ambit of parental consent, provided such treatment is “...appropriate for and proportionate to the purpose for which it is administered.” Accordingly, Murphy J proceeded to give consideration to whether the proposed treatment was both appropriate and proportionate.

On the issue of the appropriateness of the treatment, Murphy J expressed himself as satisfied on the entirety of the evidence that the treatment was appropriate and viable, and that it would prevent changes that would exacerbate the psychological issues Lucy confronted. There were two matters that Murphy J considered to be “extremely important”: the fact that the procedure was entirely reversible, and the fact that Stage 1 treatment was designed to hold puberty in abeyance until Lucy was *Gillick* competent. Cumulatively, taking all relevant matters into account, Murphy J found that court authorisation for Stage 1 treatment was not required. In so finding Murphy J said:<sup>78</sup>

... I am satisfied that the treatment proposed, namely LHRH Analogue Therapy is “...appropriate for and proportionate to the purpose” of treating the child’s Gender Dysphoria and that it is intended to be administered “for the chief purpose of preventing, removing or ameliorating ... a psychiatric disorder.”

Consequently, I do not consider that the nature of the treatment *of itself* falls into the category of case that requires the authorisation of this Court.

Murphy J went on to explain that although in his view authorisation for Stage 1 treatment was not required, that did not mean that no order at all should be made. Murphy J said that if jurisdiction has properly been invoked, the Court should proceed to hear and determine the issues brought before it within jurisdiction, including making orders about the exercise of parental responsibility. Murphy J opined that there may well be good reasons why a declaration in relation to a specific aspect of the powers and responsibilities of a parent or guardian should be made if doing so was in the subject child’s best interests. He said that there may be features of a decision in respect of medical treatment other than required authorisation that render it in a child’s best interests for an order to be made. For example, Murphy postulated that a person concerned with a child’s care, welfare or development may have doubts as to whether a proposed medical procedure consented to by the parent or parents was in fact in the child’s best interests. Recourse would therefore need to be had to the Court to clarify that aspect of parental responsibility.

Murphy J said he was persuaded that he should make an order if he was satisfied that the proposed treatment and the making of the order was in the child’s best interests. Murphy J said that although it could be argued that the making of an order that the law did not require to be made served the best interests of persons other than the child (such as the child’s treating team, or Lucy’s legal guardian), Lucy would indirectly benefit from those with legal, moral, ethical and parental decision-

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<sup>78</sup> Ibid at [99].

making responsibility for her being provided with greater certainty. Murphy J thus proceeded to make the orders sought in the application.

***Re: Sam & Terry (Gender Dysphoria) [2013] FamCA 563***

*Re: Sam & Terry* involved an application on behalf of two 16 year olds who had been diagnosed with gender dysphoria as meeting the diagnostic criteria contained in the DSM-5. Both applications sought Stage 1 and Stage 2 treatment, to be administered simultaneously. Sam was biologically male but identified as female and Terry was biologically female but identified as male. As Murphy J found that as the issues raised in both applications were effectively identical, the applications should be heard and determined together. The Director-General of the relevant government department intervened and made submissions in support of the applications. Leave was granted to rely on an affidavit sworn by Terry and Sam, on the basis of their age, the condition from which they suffered and the issues which required determination. For similar reasons, Terry was permitted to be in Court with his parents. Murphy J did not appoint an independent children's lawyer because:

- the expert evidence was unanimous that the proposed treatment was urgently required;
- the children's views were reflected in the proposed treatment and had been put before the Court via affidavits; and
- the applicants sought orders consistent with the treatment proposed by the experts.

Terry, who also had Asperger's Syndrome, had been wearing gender neutral clothes at his insistence since the age of three. He refused to wear dresses and would wear shorts if forced to wear a girl's school uniform. At the age of 12, Terry started talking about being a boy and stating that he hated being a girl.

In 2011, when Terry was aged 14, he was taken to a hospital emergency department after Terry's father noticed what appeared to be lacerations on Terry's chest. It transpired that these were abrasions caused by Terry binding his breasts with electrical tape. A tentative diagnosis of gender dysphoria was then made.

During counselling sessions, Terry admitted identifying as male for as long as he could remember. He told the counsellor that he became distressed and agitated during menstruation and refused to use sanitary products, preferring pull-up nappies so that he would not have to have contact with his genitals.

Terry had been attending a new school since 2012, where he identified and dressed as male. Murphy J recorded that Terry's peers at his new school believed him to be male.

The Court was told that delaying treatment for gender dysphoria until Terry was 18 would exacerbate his anxiety and depression, increase his risk of self harm, and affect his social skills and development of a peer network. Murphy J received evidence as to the reversibility of both stages of treatment proposed for Terry and noted that Stage 2 had irreversible effects. There was also evidence as to the risks associated with testosterone use, including breast or uterine cancer, erythrocytosis and liver damage.

In Sam's case, her parents became aware that she was self-harming in 2010-11. In 2012, Sam was referred to a specialist, to whom she disclosed that she had feelings of gender dysphoria since the

age of five. Sam told the specialist she had thought of removing her male genitals and had harmed her genitals on one occasion. Sam was subsequently found to satisfy the criteria for gender dysphoria found in the DSM-5.

Expert evidence was tendered, to the effect that a delay or refusal of treatment for Sam would increase her level of psychological distress and could precipitate a psychological decompensation. The Court was also told that the treatment would reduce mental health problems, reduce social anxiety and improve social functioning.

As with Terry, the court received evidence about the reversibility of Stage 1 and the irreversible effects of Stage 2 on Sam, including a long-term adverse effect on fertility. The Court was also told about the risks associated with oestrogen treatment, including blood clots, gallstones, abnormal liver function, weight gain, high blood triglyceride levels and cardiovascular disease.

Murphy J first considered whether the court had jurisdiction to entertain the application and power to make the orders sought, in the absence of what he described as “those two broad justifications for intervention in the rights, duties and responsibilities inherent in responsible parenting”, namely the right of the state to intervene when children are at risk and disagreement about orders affecting children.

Murphy J said that the right and authority of parents to make decisions in respect of medical treatment or procedures was subject to two broad limitations: where a child was *Gillick* competent and where a procedure was sufficiently “special” as to require Court authorisation.

Murphy J then considered the issue of Sam and Terry’s *Gillick* competence. Murphy J noted that neither of Sam and Terry’s treatment specialists considered them to be *Gillick* competent and the Department did not put a contrary position. Accordingly, Murphy J found that although Terry and Sam each demonstrated a significant degree of maturity and insight into their respective conditions, there was no other evidence suggesting that they possessed the requisite sufficiency of understanding to consent to their own treatment.

Murphy J discussed the nature of the proposed treatment. He considered the comments Nicholson CJ made in *Re: Alex* about the types of proceedings that fell within the Court’s ‘welfare’ jurisdiction and those that did not. Murphy J respectfully disagreed with Nicholson CJ that a finding that a particular condition falls outside those described by the majority in *Re: Marion* as “a special case” would lead to a finding that the treatment would “thereby not [be] within the jurisdiction of this Court”. Murphy J pointed out that a dispute about a procedure that did not fall within the jurisdiction of section 67ZC would need to be determined as parenting orders relating to an aspect of parental responsibility. As his Honour pointed out, the Court must authorise treatment in the former case but may make a particular parenting order if in the child’s best interests to do so. Murphy J also expressed doubt as to whether the category of cases that did not require court authorisation was as narrow as Nicholson CJ suggested. In particular, Murphy J said that Nicholson CJ did not appear to have regard to what Brennan J said in *Re: Marion* about psychiatric conditions, in respect of which (according to Brennan J), “therapeutic” treatment could be administered without court authorisation. Murphy J summarised the principles that apply to determining whether a particular type of medical treatment requires court authorisation in the following terms:<sup>79</sup>

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<sup>79</sup> *Re: Sam & Terry (Gender Dysphoria)* [2013] FamCA 563 at [83].

Reference to the judgments in Marion’s Case mark court authorisation as necessary in respect of a non-*Gillick*-competent child in a “special case” which is determined by reference to the following factors:

- Treatment which does not involve “preventing, removing or ameliorating a cosmetic deformity, a pathological condition or a psychiatric disorder”;
- Treatment which is inappropriate or disproportionate having regard to the cosmetic deformity, pathological condition or psychiatric disorder;
- Treatment given other than for the “chief purpose” of preventing, removing or ameliorating a cosmetic deformity, a pathological condition or a psychiatric disorder;
- The “urgency” of the proposed treatment;
- Where there is the combination of 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 where the “consequences of a wrong decision are particularly grave”.

Murphy J said that it was not possible to be didactic about the types of cases requiring authorisation and those which did not. Speaking about gender dysphoria specifically, Murphy J said:<sup>80</sup>

...cases involving treatment for Gender Dysphoria may not require court authorisation because the nature of the treatment is required to ameliorate a psychiatric disorder and the nature of the proposed treatment is such that the risk of error and the consequences for the child are eliminated or alleviated because the treatment is “reversible” (see, for example, *Re Lucy*). Other cases of Gender Dysphoria may, by reference to those or similar relevant factors, require authorisation.

Turning then to the treatment proposed for Sam and Terry, Murphy J found that Stage 1 did not require court authorisation. Murphy J described it as “plainly therapeutic” and sought to be administered to ameliorate a psychiatric disorder. As it was also completely reversible, Murphy J found that the risks associated with mis-diagnosis were low and thus the consequences of the treatment could not be described as “grave”.

By reference to the evidence before him as to the international practice guidelines and the absence of alternative treatments and the nature and severity of the manifestations of the condition suffered by each child, Murphy J considered Stage 2 treatment to be “appropriate and proportionate” to the purpose of “removing the condition”. Unlike Nicholson CJ in *Re: Alex*, Murphy J did not believe there was any real likelihood that either Sam or Terry would re-consider their gender identity. Murphy J said that were that to have occurred, the signs would already have been evident. Murphy J noted that Sam and Terry were continuing to receive professional psychological assistance, and that Sam was a member of a trans-gender support group. Further, Murphy J recorded that both would be monitored throughout Stage 2 treatment, and that the treatment could be stopped, or modified, if it was causing Sam and/or Terry distress, or if their conditions changed to the extent that Stage 2 treatment was no longer warranted.

Murphy J then said:<sup>81</sup>

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<sup>80</sup> Ibid at [85].

<sup>81</sup> Ibid at [98].

All of those factors point, in my view, to the treatment being classified as “therapeutic” and I am not prepared to dismiss it as such by reason of the nature of the condition or because the Stage 2 treatment might be but a step in a later, post-competence or post-childhood, process of wide-ranging and extensive treatment and procedures.

However, Murphy J stated that in his view, whether a procedure was therapeutic or not was only one factor the High Court of Australia required to be taken into account. Murphy J said that the test was whether the procedure was therapeutic, in tandem with the purpose of the treatment and its potential consequences.

Murphy J found that the risks associated with Stage 2 treatment, in terms of irreversibility and possible side effects, were “significant”. Murphy J went on to say that “...when the consequences are expressed as being steps on the path to changing gender, the consequences can be described as grave.”<sup>82</sup>

Murphy J found that court authorisation was required for Stage 2 treatment. His Honour considered whether making orders with respect to Stage 2 treatment would be in Sam and Terry’s best interests. Murphy J took account of relevant ‘best interests’ factors separately for Sam and for Terry, and in both cases found, by reference to the totality of the expert and other evidence, that the proposed treatment was in Sam and Terry’s best interests. Murphy J made orders in terms of a declaration that court authorisation for Stage 1 treatment was not required but to avoid the appearance of doubt, Murphy J also made orders authorising Sam and Terry’s parents to consent to Stage 1 treatment on their behalf. Murphy J made a declaration that the court’s authorisation for Stage 2 treatment for gender dysphoria was required and, somewhat unusually, went on to make a declaration that Sam and Terry’s parents were authorised to consent to Stage 2 treatment on their behalf.

## ***Re: Jamie at first instance***

### **Re: Jamie [2011] FamCA 248**

#### **Introduction**

*Re: Jamie* involved an application by the parents of a child aged 10 years and 10 months at the date of hearing (March 2011) for Stage 1 and Stage 2 treatment. Jamie was born physically male but had been identifying as female from a young age. The orders sought were for:

- (a) The administration of puberty suppressant hormones, such as implants of Zoladex (a GnRH agonist) at intervals and at a dosage as may be determined as necessary to achieve suppression of Gonadotrophins and testosterone to pre-pubertal levels under the guidance of Jamie’s treating medical practitioners including but not limited to Dr G, (Endocrinologist) and Dr C (Psychiatrist);
- (b) Additional treatment of oestrogen as may be considered appropriate by Jamie’s treating endocrinologist, currently being Dr G (Endocrinologist) and in consultation with and on the written advice of Jamie’s treating Psychiatrist, currently Dr C (Psychiatrist).

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<sup>82</sup> Ibid at [101].

In determining the application, the Court was assisted by an independent children's lawyer for Jamie, who arranged for the preparation of an urgent family report. Both the independent children's lawyer and the report writer were supportive of Jamie commencing Stage 1 treatment. The relevant government department and the Office of the Public Advocate were invited to intervene in the proceedings, particularly in light of Jamie's age. Both declined to do so.

Dessau J made orders on 28 March 2011, at the conclusion of the hearing, granting the application for Stage 1 treatment. Dessau J declined to make orders with respect to Stage 2 treatment. Her Honour observed that Stage 2 treatment was irreversible in nature and, on the basis that the treatment would not commence for another six years, when Jamie was aged 16, she could not determine in 2011 what would be in Jamie's best interests in 2017.

## **Background**

Jamie began to identify as female when she was two and a half to three and a half years old. She chose female orientated toys, began to identify with female characters on television or in movies, and reportedly told her mother "Mummy, I don't want a willy. I want a vagina." The parents' evidence was that when she started school in 2006, Jamie's insistence that she was female increased significantly. A 'turning point' came in 2007, when Jamie was adamant about wearing a ballgown to a play. Jamie's mother started buying her girls clothing after that time, which Jamie began wearing at home. Jamie commenced attending specialist psychiatric appointments in October 2007 and was diagnosed with gender identity disorder in December 2007. The family started addressing Jamie as a girl towards the end of 2008 and, in 2009, Jamie changed schools, where she was known exclusively as female.

At the age of almost 11 years, Jamie had the pubescent development of a 14 year old male, which was rapidly progressing. Jamie's parents told the Court that this was causing Jamie a heightened sense of anxiety about her future. Jamie's mother deposed:<sup>83</sup>

If [Jamie] does not received [sic] the phase 1 treatment, she will very shortly develop obvious male characteristics such as deepening of her voice, facial hair and other more masculine features which will be permanent and will not be able to be reversed. At the moment [Jamie] can live comfortably as a girl, is socially confident and suffers no teasing or social isolation. If male features become obvious, I fear that [Jamie] will not easily be able to live as female.

...

I am concerned that if [Jamie] is again placed in a position where her biological gender is publicly revealed or even questioned, she will regress emotionally, psychologically and academically. I am very concerned by Dr [C's] opinion that [Jamie] is likely to develop depression and will be at risk of self harm.

## **Evidence before the court**

Dessau J recorded that there was no dispute that the procedure for which Court authorisation was being sought (namely a treatment package for gender identity disorder comprising a two-staged regime) was a special medical procedure requiring court authorisation.

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<sup>83</sup> *Re: Jamie* [2011] FamCA 248 at [27].

Dessau J then turned to the matters contained in sub-rule 4.09(2) of the Rules.

Dessau J referred to the evidence of Dr C, who was satisfied of Jamie's consistent and firm conviction that she was a girl within the body of a boy, and that all the information indicated a consistent female identification. Dr C concluded that there was no evidence of any physical or genetic abnormality, nor of any other psychiatric disorder or major depressive or affective disorder. Dessau J noted the Dr C had "no doubt" that Jamie met the criteria for the diagnosis of "childhood gender identity disorder (transsexual type)." A second doctor prepared a report in relation to Jamie. The doctor's conclusion was that Jamie "meets DSM-IV Criteria for the diagnosis of Gender Identity Disorder of childhood (302.6)". An endocrinologist to whom Jamie was referred noted Jamie as having "persistent and profound gender identity disorder of the transsexual type."

The nature of the treatment proposed was, at the first stage, suppression of puberty through the use of a gonadotrophin releasing hormone, which was sought on an urgent basis in light of Jamie's advanced pubertal development. Dessau J received evidence that the treatment would slow the process of maturation and the growth plates of the long bones, arrest sperm production, and increase bone mineral density. The second stage of the treatment, involving the administration of cross-sex hormones, was to commence when Jamie turned 16 years old, consistent with the guidelines of the United States Endocrine Society.

