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Leading Gillick Astray? An Analysis of the Law of Consent Relevant to Trans and Gender Diverse Minors and the Commencement of Gender-Affirming Hormone Treatment

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Abstract: This article outlines and critiques the Australian jurisprudence that has addressed whether minors are able to lawfully consent to gender-affirming hormone treatment, with reference to the landmark decision of *Gillick v West Norfolk and Wisbech Area Health Authority*. Although the principle of *Gillick* competency is well recognised in law, the Australian legal developments that apply *Gillick* to decisions about the commencement of gender-affirming treatment, have taken the principle astray. The approach under Australian law has diverged down a path that does not align with the original reasoning in *Gillick*, nor its contemporary interpretation. I outline the reasoning in *Gillick* so that the foundational principles are considered before discussing how *Gillick* has been interpreted and applied in subsequent cases. I then provide an outline of the key legal developments in Australia relevant to minors and the commencement of hormone treatment for gender dysphoria. I undertake a critique of the Australian law in this field and conclude that there is a need for future judicial determination of how *Gillick* should be applied, not only in the cases relevant to gender dysphoria, but beyond, so that the position in respect of minors' decision-making is clarified. This is vitally important because the current approach to this issue has potential implications beyond cases relevant to gender-affirming hormone treatment.

Keywords: children and consent; gender affirming hormone treatment; *Gillick* competency; gender dysphoria; gender diversity

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1. Introduction

There have been over 100 applications made to the Family Court of Australia (Family Court)[1] over the last ten years in relation to gender diverse or transgender (trans) minors who wish to continue with or commence hormone treatment for gender dysphoria. The current Australian context and recommended care pathways for minors with gender dysphoria are outlined in the *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents* (Telfer et al. 2021) and summarised by the authors of another paper in this special issue (Jowett et al. 2022). The Australian cases have considered who is authorised, or not, to lawfully consent to gender affirming hormone treatment for minors with gender dysphoria. This has focused on both the issue of whether parents are lawfully permitted to consent to such treatment, as well as whether minors can lawfully consent based on the concept of *Gillick* competency. This article outlines and critiques the Australian jurisprudence that has addressed whether minors are able to lawfully consent to gender affirming hormone treatment.

The concept of *Gillick* competency stems from the House of Lords decision of *Gillick v West Norfolk and Wisbech Area Health Authority*.[2] As will be explained, this principle

[1] 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 the cases discussed in this article were determined by the Family Court prior to this change, I use the term "Family Court".

[2] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 ('*Gillick*').

recognises that although minors are generally presumed to be incompetent for the purpose of consenting to their own medical treatment or decisions about health care, they can lawfully make such decisions if they are sufficiently mature and have the capacity to fully understand the nature and consequences of the decision in question. This principle is well recognised in law, and it is generally accepted that a minor deemed competent by their treating medical practitioner can lawfully consent to medical treatment.

The application of this principle to a range of other specific contexts has been the subject of much judicial attention, debate, and scholarship, particularly in relation to decisions that carry significant consequences such as decisions about life-sustaining treatment. It is therefore not surprising that legal questions have emerged in the body of case law relevant to minors and gender affirming hormone treatment. As I argue in this article, unfortunately the Australian legal developments have taken the principle of *Gillick* competency astray, leading it down a path that does not align with the original reasoning in *Gillick*, nor its contemporary interpretation. To demonstrate this, in Part Two of this article I outline the reasoning in *Gillick* so that the foundational principles are considered before discussing how *Gillick* has been interpreted and applied in subsequent cases. In Part Three, I outline the key legal developments in Australia relevant to minors and the commencement of hormone treatment for gender dysphoria. As the law relevant to minors' decision-making in this body of caselaw is entangled with the principles relevant to parental consent, this requires a general overview of the common law developments. However, in Part IV of the article, I focus specifically on an evaluation of how the issue of *Gillick* competency has been applied to decisions about gender affirming treatment, both in Australia and in England, before critiquing the Australian position. Finally, I conclude the analysis and highlight the need future judicial determination on these issues, to clarify the Australian legal position.

Although others have similarly raised concerns with Australian law (Jowett and Kelly 2021; Ouliaris 2022; Kelly et al. 2022), such analyses focus predominantly on the most recent caselaw developments. In this article, I build on the existing literature by undertaking a thorough analysis of the key Australian decisions and evaluate the cases across the spectrum of key decisions. The analysis undertaken in this article demonstrates that the application of *Gillick* in the context of decisions about gender affirming hormone treatment has erred from the very beginning. I argue that the caselaw in this arena has adopted a particularly paternalistic approach to the issue of *Gillick* competency, which is not justified based on the reasoning in *Gillick* and its subsequent interpretation. Although the legal position on this point was changed by the Full Court in 2017, recent cases suggest that parental consent is required *in addition to* the consent of a minor assessed as *Gillick* competent, and that in cases where a parent disagrees with the clinical assessment of the minor's competency, the court must confirm the minor's competency. My key arguments address this position, which is unique and specific to Australian law in the context of decisions about gender affirming hormone treatment. I outline that the approach adopted in the most recent Australian cases suggests that a special rule applies in this context. This special rule requires parental consent in addition to the consent of a *Gillick* competent minor, and/or regards a consent provided by a *Gillick* competent minor as ineffective for the commencement of gender affirming treatment in some circumstances, unless confirmed by a court. Questions arise as to why the consent of a *Gillick* competent minor is not effective in terms of negating liability for trespass to the person/assault on the part of the health professional in cases where the parents do not also consent and/or the minor's competency is disputed by a parent. Like other commentators, I conclude that there is a need to judicially reconsider how *Gillick* is applied in the specific context of decisions about gender affirming hormone treatment, but I also note that judicial clarification of the concept is vitally important because the current interpretation has potential implications beyond cases relevant to gender affirming hormone treatment.

2. The House of Lords Decision in *Gillick* and Its Subsequent Interpretation

The House of Lords decision in *Gillick* is discussed extensively in the scholarly literature relevant to the law and decision-making by minors. I do not provide a full synthesis of the reasoning in *Gillick* in this article. However, it is worth re-engaging with some of the key reasoning in the decision for the purpose of understanding both the original reasoning in the case, and its subsequent development and interpretation. This outline of the decision in *Gillick* and its subsequent interpretation provides the basis to then evaluate the Australian case law concerning gender affirming hormone treatment in Part Four of this article.

2.1. The House of Lords Decision in Gillick

Gillick was about the legality of guidance issued by the United Kingdom's (UK) Department of Health and Social Security to National Health Service health authorities. The judicial review action challenged the view that it was lawful for medical practitioners to allow minors below the age of 16 to consent to the provision of contraceptive advice and treatment without the consent or knowledge of a parent or guardian. Although the age of majority under English law is 18 years of age,[3] the law presumes that minors aged 16 or 17 years are competent for the purpose of lawfully consenting to surgical, medical and dental treatment and that such consent is effective for the purpose of negating liability for the treating health professional under the law of trespass to the person.[4] Minors below 16 years of age are not captured by this legislative provision and hence, the issue is whether there is some other principle that allows them to lawfully consent.

There were three main issues that the House of Lords addressed in *Gillick*, including: (1) whether a minor below the age of 16 might have the capacity to lawfully consent to contraceptive advice and treatment; (2) whether the provision of contraceptive advice and treatment to a girl under 16 years of age without the consent of the parents, infringes the parents' rights in relation to the child; and, (3) whether a doctor who provides such advice and treatment to a girl under the age of 16 without parental consent, might potentially incur criminal liability.[5] It is particularly important to note that although the issue arising in *Gillick* is predominantly framed as one about consent and medical decision-making, this was not the only focus. One of the principal concerns raised in the case was about ensuring that the duty of confidence would be preserved so that young persons might access medical care and advice in circumstances where there is no involvement or approval of a parent. For this reason, the principle of *Gillick* competence emerged as a means of protecting confidentiality. As outlined below, this has been considered in the post-*Gillick* caselaw, and is an important point that I return to later in this article, when critiquing the Australian jurisprudence.

