Transgender minors and the commencement of hormone treatment for gender dysphoria: is recent English case law likely to influence the Australian legal position?

Legal Issues

Editor: Malcolm Smith

TRANSGENDER MINORS AND THE COMMENCEMENT OF HORMONE TREATMENT FOR GENDER DYSPHORIA: IS RECENT ENGLISH CASE LAW LIKELY TO INFLUENCE THE AUSTRALIAN LEGAL POSITION?

Malcolm Smith*

This article considers recent English case law addressing the issue of whether court approval is required for the commencement of hormone treatment for minors with Gender Dysphoria. In particular, the decision in Bell v The Tavistock and Portman NHS Foundation Trust [2021] EWCA Civ 1363 is considered for the purpose of both distinguishing the legal framework in England from the body of Australian law on this topic, as well as considering whether the case may potentially impact on Australian law moving forward. One important aspect of the Court of Appeal's decision in Bell, which overturned the lower court's decision, is that the case clarifies how the principle of Gillick-competency should be applied in this context. The Court of Appeal held that in line with the House of Lords' reasoning in Gillick, the assessment of a minor's capacity is for the relevant treating health care professional(s) to assess rather than judges. This interpretation may potentially impact on how this principle is applied in the Australian cases relevant to minors and Gender Dysphoria, particularly those that have required an application to court in circumstances where a minor's parent(s) disagree with the conclusion of a treating clinician who has assessed their child as Gillick-competent for the purpose of consenting to hormone treatment.

Keywords: *consent and children; Gillick-competency; Gender Dysphoria; Bell v Tavistock; puberty blockers; transgender; hormone treatment*

INTRODUCTION

In the previous issue of this Journal, Professor Joanna Manning considered three important English cases concerning decision-making by, or for, minors. Professor Manning outlined the significance of these decisions, particularly in relation to the concept of *Gillick*-competency. In this volume of the Journal, I intend to advance the discussion further in relation to the significance of the English cases concerning minors and the commencement of hormone treatment for Gender Dysphoria. This is an issue that has generated a significant body of Australian jurisprudence over the past 15 years. I consider whether these English cases will, or may, influence Australian law. I also consider how these English cases might be distinguished from the legal position in Australia.

The most controversial of these cases was the Divisional Court's decision in *Quincy Bell and Mrs A v The Tavistock and Portman NHS Foundation Trust* (*Bell*),[1] which concluded that minors are

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[1] *Quincy Bell and Mrs A v The Tavistock and Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin). As well as Professor Manning's outline of this case, for an overview of the potential impact that this decision would have had, see K Moreton, "A Backwards-Step for Gillick: Trans Children's Inability to Consent to Treatment for Gender Dysphoria – Quincy Bell & Mrs A v The Tavistock and Portman NHS Foundation Trust [2020] EWHC 3274 (Admin)" (2021) *Medical Law Review* <https://doi.org/10.1093/medlaw/fwab020>.

not likely to ever have the capacity to consent to the commencement of puberty blockers. As noted by Professor Manning, this decision was appealed to the English Court of Appeal and the Divisional Court's conclusions about the inability of minors to consent to puberty blockers, was overturned. There are some significant aspects of the English courts' reasoning in *Bell*, that I believe warrant further consideration and should be contrasted with the Australian position. In addition, the decision of the English High Court in *AB v CD* (*AB v CD*),[2] decided shortly after the Divisional Court's decision in *Bell* but before the appeal in that case, considered whether parents are lawfully able to consent to treatment for Gender Dysphoria for their children in circumstances where the minor is not able to provide lawful consent. This case is also contrasted with the Australian position.

Gender Dysphoria is defined as a condition where a child's subjectively felt identity and gender are not congruent with their biological sex, causing clinically significant distress or impairment in social functioning or other important areas of functioning.[3] Hormone treatment is typically given in two stages. Stage 1 treatment involves what is commonly referred to as puberty blockers, which suppress "the endogenous oestrogen and testosterone responsible for induction of secondary sexual characteristics".[4] In Australia, this typically involves the commencement of gonadotrophin-releasing hormone analogues for the suppression of puberty. It is recognised in Australia that Stage 1 treatment provides "time to develop emotionally and cognitively prior to making decisions on gender affirming hormone use which have some irreversible effects".[5] In relation to Stage 2 treatment, the *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents* explain:

> Gender affirming hormones oestrogen and testosterone are used to either feminise or masculinise a person's appearance by inducing onset of secondary sexual characteristics of the desired gender. Some of the effects of these medications are irreversible, whilst others have a degree of expected reversibility, that is likely, unlikely or unknown.[6]

As outlined in this piece, Australian law has required that decisions about hormone treatment for Gender Dysphoria be referred to the Family Court of Australia (Family Court),[7] based on the nature of the treatment and its potential irreversibility. I outline these legal developments for the purpose of contrasting the recent English case law, and provide an overview of how the law may be impacted moving forward.

Recent English Cases Concerning the Commencement of Hormone Treatment for Gender Dysphoria in Children

One immediate point of distinction between the Australian and English legal frameworks relevant to this issue is that *Bell* was a judicial review claim[8] that sought to challenge the policy of a public body. Moreover, the case focused predominantly on Stage 1 treatment. In contrast, the Australian case law has developed on the basis of applications to the Family Court relevant to special medical procedures in respect of both Stage 1 and Stage 2 treatment. The claim in *Bell* was commenced by two claimants seeking review of the consent practices adopted by the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Trust (Trust) in relation to puberty blockers and the treatment referral

[2] *AB v CD* [2021] EWHC 741 (Fam).

[3] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (American Psychiatric Association Publishing, 5th ed, 2013).

[4] M Telfer et al, *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents* (Version 1.3, The Royal Children's Hospital Melbourne, 2020) 15 <https://www.rch.org.au/uploadedFiles/Main/Content/adolescent-medicine/australian-standards-of-care-and-treatment-guidelines-for-trans-and-gender-diverse-children-and-adolescents.pdf>.