The Court had evidence before it that suppressing male puberty would prevent emotional and social distress for Jamie. The Court was told that Jamie would be adversely affected by developing a more male appearance, and it may have significant impact on her mood, self confidence and social functioning. Stage 1 treatment was said to "minimise the risk" of Jamie developing depression, anxiety and the related risk of self-harm and suicidal behaviour. The Court was informed that Stage 1 treatment was entirely reversible. The Court was told that part of the Stage 2 treatment that warranted particular consideration was the introduction of oestrogen, which would cause breast growth. If Jamie were thereafter to choose to live as a man, her breasts could only be removed by surgery.

The Court was informed that an alternative of just a behavioural approach to treatment would be unlikely to be beneficial for Jamie, and that Jamie would find withholding treatment as invasive within itself.

The evidence of Dr C was that he was satisfied that Jamie had been able, at an age appropriate level, to understand the consequences of continued suppression of puberty, the later treatment with oestrogen, the possibility later of developing breasts, and of the surgery to create a vagina. However, Dr C concluded that Jamie did not have the level of maturity to be responsible for a decision of such gravity, even though she possessed a good understanding of the process involved and the potential risks and benefits. The family report writer told the court that although Jamie did not have the maturity and cognitive ability to fully understand the long-term realities and consequences of her decisions, it appeared that she had "a very good understanding" of her gender identity and treatment, and of what was involved in the treatment she was requesting.

On the question of Jamie's competence to consent to Stage 1 treatment, Dessau J said:<sup>84</sup>

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<sup>84</sup> Ibid 106.

...the answer is that she probably can. Whilst I take that into account, I agree with Dr C that at Jamie's age, she still needs to be guided by her parents' decision. The finding however is clear, that Jamie herself has a good understanding of and ardently seeks the treatment to start straight away.

There was no dispute that Stage 1 treatment was necessary for Jamie's welfare. There was a difference of opinion, however, about Stage 2. Dessau J summarised that as follows:<sup>85</sup>

The decision now as to whether Stage 2 of the treatment, in five or six years, will be necessary for Jamie's welfare, is a more difficult one. The family report writer recommended that the court's approval for that treatment should be deferred until closer to the time when the decision needs to be made. That is the course urged by the ICL. The parents, supported by the doctors, urged that it be seen as two stages of the one proposed treatment and that approval should be given now for both of those stages, rather than requiring the expense of further proceedings.

Dr C's evidence was that Jamie's welfare is likely to be promoted if she knows that she will have control over the decisions in relation to her own body and identity when she is older, without the need to return to court. Both he and Dr G emphasised that no decision would be made in relation to Stage 2 of treatment for another five to six years, and then it would only proceed if Jamie were seeking the treatment, and the medical practitioners agreed that it would be in her best interests.

### **Reasons for the decision**

In arriving at her decision, Dessau J took into account Jamie's "strong and consistent views that she wants to commence treatment." Dessau J described Jamie as sufficiently mature, intelligent and informed for considerable weight to be attached to her wishes. Dessau J said:<sup>86</sup>

Jamie's long-standing wishes, the fact of her close family members being able to support her needs, and the real risks to Jamie if this treatment were not commenced, assisted me in reaching the conclusion that the Stage 1 treatment was in Jamie's best interests, and needed to commence as a matter of urgency.

Whether or not to make orders with respect to Stage 2 treatment was a matter that caused Dessau J more difficulty. Dessau J found, in line with her own decisions and those made by other judges, the two stages of treatment should be viewed as one treatment plan. However, Dessau J said she was "equally satisfied" that whether the two stages of the one treatment plan should be approved at the same time depended on all the circumstances. In the circumstances of the case, Dessau J was unable to make a determination that the second stage of treatment, which would not commence until 2016 or 2017, would be in Jamie's best interests. Dessau J said:<sup>87</sup>

The parents and doctors presented the case for approval at this point on the basis that if Jamie wants the relevant treatment when she is older and her parents and doctors consider it appropriate, then it should occur. On the other hand, if Jamie does not want the treatment then she will be supported by her parents and doctors, and the treatment will not occur. With respect, that dichotomy fails to deal with a wide and potentially far more complex spectrum of possibilities between those two clear positions. It also fails to fully appreciate the court's role in cases of special medical procedures.

The argument that the Stage 2 treatment will only be embarked upon if Jamie seeks it, and her parents and doctors support it as in her best interests, overlooks the court's role. The court is

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<sup>85</sup> Ibid at [112]-[113].

<sup>86</sup> Ibid at [119].

<sup>87</sup> Ibid at [126]-[127].

required to approve a special medical procedure. The two-phased medical procedure in this case requires approval, even if the child, her parents and doctors already agree, as they do in this case.

While acknowledging Jamie's parents' preference not to return to court as "entirely understandable", Dessau J said that she could not determine in 2011, when Jamie was still only aged ten, what was likely to be in Jamie's best interests in 2016 or 2017. Dessau J said that it was instead "... appropriate for a judge to consider those circumstances closer to that time."

## ***Re: Jamie on appeal***

### **Re: Jamie [2013] FamCAFC 110**

*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.

### **Background, grounds of appeal and parties to the appeal**

Jamie's parents subsequently appealed Dessau J's orders to a three-member bench of the Full Court of the Family Court.<sup>88</sup> Each member of the bench delivered separate judgments. As Bryant CJ recorded in her reasons, the appeal was unusual insofar as it raised issues not agitated at trial and could only be ventilated on appeal because they concerned a point of law. Jamie's parents did not challenge Dessau J's orders, which they had sought and which were being complied with. Their case was that the Court did not have jurisdiction to authorise the parents to consent to treatment, as it fell within the exercise of parental responsibility. The grounds of appeal were as follows:

1. That, contrary to the view expressed by the learned trial Judge, treatment of the condition described as "childhood gender identity disorder" with which "Jamie" was diagnosed is not a special medical procedure which displaces the parental responsibility of the appellants to decide upon the appropriate treatment for their child.
2. That Ground 1 be considered and allowed notwithstanding that no such submission was made to the learned trial Judge, and her Honour proceeded on that basis that:- "There was no dispute in this case that the procedures proposed fell within the definition of special medical procedures" (Judgment [at first instance] paragraph 33).
3. Further and in the alternative to Ground 1, once the diagnosis of childhood gender identity disorder was established and accepted and the treatment approved, the learned trial Judge erred in law and the exercise of discretion in concluding that the treatment for the disorder should be the subject of a further application to the Court when the "Stage 2" is about to commence.

The Full Court found that the gravamen of the appeal was whether treatment for childhood gender dysphoria was a treatment for which court authorisation was required. If it was not, the appellants

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<sup>88</sup> *Re: Jamie* [2013] FamCAFC 110 per Bryant CJ, Finn & Strickland JJ.

submitted that ground 3 would not need to be considered. If authorisation was found to be required, ground 3 went to the issue of the divisibility of the treatment regime and which stages of treatment required authorisation. As Bryant CJ said:<sup>89</sup>

The appeal has particular importance because it has potential relevance for a much wider range of children than just Jamie, whose parents are the appellants in this case. This is because the main issue is whether the treatment (proceeding in two stages) is a medical procedure (Secretary, Department of Health and Community Services v JWB and SMB (1992) 175 CLR 218 (“Marion’s case”)) for which consent lies outside the bounds of parental authority and requires the imprimatur of the court.

The orders sought on the appeal were declaratory, to the effect that treatment for childhood gender identity disorder was not a special medical procedure that attracted the jurisdiction of the Family Court under section 67ZC of the Family Law Act. Alternatively, the appellants sought authorisation to consent to Stage 1 and Stage 2 treatment.

The independent children’s lawyer appointed by Dessau J was a party to the appeal. Although the relevant public authority declined the invitation to intervene at the hearing, the authority filed an application seeking to intervene in the appeal. The intervention application was the subject of a separate judgment by the same Full Court bench, who were called upon to decide whether the public authority should be involved in the appeal at all and, if so, whether as an intervener and therefore a party to the proceedings, or as *amicus curiae*. Ultimately, in the decision of *Re: Jamie*,<sup>90</sup> the Full Court permitted the public authority to intervene on a limited basis, such that the authority was confined to making written and oral submissions about ground 1 of the appeal. The AHRC also intervened without objection.

## Reasons for the decision

As earlier mentioned, the three members of the Full Court bench delivered separate reasons for judgment, although all three agreed with the outcome.

### *Bryant CJ*

In her consideration of ground 1 of the appeal, Bryant CJ posed two questions: ‘is childhood gender identity disorder a bodily malfunction or disease as defined in *Marion’s case*?’, and ‘should *Re: Alex* be followed?’

On the question of whether childhood gender identity disorder is a bodily malfunction or disease, Bryant CJ commenced by rejecting the submission of the public authority that pharmacotherapeutic treatment sought for childhood gender identity disorder did not treat the psychological imperative at the heart of the condition. Bryant CJ said:<sup>91</sup>

...in my view, that is exactly what it does. If the condition involves self-identity of a different gender from the biological gender with which one is born, then the treatment can be fairly said to address the imbalance of the patient’s self-identity with some, at least, of its bodily representation. In my view, it is not, as the submissions of the public authority propose, the alteration of an otherwise

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<sup>89</sup> Ibid at [5].

<sup>90</sup> *Re: Jamie* (2012) FLC 93-491.

<sup>91</sup> *Re: Jamie* [2013] FamCAFC 110 at [67].

healthy body to accommodate a psychological imperative, but rather it is the alignment of the body with the person's self-identity.

Bryant CJ described the distinction as "critical". Bryant CJ said the submission by the public authority assumed a normative state; departure from which was abnormal. Bryant CJ referred to the decision on Chisholm J in *In Re Kevin (Validity of Marriage of Transsexual)* which found that transsexualism should be seen as an example of diversity in human sexual formation, rather than as an aberration or departure from the norm. Bryant CJ said it was therefore readily understandable that people with transsexualism were concerned about psychiatric diagnoses of gender disorder. Bryant CJ said however that it was not an issue that she needed to determine for the purpose of the appeal, given that gender identity disorder was a psychological condition contained in the DSM-IV (and as gender dysphoria in the DSM-5).

After considering the High Court of Australia's decision in *Re: Marion*, Bryant CJ said that in her view it was clear that the majority was dealing exclusively with the question of sterilisation, and particularly with an intellectually disabled child incapable of giving consent. Bryant CJ observed that Brennan J, who dissented in part, was the only member of the High Court of Australia who referred to "a pathological condition or a psychiatric disorder". Although she did not explicitly say so, it is clear Bryant CJ was answering the first question in the negative.

Bryant CJ then turned to the question of whether *Re: Alex* should be followed. Bryant CJ pointed out that it was the propositions that emerged from *Re: Alex*, rather than the outcome, that should be considered. Her Honour did so on the basis that the applicant in that case was Alex's legal guardian and it therefore may be correct to hold that court authorisation is required, whatever the other bases for arriving at the decision.

Bryant CJ considered Nicholson CJ's decision in detail, noting that the parties in *Re: Jamie* approached the case somewhat differently from the way that it was put in *Re: Alex*, with respect to matters such as whether the Court's permission was required, the divisibility of the treatment regime and the child's capacity to consent to treatment. Bryant CJ speculated that Nicholson CJ may have reached a different conclusion about capacity had he viewed Stage 1 separately from Stage 2. Bryant CJ said that, in her view, the evidence was clear that Stage 1 was a reversible process and, unlike Nicholson CJ, Bryant CJ did not think that Stage 1 could be described as "invasive, permanent and irreversible".

Bryant CJ said that it was possible that the majority in *Re: Marion* did not have in contemplation that a psychiatric disorder would fall within a group of cases for which court authorisation for treatment would be required. However, her Honour saw no reason to limit the High Court of Australia's observations to physical disease, particularly as Brennan J directly addressed the issue of psychiatric disorders. Bryant CJ concluded:<sup>92</sup>

Thus where the question is whether the treatment relates to a disease or malfunctioning of organs, including psychological or psychiatric disorders, then, in my view, if the treatment is in response to a disorder, even a psychological or psychiatric one, it is administered for therapeutic purposes. For that reason alone, in my view, the treatment at Stage 1 for gender identity disorder would not fall within the category of cases which the High Court of Australia was considering in Marion's case.

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<sup>92</sup> *Re: Jamie* [2013] FamCAFC 110 at [98].

Bryant CJ also observed, in *obiter*, that it appeared that the “novelty” of the condition described by Nicholson CJ was no longer supportable.

Bryant CJ then turned to the submission by the public authority that there was a significant risk of making the wrong decision, and thus the principles of *Re: Marion* were applicable. Bryant CJ found that the evidence in the case was “overwhelmingly indicative” of the proposed treatment being a common one. To the extent that there were differences of opinion about treatment, Bryant CJ said that as long as none of the contemplated courses of treatment were “invasive, permanent and irreversible”, the treatment would not require the Court’s approval on that ground alone. Bryant CJ said it was also important to identify that, unlike in *Re: Marion*, it was unlikely that parental interest would be in anything other than the welfare of the child.

In summarising her findings in respect of ground 1 Bryant CJ said:<sup>93</sup>

In summary, I conclude that Stage 1 treatment of childhood gender identity disorder is reversible, is not attended by grave risk if a wrong decision is made, and is for the treatment of a malfunction or disease, being a psychological rather than physiological disease. As such, and absent controversy, it falls within the wide ambit of parental responsibility reposing in parents when a child is not yet able to make his or her own decisions about treatment.

Bryant CJ then turned to ground 3, which concerned Stage 2 treatment.

Bryant CJ said in her view there was a “relevant distinction” between Stage 1 and Stage 2 treatment. The reversibility of Stage 1 was described as a “significant issue”. Bryant CJ noted that the appellant’s submissions stated that Stage 1 and Stage 2 should be dealt with together, but that their submissions did not deal with another issue; namely, whether a child may be competent to consent to Stage 2 treatment. Bryant CJ referred to the appellant’s oral testimony, which was that assessments of *Gillick* competency should principally be for the clinician, with the Court only becoming involved where there was a controversy or doubt about competence.

Bryant CJ noted the AHRC’s submissions about UNCROC and the Convention on the Rights of Persons with Disabilities (“CRPD”). With respect to UNCROC, the AHRC submitted that it should be used as “an interpretive aid” when considering Part VII of the Family Law Act. Further, the AHRC said that in ratifying UNCROC, Australia has agreed that it would respect the responsibilities, rights and duties of parents to provide appropriate direction and guidance to their children in the exercise by children of their rights, in a manner consistent with children’s evolving capacities. Bryant CJ recorded that there was High Court of Australia authority for the proposition that principal legislation is to be construed so as to give effect to, and not to breach, Australia’s international obligations.<sup>94</sup> Bryant CJ said that as the Family Law Act and UNCROC share an underlying common purpose — that being a concern that decisions are being made in children’s best interests — it was appropriate to have regard to the relevant provisions of UNCROC. Bryant CJ found that Articles 5 and 12 were particularly apposite on the question of *Gillick* competence.

After considering the spectrum of possibilities for the role of the Court, which the public authority submitted ranged from a ‘hardline’ position of no role at all upon a finding of *Gillick* competence, to the Court being required to authorise treatment irrespective of *Gillick* competency, Bryant CJ

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<sup>93</sup> *Ibid* at [108].

<sup>94</sup> See *Minister for Ethnic Affairs v Teoh* (1995) 183 CLR 273.

said that in her view, if a child was *Gillick* competent, the Court had no role. Bryant CJ also noted that Stage 2 treatment for gender identity disorder commenced at about the age of 16, which under statute in some Australian jurisdictions, and in New Zealand and the United Kingdom, was the age at which children were regarded as having decision-making autonomy over many medical treatment decisions.

Bryant CJ said:<sup>95</sup>

In my view, it would be contrary to the Convention on the Rights of the Child, and to the autonomous decision-making to which a *Gillick* competent child is entitled, to hold that there is a particular class of treatment, namely Stage 2 treatment for childhood gender identity disorder, that disentitles autonomous decision-making by the child, whereas no other medical procedure does.

Bryant CJ saw no reason to read down *Gillick*, as discussed in *Re: Marion*, because of the nature of the treatment for childhood gender identity disorder. In fact, Bryant CJ said that “of all the medical treatments that might arise, treatment for something as personal and essential as the perception of one’s gender and sexuality would be the very exemplar of when the rights of the *Gillick*-competent child should be given full effect.”

With “some reluctance” Bryant CJ concluded that she was bound by *Re: Marion* and that because there was a significant risk of making the wrong decision as to a child’s capacity to consent to Stage 2 treatment, and because the consequences of a wrong decision would be particularly grave, the Court’s authorisation was required. Bryant CJ said however that any such application would “only need to address the question of *Gillick* competence and once established the court would have no further role.” Bryant CJ postulated that the application would not need to be as extensive as an application for the Court to authorise treatment. Bryant CJ said she could see no reason why any other party would need to be involved, unless there was controversy.