The notion of *Gillick* competency is often summarised with reference to Lord Scarman's reasoning, which allows minors to make decisions about their own medical treatment when they attain 'sufficient understanding and intelligence to enable [them] to understand fully what is proposed'.[6] However, this does not reflect the full extent of Lord Scarman's approach.[7] There are some complexities in the decision which make it difficult to synthesise the different reasoning expressed in the judgments. As noted by Professor Pattinson (2018, p. 54), the majority of three in the House of Lords who held that a minor under 16 is able to lawfully consent to medical treatment, 'did not speak with one voice, and differences within and between the leading judgments have supported alternative interpretations'. Pattinson (2018, p. 56) comments:

> Lord Fraser and Lord Scarman both rejected the absolute control of parents over their minor children and accepted the capacity of mature minors to make

[3] *Family Law Reform Act 1969* (UK) s 1.
[4] *Family Law Reform Act 1969* (UK) s 8; *Mental Capacity Act 2005* (UK) ss 1, 2(5).
[5] *Gillick*, note 2, p. 166.
[6] Ibid, p. 189.
[7] On this point, see (Elliston 2007).

> treatment decisions for themselves. Lord Fraser apparently confined himself to medical treatment and reasoned by reference to the child's welfare, whereas Lord Scarman reasoned in more general terms by reference to the 'right' of a child with sufficient understanding and intelligence to make his or her own decisions.

For the purpose of reaching the threshold required to lawfully consent, Lord Fraser noted that a child under 16 has capacity to consent if they are 'capable of understanding what is proposed, and of expressing his or her own wishes'.[8] Although Lord Scarman made reference to the notion of rights in terms of children possessing the right to make health care decisions, he added to Lord Fraser's formulation of the principle, requiring that the minor attains sufficient discretion to be able to exercise a wise choice that accords with their own interests.[9] Lord Scarman's approach effectively requires a higher threshold, which moves beyond mere understanding and towards a requirement to make a wise or rational choice, which is a standard that has been expressly rejected in relation to adults.[10]

Irrespective of the different approaches adopted in *Gillick* concerning the determination of a minor's competency, as noted by Pattinson (2018, pp. 57–58), an individual's capacity may vary in accordance with the nature of the decision in question, including the long-term consequences and the gravity of the decision. This is a particularly important observation to note when applied to decisions about the commencement of gender affirming hormone treatment, as such decisions have been noted as carrying significant long-term consequences and unknown risks.[11]

An issue worth clarifying here is whether the *Gillick* test requires *actual* understanding of the decision in question (including its risks, consequences, and the gravity of the decision) to meet the threshold, or whether it is a requirement that the minor has the *capability* to understand. On this point, Professor Cave (2014, p. 107) points to the reasoning expressed in *Gillick* that suggests that the test is about the minor's *capability* to understand information. For this purpose, Cave (2014, p. 107) refers to Lord Fraser's statement in *Gillick*, who reasoned:

> Provided the patient, whether a boy or a girl, is *capable* of understanding what is proposed, and of expressing his or her own wishes, I see no good reason for holding that he or she lacks the capacity to express them validly and effectively and to authorise the medical man to make the examination or give the treatment which he advises.[12]

Cave (2014, p. 106) notes that subsequent authorities have interpreted the test in line with the capability to understand meaning, but notes the difficulties that this approach may cause in the sense that 'if capability to understand rather than actual understanding is required in order for a minor to be recognised as competent, then the assessment might legitimately be made before the minor has made a decision'. Cave (2014, p. 107) further notes that there are benefits to the interpretation of the test in this way, but that it causes a 'tension between the application of the test in court and in practice'. Nevertheless, this is an important point of clarification that is relevant to the application of the test in the context of gender affirming care, which I return to later in this article.

Before moving to consider subsequent case law it is important that I outline how the House of Lords considered the concept of parental rights and duties in *Gillick*. It was necessary for the House of Lords to address the issue of parental rights because of Mrs Gillick's assertion that a medical practitioner's right to provide contraceptive advice and treatment adversely affected her rights and duties as a parent, which included 'an

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8 *Gillick*, note 2, p. 169.
9 Ibid, p. 188.
10 See, for example, Lord Donaldson in *Re T (Adult: Refusal of Medical Treatment)* [1993] Fam 95; Butler-Sloss P in *B v An NHS Trust* [2002] 2 All ER 449.
11 The unknown risks and consequences were discussed, in particular, in *Quincy Bell and Mrs A v The Tavistock and Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin) ('*Bell*').
12 *Gillick*, note 2, p. 169.

absolute right to be informed of and to veto such advice or treatment being given to her daughters even in the "most unusual" cases which might arise'.[13] A key question that required determination in *Gillick* was whether the parental right to either make decisions for and on behalf of a child, or to be provided with information about the child's health care and treatment, is extinguished or diminished when the minor attains the threshold of competency required to make the decision. In relation to this point, the House of Lords dismissed the idea that the parental right to consent exists as a basis to exert control over the child; it was noted that such rights exist for the *benefit* of the child.[14] This is not to suggest that parents retain no rights when their child reaches the threshold for *Gillick* competency. As Lord Scarman acknowledged, parental rights *do* continue to exist and such rights are not extinguished before the age of majority.[15] Despite this, Lord Scarman qualified this statement by stating that 'parental rights are derived from parental duty and exist only so long as they are needed for the protection of the person and property of the child'.[16] It is for this reason that Lord Scarman stated that the 'parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision'.[17] In this sense, the ability to consent—based on the minor reaching a sufficient level of understanding and intelligence—allows the minor to exercise their autonomy, potentially without the involvement or knowledge of their parent(s).[18] This means that although parental rights continue to exist more broadly when a minor is competent to make their own health care decisions, they might only be exercised in circumstances where this is necessary to protect the child, an issue that is examined further below, when considering the post-Gillick case law developments.

Interestingly, Lord Fraser reasoned that although a minor under 16 years of age can lawfully consent to medical treatment if competent to do so, the 'consent of the parents should normally be asked'.[19] As noted by Pattinson (2018, p. 58), this suggested that Lord Fraser 'thought that only in exceptional circumstances should doctors proceed with just the consent of a sufficiently mature child' and that the minor's parents would be the best judge of the child's welfare. Indeed, Lord Fraser outlines a list of factors to guide medical practitioners when determining whether a minor can lawfully consent without the knowledge or involvement of their parent(s), which have become known as the Fraser Guidelines:

(1) that the girl (although under 16 years of age) will understand his advice;

(2) that he cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice;

(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 the parental consent.[20]

Lord Fraser also noted that parental control diminishes in line with the independence of the minor, 'the degree of parental control actually exercised over a particular child does in practice vary considerably according to his understanding and intelligence and it would, in my opinion, be unrealistic for the courts not to recognise these facts'.[21] Thus, despite

13 *Gillick*, note 2, p. 170 (per Lord Fraser).
14 Ibid.
15 Ibid, p. 184 (per Lord Scarman).
16 Ibid (emphasis added).
17 Ibid, p. 186.
18 *R (Axon) v Secretary of State for Health* [2006] EWHC 37 (Admin) ('*Axon*').
19 *Gillick*, note 2, p. 169.
20 Ibid, p. 174.
21 Ibid p. 171.

forming the view that the parent should be involved in the decision-making process, Lord Fraser nevertheless acknowledged that parental involvement would likely diminish in line with the development of the minor's capacity.