[5] Telfer et al, n 4.

[6] Telfer et al, n 4, 16.

[7] I acknowledge that the Family Court has been merged with the Federal Circuit Court to form the Federal Circuit and Family Court of Australia. However, for ease of reference, given that many cases considered in this piece were determined by the Family Court, I use the term "Family Court".

[8] English judicial review actions use the term "claim" instead of application, and are commenced by claimants rather than applicants, against defendants.

pathway. The first claimant, born female, commenced puberty blockers at 15 years of age and then proceeded to gender affirming hormones (testosterone) at 17 to transition and identify as male. She later underwent surgical intervention as an adult. She regretted this transition and sought to change her birth certificate to reflect her gender as female.[9] The second claimant's interest in the claim was described by the court as "largely theoretical".[10] She was concerned about the hypothetical prospect of her daughter (aged 15) being referred to GIDS and prescribed PBs, as her daughter was diagnosed with autism spectrum disorder.

The facts and context relevant to the claim in *Bell* are detailed in Professor Manning's article. Essentially, the fundamental issue in the claim was whether minors might be *Gillick*-competent to consent to the commencement of puberty blockers. The principle of *Gillick*-competency stems from the House of Lords decision in *Gillick v West Norfolk and Wisbech Area Health Authority*.[11] This case established that a minor can lawfully consent to their own health care if the minor is of sufficient maturity and intelligence to understand fully the nature and effect of the decision in question.[12] In English law, legislation provides that minors aged 16 or 17 years are presumed to be competent to consent to their own medical treatment,[13] meaning that the main focus of the case was on minors below this age. The Divisional Court concluded that minors under 16 were not likely to reach the level of understanding required to be deemed *Gillick*-competent, and therefore could not provide lawful consent to the commencement of puberty blockers. The potentially far-reaching consequences of such a decision are not difficult to imagine. As outlined below, in the Australian context, the requirement for the court to confirm the minor's competency to consent to Stage 2 treatment, resulted in a significant increase in the number of applications to the Family Court. The Divisional Court's position would have been more significant, as it would have required *all* cases where the minor was considered competent by the treating health professionals, for both Stage 1 and Stage 2 treatment to be referred to the court. The Court of Appeal noted:

> [T]he effect of the guidance [set out by the Divisional Court] was to require applications to the court in circumstances where the Divisional Court itself had recognised that there was no legal obligation to do so. It placed patients, parents and clinicians in a very difficult position. In practice the guidance would have the effect of denying treatment in many circumstances for want of resources to make such an application coupled with inevitable delay through court involvement.[14]

The Court of Appeal overturned the Divisional Court's decision. As the Divisional Court found no illegality in the policy or practice of GIDS, the Court of Appeal held that the wider issues in the case about *Gillick*-competency were beyond the relevant focus of a judicial review claim. It was stated that the case did not provide for "a general inquiry into the content of the information and understanding needed to secure the informed consent of a child",[15] and so the Divisional Court had gone far beyond what was required and the conclusions were not considered appropriate for judicial review proceedings. The Court of Appeal also found that many of the Divisional Court's findings were based on disputed and adversarial evidence, which was not properly tested.[16]

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[9] *Quincy Bell and Mrs A v The Tavistock and Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin), [83].

[10] *Quincy Bell and Mrs A v The Tavistock and Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin), [89]. The claimant's daughter had not "been referred to GIDS and having regard to the defendant's current practice, would not meet the criteria for [puberty blockers] because her parents would not support that treatment".

[11] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.

[12] In *Secretary, Department of Health and Community Services (NT) v JWB (Marion's Case)* (1992) 175 CLR 218, the Australian High Court accepted that the principle formed part of Australian law, but as it was not directly relevant to the decision before the Court, as Marion lacked the capacity in respect of the decision about the sterilisation procedure, the case is *obiter* on that point. Nevertheless, it has been accepted in many Australian cases decided by lower courts, including the Full Court of the Family Court of Australia (see, eg, *Re Jamie* (2013) 278 FLR 155; [2013] FamCAFC 110; *Re Kelvin* (2017) 327 FLR 15; [2017] FamCAFC 258).

[13] *Family Law Reform Act 1969* (UK) s 8. Legislation in some Australian States provides minors with the ability to consent to their own medical treatment. See: *Minors (Property and Contracts) Act 1970* (NSW) s 49; *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 6.

[14] *Bell v The Tavistock & Portman NHS Foundation Trust* [2021] EWCA Civ 1363, [86].

[15] *Bell v The Tavistock & Portman NHS Foundation Trust* [2021] EWCA Civ 1363, [77]–[80].

[16] *Bell v The Tavistock & Portman NHS Foundation Trust* [2021] EWCA Civ 1363, [32]–[38], [61]–[65].

The application in *Bell* did not address whether parents could lawfully consent to the commencement of puberty blockers on behalf of non-competent minors, as it was not an issue that arose on the facts (it was not the practice of GIDS to proceed with treatment on this basis). However, this was the main issue that required determination by the English High Court in *AB v CD*, where Lieven J held that parents retain the right to give lawful consent to Stage 1 treatment, irrespective of the minor's competency. Lieven J also considered whether puberty blockers should be classed as a "special" treatment, noting that the reasoning set out by the Divisional Court in Bell concerning the nature of the treatment could potentially place it within such a special category. However, ultimately Lieven J concluded that there is no legal requirement to involve the court on the basis of the treatment being a "special" case.