Bryant CJ summarised the decision she had reached as follows:<sup>96</sup>

- (a) Stage 1 of the treatment of the medical condition known as childhood gender identity disorder is not a medical procedure or a treatment which falls within the class of cases described in *Marion’s case* which attract the jurisdiction of the Family Court of Australia under s 67ZC of the Act and require court authorisation.
- (b) 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.
- (c) 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.
- (d) If the child is *Gillick* competent, then the child can consent to the treatment and no court authorisation is required, absent any controversy.
- (e) 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.

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<sup>95</sup> *Re: Jamie* [2013] FamCAFC 110 at [134].

<sup>96</sup> *Ibid* at [140].

- (f) 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.

### ***Finn J***

Finn J commenced with a brief introduction to the matter.

Finn J discussed the term “special medical procedures”, which she noted did not appear in the Family Law Act or Rules, was not used by the High Court of Australia in *Re: Marion* and nor by Nicholson CJ in *Re: Marion (No 2)*. Finn J said she preferred the term “medical procedure which requires court authorisation”. Before turning to the grounds of appeal, Finn J also said that it was important to note that Dessau J recorded that no one had taken issue with the diagnosis of gender identity disorder in the proceedings before her and that no issue regarding the diagnosis had been taken on the appeal.

Finn J described the issues raised by the appeal as “very significant”. Her Honour identified the primary issue arising in the appeal as being whether court authorisation for treatment of gender identity disorder was required under section 67ZC, or whether parental consent pursuant to section 61C was sufficient. The “subsidiary” issue identified by Finn J was, if court authorisation was required, Dessau J erred in only ordering Stage 1 treatment. Finn J disposed of that issue by stating that whether the two stages of treatment should be approved at the same time depended upon the circumstances of the case and she did not consider that Dessau J erred in refusing to authorise Stage 2 treatment, having regard to her Honour’s reasons for doing so.

In discussing the primary issue arising in the appeal, Finn J commenced by saying “there cannot...be any question” that where there is a disagreement in relation to proposed treatment between the parents and/or their child or with the child’s treating doctors, an application to the Court will be necessary. Unlike Bryant CJ, Finn J did not specify that the application needed to be brought pursuant to section 67ZC of the Family Law Act. However, Finn J noted that the appeal was solely concerned with cases where there was no disagreement.

Finn J extracted the relevant discussion from *Re: Marion*. Her Honour observed that although the High Court’s decision was concerned with the sterilisation of an intellectually disabled child, the principles of *Re: Marion* had been applied in a number of other cases where other serious forms of medical treatment were proposed. Finn J noted that the High Court of Australia considered it necessary to draw a distinction between therapeutic and non-therapeutic procedures, although the High Court acknowledged that the distinction could be uncertain. Finn J concluded by saying that there was nothing in the majority’s judgment which could be taken as limiting their observations to only a physical, as opposed to a psychiatric or psychological, malfunction or disease. Her Honour then quoted from Brennan J’s decision, which referred to psychiatric disorders. Despite the submissions made by senior counsel for the Public Advocate, Finn J said “...I am not persuaded

that Brennan J's definitions should not provide some assistance in considering the difficult issues raised by this case."<sup>97</sup>

In her conclusions about Stage 1 treatment, Finn J said that, given the evidence before Dessau J of the child's condition and the risks faced by her if she did not receive Stage 1 treatment, that stage of the treatment could be seen as therapeutic. Furthermore, Finn J found that the treatment's reversibility meant that the High Court of Australia's concerns about a wrong decision being made, and the resulting grave consequences flowing from such a decision, did not arise. As there was also no dispute between the child, her parents or her doctors, Finn J was satisfied that Stage 1 treatment did not require court authorisation.

Stage 2 was described as presenting "greater problems", if only because it was irreversible in nature, at least without surgery. Finn J said:<sup>98</sup>

This consideration must, in my view, remain important, even when it is accepted that the treatment can be categorised as therapeutic, and in this regard the concept of proportionality referred to by Brennan J must come into play.

Finn J stated that the risks of a wrong decision and the grave consequences of a wrong decision, as identified by the majority in *Re: Marion*, must exist in relation to Stage 2 treatment. Therefore, the therapeutic benefits of the treatment must be weighed against the risks involved and the consequences which arose from a treatment being irreversible. Finn J found that was a task that was appropriate for a court.

However, 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 make a decision about *Gillick* competency, or whether it was a matter for the court. After noting the submissions of the public authority and the AHRC that it was the Court that should make the decision, and in light of what the High Court of Australia said about the risk of a wrong decision being made and the 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." In so doing, Finn J expressed her reluctance at arriving at that decision, in light of the cost and stress of further court proceedings, but explained that it had been made in light of the High Court of Australia's requirements.

### ***Strickland J***

In a succinct judgment prepared with the benefit of having read the draft reasons for judgment of Bryant CJ and Finn J, Strickland J said that he concurred with the outcomes proposed by their Honours and generally for the reasons set out in both judgments. In summary, Strickland J agreed that on the evidence before the trial judge, Stage 1 treatment could be described as therapeutic. Because Stage 1 was reversible, Strickland J found that none of the concerns of the High Court of Australia about risk of the wrong decision, or grave consequences, arose. Strickland J said that,

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<sup>97</sup> Ibid at [178].

<sup>98</sup> Ibid at [180].

given there was no dispute between the child, her parents or her doctors as to Stage 1 treatment, and the form of the treatment, the treatment did not require the Court's authorisation.

Strickland J agreed with Finn J that the therapeutic benefits of Stage 2 treatment needed to be weighed against the risks involved and the consequences arising from the treatment being irreversible. Strickland J said that, given the changes that would result for the child, court authorisation should be required, except in cases where the child was able to consent to the proposed treatment. Strickland J agreed that whether a child was capable of understanding and giving informed consent to Stage 2 treatment was a threshold issue the Court must decide. This, his Honour said, was because of the High Court of Australia's requirement that courts authorise medical treatment where there is a significant risk of the wrong decision being made as to the child's capacity to consent and where the consequences of such a wrong decision are particularly grave.

The Full Court upheld the appeal and set aside Order 1 of Dessau J's orders, which authorised the parents to consent to Stage 1 treatment. Finn J explained that this did not reflect any error on behalf of Dessau J but that the order was necessary because of the issue raised on appeal but not at the hearing.

## **What principles can be discerned from *Re: Jamie*?**

The following principles, which can be discerned from *Re: Jamie*, represent the current state of Australian law with respect to the Family Court's role in authorising treatment for gender dysphoria.

- 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 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 required, 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.

## **What has happened subsequent to *Re: Jamie*?**

Since the Full Court handed down its reasons in *Re: Jamie*, and as of May 2014, judges of the Family Court have delivered three judgments in respect of applications for declarations of competency and/or authorisation to consent to medical treatment for young people. Of those, two involved transgender young people and one involved a young person with a disorder of sexual development.

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

*Re: Shane* was the first decision to be handed down following *Re: Jamie*.

*Re: Shane* involved an application by Shane’s parents for authorisation to consent to Stage 2 treatment on Shane’s behalf for the purpose of treating gender identity dysphoria. Shane, who was born biologically female but identified as male, was 16 years old at the time the application was heard. The Director-General of the relevant government department intervened. Neither the applicants nor the intervener sought the appointment of an independent children’s lawyer and Murphy J did not consider that the circumstances warranted such an appointment being made. Shane, his parents and the medical experts were unanimously in support of the proposed course of treatment, which involved the administration of an intramuscular testosterone ethantrate.

Shane was described by his mother as having always perceived himself as a boy. He preferred boys’ clothing and his friends were all male. Shane attended school as male. Shane’s parents gave evidence that, in 2012, he informed them that he was transgender. Shane was tentatively diagnosed with gender dysphoria following a referral to a consultant child and adolescent psychiatrist. Notes from Shane’s consultations, which were in evidence before the Court, were to the effect that Shane had long-standing social problems, had emerging symptoms of depression, and found puberty to be an uncomfortable, confusing and difficult time. The psychiatrist recorded that Shane reported a “strong and persistent cross-gender identification”. Shane was found to fulfil the DSM-IV diagnostic criteria for gender identity disorder. At the date of hearing, Shane was living exclusively as male and had commenced Stage 1 treatment. The expert evidence before the court was that

Stage 2 treatment would reduce the risk of further mental health problems and that delay in undertaking treatment would not “serve any purpose”, would significantly exacerbate symptoms of social isolation and anxiety, and increase the risk of depression. According to Murphy J, “significantly” Shane’s treatment team stated that there was no alternative treatment available to Shane.

The two questions that presented themselves for Murphy J were:

- Was Shane *Gillick* competent?
- Did the proposed treatment require authorisation?

On the question of *Gillick* competence, the medical evidence was that Shane, who had also been diagnosed with Asperger’s Spectrum Disorder, was an intelligent and thoughtful adolescent who had substantial insight into his condition and the proposed treatment, but was not *Gillick* competent. The legal representatives for the Director-General of the government department did not contend otherwise. Murphy J found that the fact that Shane’s parents had brought the application for authority to consent to Stage 2 treatment was confirmatory of the opinion that Shane was not *Gillick* competent.

On the question of whether the proposed treatment required authorisation, Murphy J first recorded that the Full Court in *Re: Jamie* unanimously held that Stage 2 treatment for gender dysphoria was a treatment requiring Court authorisation. That being the case, Murphy J found that the criterion for permitting authorisation was that the proposed treatment was in Shane’s best interests.

Murphy J then had regard to relevant ‘best interests’ factors. Murphy J said that the “very significant risks” associated with the proposed treatment, including irreversible effects. However, the expert evidence was that there was no alternative to the proposed course of treatment. In conclusion, Murphy J found that “[t]he unanimous expert evidence, together with the evidence of Shane’s parents and Shane’s own reports satisfy me that the proposed Stage 2 treatment is in Shane’s best interests.”

Orders were made granting Shane’s parents’ application for authorisation to consent to Stage 2 treatment for Shane.

### **Re: Sarah [2014] FamCA 208**

In *Re: Sarah*, the mother of a child aged close to 17 years born with 45X/46XY Turner Syndrome, a disorder of sexual development, sought a declaration that Sarah was competent to consent to a gonadectomy.

The orders sought in the application were:

1. A declaration or Order that the child [Sarah] born ... 1997 (“[Sarah]”) has achieved a sufficient understanding and intelligence to enable her to fully understand what is proposed and entailed in the following treatment for 45X/46XY Turner Syndrome (a “disorder of sexual development”) as to be capable of giving informed consent to such treatment:
  - (a) That under the guidance of [Sarah’s] treating medical practitioners including but not limited to Dr [H] (Paediatric Endocrinologist) and Dr [Y] (Surgeon), [Sarah] undergo a

gonadectomy to remove her gonadal tissue that failed to develop into ovaries as a result of her 45X/46Y Turner Syndrome.

- (b) Such other surgical, hormonal, psychiatric or psychological treatment as may be recommended by [Sarah's] treating medical practitioners from time to time.

An independent children's lawyer was appointed, who supported the application. Sarah, Sarah's parents, Sarah's doctors and the independent children's lawyer were all unanimous in their support of the application, which would result in the medical procedure being performed without the need for court authorisation. It was agreed that the risk of Sarah developing cancer was the primary reason for performing the proposed procedure.

Sarah's diagnosis occurred in late 2013. Sarah's condition arose from "atypical development of the sex chromosomes, the testes or ovaries, or the external genitalia." Sarah did not have functioning gonads and there was a risk of her developing a malignancy in the residual streaks of tissue in the range of 10 to 15 per cent. The medical evidence before Macmillan J was that the proposed procedure was not a sterilisation procedure as referred to in *Re: Marion*, as Sarah did not have potential fertility or hormonal function from the gonads. On that basis, the medical evidence was that the procedure was not a "special medical procedure".

Macmillan J first turned to whether the procedure was one which required court authorisation.

Macmillan J said:<sup>99</sup>

The decision of the Full Court in *Re: Jamie* [2013] FamCAFC 110 ('*Re: Jamie*') makes it clear that if the proposed treatment falls within the ambit of Marion's case and if the child is not *Gillick* competent – which will be discussed later in these reasons – the proposed treatment must be first authorised by the Court. However, if the child in question is *Gillick* competent then that child can consent to the treatment and it is not necessary for the Court to authorise that treatment.

Macmillan J said she was satisfied that the procedure was not one for which court authorisation was required. She did so on two bases. The first was that the procedure was therapeutic. The second was that the procedure was "relatively minor" and "non-invasive", as it could be performed by laparoscope and did not require overnight hospitalisation.

Macmillan J then addressed the issue of Sarah's *Gillick* competence. Although Macmillan J found that the issue was effectively moot in light of her finding that the procedure was not one for which court authorisation was required, she acceded to senior counsel for the applicant's request to make the declaration sought by the applicant, for the avoidance of any doubt.

After reviewing relevant authorities as to the declaratory power of the Family Court, and finding that there was power either under section 64B(2)(i) or section 67ZC of the Family Law Act to make a declaration, Macmillan J said that she was satisfied that the declaration was in Sarah's best interests and made orders in the terms sought.

### **Re: Spencer [2014] FamCA 310**

In *Re: Spencer* the mother of a 17 year old child, Spencer, who was born biologically female but who identified as male, sought a declaration that Spencer was competent to consent to Stage 2

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<sup>99</sup> *Re Sarah* [2014] FamCA 208 at [14].

treatment for gender dysphoria (referred to as “gender identity dysphoria” in the reasons for judgment). In the alternative, she sought the Court’s authorisation to consent to Stage 2 treatment on Spencer’s behalf.

Spencer’s father supported the application, as did Spencer’s treating doctors and a psychiatrist who provided a second opinion as to Spencer’s capacity to consent to Stage 2 treatment. There was an independent children’s lawyer appointed (although the independent lawyer’s submissions as to Spencer’s *Gillick* competence were not discussed in the judgment) but it does not appear that a family report was ordered. Johns J dispensed with the requirement under rule 4.10 of the Rules that the application and support material be served on the prescribed child welfare authority.

In her judgment, Johns J recorded that Spencer had preferred wearing male clothes, and playing with boys, since the age of three. When in secondary school, Spencer started exhibiting suicidal tendencies and received treatment for depression and anxiety. He had a large number of absences from school and, according to his mother, was “completely disengaged and disinterested”. Spencer told his psychologist in 2011 that he identified as male. In 2012, Spencer told his mother he wished to live his life as a male. He was diagnosed with gender dysphoria in June 2012.

The expert evidence before the Court was that Spencer’s emotional stage would deteriorate severely if Spencer did not receive Stage 2 treatment and that he would be at significant risk of self harm.

Johns J referred to the principles established by the High Court of Australia in *Re: Marion*. Johns J also quoted from the Full Court’s decision in *Re: Jamie*, to the effect that:

- a competent child can consent to Stage 2 treatment;
- the Court is responsible for determining if a child is *Gillick* competent; and
- this is so because the risk of making the wrong decision as to a child’s capacity to consent and the consequences of a wrong decision are particularly grave.

Johns J said that the Full Court held that once the question of *Gillick* competence was established, the Court would have no further role.

Johns J had before her affidavits from Spencer’s treating doctors, including two psychiatric reports, and a report from Spencer’s treating paediatrician. All had been asked to provide an opinion about Spencer’s capacity to consent to Stage 2 treatment. Each report addressed Spencer’s insight and maturity, his expressed wishes about undertaking Stage 2 treatment, his understanding of the proposed course of treatment, including its potential benefits and risks and the fact that it would cause irreversible physical changes, his views about alternates to undertaking Stage 2 treatment, and his likely response if Stage 2 treatment was not commenced.

Johns J found that the medical evidence “overwhelmingly supports a finding that Spencer is *Gillick* competent.” Spencer’s treating paediatrician’s report stated:<sup>100</sup>

[Spencer] is *Gillick* competent to make the decisions regarding commencement of stage two [testosterone] treatment. This has been demonstrated during our consultations where [Spencer] has engaged in sophisticated discussion around the issues of his gender identification, fertility preservation and the long term consequences of treatment both in terms of physical and psychological health and wellbeing.

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<sup>100</sup> *Re: Spencer* [2014] FamCA 310 at [45].

On the basis of the evidence of Spencer's treating practitioners, and the psychiatrist who provided a second opinion, Johns J said she was satisfied that Spencer was *Gillick* competent. Johns J also found that it was in Spencer's best interests to make the declaration sought, as to do otherwise would be to gravely compromise his health and well-being.