It is clear from the above overview that there is a difficulty in trying to find a unified approach between the judgments in terms of how the principle should be applied. Thus, Lord Scarman forms the view that the minor should make wise decisions that accord with their own best interests, potentially imposing a much higher threshold of understanding. There is also a difference between the judgments of Lord Scarman and Lord Fraser about what is required, in terms of whether actual understanding is the relevant threshold, or merely the capacity to understand. Similarly, Lord Scarman and Lord Fraser differ in relation to the impact of a finding of competency on parental rights. Whilst Lord Scarman's approach suggests that once the minor is deemed competent the parental rights in respect of that decision are extinguished, Lord Fraser's approach gives greater recognition to parental rights and suggests that parental consent should ordinarily be obtained, thus indicating that relying only on the consent of a competent minor should occur in exceptional circumstances. Notably, Lord Fraser also gives detailed guidance for medical practitioners to assist them in assessing the competency of minors, provided that the treatment the minor wishes to consent to is in their best interests. These differences in the judgments necessitate an examination of the subsequent English case law, to determine how this reasoning has been applied in other cases.

2.2. The Subsequent Interpretation and Application of Gillick under English Law

There is no doubt that *Gillick* is a landmark decision that provides competent minors with the ability to lawfully make their own medical treatment decisions in many contexts. It is important, however, to consider how the core reasoning in *Gillick* has been challenged in subsequent decisions. Lord Fraser's position, which suggests that parents should normally be asked and/or involved with the minor's decision appears to be weakened by subsequent case law. In *R (Axon) v Secretary of State for Health* ('*Axon*'), the claimant argued that parents have, at the very least, a right to be informed of treatment decisions made by their *Gillick* competent children, or to be provided with information about them.[22] In the context of this case, the arguments were again focused on reproductive decision-making, with a greater emphasis on the concept of confidentiality.[23] However, the claimant's assertion, based on human rights grounds, that as a parent she would have the right to be informed of decisions made by her children, was rejected by the English High Court. The *Axon* decision makes clear that *Gillick* competent minors are entitled to 'expect confidentiality when seeking advice about contraception and abortion' and that their right to confidentiality is also protected by reference to human rights standards (Jackson 2019, p. 335). In effect, this requires leaning in favour of Lord Scarman's approach in *Gillick*, which recognises that the parental power to consent in relation to a decision is at an end when the minor is deemed *Gillick* competent for the purposes of making that decision.

The approach adopted in *Gillick* and confirmed in *Axon* has been applied in other cases in the sphere of reproductive decision-making and contraception. In *An NHS Trust v A*, which concerned a 13-year-old minor seeking a termination of pregnancy, Mostyn J commented that if he were to find that the minor was *Gillick* competent, 'then that is the end of the matter' in terms of the court's involvement.[24] His Honour further stated that the 'question of best interests does not really inform the primary decision [that must be made] which is whether [the minor] has the necessary capacity'.[25] The minor in this case was held to be *Gillick* competent, but Mostyn J noted that he would expect the minor to require significant support and assistance from her parents and social services if she were to continue with the pregnancy, and that similarly, if she were to go ahead with

[22] *Axon*, note 18.
[23] For a discussion of the confidentiality issues, see (Cave 2009).
[24] *An NHS Trust v A* [2014] EWHC 1445 (Fam), [9].
[25] Ibid, [10].

the termination procedure, she would require her family to be at her side to assist and support her.[26] Kirsty Moreton (2015, p. 313) has commented that there is an irony in this decision, such that '[i]t is inconsistent that the law rejects collaboration in the decision-making process only to call upon it to deal with the consequences of that decision . . . ' and that a more cynical interpretation of the decision is that it is 'really a best interests decision, dressed up in autonomy language . . . '. The reality is that family members and others (such as treating health professionals) are often involved with supporting the minor making the decision, as well as supporting the consequences of such decisions. I agree that there is a need to ensure that the law recognises the minor's right to make their own decision, without the need for parental involvement. This is because there may be some minors who are not fortunate enough to have the familial support that others might have. However, familial support and involvement in the decision-making process is distinct from the right of the decision-maker to make the choice in question. Indeed, many adults who are legally competent in terms of understanding the nature and effect of a decision may nevertheless require familial support in coping with the consequences of their decision. This need for support does not necessarily diminish the individual's capacity to make the decision for themselves. It is worth noting this because, as will be discussed in the context of the Australian decisions concerning gender affirming treatment, minors are, for the most part, making decisions about gender affirming treatment with the support and involvement of their parents. Thus, not all decisions made by *Gillick* competent minors will be made within a sphere of individual confidence and parents may well be involved in the decision-making process and with supporting the minor once a decision is made. However, this should not *require* that parents are involved with the decision-making process in the form of giving consent, as this may not be possible in all cases. Indeed, the position in *Axon* seems clear on this point, that parental consent or knowledge is not a requirement, and the involvement of family members in terms of supporting the competent minor does not necessarily diminish the legal significance of the minor providing their own valid consent.

Gillick has been applied in a way that clearly provides the competent minor with a right to consent *to* treatment. However, some cases have placed limitations on the *Gillick* principle in terms of the minor's ability to make more controversial treatment decisions. Cave (2014, p. 104) comments that the lack of clarity in *Gillick* has enabled its limitation in subsequent cases, noting that this is both because the case was only intended to address one specific issue (contraceptive advice and treatment) rather than applying universally to decision-making by minors,[27] and because there have been subsequent judicial limitations that have followed, particularly in cases involving refusal of life saving treatment.

In terms of the cases that address decisions about life-saving medical treatment, some, after examining the minor's capacity for decision-making, conclude that the minor did not reach the threshold of understanding that is required to be deemed *Gillick* competent. In *Re E*,[28] for example, a 15-year-old with leukaemia wished to refuse blood products due to his religious beliefs. Although Ward J found that the minor was competent to make some decisions relating to his treatment, there were other decisions for which he lacked capacity. This was based on the conclusion that the minor did not realise the full extent of the decision in terms of the process of dying.[29] Although it might be argued that this approach aligns with the higher threshold discussed by Lord Scarman in *Gillick* so that the minor *fully* understands the decision and its consequences, some have noted that there is an exceptionally high threshold of understanding applied in such cases (Jackson 2019, p. 338). Thus, it has been noted in regards to understanding the process of death and dying, '[h]ow many adults enjoy such an insight?' (Brazier and Cave 2016, p. 468). In this context, the threshold of understanding applied in such cases has been criticised as unrealistic and far beyond what might be required, based on the reasoning in *Gillick*.

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[26] Ibid, [15].

[27] On this point, see (Lennings 2013).

[28] *Re E (a minor) (wardship: medical treatment)* [1993] 1 FLR 386.

[29] Ibid.

In contrast, there are cases where minors have been deemed *Gillick* competent, but the court has not allowed the minor's refusal of treatment to take effect where treatment is needed to avoid serious deterioration in the minor's health or to avoid death. *Re W*[30] is one of the most significant cases to address the issue and considered whether a 16-year-old with anorexia nervosa could lawfully refuse some forms of treatment that were considered to be life-saving. In *Re W*, building on the earlier reasoning in *Re R*,[31] Lord Donaldson used the analogy of a legal "flak jacket" as a basis for consent. It was noted that such a flak jacket:

> . . . protects the doctor from claims by the litigious whether he acquires it from his patient, who may be a minor over the age of 16 or a "Gillick competent" child under that age, or from another person having parental responsibilities which include a right to consent to treatment of the minor. Anyone who gives him a flak jacket (i.e., consent) may take it back, but the doctor only needs one and so long as he continues to have one he has the legal right to proceed.[32]

On the facts, *Re W* was about the application of section 8 of the *Law Reform Act 1969* (UK), which confers upon minors aged 16 or 17 years, an ability to lawfully consent to medical treatment and for health professionals to accept such consent with the same legal effect as if it had been given by the minor's parent(s). However, the case also clarified the position in respect of consent and refusal of life saving treatment by *Gillick* competent minors (below the age of 16). Lord Donaldson confirmed that the court's *parens patriae* jurisdiction is extremely wide and that there can be:

> . . . no doubt that it has the power to override the refusal of a minor, whether over the age of 16 or under that age but "Gillick competent". It does not do so by ordering the doctors to treat, which, even if within the court's powers, would be an abuse of them, or by ordering the minor to accept treatment, but by authorising the doctors to treat the minor in accordance with their clinical judgment, subject to any restrictions which the court may impose.[33]

Citing Lord Hailsham in *Re B*,[34] Lord Donaldson noted that the 'first and paramount consideration [of the court] is the well-being, welfare or interests [of the minor]', and went on to state that he regards 'it as self-evident that this involves giving [minors] the maximum degree of decision-making which is prudent'.[35] However, it also stated, '[p]rudence does not involve avoiding all risks, but it does involve avoiding taking risks which, if they eventuate, may have irreparable consequences or which are disproportionate to the benefits which could accrue from taking them'.[36] Importantly, concerning consent *to* treatment, Lord Donaldson confirmed that a minor who is 16 or 17 and is captured by section 8 of the *Law Reform Act 1969* (UK), or a minor who is younger than this and *Gillick* competent, has the right to consent *to* surgical, medical or dental treatment.[37] Lord Donaldson further added that such consent *to* treatment *cannot* be overridden by someone with parental responsibility for the minor, but can be overridden by the court.[38] He also concluded that '[n]o minor of whatever age has power by refusing consent to treatment to override a consent to treatment by someone who has parental responsibility for the minor and a fortiori a consent by the court'.[39] Importantly, the purpose of the consent given by the

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30 *Re W (a minor) (medical treatment)* [1992] 4 All ER 627, CA ('*Re W*').
31 *Re R (a minor) (wardship: medical treatment)* [1991] 4 All ER 177, CA ('*Re R*').
32 *Re W*, note 30, p. 645.
33 Ibid, p. 637.
34 *Re B (a minor) (wardship: sterilisation)* [1987] 2 All ER 206, p. 212.
35 *Re W*, note 30, p. 638.
36 Ibid.
37 Ibid, p. 639.
38 Ibid.
39 Ibid.

minor or someone with authority to give it, was stated as being *limited* to protecting the health practitioner from claims for damages for trespass to the person.[40]

Questions have emerged about whether *Re W* remains good law considering other significant legal developments since the case was decided in the early 1990s, such as the enactment of the *Mental Capacity Act 2005* (UK) and the *Human Rights Act 1998* (UK). Such questions were addressed in the more recent case of *NHS Trust v X*,[41] which focused on whether the court has the power to override the refusal of a *Gillick* competent minor.[42] The minor concerned, X, was nearly 16 at the time of the application to the English High Court and was described as 'mature and wise beyond her years'.[43] X's medical condition, sickle cell syndrome, can require the urgent administration of blood products and X wished to refuse such interventions as they were contrary to her religious beliefs. With reference to the human rights concerns, particularly those protected under the European Convention on Human Rights, and the United Nations' Convention on the Rights of the Child, Sir James Munby stated that there is:

> . . . nothing in the jurisprudence of the Strasbourg court recognising, let alone mandating States to enforce, a principle that a child, even a child who, to use our terminology, is *Gillick* competent or who has reached the age of 16, is in all circumstances autonomous in the sense that a capacitous adult is autonomous; nor, specifically, that such a child is autonomous when it comes to deciding whether or not to accept life-saving medical treatment.[44]

It was held that despite the significant legal developments since *Re R* and *Re W* and notwithstanding the significant academic criticism these cases have received, 'they remain good authority for the proposition that the child's (under-18-year-old's) competent or capacitous refusal is not always determinative' (Cave 2021, p. 538) and that any change in this position is a matter for Parliament and not the courts.[45]

These cases make clear that the court has a very wide power to authorise treatment when a minor refuses to consent to significant treatment where refusal is contrary to their interests, and that the parental power also extends to overriding the minor's *refusal* to consent. In respect of the parental power under English law in such circumstances, Professors Laurie and Mason (2016, p. 23) note that the approach in *Re R* and *Re W* implies that 'parents may legally interfere with the wishes of the mature—or *Gillick* competent—minor, at least when it comes to refusal of treatment and care'. They further note that 'whether or not the doctor accepts the proffered "flak-jacket" depends to a large extent on the severity of the condition to be treated—and the end of the line is to be found in a clinical choice between life and death where the courts will, in general, prefer professional expertise to the autonomy of the *Gillick*-competent minor' (Laurie and Mason 2016, p. 23). The approach under English law has generated significant criticism (Cave 2011; Gilmore and Herring 2011a, 2011b; Gilmore and Herring 2012). However, for the purpose of this paper, these decisions make clear that the parental power to override the minor's decision exists in relation to refusal issues only, in circumstances where the minor is refusing significant treatment contrary to their best interests, and that such a right does not extend to decisions about consenting *to* treatment.

3. Decisions about Gender Affirming Hormone Treatment

This section of the article outlines the key legal developments relevant to the commencement of gender affirming hormone treatment. The purpose is to outline how the

40 Ibid, 640.
41 [2021] EWHC 65 (Fam).
42 *NHS Trust v X* [2021] EWHC 65 (Fam) [32] ('*Re X*').
43 Ibid, [4].
44 Ibid, [120]
45 Ibid, [162].

law has developed in this area, in relation to both Australian and English law, so that an analysis of the Australian law can be undertaken in Part 4 of the article.

In Australia, the law relevant to minors' consent to the commencement of gender affirming hormone treatment has developed incrementally, by way of common law. The legal principles of significance have emerged from the field of caselaw relevant to "special medical procedures", which is focused on whether some types of medical decisions fall outside the boundaries of the parental power to consent. Although a detailed discussion of the issue of parental consent is beyond the scope of this paper, an overview of this body of jurisprudence is necessary for the purpose of explaining how the reasoning relevant to *Gillick* competency in this field has developed. Thus, the development of the law in Australia relevant to minors' decision-making and consent to hormone treatment is entangled with the law relevant to parental consent for this purpose, which mandates a discussion of both areas of law.

The cases relevant to gender affirming treatment have relied on the decision of the High Court of Australia (High Court) in *Secretary, Department of Health and Community Services (NT) v JWB*[46] *(Marion's Case)*. This decision considered whether parents could lawfully consent to a sterilisation procedure for their child with profoundly disability. *Marion's Case* established the foundational legal rules that determine the types of medical decision that might fall outside of the parental power to consent. This High Court authority remains as binding precedent relevant to the issue of children's consent, as it has not been departed from. However, it has been heavily criticised, with others noting that the impact of the decision requires reform (Stewart 2017).

The High Court was asked to determine whether Marion's parents could lawfully consent to a sterilisation procedure. In the circumstances of the case, the procedure was not regarded as therapeutic because it was not for the purpose of treating a physical disease or illness. Instead, it was to address, among other things, behavioural issues and alleviate significant future distress. The decision is complex, but in simple terms, although the High Court held that parents are normally the lawful decision makers in respect of medical treatment decisions for their children,[47] there is a need to involve the court in relation to some treatment decisions made by parents. Court involvement was considered to be a procedural safeguard due to the serious and irreversible nature of the intervention in question, thereby removing this type of decision from the parental power to consent. The High Court reasoned that court involvement is required in cases where a procedure or intervention is non-therapeutic and where there are, what I term, "further factors" of concern. The further factors discussed in *Marion's Case* include where the procedure or intervention is grave,[48] invasive and irreversible, where there is a risk that a wrong decision will be made concerning the minor's present or future capacity to consent,[49] and where a potential conflict exists between the interests of the decision-makers and treating health professionals.[50] Consequently, as the issue of non-therapeutic sterilisation met these elements, it was not something that Marion's parents could lawfully consent to and the decision about whether the procedure should be performed was subsequently determined by the court.[51]

Although, strictly speaking, *Marion's Case* set a precedent that applied to non-therapeutic sterilisation procedures, the decision was later applied to other categories of medical treatment or intervention.[52] As explained below, this resulted in the reasoning from *Marion's Case* being applied to cases concerning hormone treatment for gender dysphoria.