The Australian Legal Framework Relevant to Special Medical Procedures, Hormone Treatment and Childhood Gender Dysphoria

In Australia, legal developments have occurred through the common law, predominantly by way of cases concerning "special medical procedures". There have been significant case law developments over the course of the past 15 years. A detailed discussion of these developments is beyond the scope of this article. However, the underlying legal principles stem from the reasoning outlined by the Australian High Court in *Marion's Case*.[17] Although decided in the early 1990s, this case remains as the most authoritative Australian decision relevant to parental decision-making in respect of medical treatment.[18] The case concerned the issue of whether the parents of a minor with profound disabilities could lawfully consent to a sterilisation procedure. Sterilisation was not required to treat a physical disease or illness, but instead, was intended to alleviate significant distress (including potential future distress that may result from pregnancy) and behavioural issues, as well as potentially making it easier for Marion's parents and carers to provide her with care and support. This High Court decision is rather complex as there was differing reasoning that underpinned each of the judgments. However, in summary it was concluded that because of the risk to minors in not involving the court, some non-therapeutic medical procedures or interventions do not fall within the parental power to consent and must always be referred to the court. Most significantly, court involvement is required in circumstances where a non-therapeutic medical procedure or intervention is grave in nature,[19] invasive and irreversible, where there is a risk of a wrong decision being made about a minor's present or future capacity to consent without court involvement,[20] and where there is a potential conflict between the interests of the minor and the decision-makers and/or treating health professionals.[21] The High Court determined that the decision about sterilisation could not be made by Marion's parents, and that the court must approve the procedure. *Marion's Case* established that there is a need to involve the court in some of the most significant medical decisions impacting on children, but appeared to limit this to very serious cases, where there is no therapeutic or medical need for the intervention.[22] The case was strictly about non-therapeutic sterilisation procedures, but case law has since extended the reasoning to other categories of treatment. It has been noted that this is because the High Court in *Marion's Case* foresaw that the reasoning could apply to other interventions.[23] On this basis, the categories of special medical procedure are not closed.[24]

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[17] *Secretary, Department of Health and Community Services (NT) v JWB (Marion's Case)* (1992) 175 CLR 218.

[18] See Cameron Stewart, "Cracks in the Lintel of Consent" in I Freckelton and K Petersen (eds), *Tensions & Traumas in Health Law* (The Federation Press, 2017), who describes the decision in *Marion's Case* as a disaster, because the decision "laid down a test which provided no judicial certainty and it has led to [a situation] where the court's role is actively causing harm to children", such that unless there is "legislative reform, the High Court urgently needs to rebuild the law of consent for children" (at page 227).

[19] *Secretary, Department of Health and Community Services (NT) v JWB (Marion's Case)* (1992) 175 CLR 218, [252].

[20] *Secretary, Department of Health and Community Services (NT) v JWB (Marion's Case)* (1992) 175 CLR 218, [250]–[252].

[21] *Secretary, Department of Health and Community Services (NT) v JWB (Marion's Case)* (1992) 175 CLR 218, [250]–[252].

[22] The issue of what is regarded as "therapeutic" or "non-therapeutic" is a contentious topic and the reasoning in the High Court decision demonstrates this, as outlined by Lesley Naik, "When Is the Sterilisation of an Intellectually Disabled Child 'Therapeutic'? A Practical Analysis of the Legal Requirement to Seek Court Authorisation" (2012) 20(2) JLM 453.

[23] *Re Kelvin* (2017) 327 FLR 15, [138]; [2017] FamCAFC 258.

[24] See, eg, *Re Baby D (No 2)* (2011) 258 FLR 290, [224]; [2011] FamCA 176.

Australian cases about hormone treatment for Gender Dysphoria in minors are therefore based on the principles set out by the High Court in *Marion's Case*. As discussed below, although the earlier Australian cases determined that decisions about hormone treatment should be regarded as "special" and therefore subject to court approval, this position has changed over time. Unfortunately, however, the significant legal developments that have occurred over the last few years leave the law in an uncertain state, as discussed below.

In 2004, the Family Court decision of *Re Alex*[25] determined that both Stage 1 and Stage 2 treatment should require court approval. This conclusion was based on the principles outlined in *Marion's Case*. Nicholson CJ determined that the treatment was non-therapeutic, as it is for the treatment of a psychological condition, rather than a physical disease or illness.[26] When considering both stages of treatment together as a single treatment plan, it was determined that the treatment carried permanent, irreversible, and grave consequences, and that there was a risk of making a wrong decision without the involvement of the court. The case established a precedent requiring that such cases be referred to the Family Court. Consequently, further cases followed in the years after *Re Alex* and the issue of whether Stage 1 treatment should be subject to court approval was questioned by some judges.[27]

In 2013, the legal position was examined by the Full Court of the Family Court of Australia (Full Court) in *Re Jamie*.[28] The Full Court distinguished *Re Alex* which focused on whether a government department could provide consent to treatment for gender identity disorder under the scope of an operative care order.[29] The Full Court also set out its reasons as to why Stage 1 treatment should be regarded as falling within the parental power, but not Stage 2. Bryant CJ observed that the Court in *Re Alex* "was asked not to view the reversible first stage [of treatment] in isolation from the second stage, which could have irreversible consequences",[30] but to view the two phases together as a single treatment plan. In line with the factors in *Marion's Case*, Bryant CJ formed the view that there was less likelihood that the interests between the parties involved would be conflicting, stating that "it is unlikely that the parental interests [in the context of Jamie's treatment] would be anything other than the welfare of the child (as opposed to having a collateral interest in having the treatment carried out)".[31] The Full Court determined that Stage 1 treatment is therapeutic as it is intended to treat a psychological condition, and that court approval for the commencement of Stage 1 treatment should no longer be necessary, therefore bringing it within the parental power to consent. However, the Full Court also determined that applications to the court should continue in respect of Stage 2 treatment, based on its irreversible and serious consequences. The Full Court also decided that in circumstances where a minor is regarded as *Gillick*-competent by their treating health professionals, the court must confirm whether the minor is competent to give consent.