After finding that the power to make orders relating to the welfare of children included the power to make the declaration sought by Spencer's mother, Johns J proceeded to declare Spencer competent to give informed consent for the treatment of gender dysphoria. Orders were made in those terms.

## **The position in North America as compared with Australia**

### **Five jurisdictions compared: statute and common law**

Five North American jurisdictions were selected for comparative purposes, to provide a sense of the different approaches that have been taken towards young people and decision making about medical treatment. Two are Canadian provinces (Ontario and British Columbia) and three are states of the United States of America (New York, California and Virginia). Although it was possible to locate decisions from those jurisdictions concerning the medical treatment of young people, and particularly refusal of life-saving treatment, no decisions involving treatment of gender dysphoria were able to be identified. This is in contradistinction to Australia where, as the foregoing discussion exemplifies, there have been a number of applications for treatment for that condition. That, in turn, has provided the impetus for the jurisprudential development of the law surrounding consent to medical treatment for gender dysphoria in Australia.

#### ***Canada***

In its report entitled *Children and the Law: Medical Treatment*, the Law Reform Commission of Ireland summarised the legal position in Canada in the following terms:<sup>101</sup>

In Canada, many Provinces retain 18 as the general age of majority, but in respect of medical treatment there has been a general move towards conferring full capacity on persons from 16 years of age. In addition, for those under 16 years of age, a "mature minor" rule is well established. While the "mature minor" rule has predominantly been developed at common law, a number of recent statutory provisions have also been enacted. Provisions enacted in British Columbia and New Brunswick in 1973 and 1975 are similar to those enacted in other countries at the time, such as England and Australia. These provisions can be contrasted with more recent legislative developments in Ontario and Prince Edward Island, which are based on a functional approach to capacity and the general presumption that a person is capable of making a healthcare decision.

#### ***Ontario***

In Ontario, the *Health Care Consent Act 1996* addresses issues of medical consent.<sup>102</sup> Notably, the Act proceeds from a presumption of capacity to consent to medical treatment that is unconstrained by any age limits.

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<sup>101</sup> Law Reform Commission of Ireland, *Children and the Law: Medical Treatment*, Consultation Paper, December 2009, 81.

<sup>102</sup> See generally John Phillippe Schuman, 'When Worlds Collide: the Legal Right of Minors in Ontario to Direct Medical Treatment' (1999) 5 *Appeal Law Journal* 38-53  
<http://journals.uvic.ca/index.php/appeal/article/view/5547/3469> (accessed 20 August 2014).

Section 4(1) provides that a person is capable with respect to treatment, admission to a care facility, or a personal assistance service if the person is able to understand the information that is relevant to making such a decision and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. Section 4(2) provides that a person is presumed to be capable of making his or her own decisions about medical treatment.

In *Starson & Swayze*,<sup>103</sup> the majority of the Supreme Court of Canada said about the first ‘limb’ of the test that:

The person must be capable of intellectually processing the information as it applies to his or her treatment, including its potential benefits and drawbacks. Two types of information would seem to be relevant: first, information about the proposed treatment; and second, information as to how that treatment may affect the patient’s particular situation. Information relevant to the treatment decision includes the person’s symptoms and how the proposed treatment may affect those symptoms. The patient must be able to acknowledge his or her symptoms in order to be able to understand the information relevant to a treatment decision. Agreement with a medical professional’s diagnosis per se, or with the “label” used to characterize the set of symptoms, is not, however, required.

In respect of the second ‘limb’ the majority said:<sup>104</sup>

The second component of the test is that the person be “able to appreciate the reasonably foreseeable consequences of a decision or lack of decision”. The appreciation test has been characterized as more stringent than a mere understanding test, since it includes both a cognitive and an affective component: R. Macklin, “Some Problems in Gaining Informed Consent from Psychiatric Patients” (1982), 31 *Emory L.J.* 345. To be capable, a patient must be able not only to understand the relevant information, but also to “appreciate the reasonably foreseeable consequences of a decision or lack of decision”: s. 4(1) of the HCCA.

Under section 4(3), a person may rely on the presumption of capability unless she or he has reasonable grounds to believe that the other person is incapable of consenting to medical treatment, admission to a care facility or to receiving personal assistance services. The term “person” is not defined in the Act. However, as Schuman writes “there is no reason to believe that “person” does not include children and young people”.<sup>105</sup> *In Re: Baby R*,<sup>106</sup> the British Columbia Court of Appeal specifically held that the definition of person includes children. In *R v J(R)* it was held that the Canadian Charter of Rights and Freedoms includes children under the age of 16.<sup>107</sup> According to Schuman, therefore at law, children are persons and are presumed to be able to consent to their own medical treatment.<sup>108</sup>

Section 10 states that a health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent. The elements of consent are set out in section 11. They are:

- the consent must relate to the treatment.

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<sup>103</sup> [2003] 1 SCR 722 at [16].

<sup>104</sup> *Ibid* at [17].

<sup>105</sup> Above n 102, 42.

<sup>106</sup> (1988) 15 RFL (3d).

<sup>107</sup> (1982) 1CRR 202, 204.

<sup>108</sup> Above n 102.

- the consent must be informed.
- the consent must be given voluntarily.
- the consent must not be obtained through misrepresentation or fraud.

The patient's health practitioner is responsible for making a finding as to mental capacity. Section 15 states that capacity depends on treatment (a person may have capacity to consent to some treatments but not others) and time (a person may be capable of consenting to treatment at a certain time and incapable at another time).

In summary therefore, in Ontario a health care provider must determine, on reasonable grounds, that a child does not fully comprehend the nature or the possible consequences of the decision. If reasonable grounds for invalidating a child's consent cannot be found, the child's instructions must be followed, even where the parents' wishes contradict those of the child. Sub-section 29(1) gives health care practitioners immunity from suit where they reasonably believe that valid consent has been given by a child.

Under sections 32, 50 and 65, a person may apply to the Consent and Capacity Board for a review of a health practitioner's finding of incapacity.

Schuman wrote that, despite concerns during its passage about extending capacity for medical consent to children, the 1996 Act did not change the law. In *Johnston v Wellesley Hospital et al*<sup>109</sup> the High Court of Justice found that there is no specific age at which minors becomes legally capable of making their own medical decisions. At common law, children could direct their own treatment if they could appreciate fully the nature and consequences of the procedure in question. According to this decision therefore, children always had the right to consent to or refuse treatment, provided they understood its nature and consequences.

In the Ontario case of *Re: LDK*<sup>110</sup> which was decided before the Health Care Consent Act came into force, a 12 year old was diagnosed with acute myeloid leukaemia. Her chances of survival were 10 per cent without treatment and 30 per cent with treatment. She was a Jehovah's Witness and had refused blood transfusions as well as strongly objecting to chemotherapy. Justice Kent of the Ontario Provincial Court found that 'LDK' was sufficiently mature to make her own decision to refuse medical treatment. Treatment was not administered and LDK subsequently died from the disease.

### ***British Columbia***

Unlike Ontario, the British Columbian statute contains an age limit of 19 years. Medical consent provisions are contained in Part 2 of the *Infants Act 1996* (BC). Part 2 of the *Infants Act 1996* (BC) states that a person under the age of 19 years old (an "infant") can consent or agree to their own health care, if they are capable of doing so. "Health care" is defined as anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health related purpose, and includes a course of health care.

Pursuant to sub-section 17(3), consent is only valid where the health care provider has:

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<sup>109</sup> (1971) 2 OR 103.

<sup>110</sup> *Re LDK; Children's Aid Society of Metropolitan Toronto v K and K* (1985) 48 RFL (2d) 164.

- a) explained to the infant and has been satisfied that the infant understands the nature and consequences and the reasonably foreseeable benefits and risks of the health care; and
- (b) has made reasonable efforts to determine and has concluded that the health care is in the infant's best interests.

There is no set age at which a child becomes capable. Doctors have to use their best judgment in each case. Factors that are relevant to the decision about capability are how mature the child is and how serious the medical treatment is. At common law, the test for capable decision making focuses on a minor's cognitive development. In *Re Koch*,<sup>111</sup> Judge Quinn stated that the necessary "capacity" is a cognitive capacity. It involves the functions of understanding and appreciation as they relate to [the proposed medical treatment]". At least one commentator has described the cognitive interpretation of maturity as "highly problematic".<sup>112</sup>

Schuman wrote that:<sup>113</sup>

[u]nder their right to security under section 7 of the Canadian Charter of Rights and Freedoms, competent children may have a right to direct their own treatment. The majority of the Supreme Court in *R v Morgentaler* (1998) held that the constitutional right to security of the person must include some protection from state interference where a person's life or health is in danger.

According to Schuman "[w]here a child has expressed wishes regarding a treatment that he or she understands, ignoring that child's priorities and aspirations and forcing them, by law, to concede to the wishes of his or her parents is clearly an interference with that child's body."<sup>114</sup>

The clear point of distinction between Ontario and British Columbia is that Ontario's statute is founded on the principle of presumptive capacity, whereas the *Infants Act* contains an age limit of 19 years, below which something approximating the 'mature minor', or *Gillick*, doctrine applies.

## The United States

Huft, in her analysis of barriers experienced by transgender youth in accessing medical treatment, stated that:<sup>115</sup>

[I]legally, in the United States, a minor may begin sex reassignment with parental consent as long as the minor's doctor approves the procedure. However a legal barrier exists for many transgender youth who are unable to obtain parental consent. These individuals may be able to seek permission from the courts either by arguing that their parents neglected them by not allowing them medically necessary treatment or by arguing under a Mature Minor doctrine.

In summarising the position in the United States concerning young people and consent to medical treatment, Horshall said:<sup>116</sup>

<sup>111</sup> [1997] O.J. No. 1487 (Cont. Gen. Div.).

<sup>112</sup> Lucinda Ferguson, *The End of An Age: Beyond Age Restrictions for Minors' Medical Treatment Decisions*, paper prepared for the Law Reform Commission of Canada, October 2004, 13.

<sup>113</sup> Above n 102, 5.

<sup>114</sup> *Ibid.*

<sup>115</sup> Mary Huft, 'Statistically Speaking: the High Rate of Suicidality Among Transgender Youth and Access Barriers to Medical Treatment in a Society of Gender Dichotomy', (2008) 28 *Children's Legal Rights Journal* 53, 55.

<sup>116</sup> Leora Horshall, 'What Can We Do for You Today: Minors' Medical Consent Legislation and Sexual Minority Youth' (2012) 32 *Children's Legal Rights Journal* 37, 44.

[a]ll states have begun to provide for the health of minors by creating various minors' medical consent laws. Allowing minors to seek care for several conditions commonly relevant to the lives of adolescents and establishing a variety of means by which they may proceed with non-parental consent increases the likelihood that youths will get the care they need.

The following are some examples.

### *New York*

Shield stated that the law governing access to medical treatment in New York is similar to many of those across the United States.<sup>117</sup> At common law, minors are considered to be legally incompetent and incapable of consenting to their own medical treatment. Shield wrote that the United States Supreme Court said in *Carey v Population Services International*<sup>118</sup> said “the law has generally regarded minors as having a lesser capacity for making important decisions.” In the 1976 decision of *Bellotti v Baird*<sup>119</sup> the United States Supreme Court noted that minors demonstrate “unquestionably greater risks of inability to give an informed consent than do adults.” In the second *Bellotti v Baird* decision delivered in 1979,<sup>120</sup> the United States Supreme Court justified the minimisation of minors' rights on the basis of their “peculiar vulnerability”.

Individuals gain the right to give informed consent to medical treatment upon attaining the age of 18. The New York Court of Appeals in *Rivers v Katz* stated:<sup>121</sup>

In our system of a free government, where notions of individual autonomy and liberty are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure [sic] that the greatest possible protection is accorded to his autonomy and freedom from unwanted interference with the furtherance of his own desires.

According to Shield, children, by definition, lack capacity to take care of themselves. They are assumed to be subject to the control of their parents and if parental control falters, the state must play its part as *parens patriae*. There is a rebuttable presumption that parents are acting in their children's best interests.<sup>122</sup>

At the time of writing in 2008, Shield said that there was only one New York opinion to consider the ‘mature minor’ doctrine, that being the decision *In re Long Island Jewish Medical Center*.<sup>123</sup> In that case the court was asked to decide whether a young man only months shy of his 18<sup>th</sup> birthday, who was a Jehovah's Witness, could refuse a life-saving blood transfusion. The New York Supreme Court held the young man was not competent to make his own decision and relied on certain facts in reaching that conclusion, including that he had never dated or been away from home, he consulted his parents before making decisions, and testified that he considered himself a child. The Court concluded that he could not demonstrate a “mature understanding of his own religious beliefs or of the fatal consequences to himself.” Shield stated that because the young man was found not to be a mature minor, “this case leaves unclear whether the mature minor doctrine is

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<sup>117</sup> Sonja Shield, ‘The Doctor Won't See You Now: Rights of Transgender Adolescents to Sex Reassignment Treatment’ (2008) 7 *Dukeminier Awards Best Sexual Orientation & Gender Law Review* 99, 102.

<sup>118</sup> (1977) 431 US 678. See discussion in *ibid*, 131-2.

<sup>119</sup> (1976) 428 US 132.

<sup>120</sup> (1979) 443 US 622.

<sup>121</sup> (1986) 504 NYS 2d 74 at 78.

<sup>122</sup> Above n 117, 133.

<sup>123</sup> (1990) 557 NYS 2d 239.

precedential law in New York.” As Shield observed however, commentators have argued that the court would not have applied a mature minor test unless it was accepted as a viable legal doctrine.<sup>124</sup>

If a parent or foster carer will not give consent for a child to access transgender related health care, the minor may be able to seek permission from the court. One option is to ask the court to find that the parent neglected the minor by failing to allow necessary medical treatment. Section 1012(f) of New York’s *Family Court Act* permits the court to order medical treatment for a minor if the court finds the minor to be neglected. This option is most commonly exercised in cases where the child’s life is at risk but, as discussed below, has also been applied in situations where medical treatment was in the best interests of the child.

There are examples of New York courts intervening in circumstances where parents have refused to authorise routine medical care that would permit their child to lead a normal and healthy life. For example in *In Re Rotkowitz*<sup>125</sup> the Domestic Relations Court (now the Family Court) ordered emergency surgery for a 10 year old for a foot deformity over the father’s objections. The Court said:<sup>126</sup>

I must conclude that it was the intention of the Legislature to give power to the justices of this court to order an operation not only in an instance where the life of the child is to be saved but also in instances where the health, the limb, the person and the future of the child is at stake.

The case of *In Re Sampson*<sup>127</sup> involved a 16 year old with Von Recklinghausen’s disease, which was not life threatening or health threatening, but for which treatment was risky and opposed by the young person’s parents. Treatment was ordered at first instance. On appeal, the New York Court of Appeal found that the power of the court to order medical treatment is not limited to “drastic or mortal circumstances”. Parental refusal of medical treatment was found to constitute neglect.

There are certain exceptions that permit minors to consent to their own care. In New York, minors can consent to substance abuse treatment, outpatient mental health services, HIV tests and treatment for a sexually transmitted disease. Section 2504 of New York Public Health Law provides that people who are married or who are parents, and who are thereby considered to be ‘emancipated’, can provide consent for medical, dental, health and hospital services. Under the same section, where a person is under the age of 18 and “in the physician’s judgment an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the person’s life or health”, the person can consent to their own medical treatment.

Shield maintained that “with the codification of statutory exceptions to informed consent law, the New York State Legislature has signalled its approval of the growing trend towards adolescent decision-making under the law.”<sup>128</sup>

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<sup>124</sup> Above n 117, 156.

<sup>125</sup> (1941) 25 NYS 2d 624.

<sup>126</sup> *Ibid* 627.

<sup>127</sup> (1972) 278 NED 900.

<sup>128</sup> Above n 117, 156.

## *California*

Generally, in California, minors cannot consent to medical diagnosis, care, or treatment. Section 6500 of California's Family Code provides that a minor is person aged under 18 years. Accordingly, a parent or legal guardian must give consent. However, there are certain statutory exceptions that permit people under the age of 18 to consent to their own medical care, or consent to particular types of treatment where they are 12 years or older.

Section 6924(3)(b) of the Code provides that:

A minor who is 12 years of age or older may consent to mental health treatment or counselling on an outpatient basis, or to residential shelter services, if both of the following requirements are satisfied:

- (1) The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services.
- (2) The minor (A) would present a danger of serious physical or mental harm to self or to others without the mental health treatment or counselling or residential shelter services or (B) is the alleged victim of incest or child abuse.