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46 *Secretary, Department of Health and Community Services (NT) v JWB (Marion's Case)* (1992) 175 CLR 218 ('*Marion's Case*').
47 Ibid, p. 239.
48 Ibid, p. 252.
49 Ibid, pp. 250–52.
50 Ibid.
51 *Re Marion (No 2)* (1992) 17 Fam LR 336.
52 *Re Kelvin* [2017] FamCAFC 258 ('*Re Kelvin*').

Importantly, it should be noted that *Gillick* was approved in *Marion's Case* as part of the Australian common law.[53] Technically, *Gillick* was affirmed by the Australian High Court on an *obiter* basis, given that the minor concerned was not *Gillick* competent and the primary question before the Australian High Court was whether Marion's parents could consent to a non-therapeutic sterilisation procedure.

In contrast to the position under English law, there has been some difference in interpretation in terms of how *Gillick* has been applied in Australia. In relation to the *court's* power to override a minor's decision about medical treatment, the position in Australia is similar to that outlined above in relation to English law. Thus, Australian cases have confirmed that the court has a very wide power to make decisions for and on behalf of minors, and that under the *parens patriae* jurisdiction it is the minor's welfare and best interests that must be prioritised by the court.[54] It should be noted, however, that the vast majority of cases concerning gender affirming treatment have been dealt with by the Family Court, rather than the state and territory supreme courts. This is an important point of distinction because although the Family Court's welfare jurisdiction in respect of decisions about children is similarly focused on the welfare and best interests of the child, it is not technically as wide as the *parens patriae* jurisdiction, as the welfare jurisdiction is created by statute rather than emerging from an inherent power.[55]

In relation to the parental power, in *Marion's Case* McHugh J affirmed the position in *Gillick* that once a minor is regarded as competent to make their own decisions about treatment, the parental power to consent comes to an end,[56] and that the position adopted in the English refusal cases is inconsistent with *Gillick*.[57] This means that, at least concerning the parental power, Australian law seems to adopt a different approach to the law in England and Wales, specifically in relation to the position adopted in *Re W*, which confirms that parents have a right to veto the refusal of life saving treatment by a *Gillick* competent minor. As noted by Mathews and Smith (2018, pp. 190–91), what is likely in Australia 'is that if a *Gillick*-competent child refused treatment that would save or prolong his or her life (whether or not the parents consented to the treatment), the court would override the child's refusal in its *parens patriae* jurisdiction'.

Under the authority of *Marion's Case*, in relation to medical decisions made by *Gillick* competent minors, there is no *parental* power to veto the minor's decision (even in cases of refusal). However, similar to the position under English law, the *court* does have a very wide power to interfere and overrule the minor's consent to, or refusal of, treatment. Despite this, as discussed below, this does not seem to be the position adopted by the Family Court in the specific context of decisions about gender affirming treatment.

3.1. Australian Law Relevant to Minors and Hormone Treatment for Gender Dysphoria

The 2004 Family Court decision of *Re Alex*[58] was the first Australian case to establish that hormone treatment for gender dysphoria should be regarded as a special medical procedure. The decision determined that both Stage 1 (puberty blockers) and Stage 2 treatment (gender affirming hormones) must be approved by the court. Applying *Marion's Case*, Nicholson CJ held that both stages should be treated as non-therapeutic due to the purpose of the treatment being to treat a psychological condition rather than a physical disease or illness.[59] Nicholson CJ also determined that both stages of treatment should be

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[53] *Marion's Case*, note 46, pp. 238–39.

[54] See *The Sydney Children's Hospitals Network v X* [2013] NSWSC 368 and *X v The Sydney Children's Hospitals Network* (2013) 85 NSWLR 294.

[55] For an overview of the difference between the Family Court's welfare jurisdiction and the Australian state and territory supreme courts' *parens patriae* jurisdiction, see (Then and Appleby 2010).

[56] *Marion's Case*, note 46, p. 316 (per McHugh J).

[57] Ibid, pp. 316–17.

[58] *Re Alex* [2004] FamCA 297 ('*Re Alex*').

[59] 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

considered together as a single treatment plan and held that both required the approval of the court. With reference to the further factors from *Marion's Case*, it was held that because the two stages of treatment carried permanent, irreversible, and grave consequences, and that there was a risk of making a wrong decision without the involvement of the court, there was a requirement for the court to make the decision rather than a parent or guardian.[60]

In relation to the issue of *Gillick* competency, Nicholson CJ determined that the question of whether the minor is competent is, based on the reasoning in *Marion's Case*, a threshold issue. This required the court to consider 'whether Alex had achieved "a sufficient understanding and intelligence to enable him or her to understand fully what is proposed".'[61] In determining this issue, Nicholson CJ weighed up the expert evidence. Evidence from Mr T, who prepared the family report in the matter, stated that Alex 'appears very knowledgeable about, and would seem to have an intellectual understanding of, the treatment process, including the stages of the treatment, some of the intended effects, as well as the side-effects of the medication and what the treatment process is', but that it was not clear whether Alex 'understands the full implications of the treatment'.[62] Evidence from the treating child psychiatrist noted that Alex *could* appreciate 'the nature of the proposed treatment and its consequences better than he would expect other young people his age to understand it, and that Alex has acquired this information over a fairly short space of time'.[63] However, the treating psychiatrist opined that whilst Alex fully understood the proposed treatment, its side effects, and benefits, it was 'not appropriate' that Alex should be wholly responsible for making the decision about commencing hormone treatment.[64] Interestingly, Nicholson CJ noted that the experts' evidence suggested, in fact, that Alex may have been *Gillick* competent or would attain this threshold shortly after the application was made to the court. Despite this, his Honour concluded that the matter should be decided by the court.[65]

Nicholson CJ rejected the submission made by the Human Rights and Equal Opportunity Commission (intervener in the matter) that once a child achieves a sufficient understanding and intelligence to enable them to understand fully what is proposed, the court has no further involvement.[66] Nicholson CJ concluded that it was not "appropriate" for Alex to make the decision despite stating that the 'question of best interests does not really inform the primary decision [that must be made] which is whether [the minor] has the necessary capacity'.[67] Nicholson CJ considered that the nature of the decision about consenting to hormone treatment should be distinguished from a decision about contraceptive advice and treatment.[68] It was further stated that '[i]t is highly questionable whether a 13 year old could ever be regarded as having the capacity [to consent to Stage 1 and Stage 2 treatment], and this situation may well continue until the young person reaches maturity'.[69] Ultimately, Nicholson CJ did not conclude on Alex's competency, noting that it would be in Alex's best interests to undergo the treatment in question, and that 'the capacity of Alex to give his own consent would be an academic question' unless the application were refused.[70]

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expressions 'therapeutic' and 'non-therapeutic', because of their uncertainty. But it is necessary to make the distinction, however unclear the dividing line may be': *Marion's Case*, note 46, p. 251.

60 In this case, Alex was under the care of the local authority, so the decision in question did not, strictly speaking, relate to parental consent.

61 *Re Alex*, note 58, [156].

62 Ibid, [160].

63 Ibid, [162] (emphasis added).

64 Ibid, [164].

65 Ibid, [165].

66 Ibid, [173].

67 *An NHS Trust v A*, note 25, [10].

68 *Re Alex*, note 58, [173].