In the years following *Re Jamie*, the number of cases to the Family Court increased significantly and this resulted in a position where judges were questioning whether court involvement should be required. The issues were again referred to the Full Court for determination in 2017 in the case of *Re Kelvin*,[32] this time by way of case stated.[33] The Full Court was asked to clarify the law in terms of whether an application

[25] *Re Alex* (2004) 180 FLR 89; [2004] FamCA 297.

[26] This is likely to reflect the approach of the plurality in *Marion's Case*. Thus, it was stated "first it is necessary to make clear that, in speaking of sterilisation in this context, we are not referring to sterilisation 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": *Secretary, Department of Health and Community Services (NT) v JWB (Marion's Case)* (1992) 175 CLR 218, [48].

[27] See, eg, *Re Sam* (2013) 49 Fam LR 417; [2013] FamCA 563.

[28] *Re Jamie* (2013) 278 FLR 155; [2013] FamCAFC 110.

[29] *Re Jamie* (2013) 278 FLR 155, [173] (Finn J); [2013] FamCAFC 110.

[30] *Re Jamie* (2013) 278 FLR 155, [81]; [2013] FamCAFC 110.

[31] *Re Jamie* (2013) 278 FLR 155, [107]; [2013] FamCAFC 110.

[32] *Re Kelvin* (2017) 327 FLR 15; [2017] FamCAFC 258.

[33] The case arose by way of a case stated *Re Kelvin* (2017) 327 FLR 15; [2017] FamCAFC 258, referred to the Full Court by Watts J (the judge deciding the original application made by the applicant's father in respect of a request for authorisation of stage two treatment for GD) made pursuant to s 94A(1) of the *Family Law Act 1975* (Cth).

should be required to authorise the commencement of Stage 2 treatment and/or whether the court must confirm the minor's competency to consent to hormone treatment. The Full Court in *Re Kelvin* held that parents and minors (if *Gillick*-competent) can lawfully consent to hormone treatment without the need for court involvement, provided that the treatment is provided in accordance with relevant treatment guidelines and standards. However, it was also determined that decisions must be referred to the court for determination if there is a controversy, which means where there is disagreement between the decision-makers and/or clinical team about whether treatment should commence, or where there is a dispute about the minor's competency.

In terms of departing from its earlier decision, the majority judgment in *Re Kelvin* noted that this was generally permissible if the earlier decision was found to be "plainly wrong".[34] On this point, the applicant, the Independent Children's Lawyer, as well as a number of the interveners, submitted that the decision in *Re Jamie* was plainly wrong, particularly the Court's application of the principles set out in *Marion's Case*.[35] However, the majority stated that "it is unnecessary and indeed inappropriate for this Court to find that *Re Jamie* was 'plainly wrong' in order to answer" the relevant questions referred to the court.[36] Instead, the majority identified that "there is a factual difference between the two cases that has relevant legal significance, [such that] there has been a change in the factual understanding on which the earlier decision [in *Re Jamie*] was based".[37] For this purpose, the majority relied on the change in medical understanding and knowledge around gender dysphoria, including the changes in the DSM, and that relevant standards had been published both nationally and internationally.[38] Despite the outcome in *Re Kelvin*, which appeared to remove the general requirement to refer such cases to the court, more questions have since arisen about the ongoing need for the court's involvement, as outlined below.

Unlike the legal position in England and Wales, which has examined the need for the court's involvement based on the notion of *Gillick*-competency, predominantly under the lens of a judicial review action that examined the legality of a treatment protocol and consent process, the Australian position is more complex and has revolved around the principles relevant to special medical procedures. This obviously demonstrates how the two frameworks are legally distinct and that the potential for the *Bell* decision to impact on Australian law is somewhat limited. Nevertheless, there is the potential for aspects of the reasoning in the recent English case law, particularly the Court of Appeal's decision in *Bell*, to have a significant impact on Australian law. Before considering the potential impact of *Bell* on the Australian legal framework, I will first outline the most recent Australian case law in this field, to highlight the specific issues of concern on this point.

As outlined above, the majority in *Re Kelvin* did not go as far as saying that the Full Court's earlier decision in *Re Jamie* was "plainly wrong" (although the minority judgment did form this view). The majority determined that there was a factual difference since *Re Jamie*, referring to the significant change in the medical understanding of Gender Dysphoria as a condition and its treatment.[39] Consequently, cases decided since *Re Kelvin* have held that elements of the Full Court's reasoning in *Re Jamie* remain binding,[40] in relation to the need to refer some cases to the court for determination.

Since *Re Kelvin*, there have been a number of cases that have caused some uncertainty about the current state of the law in Australia on this topic. The cases have addressed decisions about Stage 3 treatment

[34] *Re Kelvin* (2017) 327 FLR 15, [169]; [2017] FamCAFC 258, citing *Nguyen v Nguyen* (1990) 169 CLR 245, 268–270 (Dawson, Toohey and McHugh JJ); *Gett v Tabet* (2009) 254 ALR 504, [261]–[301]; [2009] NSWCA 76; *F Firm v Ruane* (2014) 292 FLR 348, [163]; [2014] FamCAFC 189.

[35] For an overview of some of the key issues with the application of *Marion's Case* in the decision of *Re Jamie*, see Felicity Bell, "Children with Gender Dysphoria and the Jurisdiction of the Family Court" (2015) 38(2) *UNSW Law Journal* 426.

[36] *Re Kelvin* (2017) 327 FLR 15, [171]; [2017] FamCAFC 258.

[37] *Re Kelvin* (2017) 327 FLR 15, [183]; [2017] FamCAFC 258.

[38] Telfer et al, n 4; The World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexual Transgender, and Gender Nonconforming People* (Version 7, 2012) <https://www.wpath.org/publications/soc>.

[39] *Re Kelvin* (2017) 327 FLR 15, [183]; [2017] FamCAFC 258.