Section 6926(b) states that "a minor who is 12 years of age or older may consent to medical care and counselling relating to the diagnosis and treatment of a drug or alcohol related problem."

Minors can 'self consent' when living separately and apart. According to section 6922 of the Family Code, "separate and apart" means that a person has to be at least 15 years old and managing their own finances. Young people do not need to have parental consent to live apart, the duration of the separation is not considered, and a young person's status as living "separate and apart" is not affected by receiving financial support from his or her parents. Hoshall observed that the 'living separate and apart' provisions may be useful for transgender young people who are estranged from their parents as it would increase the likelihood that they are legally able to consent to their own care, including medical treatment.<sup>129</sup>

New York and California are similar, insofar as their respective legislation contains age limits and both jurisdictions recognise particular exceptions, as well as the concept of 'emancipation'. However, on its face at least it appears that California's Family Code has more exceptions than New York. New York also does not have legislation yet in place similar to California's School Success and Opportunity Act.

On 1 January 2014, the School Success and Opportunity Act came into effect in California. The Act was the first of its kind in any American state. The Act recognises the right of public school students to participate in sex-segregated programmes, activities and facilities based on their self-perception rather than birth gender. These include physical education classes, sports teams, toilets, changing rooms and any other school event, activity or program that separates or makes gender-based distinctions among students.

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<sup>129</sup> Above n 116, 38.

## *Virginia*

In Virginia, persons aged 18 and over are able to make decisions about their own medical treatment. However, Virginia has enacted what Hoshall described as a “lengthy but functional statute that satisfactorily addresses...concerns for persons wishing to provide health care to LGBTQ [lesbian, gay, bisexual, transgender, queer or questioning] youth”.<sup>130</sup> Hoshall observed that although the statute contains eleven primary points and numerous sub-points, and thus is longer than that created in most other states, it is “supremely useful because it provides the answer to nearly every relevant question.” The pertinent provisions follow:

Section 54.1-2969A concerns authority to consent to surgical and medical treatment of certain minors. It states:

Whenever any minor who has been separated from the custody of his parent or guardian is in need of surgical or medical treatment, authority commensurate with that of a parent in like cases is conferred, for the purpose of giving consent to such surgical or medical treatment:

- Upon judges with respect to minors whose custody is within the control of their respective courts.
- Upon local directors of social services or their designees.
- Upon the Director of the Department of Corrections or the Director of the Department of Juvenile Justice or his designees with respect to any minor who is sentenced or committed to his custody.
- Upon the principal executive officers of state institutions with respect to the wards of such institutions.
- Upon the principal executive officer of any other institution or agency legally qualified to receive minors for care and maintenance separated from their parents or guardians, with respect to any minor whose custody is within the control of such institution or agency.
- Upon any person standing in loco parentis, or upon a conservator or custodian for his ward or other charge under disability.

Where the consent of a parent or guardian of a minor in need of surgical or medical treatment is unobtainable, authority commensurate with that of a parent is placed in judges of juvenile and domestic relations district courts.

Section 54.1-2969E details specific types of treatment for which any minor may self-consent. They are:

1. Medical or health services needed to determine the presence of or to treat venereal disease or any infectious or contagious disease that the State Board of Health requires to be reported;
2. Medical or health services required in case of birth control, pregnancy or family planning except for the purposes of sexual sterilization;
3. Medical or health services needed in the case of outpatient care, treatment or rehabilitation for substance abuse as defined in § 37.2-100; or
4. Medical or health services needed in the case of outpatient care, treatment or rehabilitation for mental illness or emotional disturbance.

A minor is deemed to be an adult for the purpose of consenting to medical or health services in the above four sub-categories. There is no minimum age of consent. According to Horshall, arguably

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<sup>130</sup> Ibid 42.

“family planning” includes counselling young LGBTQ young people about sexual orientation and gender identity, because intimate relationships are often integral to the building of families.<sup>131</sup>

Similar to New York’s emancipation doctrine, a minor who has been married is deemed to be an adult for the purpose of giving consent to surgical and medical treatment, save for a sterilisation procedure, and pregnant minors are deemed to be adults for the sole purpose of giving consent for surgical and medical treatment relating to the delivery of the child. The statute also provides that any minor 16 years of age or older may, with the consent of a parent or legal guardian, consent to donate blood.

The statute also contains an immunity from suit for medical service personnel in circumstances where a delay in providing medical or surgical treatment to a minor may adversely affect a minor’s recovery and no person authorised to consent to treatment for such minor is available within a reasonable time under the circumstances. However, in the case of a minor 14 years of age or older who is physically capable of giving consent, such consent is required to be obtained first.

## **Similarities and differences between North America and Australia**

Although it is difficult to generalise, in light of the foregoing analysis, some similarities and differences between Canada, the United States and Australia, can be observed in respect of medical treatment for young people generally (including refusal of medical treatment). The differences tend to outweigh the similarities. Given the lack of available relevant North American case law, it is not possible to compare Australia’s approach to the treatment of gender dysphoria in children and adolescents with that of Canada and the United States.

### **Similarities between North America and Australia**

#### ***The ‘mature minor’ doctrine and Gillick competence***

The first area of commonality between North America and Australia is the use of the ‘mature minor’, or *Gillick*, test in assessing capacity to consent to medical treatment. The ‘mature minor’ test that operates in North America usually arises in the context of statutory provisions concerning young people and consent to medical treatment. The test of *Gillick* competence however is one that was developed at common law in the United Kingdom and applied in that context by the Family Court of Australia. Nevertheless, at both statute (North America) and common law (Australia), the tests have similar features. These are, in effect, that the child or young person must fully understand the nature of the treatment proposed and fully understand the consequences of the procedure being performed; both potentially positive and negative.

#### ***Consent to treatment versus refusal of treatment***

The second area of commonality is the distinction drawn in both North America and Australia between consent to medical treatment and refusal of medical treatment, particularly where that treatment is potentially life-saving. It is apparent from decisions such as *Re Long Island Jewish Medical Centre* in New York, and the New South Wales Court of Appeal in *Re: X v The Sydney Children's Hospitals Network*,<sup>132</sup> which both involved 17 year olds who were members of the Jehovah’s Witness faith and who wished to refuse life-saving blood transfusions, that courts

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<sup>131</sup> Ibid.

<sup>132</sup> [2013] NSWCA 320.

proceed very cautiously in assessing competency where the consequence may be the death of a child. The decision of *Re Long Island Jewish Medical Centre* was discussed earlier in the paper. In *Re: X v The Sydney Children's Hospitals Network*, although the trial judge was satisfied in a general sense that the young person was capable of understanding and consenting to or withholding consent for a particular form of treatment, he nevertheless made orders sought by the treatment hospital that blood products be administered. Those orders were upheld on appeal as being within power, despite the trial judge's findings as to the young person's capacity. The Ontario decision of *Re: LDK* is one of the few that can be located where a young person's right to refuse consent to potentially life-saving medical treatment was upheld,<sup>133</sup> and even this decision is thought by some to have been influenced by the fact that the young person's chances of survival were only 30 per cent even if treatment were administered, and the side effects were severe.<sup>134</sup>

## Differences between North America and Australia

### *Statute versus common law*

Consent to medical treatment statutes appear to be commonplace in Canada and the United States, and represent the standard legal response to resolving issues associated with young people and consent to medical treatment. In Australia however, only two states have codified their law with respect to consent to medical treatment by young people and, self-evidently, there is no national consent to medical treatment statute in Australia. In Australia therefore, issues regarding young people's access to or refusal of medical treatment have, and continue to be, largely determined by reference to common law principles, rather than by statute. It is however recognised that North American courts have recourse to the common law 'mature minor' doctrine when resolving disputes about medical treatment which involves young people.

### *Decision making responsibility – medical versus legal*

Allied to the above, a significant area of difference between North America and Australia lies in who has responsibility for undertaking competency assessments: is it a medical process, or a legal process? In those North American jurisdictions surveyed, the decision is principally a medical one, in the sense that a young person's physician decides whether or not a young person has the capacity to choose or refuse medical treatment. In North America, courts and quasi-judicial bodies have residual jurisdiction in the event that there is a dispute about medical treatment or a challenge to a finding of capacity or incapacity,<sup>135</sup> and can also provide consent to medical treatment where a parent is unavailable to do so.<sup>136</sup> However, it is doctors, and not courts, who are vested with the primary decision making responsibility as to whether a young person is competent to consent to, or refuse, medical treatment. In Australia, at a Commonwealth level at least, *Re: Jamie* is authority for the proposition that competency assessments are to be undertaken by the Family Court and the decision therefore is a legal rather than a medical one. This is a likely explanation for why there is a comparative abundance of Australian decisions involving medical treatment for young people with gender dysphoria as compared with North America.

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<sup>133</sup> See also the decision of the Newfoundland Family Court in *Re Y. (A.)* (1993) 111 Nfld. & PEIR 91, where a similar decision was reached. See generally Susan Woolley, 'Children of Jehovah's Witnesses and adolescent Jehovah's Witnesses: what are their rights?' (2005) 90 *Archives of Disease in Childhood* 715 <<http://adc.bmj.com/content/90/7/715.full>> (accessed 21 August 2014).

<sup>134</sup> Above n 101, 146.

<sup>135</sup> For example, Ontario's Consent and Capacity Board.

<sup>136</sup> For example, section 54.1-2969 of the Code of Virginia.

### ***Age of consent***

In Canada and the United States, in those provinces and states that have enacted consent to medical treatment statutes that set an age of consent, it is usually no older than 16 years and sometimes younger – 12 and 14 years in some circumstances, depending upon what is being consented to. In Australia however, the Family Court’s ‘welfare’ jurisdiction can be attracted in respect of people until they turn the age of 18 years.<sup>137</sup> Many of the decisions of the Family Court, and particularly the more recent decisions, involved applications to Court in respect of adolescents aged 16 and 17 years.<sup>138</sup> In Australia therefore, the Commonwealth retains a major role in making treatment decisions for adolescents aged 16 years and older, where the treatment sought falls outside the types of procedures that parents can consent to, or where there is a dispute around medical treatment. Generally speaking, in Canada and the United States, adolescents aged 16 years and over are adults for the purpose of making decisions about medical treatment.

### ***Types of medical procedures and presumptive capacity***

In Canada and the United States, consent to medical treatment statutes tend to delineate the types of treatments young people can consent to themselves; usually in the areas of sexual and reproductive health, mental health, counselling and support, and drug and alcohol related issues. In certain jurisdictions, such as New York, a child must have reached a particular age before legally being able to self consent to defined types of treatment. However, Australia has tended not to particularise treatments that young people have the capacity to consent to, either by way of statute or at common law. As far as the Court’s jurisdiction under section 67ZC is concerned, there is no fixed category or type of treatment that requires court permission, although it is now clear that Stage 1 treatment for gender dysphoria is not a procedure requiring court authorisation. The two Australian states that have legislatively intervened in the medical consent arena have tended to legislate quite broadly, permitting young people over the age of 16 to make decisions about “medical treatment” or similar. The concept of presumptive capacity to consent, which applies in Ontario, is not one known to Australian law. Under the Family Law Act, the best interests of the child is the paramount consideration, recognising of course that the views of the child are given greater weight where a child is older and more mature.

### ***In loco parentis, emancipation and neglect***

Australian law makes limited provision for substituted decision making about medical treatment for young people, when a person other than a parent is seeking orders with respect to a child. As far as the Family Court is concerned, any person concerned with the care, welfare and development of a child can apply for a parenting order. In the ordinary course of events, that is not a difficult hurdle to navigate. However, where applications are brought under section 67ZC there are certain Constitutional requirements that must be met<sup>139</sup> that arguably make it more difficult for non-parents to apply for orders, even where the applicant is a government department and the child the subject of a guardianship order. These complexities are discussed in the decisions of Carter J in *Re: Brodie (Jurisdiction)* and Murphy J in *Re: Lucy*. In the overwhelming majority of cases decided under section 67ZC, the applicant was the parent. It is understood that there have only been two cases

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<sup>137</sup> *Re: Bernadette* (2011) FLC 93-463.

<sup>138</sup> *Re: O* (aged 16 at date of application); *Re: Rosie* (aged almost 17 at date of application); *Re: Alex* (aged over 17 at date of application for a double mastectomy); *Re: Sam & Terry* (aged 16 at date of application); *Re: Shane* (aged 16 at date of application); *Re: Spencer* (aged 16 at date of application).

<sup>139</sup> *Minister for Immigration and Multicultural and Indigenous Affairs v B and Anor* (2004) 219 CLR 365.

(*Re: Alex* and *Re: Lucy*) where the applicant was the relevant government department. Unlike the Code of Virginia, for example, the New South Wales and South Australian medical consent statutes do not make provision for categories of non parent persons who can consent on a child's behalf (including courts) or for people who can provide consent for treatment when a parent is unable to do so. Equally, the concepts of 'emancipation' and 'neglect', which exist in New York and California as vehicles to vest young people with decision-making autonomy, are not recognised in Australia.

### ***Human rights instruments***

The Canadian Charter of Rights and Freedoms and the United States Constitution<sup>140</sup> have assumed significance in litigation surrounding young people's decision-making autonomy. Australia has no such charter or bill of rights, with the result that the invocation of human rights norms in Australian decisions involving consent to medical treatment has been comparatively limited. It is possible to discern from the 2009 decision in *Re: Alex* and Bryant CJ's judgment in *Re: Jamie* that international human rights are assuming a greater role in decision making around medical treatment for young people. The AHRC, in its role as intervener in applications for authorisation to consent to medical treatment, has made an important contribution in this regard.

## **Would having a human rights instrument have made a difference to the outcome in *Re: Jamie*?**

Based on some of the Canadian and American decisions, and having regard to litigation around *Gillick* competence in the United Kingdom, which also has a Human Rights Act, it is at least arguable that the Full Court in *Re: Jamie* could have found that Stage 2 treatment for gender dysphoria was not a procedure requiring Court authorisation if Australia had a human rights instrument. This would be particularly so if such an instrument contained articles directed towards concepts such as the right to liberty and security of the person, the right of identity, the right to autonomy and personal legal rights, and the right to equal protection and equal benefit of the law.

That is not necessarily because these rights have been given precedence in litigation around young people and medical treatment in those jurisdictions that have a bill or charter or rights, but more because of the significance rights-based arguments assume in proceedings involving medical treatment for young people. The fact that treatment for gender dysphoria involves positive consent to medical treatment, rather than refusal of potentially life-saving medical treatment, which seems to be a significant point of departure as far as findings about decision-making capacity are concerned, is also a salient factor. Some of the more significant decisions from Canada, the United States and the United Kingdom, decided by reference to human rights instruments, are discussed below.

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<sup>140</sup> See for example the United States Supreme Court's decision in *Roper v Simmons* (2005) 543 US 551. One academic commentator argues that "[a] careful, context-specific analysis of the adolescent characteristics identified by the *Roper* Court shows that, rather than positing a conceptual barrier, the decision supports a presumption in favor of allowing transgender youth to obtain hormones without parental consent." See Maureen Carroll, 'Transgender Youth, Adolescent Decision Making, and *Roper v Simmons*' (2009) 56 *University of California, Los Angeles Law Review* 725.

## Relevant decisions from Canada

In *B. (R.) v. Children's Aid Society of Metropolitan Toronto*,<sup>141</sup> the Supreme Court of Canada heard an appeal from a decision of the Ontario Court of Appeal. The subject matter of the appeal involved a wardship order that had been made in respect of a young child who had exhibited many physical ailments and received a number of medical treatments. Prior to the wardship order being made, the child's treating physicians had avoided the use of a blood transfusion because the child's parents were Jehovah's Witnesses. Upon the wardship order being made under the Ontario *Child Welfare Act*, the child received a blood transfusion. The appellants, the child's parents, asserted that the *Child Welfare Act* infringed article 7 of the Canadian Charter of Human Rights and Freedoms because it, inter alia, denied them the right to choose medical treatment for their child. The Supreme Court of Canada dismissed the appeal.

La Forest, L'Heureux-Dubé, Gonthier and McLachlin JJ found that the liberty protected by s 7 of the Charter did not mean unconstrained freedom. Their Honours said that the state undoubtedly had the right to impose many types of restraints on individual behaviour, and not all limitations would attract Charter rights.