69 Ibid.

70 Ibid, [169].

In the years after *Re Alex* was decided, the issue of whether Stage 1 treatment fell within the boundaries of parental consent or should be subject to court approval was questioned by some judges.[71] In 2013, this resulted in an appeal to the Full Court of the Family Court of Australia (Full Court) in *Re Jamie*.[72] This is an important decision as it adopted a different approach to Nicholson CJ in *Re Alex*, and thereby set a precedent for future Family Court applications. The Full Court noted that *Re Alex* should be distinguished as it focused on whether a government department could provide consent to treatment for gender identity disorder (as it was then termed under the DSM IV), under the scope of an operative care order, rather than parental consent.[73] The Full Court held that parents can lawfully consent to Stage 1 treatment, but not Stage 2. Bryant CJ explained that this approach could be justified because in *Re Alex* the court 'was asked not to view the reversible first stage [of treatment] in isolation from the second stage, which could have irreversible consequences',[74] but instead, to consider both stages together as a single treatment plan. The Full Court considered and applied the reasoning in *Marion's Case*, holding 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. In relation to the "further factors" from *Marion's Case*, it was reasoned that they did not apply to Stage 1 treatment in the same way that they applied to non-therapeutic sterilisation. Thus, Bryant CJ did not think that it was likely that there would be a conflict of interests between the parties involved. Her Honour stated '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)'.[75] Despite this, the Full Court concluded that applications to the court should continue to be required in respect of Stage 2 treatment and that parents could not consent to this treatment, based on its irreversible and serious consequences. This reasoning has received significant criticism based on the application of *Marion's Case*, particularly because the Full Court held that Stage 1 treatment for gender dysphoria is therapeutic and thereby outside the reasoning of the High Court in *Marion's Case*. Others have observed that if Stage 1 treatment fell within the parental power to consent based on its therapeutic nature, this should also apply to Stage 2 treatment (Smith 2013; Bell 2015; Stewart 2017). Interestingly, the Full Court also decided that in circumstances where a minor is assessed as *Gillick*-competent by their treating health professionals, an application *must* be made to the court so that the court could confirm the minor's competency for the purpose of consenting to the treatment.[76]

When considering the issue of *Gillick* competency in *Re Jamie*, Bryant CJ made reference to the United Nations' Convention on the Rights of the Child.[77] In particular, Article 12, which requires assurance that a child who is 'capable of forming his or her own views' has a right to express those views freely in all matters that affect them, and that such views be given due weight in accordance with the age and maturity of the child.[78] Submissions made to the Full Court by the Public Authority in respect of how the court should approach the *Gillick* competency of the minor outlined that irrespective of whether or not the minor is considered to be *Gillick* competent, the court should 'retain and exercise its role as an oversighting body'.[79] Bryant CJ seemed to accept this proposition that it is the court that should determine the matter of *Gillick* competency in such cases, despite noting:

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71 See, for example, *Re Sam and Terry* [2013] FamCA 563.
72 *Re Jamie* [2013] FamCAFC 110 ('*Re Jamie*').
73 Ibid, [173].
74 Ibid, [81].
75 Ibid, [107].
76 Ibid, [137].
77 *United Nations Convention on the Rights of the Child*, 20 November 1989, 1577 UNTS 1989.
78 *Re Jamie*, note 72, [121]–[122].
79 Ibid, [127].

> 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 two treatment for childhood gender identity disorder, that disentitles autonomous decision-making by the child, whereas no other medical procedure does. The High Court in Marion's case, adopting the formulation in *Gillick*, held at 237 that a child is capable of giving informed consent when he or she "achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed".[80]

Indeed, it was further stated that 'one might think 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'.[81] However, Bryant CJ concluded that it is the court that should determine, or at least, confirm, the minor's competency,[82] which was similarly the conclusion of Finn J[83] and Strickland J.[84] Bryant CJ explained the reason for such a conclusion:

> In *Marion's case*, the majority held that court authorisation was required first because of the significant risk of making the wrong decision as to a child's capacity to consent, and secondly because the consequences of a wrong decision are particularly grave.
>
> It seems harsh to require parents to be subject to the expense of making application to the court with the attendant expense, stress and possible delay when the doctors and parents are in agreement but I consider myself to be bound by what the High Court said in *Marion's case*.[85]

It can be seen here that the "further factors" from *Marion's Case* are brought into the discussion of *Gillick* competency to justify the court's involvement with confirming the minor's capacity. It was confirmed that such an application would only need to address the issue of the minor's *Gillick* competency and if the minor's capacity is confirmed by the court, there is no further role for the court in the matter.[86]

Following this decision, as the number of applications to the Family Court increased year by year, judges were beginning to question the Full Court's approach in *Re Jamie*, raising the question about whether there was a need to involve the court for Stage 2 treatment.[87] Four years after the Full Court decided *Re Jamie*, the law again required clarification when Watts J referred a number of questions to the Full Court for determination by way of a case stated.[88] The Full Court in *Re Kelvin*[89] was asked to clarify the legal position surrounding parental consent for Stage 2 treatment and whether this treatment fell outside the boundaries of parental consent. The Full Court was also required to clarify whether the court must confirm the minor's competency to consent to hormone treatment for gender dysphoria. The Full Court held that parents for non-competent children and *Gillick* competent minors can lawfully consent to both Stage 1 and Stage 2 treatment without the need for court involvement, where treatment is provided in accordance with national and

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80 Ibid, [134].
81 Ibid, [135].
82 Ibid, [137].
83 Ibid, [186].
84 Ibid, [196].
85 Ibid, [137]–[138].
86 Ibid, [139].
87 See *Re Martin* [2015] FamCA 1189 and *Re Lucas* [2016] FamCA 1129.
88 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).
89 *Re Kelvin* [2017] FamCAFC 258.

international treatment guidelines and standards.[90] However, it was also held that in cases of "controversy"—that is, where there is a *genuine* disagreement or controversy between the decision-makers and/or clinical team about whether treatment should commence—an application must be made to the court. Indeed, it is important to note that the Full Court in *Re Kelvin*, stated that a controversy occurs where there is disagreement 'about whether the *treatment should be administered*',[91] and it is worth highlighting that the reasoning of the majority does not specifically mention a controversy as including parental disagreement with the conclusion of the treating medical practitioner about the minor's competency.

The Full Court in *Re Kelvin* agreed that it was necessary to depart from the Court's earlier decision in *Re Jamie*. However, there were different reasons underpinning the conclusions of the majority and minority judgments. The majority in *Re Kelvin* noted that it is generally permissible to depart from an earlier decision if that decision is found to be "plainly wrong".[92] The applicant, the Independent Children's Lawyer, and some of the interveners submitted that the decision in *Re Jamie* was plainly wrong, particularly the Court's application of the reasoning in *Marion's Case*.[93] However, the majority concluded 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.[94] Instead, the majority departed from that decision on the basis 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'.[95] In contrast, the minority reached the view that the decision in *Re Jamie* was "plainly wrong" and as a result, the decision should be departed from. The approach in *Re Kelvin* was summarised by Watts J in *Re Imogen (No. 6)*[96] ('*Re Imogen*'):

> In *Re Kelvin*, the Full Court determined that:
>
> a. Given the current state of medical knowledge, stage 2 treatment was therapeutic and was treatment for which consent no longer lies outside the bounds of parental authority or requires the imprimatur of the court (reversing the position in *Re Jamie*), and
>
> b. In respect of stage 2, if the child, the parents and the medical practitioners agree a child is *Gillick* competent, there was no need for the Court to determine *Gillick* competence (reversing the position in *Re Jamie*), and
>
> c. If all agree, a *Gillick* competent child can consent to stage 2 treatment, and
>
> d. If a child is not *Gillick* competent and the treating medical practitioners agree, the child's parents can consent to stage 2 treatment without court approval.[97]

Although it was initially thought that the Full Court had clarified the law in *Re Kelvin*, and that generally there is no need to involve the court except in cases of controversy, there is subsequent case law that confuses the position. In *Re Imogen*, Watts J held that because the majority in *Re Kelvin* did not determine that *Re Jamie* was "plainly wrong", there are elements of *Re Jamie* that remain as binding precedent. Hence, Watts J held in *Re Imogen* that there are some instances where an application to the court must still occur. His Honour stated that in cases where a parent or medical practitioner disputes either the minor's *Gillick* competence, the diagnosis of gender dysphoria, or the proposed treatment, then

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90 Ibid, [162].