[40] See the comments of Watts J in *Re Imogen (No 6)* (2020) 61 Fam LR 344; [2020] FamCA 761.

(an issue that was not addressed in *Re Kelvin*),[41] cases of disagreement between parents and the minor's treating health professionals,[42] and cases where the consent of both parents for the commencement of treatment cannot be obtained.[43] In *Re Imogen (No 6)* (*Re Imogen*),[44] Watts J determined that because the majority of the Full Court in *Re Kelvin* did not conclude that *Re Jamie* was "plainly wrong", this technically left some aspects of the earlier decision in *Re Jamie* in place. Watts J determined that applications to the court must occur in circumstances where:

(1) the young person is not considered *Gillick*-competent by their treating medical practitioner(s);
(2) where there is disagreement within the treating team such that a medical practitioner does not think it appropriate to commence treatment; and/or
(3) where one or both of the parents object to treatment, including where they disagree that the minor is *Gillick*-competent.[45]

Cases decided after *Re Imogen* have determined that an application to the court is required where the consent of both parents cannot be obtained, even in circumstances where one parent has separated from the other due to family and domestic violence and abuse.[46] Although the case law concerning hormone treatment for the treatment of Gender Dysphoria in children appears to adopt a similar position to other types of medical treatment involving children where there is disagreement between the parents and/or treating health professionals and the court is required to make a best interests determination, there are some significant differences. Thus, the basis for referring the matter to the court in cases concerning hormone treatment for childhood Gender Dysphoria is not solely to resolve disagreements with reference to best interests considerations, but extends, for example, to requiring the consent of both parents where there is no live disagreement on the facts (but where one parent may be estranged), and mandating court involvement where parents disagree with the clinical assessment of the minor's *Gillick*-competency. In relation to the latter, other commentators have noted that the requirement is out of step with the law relevant to *Gillick*-competency. Thus, as noted by Stephanie Jowett and Fiona Kelly:

> It was the conclusion of Watts J that where there is a dispute about any of diagnosis, treatment or competency, the matter should come before the Court. The legal basis for this conclusion is not clearly articulated in *Re Imogen*. In Watts J's view, his judgment merely clarified law laid out by the Full Court in *Re Jamie* and *Re Kelvin*, which requires court intervention in the case of "parental dispute". We acknowledge that Watts J was bound by the Full Court decisions in *Re Jamie* and *Re Kelvin* to the extent that the existence of a parental dispute may give rise to a role for the court. However, his Honour's interpretation of those judgments to allow for any type of dispute to usurp the wishes of a competent young person represents in our view a novel incursion on *Gillick* competency.[47]

Recent Australian Decisions and the Potential Impact of Bell

In *Bell*, the Divisional Court's conclusion that a minor is not likely to reach a level of competence required for the purpose of being deemed *Gillick*-competent to consent to the commencement of Stage 1 treatment, was based on the following:

> It follows that to achieve Gillick competence the child or young person would have to understand not simply the implications of taking PBs [puberty blockers] but those of progressing to cross-sex hormones [CSH]. The relevant information therefore that a child would have to understand, retain and weigh up in order to have the requisite competence in relation to PBs, would be as follows: (i) the immediate consequences of the treatment in physical and psychological terms; (ii) the fact that the vast majority

[41] *Re Matthew* [2018] FamCA 161; *Re Ryan* [2019] FamCA 112.

[42] *Re Imogen (No 6)* (2020) 61 Fam LR 344; [2020] FamCA 761.

[43] *Re A* (2020) 6 QR 718; [2020] QSC 389.

[44] *Re Imogen (No 6)* (2020) 61 Fam LR 344; [2020] FamCA 761.

[45] *Re Imogen (No 6)* (2020) 61 Fam LR 344, [35]; [2020] FamCA 761.

[46] *Re A* (2020) 6 QR 718, [9]–[10]; [2020] QSC 389.

[47] S Jowett and F Kelly, "Re Imogen: A Step in the Wrong Direction" (2021) 34(1) *Australian Journal of Family Law* 31, 45 (footnotes omitted).

> of patients taking PBs go on to CSH and therefore that s/he is on a pathway to much greater medical interventions; (iii) the relationship between taking CSH and subsequent surgery, with the implications of such surgery; (iv) the fact that CSH may well lead to a loss of fertility; (v) the impact of CSH on sexual function; (vi) the impact that taking this step on this treatment pathway may have on future and life-long relationships; (vii) the unknown physical consequences of taking PBs; and (viii) the fact that the evidence base for this treatment is as yet highly uncertain.[48]

The Court of Appeal in *Bell* criticised this approach on the basis that the Divisional Court relied on untested and adversarial evidence.[49] It was noted in relation to the progression from Stage 1 to Stage 2 treatment that there was a "difficulty in drawing conclusions from statistics [relied upon by the Divisional Court] which are not fully explained or explored in an evidential context where they were peripheral to the legal dispute before the Divisional Court and where any apparent differences were not capable of being tested forensically".[50] In addition, the Court of Appeal was critical of the Divisional Court's approach to *Gillick*-competency. The Court of Appeal noted that the guidance and factors outlined by the House of Lords in *Gillick* (particularly the factors outlined by Lord Fraser and Lord Scarman[51]) were not intended to be binding principles of law.[52] Instead, each element constituted "an area for evaluation, rather than a conclusory statement of fact or medical opinion".[53] The Court of Appeal pointed to several conclusions drawn by the Divisional Court that were inconsistent with the guidance in *Gillick*, which included the conclusion that the majority of persons commencing Stage 1 treatment would proceed to Stage 2 treatment, the conclusion that there are unknown physical and long-term consequences of Stage 1 treatment, and that the evidence base for Stage 1 treatment is highly uncertain.[54] The Court of Appeal stated that "the [Divisional Court] was not in a position to generalise about the capability of persons of different ages to understand what is necessary for them to be competent to consent to the administration of puberty blockers"[55] the effect of which was to "require applications to the court in circumstances where the Divisional Court itself had recognised that there was no legal obligation to do so".[56] Ultimately, the Court of Appeal concluded that any determination of the minor's competency falls to treating health professionals to decide, with reference to factors established in law. Thus, it was stated:

> The *ratio decidendi* of *Gillick* was that it was for doctors and not judges to decide on the capacity of a person under 16 to consent to medical treatment. Nothing about the nature or implications of the treatment with puberty blockers allows for a real distinction to be made between the consideration of contraception

[48] *Quincy Bell and Mrs A v The Tavistock and Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin), [138].