Significantly however, their Honours went on to say (emphasis added):<sup>142</sup>

On the other hand, liberty does not mean mere freedom from physical restraint. **In a free and democratic society, the individual must be left room for personal autonomy to live his or her own life and to make decisions that are of fundamental personal importance.**

The right to nurture a child, to care for its development, and to make decisions for it in fundamental matters such as medical care, are part of the liberty interest of a parent. The common law has long recognized that parents are in the best position to take care of their children and make all the decisions necessary to ensure their well-being. This recognition was based on the presumption that parents act in the best interest of their child. Although the philosophy underlying state intervention has changed over time, most contemporary statutes dealing with child protection matters, and in particular the Ontario Act, while focusing on the best interest of the child, favour minimal intervention. In recent years, courts have expressed some reluctance to interfere with parental rights, and state intervention has been tolerated only when necessity was demonstrated, **thereby confirming that the parental interest in bringing up, nurturing and caring for a child, including medical care and moral upbringing, is an individual interest of fundamental importance to our society.**

The decision of the Supreme Court of Canada in *AC v Manitoba (Director of Child and Family Services)*<sup>143</sup> is also of considerable significance. It was referred to by the New South Wales Court of Appeal in *X v Sydney Children's Hospital Networks*, referred to earlier. The following discussion is taken from that judgment:<sup>144</sup>

42 Finally, it is helpful to refer to the judgment of the Supreme Court of Canada in *AC v Manitoba (Director of Child and Family Services)* 2000 SCC 30; [2009] 2 SCR 181. The principal judgment was delivered by Abella J (for Le Bel, Deschamps, Charron JJ and herself). The applicant,

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<sup>141</sup> [1995] 1 SCR 315.

<sup>142</sup> *Ibid* 317-318.

<sup>143</sup> [2009] 2 SCR 181.

<sup>144</sup> [2013] NSWCA 320 [42]-[46].

AC, was 14 years and 10 months when she was admitted to hospital suffering lower gastro-intestinal bleeding as a result of Crohn's disease. As a Jehovah's Witness, she refused blood transfusions under any circumstances. A court order was requested under the Manitoba Child and Family Services Act...

...

43 A transfusion was ordered and AC recovered: [13]. However, AC and her parents complained that the order should not have been made because s 25(8) only applied to minors under 16 without capacity and, alternatively, that those provisions were unconstitutional as unjustifiably infringing AC's rights under the Charter of Rights and Freedoms.

44 The applicant was unsuccessful on both issues, but for reasons which are not presently significant. However, in construing the legislation and considering the justification for such provisions under the Charter, Abella J discussed a number of matters concerning common law principles.

45 After referring to *Gillick* and *Re W*, Abella J noted that the English Court of Appeal had "definitively established that even 'mature minors' were subject to the court's inherent *parens patriae* jurisdiction": at [54]. She also stated, in a passage not challenged in this Court, that "[t]o date, no court in the United Kingdom has allowed a child under 16 to **refuse medical treatment that was likely to preserve the child's prospects of a normal and healthy future**, either on the ground that the competence threshold had not been met ... or because the court concluded that it had the power to override the wishes of even a '*Gillick*-competent' child": at [57]. Further, the reasons, at [58], adopted a passage from the judgment of Kerans JA in *JSC v Wren* (1986) 76 AR 115 (CA) in respect of a 16 year old girl who had received medical approval for a therapeutic abortion, but whose parents sought to assert their rights of veto until she reached majority at the age of 18:

"Parental rights (and obligations) clearly do exist and they do not wholly disappear until the age of majority. The modern law, however, is that the courts will exercise increasing restraint in that regard as a child grows to and through adolescence."

46 After reviewing the law in other jurisdictions (including reference to *Marion's case*) Abella J concluded:

"[66] Individual states have approached the issue of adolescent decision-making in various ways, some enacting statutory exceptions to the default presumption of incapacity, and some embracing the common law 'mature minor' doctrine to varying degrees. As in the UK and Canada, no state court has gone so far as to suggest that the 'mature minor' doctrine effectively 'reclassifies' mature adolescents as adults for medical treatment purposes. ...

[69] What is clear from the above survey of Canadian and international jurisprudence is that while courts have readily embraced the concept of granting adolescents a degree of autonomy that is reflective of their evolving maturity, they have generally not seen the 'mature minor' doctrine as dictating guaranteed outcomes, **particularly where the consequences for the young person are catastrophic.**"

Binnie J was in dissent and found the provincial Act to be unconstitutional. Binnie J said, in summary (emphasis added):<sup>145</sup>

**In my opinion the deprivation of liberty or security of the person does not accord with the principles of fundamental justice where the only justification advanced for the deprivation, namely the incapacity of the young person, has been accepted by the applications judge not to exist.**

...

**[S]trong as is society's belief in the sanctity of life, it is equally fundamental that every competent individual is entitled to autonomy to choose or not to choose medical treatment except as that autonomy may be limited or prescribed within the framework of the Constitution. The rights under s. 2 (a) of the Charter (religious freedom) and s. 7 (liberty and security of the person) are given to everyone, including individuals under 16 years old.**

The New South Wales Court of Appeal in *X & Sydney Hospital Networks*<sup>146</sup> said that the Charter cases in Canada, as well as the constitutional cases in the United States of America and other countries with constitutional provisions similar to the United States' Bill of Rights, are "instructive" on the issue of balancing fundamental human rights principles. The New South Wales Court of Appeal quoted from the Ontario Court of Appeal decision in *Malette v Shulman*,<sup>147</sup> which involved an adult Jehovah's Witness who arrived at hospital unconscious but with a signed medical alert card stating that no blood should be administered under any circumstances. The emergency doctor gave blood, and was sued for battery. In addressing the conflicting values, the Court stated:<sup>148</sup>

The state's interest in preserving the life or health of a competent patient must generally give way to the patient's stronger interest in directing the course of her own life .... Recognition of the right to reject medical treatment cannot ... be said to depreciate the interest of the state in life or in the sanctity of life. Individual free choice and self-determination are themselves fundamental constituents of life. To deny individuals' freedom of choice with respect to their health care can only lessen, and not enhance, the value of life.

Having regard to certain of the comments made by the majority in *B. (R.) v. Children's Aid Society of Metropolitan Toronto* about the importance under the Canadian charter of "personal autonomy" and the ability to make decisions "of fundamental personal importance", those of Abella J in *AC v Manitoba (Director of Child and Family Services)* about the diminishing role of courts in making decisions about medical treatment for adolescents, and the Ontario Court of Appeal's comments about free choice as a "fundamental constituent of life", it is conceivable that the outcome in *Re: Jamie* may well have been different if Australia had a human rights charter. For example, the Full Court could have found that, as the consequences of Jamie receiving Stage 2 treatment were not "catastrophic", court authorisation was not required. Indubitably, if Australia had a human rights charter and an interpretation similar to that of Binnie J's was placed on the charter, not only would the Full Court would in all likelihood have found that court authorisation for Stage 2 treatment was

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<sup>145</sup> [2009] 2 SCR 181 at [175], [192].

<sup>146</sup> [2013] NSWCA 320 at [58].

<sup>147</sup> (1990) 72 OR (2d) 417.

<sup>148</sup> *Ibid* at [429f].

not required, but also that the Court had no residual jurisdiction following a finding of *Gillick* competency.

## Relevant decisions from the United States

Writing in 2005, Beh and Diamond stated that “[A]lthough no published cases have considered the appropriateness of hormonal injections, there have been surprising glimmers of such understanding in judicial decisions in the United States considering “real life” treatment of adolescent GID [gender identity disorder]”.<sup>149</sup> The cases referred to by Beh and Diamond are centred around ‘due process’ violations and constitutional breaches on the grounds of discrimination.

The first case was *Doe & Yuntis*.<sup>150</sup> A school district code prevented Pat Doe, a biological male, from wearing female clothing or accessories to school. Doe challenged the dress code, claiming it constituted discrimination on the basis of disability under the Massachusetts Constitution. The court concluded that gender identity disorder constituted a handicap. The court refused to dismiss Doe’s claim, as sought by the school, and in so doing noted that expert testimony supported Doe’s allegation that requiring him to wear boy’s clothing would be “injurious to her psychiatric health”.

The second case was *Doe & Bell*.<sup>151</sup> Doe was a 17 year old diagnosed with gender identity disorder who resided in foster care in New York State. Doe’s treatment plan involved her wearing girl’s clothing, accessories and makeup, and other items to make her look more feminine. Ostensibly for behavioural reasons, Doe was placed in an all-male facility, where she was not permitted to wear female attire. At issue was whether the administration had discriminated against Doe, in breach of New York State Human Rights Law. The court found that Doe suffered a disability, defined under statute as including any “medically diagnosable impairment”. The court rejected the administration’s argument that permitting Doe to wear feminine clothing would “jeopardise the safety of the residents and staff” and “threaten the safety and security of the institution”. The court found that the authority had an obligation to comply with the Human Rights Law mandate to provide reasonable accommodation to people with disabilities.

Beh and Diamond concluded that although “[n]either of these cases involved a discussion of medical interventions, in each case the court supported and protected an adolescent implementing a psychiatrically approved real life plan.”

It is difficult to draw conclusions from the United States decisions involving young people with gender identity dysphoria. Although adolescents’ rights to live in their affirmed gender have been upheld, this has largely been secured by reference to disability discrimination laws. As discussed below, Australia is a signatory to the CRPD and has anti-discrimination statutes in place on a national level that includes discrimination on the basis of sex, gender and gender identity, and similarly in some states. Therefore, having regard to Australian anti-discrimination law, it is likely that there would be a similar outcome. The United States’ and Australia’s treatment of gender dysphoria as a medical condition is also an approach that both jurisdiction share.

Although it is not a decision involving transgender young people, academic commentator Carroll argued that the United States Supreme Court’s decision in *Roper & Simmons*, which invalidated the

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<sup>149</sup> Above n 40, 272.

<sup>150</sup> 15 Mass L Rep 278.

<sup>151</sup> 754 NYS 2d 846.

juvenile death penalty, supported a presumption in favour of allowing transgender youth to obtain hormones without parental consent.<sup>152</sup> Carroll's argument proceeded on the basis that the *Roper* Court identified three general characteristics associated with adolescent decision making: impulsivity, susceptibility and incomplete character formulation. Applying these characteristics as they pertain to the legal capacity of transgender youth to consent to hormone treatment, Carroll postulated that:

- The *Roper* Court noted that adolescents more often exhibit “a lack of maturity and an underdeveloped sense of responsibility”, which results in “impetuous and ill-considered actions and decisions”. In the case of transgender youth, because hormones can only be legally obtained through consultation with a medical professional in a more organised, formal and monitored environment, and because informed consent is a pre-condition, the medical decision-making environment guards against impulsive decision making. Carroll asserted that the delay between the decision to seek hormones and their eventual attainment was a further relevant consideration.
- Transgender youth face sustained and extraordinary pressure (from peers, adults and institutions) to conform to the gender traditionally associated with their birth-assigned sex. By presenting a nonconforming gender in the face of massive pressure not to do so, transgender youth exhibit the ability to make decisions that do not depend on peer approval.
- The *Roper* Court said that, in a juvenile justice context, adolescents' incomplete character formation suggests they would be more responsive to rehabilitation later in life. In the context of transgender youth's access to hormones, the question arises as to the risk of reverting to their birth-assigned sex later in life. Carroll maintained that research suggests that very few transgender youth identify with their birth-sex later in life and thus impeding access to hormones out of concern about incomplete character formation would do more harm than good. Carroll also argued that denying access to hormones would restrict adolescents' ability to express their identity, which impedes character development, whereas granting access would facilitate that development.

## Relevant decisions from the United Kingdom

The United Kingdom too has enacted a human rights statute, the *Human Rights Act 1998* (UK), and there have been decisions concerning young people's consent to medical treatment as viewed through the prism of both *Gillick* competence and the rights enshrined under the United Kingdom Act. Bryant CJ discussed these in her paper ‘It's My Body, Isn't It: Children, Medical Treatment and Human Rights’.<sup>153</sup> The following is extracted from that paper.

It is instructive to compare the way the Family Court of Australia treats the issue of a child's *Gillick* competence with that of family courts in Britain, where a Human Rights Act is in force. My interest lies in determining whether and to what extent the Human Rights Act has been relied upon to imbue *Gillick* with new meaning.

The *Human Rights Act 1998* (UK) was enacted “to give further effect to rights and freedoms guaranteed under the European Convention on Human Rights”. The articles of the European Convention on Human Rights and Fundamental Freedoms form a schedule to the Human Rights Act

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<sup>152</sup> Carroll, above n 140.

<sup>153</sup> Diana Bryant, ‘It's My Body, Isn't It: Children, Medical Treatment and Human Rights’ (2009) 35 *Monash University Law Review* 193, 202-206.

and are protected rights under the Human Rights Act. Rights are enforceable against public authorities and all public authorities must act in a way that is compatible with those rights unless required to do so by other legislation. The Human Rights Act also provides, in section 3, that where possible, all legislation is to be interpreted in accord with Convention rights. As far as children and medical treatment is concerned, the preponderance of the litigation has involved Article 8. Article 8 states:

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

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

The post-*Gillick* but pre-Human Rights Act jurisprudence on children and medical treatment has been controversial. Two decisions of the United Kingdom's Court of Appeal in particular were criticised as a 'retreat' from *Gillick*. Interestingly, both cases, *Re: R* and *Re: W*, were heard and determined without any reference to European Convention rights, Strasbourg jurisprudence or UNCROC.

*Re: R (a Minor (Wardship: Medical Treatment))* concerned a 15 year old girl who had been placed in a psychiatric unit and where it had been decided she ought to be treated with anti-psychotic drugs. R refused this course of treatment and the local authority instituted wardship proceedings. The Court of Appeal held that R was not *Gillick* competent because she did not have a full understanding of the nature of the proposed treatment, nor a full understanding of the consequences of the treatment or of failing to administer treatment.

...

*Re: W* involved a 16 year old girl (who was thus competent to consent to medical treatment by virtue of section 8 of the Family Law Reform Act 1969) who suffered from anorexia nervosa. Her parents were deceased and she was in the care of the local authority. When her condition deteriorated, the local authority sought to transfer her to a facility specialising in eating disorders, where treatment would be administered against her wishes, including artificial feeding. W resisted the application on the basis that section 8 of the Family Law Reform Act conferred on her the same rights as an adult to refuse medical treatment. The Court of Appeal disagreed. Lord Justice Balcolme found that the Court should not "lightly" override the decision of a minor of sufficient age and understanding to make an informed decision. Nevertheless, where in the court's view the child's wishes are in conflict with his or her best interests, the child's wishes may be overridden.

...

This line of reasoning continued in subsequent cases, whereby a 15 year old Jehovah's Witnesses was compelled to undergo blood transfusions she described as being "like rape", a heart transplant was ordered to be performed against her wishes on a 15 year old girl who was found to be clearly *Gillick* competent, and where a hospital was granted leave to administer blood products to an almost 17 year old male who was a committed Jehovah's Witness. There was no reference to the European Convention on Human Rights and Freedoms or UNCROC in these decisions.

Academic Michael Freeman concluded his analysis of these cases with the following statement:

The law clearly now discriminates and does so on the grounds of age when the clear intention of the highest court in *Gillick* was to adopt a functional, rather than a status based approach. An elderly schizophrenic in Broadmoor can refuse treatment: an intelligent 15 year old girl cannot.

### ***Post Human Rights Act litigation – Axon and the reinvigoration of Gillick***

...

As noted rights theorist Jane Fortin has observed, many of the human rights embodied in the European Convention on Human Rights, and therefore in the *Human Rights Act 1998* (UK), reflect a belief in liberty and autonomy. On this basis, a reappraisal of the protective approach adopted by the Court of Appeal in *Re: R* and *Re: W* may be warranted.

That ‘reappraisal’ has emerged in the shape of the decision in *Re: Axon*, the first post Human Rights Act reassessment of *Gillick*.

The facts of *Axon* are strikingly similar to those in *Gillick*. Mrs Axon sought to attack, by judicial review, some best practice guidelines developed for use by doctors in providing advice and treatment for young people on contraception, sexual and reproductive health. Mrs Axon contended that the guidelines were unlawful in excluding parents from decision making about their children’s lives and, significantly, the guidelines breached parents’ Article 8 Convention rights to privacy of family life. The tension between a child’s Article 8 right to autonomy and privacy and a parent’s Article 8 right to family life, including the obligation to make decisions in the best interests of their children, was at the crux of the dispute. Ms Axon argued in effect that the duty of confidentiality owed by doctors to their patients, including minors, was limited: parents can only discharge their obligations as parents if they have information available to them to do it.

...

