

The (fe)male conundrum

Young people and sex reassignment: who should be the judge? And should the age of medical consent be lowered to 16?

By Alexandra Jane Finemore

In recent years, the Family Court of Australia (Family Court) has made orders allowing children to undergo gender reassignment treatment while also acknowledging the child's ability to provide valid consent.¹ These judgments have sparked debate over whether the Family Court is the appropriate body to be making complex medical decisions about children with gender identity disorder, especially when the child and his or her specialists agree on the necessary treatment. Court authorisation of this nature acts as a procedural safeguard for health professionals while placing significant financial and emotional burdens on young people diagnosed with gender identity disorder and their parents/

guardians. This dilemma was recently considered by the Full Court on appeal from the decision by Justice Dessau in *Re Jamie*.²

GENDER IDENTITY DISORDER

Gender identity disorder or *transsexualism* describes a person who exhibits a significant discontent with their biological sex. Gender dysphoria is the distress and unease experienced if the gender identity and sex are not completely congruent.³ In many cases heard by the Family Court this distress and unease has led to depression and self-harm. The favoured response is to accept the condition and use medical techniques to ease the transition between sexes.⁴ However, vigorous assessment and an extended diagnostic process is required to ensure the transition is the best option for the patient. The first stage of this transition is known as "pubertal suspension". The Endocrine Society suggests that pubertal suspension be initiated at about the age of 16 and that surgery is deferred until the individual is at least 18.⁵

GILICK COMPETENCE

The House of Lords decision in *Gillick v West Norfolk and Wisbech Area Health Authority (Gillick)*⁶ was the first case to consider a minor's ability to consent to medical treatment. In this UK case, a mother of five daughters under the age of 16 sought

assurance from the relevant health authority that her daughters would not be given contraceptive advice or treatment without her consent. Mrs Gillick sought this assurance after the Department of Health and Social Security advised doctors that they could do so in certain circumstances. Mrs Gillick brought an action against the health authority and the department seeking a declaration that the advice was unlawful. She proposed that a child under the age of 16 is incapable of giving consent to contraceptive treatment. The House of Lords rejected Mrs Gillick's application. In speaking for the majority, Lord Scarman said the parental right to determine whether or not their minor child would have medical treatment "terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed."⁷

The decision of the House of Lords in *Gillick* was endorsed by the High Court of Australia in *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)*.⁸ In *Marion's case* the child was a 14-year-old girl suffering from an intellectual disability, deafness and epilepsy. Her parents sought an order authorising the sterilisation of their daughter or a declaration that it was lawful for them to consent to the procedure. Marion (not her real name) lacked the capacity to make an informed decision about whether to consent or refuse consent to the medical procedure. In most circumstances of



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this nature, the parent or guardian will have the authority to make the decision on behalf of their child, but the Court recognised that parental authority to consent for a minor is not absolute. The majority held that there is a category of “special medical procedures” to which parents cannot give effective consent. In determining this issue, the majority drew a distinction between therapeutic and non-therapeutic sterilisation. The High Court, with the exception of Deane J, held that parents could never consent to sterilisation for non-therapeutic purposes. Their reasoning was that parents are likely to take into account their own interests and those of other family members, which may conflict with the child’s best interests.⁹

GENDER IDENTITY DISORDER AND THE FAMILY COURT

The *Family Law Act 1975* (Cth) provides that the Family Court of Australia has jurisdiction to make orders “relating to the welfare of children”.¹⁰ In deciding whether to make such an order, the Court must regard the best interests of the child as the “paramount consideration”.¹¹

The first Australian case to consider gender reassignment treatment for a minor received considerable attention in both the academic and public arenas.¹² *Re Alex – Hormonal Treatment for Gender Identity Dysphoria (Re Alex)*¹³ was heard by Nicholson CJ sitting as a trial judge. The issue before the Court was whether Alex’s legal guardian had the authority to consent to the first two phases of hormone treatment or “pubertal suspension”. The landmark decision recognised that the proposed treatment for Alex was a type of medical treatment requiring authorisation by the Family Court under the welfare jurisdiction.¹⁴ Chief Justice Nicholson held that the current state of knowledge regarding the cause of transsexualism was insufficient to prove that it was a malfunction or disease.¹⁵ The Chief Justice also found that the evidence did not establish that the 13-year-old had the capacity to decide for himself whether to consent to the proposed treatment. The Court concluded that the nature of the proposed treatment was such that Court authorisation was required, even though surgical intervention was not yet contemplated.¹⁶ This decision set in motion a trend whereby the Court conceived all treatment for transsexualism in children and adolescents as a “special medical procedure” to which a parent or guardian cannot consent.