91 Ibid, [167] (emphasis added).

92 Ibid, [169] 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.

93 For an overview of some of the key issues with the application of *Marion's Case* in the decision of *Re Jamie*, see (Bell 2015).

94 *Re Kelvin* [171].

95 Ibid, [183].

96 [2020] FamCA 761.

97 Ibid, [33].

an application to the court is *mandatory*.[98] It was held that if the only dispute is about the minor's *Gillick* competency, then the court should determine this by way of a declaration and that this is not a best interests consideration.[99] If there is a dispute about diagnosis or treatment, then the court must resolve this and determine the diagnosis and treatment, and make appropriate orders based on best interests considerations.[100] Watts J also added that 'if a parent or legal guardian does not consent to an adolescent's treatment for gender dysphoria, a medical practitioner, who is willing to do so, should not administer treatment to an adolescent who wishes it, without court authorisation'.[101] For this purpose, *Re Imogen* imposes a requirement that parental consent must be obtained *in addition to* the consent of the minor, even if the minor is *Gillick* competent. Thus, Watts J summarised:

> This judgment confirms the existing law is that any treating medical practitioner seeing an adolescent under the age of 18 is not at liberty to initiate stage 1, 2 or 3 treatment without first ascertaining whether or not a child's parents or legal guardians consent to the proposed treatment. Absent any dispute by the child, the parents and the medical practitioner, it is a matter of the medical professional bodies to regulate what standards should apply to medical treatment. If there is a dispute about consent or treatment, a doctor should not administer stage 1, 2 or 3 treatment without court authorisation.[102]

Watts J does not reference specific reasoning in the judgment of *Re Jamie* or *Re Kelvin* to support his conclusions in this regard. As noted by Jowett and Kelly (2021, p. 45), the legal basis for such an approach is not clear, and '[i]n 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"'. In Part Four of this article, I analyse not only the approach of Watts J in *Re Imogen* in relation to *Gillick* competency, but also the earlier key decisions discussed above, in terms of how they have applied the reasoning in *Gillick*. As I argue, Australian law on this topic is not based on a consistent application of the reasoning in *Gillick*, nor its subsequent interpretation, and from the very first decision relevant to gender affirming treatment, has gone astray in its interpretation and application of the *Gillick* test.

3.2. The English Decisions in Bell

Before turning to my analysis of the existing law, it is important to also outline the recent English jurisprudence that has considered the issue of whether a *Gillick* competent minor can consent to hormone treatment for gender dysphoria.[103] This is relevant because the interpretation of the *Gillick* test in this context was clarified by the English Court of Appeal.[104] In the judicial review claim of *Quincy Bell and Mrs A v The Tavistock and Portman NHS Foundation Trust and Ors* ('*Bell*'),[105] the claimants attempted to challenge the lawfulness of the consent processes of the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Trust (Trust) concerning Stage 1 treatment for minors with gender dysphoria. The GIDS's policy recognised that a minor may consent to hormone treatment for gender dysphoria. However, the English High Court concluded that minors below 16 years of age are not ever likely to be regarded as *Gillick* competent to consent to Stage 1 treatment. Although this approach was subsequently overturned by the Court of Appeal in September 2021, an examination of the approach in the High Court decision is

98 Ibid, [35].
99 Ibid.
100 Ibid.
101 Ibid.
102 Ibid, [63].
103 [2020] EWHC 3274 (Admin) (*Bell*).
104 *Quincy Bell and Mrs A v The Tavistock and Portman NHS Foundation Trust and Ors* [2021] EWCA Civ 1363 (*Bell* Court of Appeal).
105 *Bell*, note 103.

warranted because of the conclusions reached about the concept of *Gillick* competency, and some of the similarities that such conclusions share with the Australian jurisprudence.[106]

The claimants argued that minors would never be *Gillick* competent to consent to the commencement of gender affirming care. Outlining the treatment pathway, the High Court noted that minors may be referred to two other NHS Trusts (the first and second interveners in the claim) and then proceed with gender affirming care, if determined appropriate, under the care of those NHS Trusts. The English High Court held that the decision to commence gender affirming treatment, along with its unknown risks and consequences, is so significant that a minor below 16 years of age was unlikely to understand the implications of such a decision. The High Court determined that the commencement of Stage 1 treatment was effectively a clinical pathway to Stage 2 treatment, and for this reason, the minor must understand all stages of treatment at the time they commence the first stage. It was stated:

> It follows that to achieve *Gillick* competence the child or young person would have to understand not simply the implications of taking [puberty blockers (PBs)] 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 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.[107]

On appeal, the Court of Appeal disagreed with the High Court's conclusions. The Court of Appeal overturned the decision, referring to the fact that the claim was a judicial review action, rather than a decision about a specific minor's competence. It was also concluded that the High Court had not found that there was illegality in the policy or practice of the defendants.[108] With reference to Lord Fraser and Lord Scarman's approach in *Gillick*, the Court of Appeal stated that their Lordships' approach in *Gillick* was to provide relevant *guidance* for determining the minor's competency.[109] The Court of Appeal stated that the factors provided as guidance in *Gillick* were 'an area for evaluation, rather than a conclusory statement of fact or medical opinion'[110] and that some of the eight elements outlined by the English High Court (quoted above), failed to align with the approaches of

106 For a comparison of the approaches under Australian and English law, see (Smith 2023).

107 *Bell*, note 11, [138].

108 *Bell* Court of Appeal, note 104, [86].

109 Ibid. 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*, p. 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*, p. 189).

110 *Bell*, Court of Appeal, note 104, [74].

Lord Fraser and Lord Scarman in *Gillick*.[111] When interpreting the *Gillick* test, the Court of Appeal held that the different aspects of the guidance found in the *Gillick* judgment were not intended to serve as statements of law,[112] and that the High Court in *Bell* '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'.[113] To put it clearly and without doubt, 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 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.[114]

The Court of Appeal did conclude that the issues raised in the context of minors consenting to gender affirming hormone treatment, are complex, and that:

> They raise all the deep issues identified in *Gillick*, and more. Clinicians will inevitably take great care before recommending treatment to a child and be astute to ensure that the consent obtained from both child and parents is properly informed by the advantages and disadvantages of the proposed course of treatment and in the light of evolving research and understanding of the implications and long-term consequences of such treatment. Great care is needed to ensure that the necessary consents are properly obtained. As *Gillick* itself made clear, clinicians will be alive to the possibility of regulatory or civil action where, in individual cases, the issue can be tested.[115]

This clarifies the position under English law; that the assessment of a minor's competency is for medical practitioners to determine rather than the courts. This reasoning should be considered carefully in Australia moving forward. It is logical that the future direction of Australian law should be influenced by the English common law on this point, given that Australia adopted the *Gillick* principle from English law. Even if there are some differences in the subsequent interpretation of *Gillick* under Australian law, such as McHugh J in *Marion's Case* suggesting that the parental power is at an end in all respects once the minor achieves a sufficient degree of understanding and maturity to make their own decisions, this does not provide an impetus to disregard other English jurisprudence that interprets *Gillick*. It is important to note that the Court of Appeal's interpretation of *Gillick* in the *Bell* decision is not inconsistent with *Gillick*. Thus, McHugh J's statement in *Marion's Case* about not following post-*Gillick* caselaw from England, was made on the basis that such reasoning (specifically, that expressed by Lord Donaldson in *Re R*) was *inconsistent* with *Gillick*.[116] Hence, authority that interprets and applies *Gillick* in a manner that is consistent with the House of Lords reasoning would continue to be highly influential in Australia.