Mrs Axon asserted that the best practice guidelines were a “plain interference” with parents’ right to respect for family life and parental rights under Article 8 of the European Convention. Silber J rejected this argument. He distinguished *Neilson* (which Mrs Axon cited in support of her application) on the basis that it was concerned with Article 5 rights and not with any alleged parental right to be informed of medical advice or treatment sought by a child. Silber J’s conclusions on the asserted Article 8 right to exercise parental rights were fortified by reference to the *Gillick* principle. He concluded:

[A]ny right to family life on the part of a parent dwindles as their child gets older and is able to understand the consequence of different choices and then to make decisions relating to them. ... As a matter of principle, it is difficult to see why a parent should still retain an article 8 right to parental authority relating to a medical decision where the young person concerned understands the advice provided by the medical professional and its implications.

Silber J again referred to *Gillick* in his consideration of the Strasbourg jurisprudence, which he found did not confer any right of parental power or control through Article 8 that was broader than that conferred by domestic law. He quoted the words of Lord Scarman as describing the parameters of parental rights as existing “primarily to enable the parent to discharge his duty of maintenance, protection and education until he reaches such an age as to be able to look after himself and make his own decisions.”

...

Silber J quoted with approval from Lord Justice Thorpe’s decision in *Mabon*, which concerned the right of children to instruct their own counsel in private family law proceedings, where his Honour said: “Unless we in this jurisdiction are to fall out of step with similar societies as they safeguard Article 12 rights, we must, in the case of articulate teenagers, accept that the right to freedom of expression and participation outweighs the paternalistic judgment of welfare.”

Silber J concluded “the right of young people to make decisions about their own lives by themselves at the expense of the views of their parents has now become an increasingly important and accepted feature of family life.”

*Axon* is authority for the proposition that if a human rights act were in existence in Australia, which contained rights similar to those in Article 8 of the European Convention (which in turn is a Schedule to the United Kingdom’s Human Rights Act), and if the Full Court interpreted those rights in the same way as Silber J, in all likelihood it would have arrived at the conclusion that court authorisation for Stage 2 treatment for gender identity dysphoria was not required. However, Silber J did not go as far as Binnie J in *AC & Manitoba*, and so in reliance on *Axon* the Full Court could have found that the Family Court retained its jurisdiction with respect to decision-making around medical treatment for *Gillick*-competent young people in certain circumstances; particularly in cases involving refusal of life-saving medical treatment.

## **Current human rights protections for transgender young people in Australia**

It should however be remembered that although the Australian Constitution contains few explicit rights protections and that Australia does not have a bill of rights, human rights charter or equivalent, that does not mean that there is no human rights protection for transgender people, including young people.

High Court of Australia authority provides that statutes should be interpreted in a manner consistent with international conventions to which Australia is a signatory, which includes UNCROC and the CRPD.<sup>154</sup> The Family Law Act was amended in 2011, effective as of 7 June 2012, to provide that an additional object of Part VII of the Act, which concerns children, is to “give effect to the Convention on the Rights of the Child.”<sup>155</sup> As stated by Bryant CJ in her judgment in *Re: Jamie*, Articles 5 and 12 of UNCROC are apposite to the question of *Gillick* competence.

The Australian Government is required to provide statements of compatibility with human rights for all new bills and disallowable legislative instruments.<sup>156</sup> This scrutiny process is designed to encourage early and ongoing consideration of human rights issues in policy and legislative development. It also aims to improve parliamentary scrutiny of new laws for consistency with rights and freedoms in the seven core human rights treaties to which Australia is a party.<sup>157</sup>

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<sup>154</sup> *Minister for Ethnic Affairs v Teoh* (1995) 183 CLR 273.

<sup>155</sup> *Family Law Legislation Amendment (Family Violence and Other Measures) Act 2011* (Cth), s 13.

<sup>156</sup> *Human Rights (Parliamentary Scrutiny) Act 2011* (Cth).

<sup>157</sup> They are:

International Covenant on Civil and Political Rights (ICCPR)

International Covenant on Economic, Social and Cultural Rights (ICESCR)

Convention on the Rights of the Child (CRC)

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

Convention on the Rights of Persons with Disabilities (CRPD)

Convention on the Elimination of All Forms of Racial Discrimination (CERD)

Convention against Torture (CAT)

One Australian state, Victoria,<sup>158</sup> and one territory, the Australian Capital Territory,<sup>159</sup> have human rights charters. In Victoria, the overriding purpose of the Charter is to require the Victorian Government, public servants, local councils, Victoria Police and other public authorities to act compatibly with human rights, and to consider human rights when developing policies, making laws, delivering services and making decisions. However, unlike human rights acts and charters in jurisdictions such as Canada and the United Kingdom, rights are not actionable as such. The role of the Supreme Court of Victoria is limited to issuing a declaration of inconsistent interpretation.

The AHRC was established in 1986. The functions of the AHRC are to:<sup>160</sup>

- resolve complaints of discrimination or breaches of human rights under federal laws
- hold public inquiries into human rights issues of national importance
- develop human rights education programs and resources for schools, workplaces and the community
- provide independent legal advice to assist courts in cases that involve human rights principles
- provide advice and submissions to parliaments and governments to develop laws, policies and programs
- undertake and coordinate research into human rights and discrimination issues.

The AHRC administers federal anti-discrimination legislation including the *Sex Discrimination Act 1984* (Cth), the *Disability Discrimination Act 1992* (Cth) and the *Age Discrimination Act 2004* (Cth). Both UNCROC and the CRPD are ‘declared instruments’ under the *Australian Human Rights Commission Act 1986* (Cth). This means that the AHRC is able to conciliate complaints about acts or practices of the federal government which breach the rights in both treaties. The office of the National Children’s Commissioner was established as part of the AHRC in 2013.

In 2008-9, the AHRC undertook a sex and gender diversity project. This culminated in the report *Sex Files: the Legal Recognition of Sex in Documents and Government Records*. In 2010 the AHRC conducted a consultation to canvas the experiences and views of people who may have been discriminated against on the basis of their sexual orientation and sex and/or gender identity. A report, entitled *Addressing Sexual Orientation and Sex and/or Gender Identity Discrimination*, was released following the consultation process.<sup>161</sup> These projects, and the recommendations contained in the reports produced as a result, led to two important developments. First, as referred to in Bryant CJ’s judgment in *Re: Jamie*, the *Sex Discrimination Act 2004* (Cth) was amended by the *Sex Discrimination (Sexual Orientation, Gender Identity and Intersex Status) Act 2013* (Cth) to make it unlawful to discriminate on the basis of sexual orientation, gender identity and intersex status under federal law.<sup>162</sup> Secondly, in July 2013 the Australian government released guidelines on the recognition of sex and gender. The introduction to those guidelines states:<sup>163</sup>

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<sup>158</sup> *Charter of Human Rights and Responsibilities Act 2006* (Vic).

<sup>159</sup> *Human Rights Act 2004* (ACT).

<sup>160</sup> *Australian Human Rights Commission Act 1986* (Cth), s 11.

<sup>161</sup> See <<https://www.humanrights.gov.au/lesbian-gay-bisexual-trans-and-intersex-equality>> (accessed 3 September 2014).

<sup>162</sup> The three Canadian provinces and the two states of the United States discussed for comparative purposes also have laws in place that prohibit discrimination. However, it appears that only Ontario and California recognize gender identity as a ‘protected attribute’ against which discrimination is unlawful. New York and British Columbia prohibit discrimination on the grounds of sexual orientation but not gender identity, and Virginia does not prohibit

The Australian Government recognises that individuals may identify and be recognised within the community as a gender other than the sex they were assigned at birth or during infancy or as an indeterminate sex and/or gender, and this should be recognised and reflected in their personal records held by Australian Government departments and agencies. Increased consistency in the way the Australian Government collects and records sex and gender will strengthen Australia's identity security system, the integrity of agency records and the accuracy of individual personal records, in line with the Australian Government's approach to identity security.

A recent decision of the High Court of Australia held that the *Births, Deaths and Marriages Registration Act 1995* (NSW) permitted the Registrar to register a person's sex as "non-specific".<sup>164</sup> Norrie, who had undergone a "sex affirmation procedure", applied to the Registrar under the Act to register both a change of sex to "non-specific" and a change of name. The Registrar issued Norrie a Change of Sex certificate and a Change of Name certificate, both of which recorded Norrie's sex as "not specified". Later, the Registrar advised Norrie that the Change of Sex certificate was invalid, and re-issued a Change of Name certificate that recorded Norrie's sex as "not stated".

Norrie lodged an application for review of the Registrar's decision in the New South Wales Administrative Decisions Tribunal. The Tribunal rejected Norrie's application, holding that it was not open to the Registrar to record Norrie's sex as "non-specific". The appeal panel of the Tribunal dismissed an appeal against that decision. Norrie's appeal to the Court of Appeal was upheld.

By special leave, the Registrar appealed to the High Court of Australia. The issue was whether it was within the Registrar's power to record the sex of a person as "non-specific". The High Court of Australia decided that the Act recognised that a person may be neither male nor female and so permits the registration of a person's sex as "non-specific".

A recent article concerning the High Court of Australia's decision in *Norrie* described it as one which is quite narrow in its practical application, yet is "momentous" in opening up debate in legal discourse about redefining sex and gender.<sup>165</sup>

## What does the future hold?

Having regard to *Re: Alex*, the first instance decisions following *Re: Alex*, the Full Court's decision in *Re: Jamie*, and statute and case law in international jurisdictions, it is apparent Australia is a leader in the development of the law surrounding medical treatment for young people with gender dysphoria. *Re: Jamie* is however 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. *Re: Jamie* is likely to act as a spur for further proceedings being initiated which challenge the boundaries of the current state of the law governing young people and medical treatment. Accordingly, there is every reason for

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discrimination on the basis of either. The New York State Assembly has passed the Gender Expression Non Discrimination Bill seven times since 2007 but it has not come on for a vote in the Senate.

<sup>163</sup> *Australian Government Guidelines on the Recognition of Sex and Gender*, Commonwealth of Australia, July 2013, 2 <<http://www.ag.gov.au/Publications/Pages/AustralianGovernmentGuidelinesontheRecognitionofSexandGender.aspx>> (accessed 3 September 2014).

<sup>164</sup> *NSW Registrar of Births, Deaths and Marriages v Norrie* (2014) 88 ALJR 506. The High Court of Australia's judgment summary can be found at <<http://www.hcourt.gov.au/publications/judgment-summaries/2014-judgment-summaries>> (accessed 3 September 2014).

<sup>165</sup> Aileen Kennedy, 'Gender Identity: Reassessing the Definition of Sex and Gender' (2013) 38 *Alternative Law Journal* 186.

confidence that the jurisprudence will develop further, and develop rapidly, following *Re: Jamie*. The following are issues that may present themselves for judicial consideration.

### **Enactment of ‘consent to medical treatment’ statutes**

Shield argued that “[l]egislation is the optimal solution to transgender adolescents’ current difficulties in obtain sex reassignment treatment.” Shield went on to say that, in the North American context at least, “our current piecemeal approach to establishing exceptions to the informed consent law is confusing to doctors, judges, and minors alike.”<sup>166</sup> That raises the issue of whether there is a realistic prospect of a national ‘consent to medical treatment’ statute being enacted in Australia and what such a statute might contain.

There would be Constitutional hurdles to overcome if a national statute was contemplated, as there is no obvious head of power under the Constitution that would permit the Commonwealth to trespass into an area that is the province of the states. A condition precedent to a national statute would likely be the states agreeing to refer their powers with respect to decision-making about medical treatment for young people to the Commonwealth. In the family law jurisdiction, this has occurred with respect to ex nuptial children and proceedings arising from the breakdown of a de facto relationship.

In the absence of a national consent to medical treatment act, another possibility is that those states and territories that have yet to enact consent to medical treatment legislation (being those states and territories other than New South Wales and South Australia) might move to do so, either on a collective or individual basis. Thus it is conceivable that model laws around medical treatment could be developed through the Standing Committee on Law and Justice, of which all states and territories are members, and enacted. This has already occurred in areas including tort law reform and succession laws. Having regard to consent to medical treatment statutes that already exist in Australia, and those that are in force in Canada, the United States and the United Kingdom, were that to take place at either a national or an expanded state level, 16 years is the likely age at which young people would be legally able to make their own decisions about medical treatment, both positively (consent to) and negatively (refusal of). There would appear to be little reason to think that even if Australia were to move towards a statutory model, a more permissive system of presumptive capacity, such as that which exists in Ontario, would be adopted.

As Shield rightly pointed out, legislation could take a variety of forms. First, the ‘mature minor’ doctrine, or conditions precedent to being found to be *Gillick* competent, could be enshrined in statute. Shield stated that “[c]odification of the ‘mature minor’ doctrine would allow all minors who demonstrate that they understand the risks and consequences of their actions or otherwise to demonstrate a capacity for adult judgments to make their own medical decisions.”<sup>167</sup> Secondly, a specific exception to the informed consent law for transgender youth could be established. Shield wrote that this would reflect the fact that adolescents in such circumstances have both a greater capacity and need to make decisions than other adolescents without similar experience would. Shield’s observation accords with comments made by Bryant CJ in *Re Jamie* in her refutation of the argument that there exists a particular class of treatment that disentitles autonomous decision-making by a child. Bryant CJ said that “treatment for something as personal and essential as the

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<sup>166</sup> Above n 117, 165.

<sup>167</sup> Ibid 166.

perception of one's gender and sexuality would be the very exemplar of where the rights of a *Gillick*-competent child should be given full effect.”

The third possibility Shield suggested was to allow a third party to ascertain a minor's ability to consent, or to consent on the minor's behalf. *Re: Jamie* already stands for the proposition that responsibility for deciding whether or not a child is legally competent to consent to Stage 2 treatment lies with the Family Court. The Court also has a role in deciding whether Stage 1 and/or Stage 2 treatment should be authorised in circumstances where there is disagreement between a child, his or her parents or his or her doctors. Although enacting legislation to circumscribe the Family Court's role in making decisions about medical treatment for young people may provide greater certainty, it also has the potential to reduce flexibility and discretion in the application of legal principle and retard the development of the law in this dynamic area.

Shield also proposed a system of surrogate decision makers who could consent to medical treatment on a minor's behalf. As early discussed, surrogate decision making is not a concept known to Australia's private family law jurisdiction and it would therefore be surprising if any legislative intervention in the area of consent to medical treatment was so orientated. Australia can also be distinguished from the United States on the basis that although independent children's lawyers, where appointed, are not child-advocates as such, and cannot make decisions on a child's behalf, they nevertheless play an important role in putting evidence before the court as to what orders would be in a child's best interests.<sup>168</sup> Invariably in proceedings for authorisation to undertake medical treatment (and seemingly also in applications for declarations of competency), that includes evidence of the child or young person's wishes.

### **Reconsideration of the *Re: Marion* guidelines**

In the event that an order providing for consent to perform medical treatment (ideally in the context of an application for Stage 2 treatment of gender dysphoria) was appealed to the High Court of Australia, it would fall to the High Court to consider whether *Re: Marion* remains good law. This presumably would also involve consideration of the extent to which particular medical procedures require curial authorisation, other than those involving the sterilisation of a young person with an intellectual disability for a non-therapeutic purpose. Some commentators have argued that the *Re: Marion* guidelines were developed specifically in the context of intellectual disability and on that basis, appear to be suggesting that consent to medical procedures to be performed on young people who do not have an intellectual disability falls within the exercise of parental responsibility, and/or that assessments of *Gillick* competence do not need to be undertaken by courts.<sup>169</sup> It would be extremely useful for the High Court of Australia to consider that issue, and those related to it, particularly in light of the developments that have occurred in medical treatment of certain conditions (including gender dysphoria) since *Re: Marion* was decided. It is recognised however that unless pro bono legal assistance was procured, as it was in *Re: Jamie*, the cost of pursuing an appeal to the High Court of Australia would be prohibitive.

### **The role of the Family Court of Australia**

The Family Court's role in hearing and determining applications for consent to medical treatment has been relatively fluid, insofar as the types of conditions which attract the court's supervisory

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<sup>168</sup> *Family Law Act 1975* (Cth), s 68LA.

<sup>169</sup> See for example Dr Malcolm K Smith, 'Health and Guardianship Law' (2013) 33 *Queensland Lawyer* 182, 187.

jurisdiction have been broad and undefined. As a result of *Re: Jamie* however, it is clear that *Gillick* competent children and young people, or the parents of non-*Gillick* competent children, can consent to Stage 1 treatment for gender dysphoria. This represents a considerable advance from *Re: Alex*, where Nicholson CJ said he doubted that a young person (or at least a person aged 13 years) would ever be competent to consent to treatment for that condition.