RECENT CASE LAW

In *Re Jamie (Special Medical Procedure)*,¹⁷ the Family Court refused to authorise the second stage of pubertal suspension where it was planned for five to six years after the first stage. Jamie’s parents brought an appeal before the Full Court on the basis that the Family Court had no jurisdiction to make orders of this type. The Family Court noted that gender identity disorder has a two-phase treatment process. “Stage one” is fully reversible and “stage two” was found to be irreversible without surgical intervention. The Court found that if either stage of treatment was in dispute then the Court would make a determination under the welfare power found in s67ZC of the Act. In *Jamie’s case* the child, parents and treating medical professionals agreed on the commencement of both stages of treatment. The Court found that Jamie, her parents and her medical professionals could agree to implement stage one treatment and that court authorisation was not required. In terms of stage two treatment, the Court found that court authorisation was required because of two factors:

- there was a significant risk of the wrong decision being made as to the child’s capacity to consent to treatment, and
- the consequences of such a wrong decision would be particularly grave.

Interestingly, the Court found that if a child is found to be able to give informed consent (i.e. the child is “Gillick” competent) then the child can consent to stage two treatment without court authorisation. However, the question of whether the child is *Gillick* competent is still a matter to be determined by the Court.

In recent years, the Family Court has recognised the child’s capacity to give consent in two other cases involving a minor with gender identity disorder. In the case of *Re O (Special Medical Procedure)*,¹⁸ Dessau J supported the views of O’s parents and all the expert evidence which showed that O’s mental health would be placed at serious risk without the proposed treatment.¹⁹ The decision in *Re O* was the first to acknowledge the minor’s ability to make an informed decision about the procedure. In doing so, Dessau J followed rule 4.09(2)(g) of the Family Law Rules 2004 (Cth), which does not reflect any of the factors set out in *Marion’s case*. O had reached the age of 16 and was described as “incredibly bright” and in some areas more mature than his peers.²⁰ In *Re Rosie*²¹ the minor was also 16 and the judge found she had the capacity to provide valid consent. It was claimed

by Rosie’s clinicians that she had a “well-researched understanding of the treatment options” and had the intellectual capacity to understand the implications of the proposed treatment.²² In *Re O* and *Re Rosie*, the Court made orders authorising consent to both stages of the proposed treatment.

THE LAW OVERSEAS

Pubertal suspension is now offered in the United States, the Netherlands, Norway, Germany, Canada, Belgium, Britain, New Zealand and Australia. In Britain, people who have attained the age of 16 are presumed to be capable of giving effective consent to any “surgical, medical or dental treatment”.²³ Likewise, the law in New Zealand provides that any minor of or over 16 can legally give consent to all phases of gender reassignment treatment provided that consent was fully informed.²⁴

Australia remains the only country that requires court authorisation for gender reassignment treatment for minors. In Australia, a court’s assessment of a child’s ability to provide informed consent can occur until he or she turns 18.²⁵ Other countries that offer pubertal intervention may provide it on the basis of the informed consent of the child and their guardian and do not require the court’s permission.²⁶

PROPOSALS FOR REFORM

The obvious difficulties associated with court proceedings are the costs to parents/guardians and the inevitable delays experienced by minors in need of treatment.²⁷ In addition, the adversarial approach of the court is often unsuitable for making decisions that involve the views of a child. There is a real possibility that children with gender identity disorder are being refused treatment because of these factors.

The recent appeal decision of the Full Court in *Re Jamie*²⁸ is an example of such inconvenience. Although the Court had recently decided two cases where it approved both stages of the treatment plan simultaneously,²⁹ Justice Dessau pointed out that Jamie was only 10 and there were “all sorts of vagaries and potential factors” that would make it impossible to predict the best interests of the child five years before the second phase of treatment.³⁰ The Court recognised the emotional and financial expense of a further hearing but stated that any further treatment would have to be the subject of a separate court application at the relevant time.³¹

The simplicity and efficiency of the informed consent model adopted by other countries is a potential alternative to the current process which involves proceedings at the Family Court. However, it is important to note that Family Court judges are obliged

to hear cases regarding gender reassignment treatment because there is a grave risk that a wrong and irreversible decision might be made. If court approval for gender reassignment treatment is deemed unnecessary, some other form of review must be implemented to safeguard the decision to proceed with treatment. For example, responsibility of this nature could be given to a specialised state tribunal similar to the NSW Guardianship Tribunal³² or the Victorian Patient Review Panel.³³ The tribunal should be required to consider evidence from a multidisciplinary team and the welfare of the child should be their paramount consideration.³⁴

The Victorian Civil and Administrative Tribunal Guardianship List would be a more cost-effective, informal and potentially more efficient alternative to the Family Court. The Guardianship List already has jurisdiction to make decisions regarding special medical procedures for people with disabilities who lack capacity.

South Australian legislation already provides that a person of or over 16 years of age may make decisions about his or her medical treatment as validly and effectively as if that person were an adult.³⁵ The child can consent if the medical practitioner is of the opinion that the child is capable of understanding the nature, consequences and risks.³⁶ The treatment must be in the best interests of the child's health and wellbeing and that opinion must be supported by the written opinion of at least one other medical practitioner who has personally examined the child.³⁷ No distinction is drawn between ordinary medical treatment and special medical treatment. With respect to children under 16, treatment can be administered where a parent or guardian consents.