[49] *Quincy Bell and Mrs A v The Tavistock and Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin), [38].

[50] *Quincy Bell and Mrs A v The Tavistock and Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin), [27].

[51] *Bell v The Tavistock & Portman NHS Foundation Trust* [2021] EWCA Civ 1363. For example, Lord Fraser outlined that "the doctor will … be justified in proceeding without the parents' consent or even knowledge provided he is satisfied on the following matters: (1) that the girl (although under 16 years of age) will understand his advice; (2) that he cannot persuade her to inform her parents …; (3) that she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment; (4) that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer; (5) that her best interests require him to give her contraceptive advice, treatment or both without parental consent" (*Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, 174). Lord Scarman outlined that "[i]t is not enough that [the minor] should understand the nature of the advice which is being given: she must also have a sufficient maturity to understand what is involved. There are moral and family questions, especially her relationship with her parents; long-term problems associated with the emotional impact of pregnancy and its termination; and there are the risks to health of sexual intercourse at her age, risks which contraception may diminish but cannot eliminate. It follows that a doctor will have to satisfy himself that [the minor] is able to appraise these factors before he can safely proceed upon the basis that she has at law capacity to consent to contraceptive treatment. … it further follows that ordinarily the proper course will be for him, as the guidance lays down, first to seek to persuade the girl to bring her parents into consultation, and if she refuses, not to prescribe contraceptive treatment unless he is satisfied that her circumstances are such that he ought to proceed without parental knowledge and consent": *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, 189.

[52] *Bell v The Tavistock & Portman NHS Foundation Trust* [2021] EWCA Civ 1363, [80]–[81].

[53] *Bell v The Tavistock & Portman NHS Foundation Trust* [2021] EWCA Civ 1363, [74].

[54] *Bell v The Tavistock & Portman NHS Foundation Trust* [2021] EWCA Civ 1363, [74].

[55] *Bell v The Tavistock & Portman NHS Foundation Trust* [2021] EWCA Civ 1363, [85].

[56] *Bell v The Tavistock & Portman NHS Foundation Trust* [2021] EWCA Civ 1363, [86].

> in *Gillick* and of puberty blockers in this case bearing in mind that, when *Gillick* was decided 35 years ago, the issues it raised in respect of contraception for the under 16s were highly controversial in a way that is now hard to imagine.[57]

Despite making clear that the assessment of *Gillick*-competency is for clinicians to determine and not judges, it was noted that clinicians:

> must satisfy themselves that the child and parents appreciate the short and long-term implications of the treatment upon which the child is embarking and to exercise their clinical judgement knowing how important it is that consent is properly obtained according to the particular individual circumstances, as envisaged by Gillick itself, and by reference to developing understanding in this difficult and controversial area.[58]

Importantly, the Court of Appeal concluded that the Divisional Court imposed an improper restriction on the *Gillick* test of competence by the declaration that was made, as well as the imposition of age criteria and necessitating an application to court in all future cases.[59]

The Court of Appeal decision in *Bell* is significant in terms of clarifying the *Gillick*-competency test and its application in cases concerning hormone treatment for childhood Gender Dysphoria under English law. It will be interesting to see whether this reasoning has any impact on the future direction of Australian law in this field. Interestingly, after the Divisional Court's decision in *Bell*, some Australian cases noted that the decision may have a potential impact on Australian law and/or practice. In a series of decisions from the Family Court of Western Australia, it is noted that the Divisional Court's decision had prompted some service providers to review their practices and processes.[60] Indeed, it was submitted by the respondent in the applications to the Family Court of Western Australia, which had responsibility for the provision of healthcare services to minors with Gender Dysphoria, that pending a review of its practices and procedures an application to the court should be required in *all* cases involving treatment for Gender Dysphoria in children.[61] The same service provider also submitted that although it did not consider *Bell* a barrier to treatment (referring to the Divisional Court's decision), it was stated that the decision nevertheless provides clarification or guidance for the operation of the legal framework within which treatment decisions are made. This is a surprising conclusion, given that the Divisional Court in *Bell* made absolutely no reference to Australian law, and was instead focused solely on the issue of *Gillick*-competency under the lens of a judicial review application. Thus, one important point of distinction that can be made in this regard is that Australian service providers have recognised that treatment, including Stage 1 treatment, can be commenced in circumstances where the minor is not regarded as *Gillick*-competent, but the parents are willing to consent to the treatment. As outlined above, the initial Australian case law in this field was focused on the issue of whether parents can lawfully consent to Stage 1 treatment for their child in circumstances where the minor is not *Gillick*-competent. In contrast, the approach adopted as a matter of practice by GIDS in England, was that puberty blockers would not be commenced on the basis of parental consent alone in circumstances where the minor is not *Gillick*-competent,[62] as the consent of *both* the minor and the parents was required.[63] This position requiring consent of both the minor and parents was reviewed following the Divisional Court's decision.[64] This context also helps demonstrate why the underlying legal approaches in each jurisdiction are distinct. In Australia, in circumstances where consent is lawfully provided (which can include consent provided by the minor's parents if the minor is not *Gillick*-competent), there is no apparent reason (following

[57] *Bell v The Tavistock & Portman NHS Foundation Trust* [2021] EWCA Civ 1363, [76].