It is conceivable — particularly if gender dysphoria was no longer included in the DSM as a psychiatric condition — that a judge could decide that the Court's consent to Stage 2 treatment was unnecessary. Finn J and Strickland J's judgments in *Re: Jamie* confirm that Stage 2 treatment is therapeutic but that fact alone is not determinative of the outcome. As Brennan J said in *Re: Marion*, an assessment of proportionality is also required. Thus, unless *Re: Jamie* was overturned or distinguished, a single judge would need to find that the risks involved in undertaking the treatment, and the consequences of undertaking the treatment, were outweighed by the treatment's therapeutic benefit. The Full Court's reasoning in *Re: Jamie* suggests that such a finding would be more likely to occur where there was evidence that the irreversible effects of cross-hormone treatment could be mitigated, as the reversibility of Stage 2 treatment, or lack thereof, was given particular prominence in each of the three judgments.

As of May 2014 there had been several applications filed in the Family Court of Australia for a declaration that a young person was competent to consent to their own medical treatment. One judgment has been delivered in respect of such an application, being that of Johns J in *Re: Spencer*. Although it is not a declaration of competency as such, Macmillan J in *Re: Sarah* made a declaration that a particular form of medical treatment (a gonadectomy to be performed on a young person with a disorder of sexual development) was not a special medical procedure requiring court authorisation. As earlier discussed, after considering the relevant authorities, Macmillan J found that she had jurisdiction under the Family Law Act to make the declaration sought. Similarly, Johns J referred to relevant Family Court and High Court of Australia authority in concluding that the power to make orders relating to the welfare of children included the power to grant declaratory relief.

As a consequence of *Re: Jamie*, and for as long as it remains good law, the Family Court will have a role in hearing and determining whether young people satisfy the test of *Gillick* competency and in deciding whether or not to make a declaration that a particular form of medical treatment does not require court authorisation. The Court's jurisdiction to make a declaration, either as to competency or as to whether court authorisation for medical treatment is required, is likely to be an area that will receive further judicial scrutiny. Appellate guidance on the issue of jurisdiction to grant declaratory relief in Part VII proceedings would be particularly welcomed.

### **Competency assessments – development of criteria**

In light of the Full Court's decision in *Re: Jamie*, the task that befalls the Court when dealing with an application for Stage 2 treatment, or where the Court is asked to make a declaration of competency, is to decide whether or not a young person is *Gillick* competent and therefore able to make their own treatment decisions, absent disagreement. It would be surprising therefore if there was not jurisprudential guidance developed as to what matters should be considered, what the court must be satisfied of, and to what standard, in deciding whether or not a child satisfies the *Gillick* test. In the Canadian decision of *AC & Manitoba (Director of Child and Family Services)*, Abella J

surveyed the general literature on child development and set out a list of seven factors which could be taken into account when assessing competence. These were:<sup>170</sup>

- The nature, purpose and utility of the recommended medical treatment, including its risks and benefits.
- Whether the young person demonstrated the intellectual capacity and sophistication to understand the information relevant to making the decision and to appreciate the potential consequences.
- Whether there was reason to believe that the young person's views were stable and a true reflection of his or her core values and beliefs.
- The potential impact of the young person's lifestyle, family relationships and broader social affiliations on his or her ability to exercise independent judgment.
- Whether there were any existing emotional or psychiatric vulnerabilities.
- Whether the young person's illness or condition had an impact on his or her decision-making ability.
- Whether there was any relevant information from adults who know the adolescent, such as teachers or doctors.

Abella J emphasised that the list of seven factors was not intended as a mandatory formula but was designed to assist courts in assessing the extent to which a child's wishes "reflect true, stable and independent choices".<sup>171</sup> In Australia, that task is made significantly easier through the appointment of independent children's lawyers and the commissioning of family reports, as well as through the use of expert evidence.

In the United Kingdom, Lord Fraser, a judge in the majority in *Gillick*, set out five matters which, if followed by a prescribing doctor, would mean that the doctor was acting lawfully in prescribing contraceptives to a person aged under 16. These five matters have become known as the "Fraser Guidelines". The first of the five guidelines captures the essence of the majority's decision in *Gillick*; namely that the person understands the doctor's advice.

The development of guidelines by way of judicial decision making is not unfamiliar to the Family Court. The decisions in *Re: K*<sup>172</sup> and *Re F: Litigants in Person Guidelines*<sup>173</sup> are examples. In the context of medical procedures requiring court authorisation, the rules governing medical procedure applications and the matters the court should take into account under rule 4.09(1) are based on list of factors enumerated by Nicholson CJ in *In Re: Marion (No 2)*.<sup>174</sup>

### **The limits of *Gillick* competence**

A highly topical issue, and one that has attracted much curial and academic attention in Australia and internationally, is whether courts retain supervisory jurisdiction in respect of *Gillick* competent children, and if so, in what circumstances.

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<sup>170</sup> [2009] 2 SCR 181 at [96].

<sup>171</sup> *Ibid.*

<sup>172</sup> (1994) FLC 92-461.

<sup>173</sup> (2001) FLC 93-072.

<sup>174</sup> (1994) FLC 92-448.

In *Re: Jamie*, the public authority submitted that there was a spectrum of opinion as to the limits of *Gillick* competence in the context of applications for treatment for gender dysphoria. The first position advanced by the public authority was that *Gillick* competence was determinative of the matter, irrespective of the type of treatment being sought and whether there was disagreement between the child, parents and doctors. The second position was that, even when the Court found that a child was competent to consent to their own treatment, it retained jurisdiction where there was disagreement. The third position was that a person under the age of 18 should never be capable of consenting to their own treatment for gender dysphoria, given that the effect of treatment was to alter an otherwise healthy body to align it with their ‘brain sex’. The public authority supported the third position. The AHRC supported the second.

The Full Court did not engage directly with the question of the limits of *Gillick* competence, as it was unnecessary to do so for the purpose of determining the appeal. Despite some robust comments made by Bryant CJ about adolescent decision making, ultimately all three members of the Full Court effectively adopted the second position; namely that the Court’s jurisdiction was attracted by the presence of disagreement, even where a young person is *Gillick* competent. Interestingly, but incorrectly, Johns J in the decision of *Re: Spencer* interpreted the Full Court’s decision to mean that “once the question of *Gillick* competence was established, the Court would have no further role.”

Exploring the ‘metes and bounds’ of *Gillick* competence is something that would be expected to occur as a consequence of clear direction from the Full Court in *Re: Jamie* that a competency assessment should precede any application for authorisation of treatment for gender dysphoria. The age at which Stage 2 treatment usually commences, being 16 years, and the significance ascribed to the fact that transgender young people have usually been living consistently and unwaveringly in their affirmed sex for many years by the time such an application is made, are likely to be of particular relevance to the determination of the question of *Gillick* competency. It should be recalled that the decision in *Gillick* concerned only children under the age of 16, and this fact may assume greater significance in the application of *Gillick* principles to medical procedures involving children aged 16 years and over.

One potentially fertile area for exploration is the distinction between the capacity to consent to medical treatment and the capacity to refuse medical treatment, particularly where a young person’s life is at risk. Post *Gillick* jurisprudence in the United Kingdom and recent decisions of the majority of the Supreme Court of Canada in *AC & Manitoba* and of the New South Wales Court of Appeal in *X & Sydney Hospital Network* are suggestive of the fact that the sanctity of life will take precedence over individual dignity in decisions about the refusal of life-saving treatment, even in jurisdictions with a human rights charter. However, although Stage 2 treatment for gender identity dysphoria may be life-saving in the sense that it could prevent transgender young people from serious harm, including self-harm, it can logically be distinguished from the administration of blood transfusions for aggressive forms of cancer, without which the prognosis is that the patient will die.

In light of the decision of Silber J in *Axon* and Binnie J’s strongly worded dissent in *AC & Manitoba*, as well as Australian decisions on the limits of courts’ supervisory jurisdiction, there is reason to be confident that *Gillick* competence will assume more prominence in applications for authorisation of Stage 2 medical treatment. It is to be hoped that the important distinction between

consent to and refusal of medical treatment, and the type of treatment for which a declaration of competency is being sought, will be the subject of further judicial consideration.

It would also be of assistance for there to be some discussion of the concept of disagreement in ousting a *Gillick* competent child's right to make decisions about their own medical treatment. Who it is that disagrees, what they disagree about, whether there is a 'reasonableness' requirement surrounding the disagreement, and how much significance should be accorded to a young person's views in the event of disagreement, are some of the issues ripe for judicial contemplation.

## Gender dysphoria as a “disorder”

It will be recalled that Nicholson CJ in *Re: Alex* doubted that “gender identity disorder” was a “disorder”. In *Re: Bernadette*, Collier J recorded that there was criticism of attempts to treat transsexualism as a mental illness and that none of the experts in *Re: Bernadette* expressed a view that mental illness was a satisfactory explanation for gender identity disorder. Bryant CJ in *Re: Jamie* said:<sup>175</sup>

It may be that in time to come, transsexualism will no longer be described as a disorder, but for the time being, and for the foreseeable future, the weight of professional opinion is that it represents a particular category of pathology or mental illness.

The World Professional Association for Transgender Health, the body responsible for the development of the Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, released a statement in May 2010 urging the de-psychopathologisation of gender nonconformity worldwide. This statement noted that “the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally diverse human phenomenon [that] should not be judged as inherently pathological or negative.”<sup>176</sup>

Wallbank has said:<sup>177</sup>

Psychiatrists and psychologists have come to rely upon the DSM terminology, notwithstanding its defects and difficulties, so as to give legitimacy and professional protection when diagnosing and treating transsexualism; especially in children. The reality is, however, that the truly important role performed by psychiatry and psychology in the medical treatment of transsexualism, in both adults and children, is to rule out disorder or illness as an explanation for the phenomenon.

If gender dysphoria was de-classified as a psychiatric disorder, it would nevertheless still be incumbent upon the Family Court (assuming it retained a role with respect to such applications for consent for medical treatment) to decide whether or not gender dysphoria was a “malfunction or disease” for the purpose of the *Re: Marion* guidelines, for as long as those guidelines remain good law.

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<sup>175</sup> [2013] FamCAFC 110 at [69].

<sup>176</sup> World Professional Association for Transgender Health, *De-Psychopathologisation Statement*, 26 May 2010, [http://www.wpath.org/site\\_page.cfm?pk\\_association\\_webpage\\_menu=1351&pk\\_association\\_webpage=3928](http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3928) (accessed 3 September 2014).

<sup>177</sup> Similar issues arose around the pathologisation of homosexuality, which was included as a mental disorder in the DSM until it was removed in 1973.

## Binary conceptions of gender

There have already been significant developments, in Australia and internationally, that suggest that legislators and courts are giving greater recognition to the diversity of human sexuality in conceptualising sex, gender and gender identity. Some of those developments, such as outlawing discrimination on the basis of gender identity in Australia, have been discussed earlier. Judicial conceptualisations of what it means to be ‘male’ and ‘female’ have also changed markedly. In 1971, the decision of Ormrod J in *Corbett v Corbett*<sup>178</sup> became authority in the United Kingdom, in Australia and in other jurisdictions for the proposition that sex is fixed at birth irrespective of psychology, and that the effects of medical intervention are irrelevant. The correctness of the reasoning in *Corbett* was affirmed by the House of Lords in *Bellinger v Bellinger* in 2003.<sup>179</sup>

In 2001, in the case of *Re Kevin (Validity of Marriage of a Transsexual)*,<sup>180</sup> Chisholm J examined in detail what it means to be a ‘man’ and a ‘woman’ for the purpose of deciding whether a transsexual person could marry under Australian law. In what has been described as a “powerful” and “well-reasoned” judgment, Chisholm J departed from strict reliance on biological features to determine sex. Chisholm J said that he considered ‘brain sex’ to make a significant contribution to the development of a person’s sexual identity. Chisholm J stated “...it is wrong to say that a person’s sex depends on any single factor, such as chromosomes or genital sex; or some limited range of factors, such as the state of the person’s gonads, chromosomes or genitals (whether at birth or at some other time).” The decision was upheld by the Full Court of the Family Court.

Bryant CJ, in her 2009 paper ‘It’s My Body, Isn’t It?’,<sup>181</sup> observed that *Re: Kevin* has been relied upon in litigation in the European Court of Human Rights. The Grand Chamber of the European Court of Human Rights, in the decisions of *Goodwin v United Kingdom* and *I v United Kingdom*, quoted extensively from *Re Kevin* in ultimately finding that the failure of states to legally recognise gender reassignment breached Article 8 of the European Convention.

Wallbank, who acted for the applicants in *Re: Kevin*, has said that the decision in *Re: Kevin*:<sup>182</sup>

... continues and expresses a long international common law tradition of cases dealing with transsexualism in a culturally inclusive way. In its expert and detailed exploration of transsexualism as an example of the human condition, it is a general teaching, as much as a legal judgment, and represents the foundation of a new era in human rights for people who experience a phenomenon which has been so mystified and misunderstood.

Both ‘statute’ and ‘judge-made’ law have evolved considerably to reflect contemporary understandings of sex and gender identity. Having regard to Chisholm J’s decision in *Re Kevin*, to the ‘gender dysphoria’ cases heard in the Family Court of Australia, and to Bryant CJ’s comments in *Re: Jamie* about the importance of recognising diversity in human sexuality, it is to be expected that family law will continue to develop in a way that is sensitive to and inclusive of the needs of transgender young people.

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<sup>178</sup> [1971] P 83.

<sup>179</sup> [2003] 2 AC 467.

<sup>180</sup> [2001] FamCA 1074.

<sup>181</sup> Above n 152.

<sup>182</sup> Above n 45, 34.

## Reasoning by reference to human rights law

Finally, it is apparent that even in the absence of a specific national human rights charter, like Canada's Charter of Rights and Freedoms, the language of human rights will increasingly permeate Australian decision making surrounding young people generally, and consent to medical treatment for young people specifically.

As earlier discussed, the AHRC is frequently invited to intervene in such proceedings and to make submissions directed towards the applicability of international human rights instruments to domestic family law proceedings. Before the Full Court in *Re: Jamie*, the AHRC said that various articles of UNCROC (Articles 3, 5, 12 and 18) and of the CRPD (Articles 3, 7 and 12) were relevant to the appeal. Consistent with the High Court of Australia's decision in *Teoh*, the AHRC submitted that UNCROC and the CRPD should be interpretative aids when hearing applications under the Family Law Act. The AHRC further submitted that it is important for children to have input into decisions affecting them, including decisions about medical treatment. Bryant CJ's reasons in *Re: Jamie* in particular refers to children's rights under international conventions and under the Family Law Act, especially in the context of young people's capacity to consent to their own medical treatment. Bryant CJ also had regard to human rights instruments in her 2009 judgment in *Re: Alex*.

The Full Court's decision in *Re: Jamie* represents a significant departure from the earlier decision of *Re: Alex*; one that was arrived at by reference to and having regard to children's rights at international law. Given recent developments in Australia, such as the establishment of the position of a National Children's Commissioner, it would be surprising if judicial reasoning surrounding applications for consent for medical treatment was not increasingly imbued with the language of international human rights.

## Conclusion

*Re: Jamie* is an important and significant decision. For the first time, the Family Court of Australia has provided guidance at appellate level about whether and in what circumstances court authorisation for treatment for gender dysphoria is required. The Court's role, as an assessor of a young person's capacity to consent to their own treatment and as an arbiter where a child is not *Gillick* competent or where there is disagreement, is more clearly defined as a result. The Full Court has also determined that a "disease" or "malfunction" can include psychological and psychiatric conditions, that treatment for such conditions can be therapeutic, that an assessment of proportionality between the benefit to the child and the risks of the procedure is required, and that the reversibility of the treatment is a key consideration. The state of the law in Australia as to what children and young people can and cannot consent to on their own behalf, and who makes the decision about legal capacity, is much clearer as a result of *Re: Jamie*.

There are significant differences between the approach taken in Australia and that in Canada and the United States. The Family Court of Australia has a much greater role in making treatment decisions than do courts in North America. For this reason, there is a wealth of Australian jurisprudence on medical treatment for transgender young people as compared with that available in those countries. Despite an absence of North American case law however, there is much that Australia can learn from Canada and the United States, and from other jurisdictions that have a

human rights charter or act, such as the United Kingdom. Decisions like those of the Supreme Court of Canada in *AC & Manitoba*, and of Silber J in *Axon*, which both involved consideration of competing rights under human rights enactments, demonstrate that some of the complex issues arising in the area of young people and medical treatment are thrown into sharp relief when ‘charter rights’ are invoked.

History suggests that it is unlikely that Australia will legislate to create a human rights act in the near future, but that does not mean that young people’s human rights have no place in the Family Court’s jurisprudence. In part due to the intervention of the AHRC, and in part due to greater community understanding of non-gender conformity, it is likely young transgender people’s human rights will be at the forefront as the Family Court continues to grapple with the myriad complexities that arise in the area of competency and consent to medical treatment.