Lowering the age of medical consent to 16 may be a valid contribution to federal legislation. Classifying minors as young people below 16 would have eliminated the burden of pursuing court proceedings in recent cases such as *Re Bernadette*,³⁸ *Re O* and *Re Rosie*. It is necessary to clarify the position at a federal

level to ensure there is a consistent approach applicable to all jurisdictions in relation to the ability of young people to consent to medical procedures.³⁹

CONCLUSION

It is clear that the diagnosis and treatment of children and young people suffering from gender identity disorder is a highly specialised and sensitive process far beyond the expertise of a judge. It seems only logical that such a complex medical task should be left in the hands of relevant health professionals with an additional review process less burdensome than court proceedings. Unfortunately, the recent appeal from *Re Jamie* did not rule out gender reassignment treatment as a special medical procedure requiring court approval. The time is ripe for Parliament to intervene and enact legislation that transfers this responsibility to a specialised tribunal or at the very least decreases the age of medical consent to 16. In situations where an application is refused or where there is disagreement between parents/guardians, an avenue of appeal to the Family Court should remain. ●

ALEXANDRA JANE FINEMORE is a lawyer at Richmond & Bennison working in the areas of family law and property law. She is a member of the YLS Professional Development Committee and a member of BottledSnail Productions Inc.

1. *Re O (Special Medical Procedures)* [2010] FamCA 1153, *Re Jamie (Special Medical Procedure)* [2011] FamCA 248, *Re Rosie (Special Medical Procedure)* [2011] FamCA 63.
2. [2011] FamCA 248.
3. *The Diagnostic and Statistical Manual of Mental Disorders (DSM-V)* (American Psychiatric Association, 5th edition, 2013).
4. Walter Meyer III et al, *The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorder* (World Professional Association for Transgender Health, 6th edn, 2001).
5. The Endocrine Society, *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline* (18 January 2012), www.endo-society.org/guidelines/final/upload/Endocrine-Treatment-of-Transsexual-Persons.pdf.
6. [1986] 1 AC 112.

7. Note 6 above, at [189].
8. *Marion's case*, (1992) 175 CLR 218.
9. Note 8 above, at [50].
10. *The Family Law Act* 1975, s67ZC(1).
11. Note 10 above.
12. Danny Sandor, 'Sex and Drugs and Media Roll – The Family Court's decision in *Re Alex*' (2004) *Australian Children's Rights News* 21.
13. (2004) Fam CA 297.
14. *The Family Law Act* 1975, s67ZC.
15. Note 13 above, *Re Alex* at [195].
16. Note 13 above, *Re Alex* at [121].
17. *Re Jamie (Special Medical Procedure)* [2011] FamCA 248.
18. [2010] FamCA 1153.
19. Note 18 above, at [59].
20. Note 1 above, *Re O*, at [80].
21. Note 1 above, *Re Rosie*.
22. Note 21 above, at [95].
23. *Family Law Reform Act* 1969 (UK) cl46, s8.
24. *Care of Children Act* 2004 (NZ), s36.
25. *Family Law Act* 1975 (Cth), s4: "child ... means a person under 18".
26. Emma Geard, 'Sex reassignment treatment for minors in New Zealand – the ability of minors or their guardians to consent' (2011) 7 *New Zealand Family Law Journal* 12.
27. See comments made by Murphy J in *Re Sean and Russell (Special Medical Procedure)* (2010) 44 Fam LR 210.
28. *Re Jamie (Special Medical Procedure)* [2013] FamCAFC 110.
29. *Re O (Special Medical Procedure)* [2010] FamCA 1153 and *Re Rosie (Special Medical Procedure)* [2011] FamCA 63.
30. Note 29 above, at [128].
31. Shrikkanth, Rangarajan, 'Authorisation of treatment stages in gender identity disorder' (2011) *Australian Health Law Bulletin* p84.
32. *The Children and Young Persons (Care and Protection) Act* 1998 (NSW) prohibits a person carrying out special medical treatment on a child, defined as under 16 years of age, other than with the consent of the NSW Guardianship Tribunal (see s175).
33. The Patient Review Panel was established by *Assisted Reproductive Treatment Act* 2008 (Vic) (see s84).
34. The British Society for Paediatric Endocrinology and Diabetes, *Statement on the Management of Gender Identity Disorder (GID) in Children and Adolescents* (18 January 2012): www.bsped.org.uk/clinical/docs/BSPEDStatementOnTheManagementOfGID.pdf.
35. *Consent to Medical Treatment and Palliative Care Act* 1995 (SA), s6.
36. Note 35 above, s12.
37. Note 36 above.
38. [2010] FamCA 94.
39. Kate Parlett and Kylie-Maree Weston-Scheuber, 'Consent to treatment for Transgender and Intersex Children' (2004) 9 *Deakin Law Review* p395.



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