[58] *Bell v The Tavistock & Portman NHS Foundation Trust* [2021] EWCA Civ 1363, [93].

[59] *Bell v The Tavistock & Portman NHS Foundation Trust* [2021] EWCA Civ 1363, [94].

[60] See *Re G2* [2021] FCWA 98; *Re G3* [2021] FCWA 99; *Re G4* [2021] FCWA 102.

[61] *Re G4* [2021] FCWA 102, [38].

[62] *Quincy Bell and Mrs A v The Tavistock and Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin), [47].

[63] *Bell v The Tavistock & Portman NHS Foundation Trust* [2021] EWCA Civ 1363, [5].

[64] See P Dunne, "Case and Comment, Childhood in Transition: Can Transgender and Non-Binary Minors Provide Lawful Consent to Puberty Blockers?" (2021) 80(1) *Cambridge Law Journal* 15.

the decision in *Re Kelvin*) as to why an application to the court should be required, unless there is a "controversy" that necessitates such an application. On this basis, the Divisional Court's decision in *Bell* should not be considered influential in terms of providing a basis to retreat to the pre-*Kelvin* position for the purpose of requiring all cases concerning treatment for Gender Dysphoria in minors, to be referred to the court. Such a view is particularly well supported when considering the decision of the Court of Appeal in *Bell*, which overturned the conclusions of the Divisional Court in relation to *Gillick*-competency.

One further issue that is significant in nature, in terms of its potential impact on Australian law, is the conclusion reached by the Court of Appeal in *Bell* concerning the determination of *Gillick*-competency and this falling to clinicians to determine, rather than judges. There is no doubt that the Court of Appeal in *Bell* concluded that the *ratio* in *Gillick* clearly establishes that it is for clinicians to determine minors' competence based on relevant guidance set out in that case. If the Court of Appeal's reasoning were to be considered for the purpose of influencing Australian law, then arguably there should no longer be a need to refer some cases to the Family Court for determination. Thus, recent applications have been made to the court where the minor is regarded as *Gillick*-competent by their treating clinicians, but one parent objects to the treatment and/or does not agree that the minor is competent to make the decision.[65] If the determination of *Gillick*-competency rests with clinicians, it is unclear why judges should need to confirm that assessment, particularly if the parental power is at an end once the minor reaches a level of competency to make their own decisions. Thus, the Court of Appeal in *Bell* formed the view that there is no basis for the court's involvement in such circumstances. It is possible that the Family Court might distinguish this approach and maintain that the position in Australia should continue, requiring applications to be be made in cases where parents disagree with the clinician's assessment of Gillick-competency. It might be argued that the application to the court is simply to *confirm* the minor's competence in accordance with the clinician's assessment, rather than the judge's *assessment* of the minor's competency. Ideed, in many of the pre-*Kelvin* Family Court decisions, the court appears to simply *confirm* the minor's capacity based on the conclusions of the treating clinicians as outlined in evidence. In many of the cases, the court confirms the minor's capacity without explicitly detailing or analysing the factors relevant to establishing *Gillick*-competency.[66] Potentially, as judges in these cases are not *determining* the minor's competency, but are simply confirming it based on medical evidence, an argument may be put forward that the position is consistent with the *ratio* of *Gillick*. Notably, the Family Court, in a number of cases, has outlined a checklist of factors for the purpose of assessing a minor's competency,[67] as follows:

(1) an ability to comprehend and retain both existing and new information regarding the proposed treatment;
(2) an ability to provide a full explanation, in terms appropriate to the child's level of maturity and education, of the nature of the treatment;
(3) an ability to describe the advantages of the treatment;
(4) an ability to describe the disadvantages of the treatment;
(5) an ability to weigh the advantages and disadvantages in the balance, and arrive at an informed decision about whether and when to proceed with the treatment;
(6) an ability to understand that the decision to proceed with phase 2 treatment could have consequences that cannot be entirely foreseen at the time of the decision;[68]
(7) an ability to understand that the treatment will not necessarily address all or any of the psychological and social difficulties that the person had before the commencement of treatment; and

[65] See, eg, *Re Ash* [2021] FedCFamC1F 100.

[66] See *Re Shay* [2016] FamCA 998; *Re Dallas* [2016] FamCA 1131.

[67] This list has evolved from the decisions in *Re Lincoln (No 2)* [2016] FamCA 1071, *Re Elliott* [2017] FamCA 1008 and *Re Imogen (No 6)* (2020) 61 Fam LR 344; [2020] FamCA 761.

[68] It should be noted that item six was not explicitly listed in the requirements nor directly analysed in the cases of *Re Lincoln (No 2)* [2016] FamCA 1071 and *Re Elliott* [2017] FamCA 1008, but was listed in *Re Imogen (No 6)* (2020) 61 Fam LR 344, [184]–[185]; [2020] FamCA 761.

(8) being free to the greatest extent possible from temporary factors that could impair judgment in providing consent to the treatment.

At present, clinicians providing evidence to the court are required to address these factors when undertaking their assessment.[69] There is no reason, however, at least in principle, why these factors cannot be taken as a checklist of relevant factors that must be determined by the clinician when assessing a minor's capacity in this context, so that an application to court is not considered necessary if the minor is deemed *Gillick*-competent by the clinical team. This argument is further strengthened when considering the High Court's approach to *Gillick*-competency in *Marion's Case*. It was recognised in *Marion's Case* (and Watts J acknowledged this in *Re Imogen*[70]) that once a minor is regarded as competent to make their own decisions about treatment, the parental power to consent comes to an end.[71] What, then, is the basis in law for the requirement to involve the court? If a dispute is raised by a parent about their child's capacity (where capacity is confirmed by a health professional) thereby necessitating court involvement based on *Re Imogen*, a question arises as to how this position aligns with Gillick, especially in light of the High Court's reasoning in *Marion's Case* which determined the parental power is at an end when the minor is assessed as *Gillick*-competent by their treating clinician. The legal basis for such a requirement requires clarification, particularly in light of the Court of Appeal's conclusions in *Bell* about the determination of *Gillick*-competency resting with clinicians.

Finally, it is worth noting that the reasoning in *AB v CD* concerning the potential classification of Stage 1 treatment as "special", is also unlikely to influence Australian law. When considering whether puberty blockers are a "special" form of treatment in *AB v CD*, although it was determined that they should not be regarded as such, Lieven J noted:

> It is easy to see that arguments might be raised that paragraphs 11(d) and (e) [of the Serious Medical Treatment Practice Guidance (*Practice Guidance (Court of Protection: Serious Medical Treatment))* [2020] 1 WLR 641] would apply to the administration of [puberty blockers] for Gender Dysphoria and that therefore the principles applicable to adults lacking capacity should be extended to children.[72]

Ultimately, it was concluded that there was no *legal* requirement in English law to refer such cases to the court, but that if such a requirement were to exist, this would be because it should be considered a matter a good practice to involve the court.[73] The position under English law is therefore different in respect of special medical treatments as if such a requirement were to exist, it was noted that it would not be mandatory unlike under Australian law, (although Lieven J noted that it might be a breach of relevant professional standards to not involve the court in "special" cases). In Australia, the significant body of case law relevant to this topic has examined the issue of whether Stage 1 and/or Stage 2 treatment should be classed as special and at times, the law has determined that applications to the court are mandatory due to the risks involved in the treatment. However, the law is now clearer in relation to Stage 1 treatment – it is no longer regarded as "special" and there is generally no requirement to involve the court with

[69] Indeed, if a clinician fails to address the relevant factors and/or reasons as to why the minor is deemed *Gillick*-competent in their evidence, then the court may refuse to confirm the minor's competency. In *Re Jan* [2016] FamCA 1171 the clinician formed the view that the minor was *Gillick*-competent, but as the reasons for this conclusion were not adequately outlined in the evidence, the judge could not confirm the minor's competency.

[70] *Re Imogen (No 6)* (2020) 61 Fam LR 344, [28]; [2020] FamCA 761.

[71] See *Secretary, Department of Health and Community Services (NT) v JWB (Marion's Case)* (1992) 175 CLR 218, 316 (McHugh J).

[72] *AB v CD* [2021] EWHC 741 (Fam), [96]. Here, Lieven J was referring to the fact that the claimants in *Quincy Bell and Mrs A v The Tavistock and Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin) submitted that the Divisional Court should follow the Serious Medical Treatment Practice Guidance (*Practice Guidance (Court of Protection: Serious Medical Treatment)* [2020] 1 WLR 641) relevant to the Court of Protection's jurisdiction, established under the *Mental Capacity Act 2005* (UK). Paragraph 10 explains that medical decisions (other than the provision of life-sustaining treatment) involving a potentially serious interference with a person's rights under the European Convention on Human Rights should be the subject of an application, so the court can comprehensively analyse the considerations relevant to the person's capacity and best interests. Paragraph 11 gives examples of circumstances that fall into this category, including where the proposed procedure is "experimental or innovative" or where the treatment involves "a significant ethical question in an untested or controversial area of medicine".

[73] See the concluding remarks of Lieven J in *AB v CD* [2021] EWHC 741 (Fam), [119]–[125].

decisions about Stage 1 treatment in Australia, except if there was a significant concern about the minor's best interests. The Full Court in *Re Jamie* made clear that there was a need to depart from the view that Stage 1 treatment should be regarded as special. It is therefore highly unlikely that the courts would revert to classifying Stage 1 treatment as "special" (except if there were some discovery about the long-term impacts of the drugs, that warranted court oversight). In contrast, it is clear that difficulties remain in respect of the authorisation of Stage 2 treatment and decisions about such treatment in Australia continue to come before the courts, although this appears to be based on the fact that there is disagreement between decision-makers rather than concern about the treatment being regarded as "special". In this sense, the reasoning around the "special" nature of the treatment outlined in the recent English caselaw is unlikely to influence the future direction of Australian law in terms of whether treatment should be classed as "special".

Concluding Remarks

The question of whether young transgender persons should be subject to court oversight in relation to decisions about the commencement of hormone treatment for Gender Dysphoria has presented challenges for the judiciary. The recent case law in England was outlined in detail in Professor Manning's article in the previous volume of this Journal. I have further considered the relevant factual and legal background of these cases, together with the potential impact that they may have on Australian law. While the more restrictive and cautious reasoning adopted by the Divisional Court in *Bell* is unlikely to influence the law in Australia – which would in any event represent a backwards step for Australian law – the Court of Appeal's approach in *Bell* has the potential to advance Australian law in this field moving forward. The Court of Appeal's clarification of the principle of *Gillick*-competency, makes clear that decisions about a minor's competency rest with the minor's treating clinician(s) and not judges. When *Re Kelvin* was decided, it was anticipated that there would be fewer applications to the court for the approval of hormone treatment for Gender Dysphoria in children. Since the Full Court decided that case in 2017, the number of cases falling under the category of "controversy" has been steadily increasing in Australia. Whether this most recent statement of the law as outlined by the Court of Appeal in *Bell*, will influence the overly restrictive interpretation of the principle of *Gillick*-competency as put forward by Watts J in *Re Imogen*, remains to be seen. However, it is my view that the Family Court should consider the possibility of whether court oversight of such decisions is still required in cases where the minor is deemed *Gillick*-competent, but their parents disagree, particularly when the notion of *Gillick*-competency is considered in line with the interpretation afforded to it in *Marion's Case*.