4. Analysis of the *Gillick* Test as Applied under Australian Law in Cases Concerning Minors and Gender Affirming Treatment

Building on the overview of the law outlined in Part 3, in this section of the article I analyse the law and demonstrate how the application of the *Gillick* principle was taken off track in the cases relevant to gender affirming hormone treatment. I consider how *Gillick* is applied across the spectrum of key decisions in this field, to highlight the problems with the approach adopted in this body of jurisprudence.

111 Ibid.
112 Ibid, [80]–[81].
113 Ibid, [85].
114 Ibid, [76] (emphasis added).
115 Ibid, [92].
116 *Marion's Case*, note 46, pp. 316–17.

From the outset, Australian case law concerning gender affirming hormone treatment for minors has adopted a paternalistic approach to the *Gillick* principle. The approach adopted in many of the Australian cases suggests that the role of medical practitioners in assessing and determining the minor's competency, should be assumed by the courts, which appears to be inconsistent with the approach in *Gillick*, and as confirmed in subsequent jurisprudence (such as the Court of Appeal's conclusions in *Bell*).

In *Re Alex*, as outlined above, Nicholson CJ did not ultimately conclude on the issue of whether Alex had the capacity to consent, despite acknowledging that in line with *Marion's Case* and as a *threshold* question it was necessary to consider Alex's competency.

When reading Nicholson CJ's conclusions, his reasoning suggests that Alex was at least potentially *capable* of reaching the threshold of understanding required for *Gillick* competency—either at the time of the application or shortly after. As outlined above, *Gillick* suggests that the correct approach is to determine whether the minor is *capable* of reaching the level of understanding required. In the context of Alex's understanding and based on the evidence discussed, this seemed possible. Nevertheless, Nicholson CJ did not conclude on Alex's competency. What also appears inconsistent in Nicholson CJ's reasoning is that he stated that the 'question of best interests does not really inform the primary decision [that must be made] which is whether [the minor] has the necessary capacity', but concluded that it was not *appropriate* for Alex to make the decision.[117] This might be explained by the reasoning that Nicholson CJ believed gender affirming hormone treatment should be distinguished from decisions about contraceptive advice and treatment. However, the reference to the appropriateness of making the decision suggests that best interests considerations ultimately took precedence and had a significant bearing on the findings in relation to Alex's competency.

Decisions about Alex's treatment came before the court again in 2009 in the form of an application seeking the court's approval for surgery in the form of a bilateral mastectomy.[118] Nicholson CJ's approach in the earlier application relating to Alex appear to influence this subsequent decision. Much of the evidence relevant to this later application suggested that Alex was indeed capable of understanding the nature and consequences of the decision, and it was noted that 'Alex is an intelligent, thoughtful, reflective and creative young person with well developed adaptive skills'.[119] However, Bryant CJ, who determined this application in 2009, stated:

> . . . I am not satisfied that Alex is not *Gillick* competent and therefore unable to himself consent to the surgery. However, as the parties, the [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.[120]

Bryant CJ made the decision based on best interests considerations. Although noting that her Honour was limited by the evidence before her, the conclusion about Alex's competency seems at odds with the view that the minor's *Gillick* competency should be determined as a threshold matter.[121] If the determination of a minor's competency is indeed a threshold matter, it is not logically an "academic" question that the court can choose to gloss over. It might also be argued that some of Bryant CJ's earlier reasoning from this

117 *An NHS Trust v A*, note 25, [10].
118 *Re Alex* [2009] FamCA 1292.
119 Ibid, [146].
120 Ibid, [147].
121 *Re Alex*, note 58, [156].

application, appears to influence the leading judgment that her Honour later delivered in *Re Jamie*.

When the Full Court addressed the issue of the minor's *Gillick* competency in *Re Jamie*, like the earlier decisions, it was noted that the determination of the minor's competency is a threshold matter.[122] Indeed, in *Re Jamie*, Bryant CJ found that in circumstances where the minor is found to be *Gillick* competent, there remains no role for the Court. Her Honour reasoned that:

> 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 two treatment for childhood gender identity disorder, that disentitles autonomous decision-making by the child, whereas no other medical procedure does. The High Court in *Marion's case*, adopting the formulation in *Gillick*, held at 237 that a child is capable of giving informed consent when he or she "achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed".[123]

In contrast to Nicholson CJ's view in *Re Alex*, Bryant CJ reasoned that there was no justification for reading down the significance of a conclusion that the minor is *Gillick* competent, simply 'because the treatment is for childhood gender identity disorder'.[124] It was noted that the significance of the decision relating to 'one's gender and sexuality would be the very exemplar of when the rights of the *Gillick*-competent child should be given full effect'.[125] Despite appropriately recognising the foundational aspects of the *Gillick* principle, the Full Court held that because of the nature of Stage 2 treatment, the court should retain its oversight of such treatment, including confirming the minor's competency to consent.

The issue with the Full Court's approach is that it merges issues relevant to parental consent with concepts relevant to decision-making by *Gillick* competent minors. Bryant CJ acknowledges in *Re Jamie* that 'if the child is *Gillick* competent court authorization of the special medical procedure is not necessary',[126] thus suggesting that concepts relevant to special medical procedures are different to those relevant to the minor's *Gillick* competency. As also explained above, in *Re Jamie* the Full Court relied on the "further factors" from *Marion's Case* to justify the court's oversight in terms of assessing the minor's competency, pointing to the significant risk of making a wrong decision about the minor's capacity to consent, and referring to the gravity of a wrong decision.[127] However, this overlooks the fact that the focus of the High Court in *Marion's Case* when outlining the further factors was on the issue of *parental* consent. Thus, the court was considering substitute decision making—that is, the issue of whether it was appropriate that very significant decisions might be made by *others* (in that case, parents) for an individual who is not competent (on the facts, a child), without the court's involvement. This focus in *Marion's Case* on the risk of making a wrong decision was not situated within a discussion of whether a competent minor could make such a decision for themselves. Moreover, the High Court in *Marion's Case* was cognisant of the dangers that might exist when *others* make decisions for persons with intellectual disability, and in particular, the risk of a wrong decision, and incorrect assumptions, being made, about an individual's capacity due to the impact of such an intellectual disability. This is noted by Felicity Bell (2015, p. 446):

> Having described the *Gillick* test, the majority [in *Marion's Case*] noted that "the fact that a child suffers an intellectual disability makes consideration of the

122 *Re Jamie*, note 72, [129].
123 Ibid, [134].
124 Ibid, [135].
125 Ibid, [135].
126 Ibid, [124], citing the public authority's submissions, which cited Bryant CJ's approach in *Re Alex*, note 118.
127 *Re Jamie*, note 72, [137].

> capacity to consent *a different matter*". The majority explained that this was due to the widely differing capabilities of children with disabilities, who cannot be treated as homogenous. Importantly, their Honours concluded "there is no reason to assume that all disabled children *are incapable* of giving consent to treatment".

Bell (2015, p. 446) relevantly notes that in this context, the High Court was cautious about not having decisions overseen by the court because it cannot be assumed that 'medical professionals would always make "correct" decisions', in a situation where the individual is not capable of making their own decision. Thus, the majority in *Marion's Case* 'clearly distinguish the assessment of competency in the case of children with intellectual disabilities from the assessment of those without' and it is the presence of intellectual disability that results in the conclusion that there is a risk of making a wrong decision when others are making decisions about the child's future capacity to consent (Bell 2015, p. 447). Bell (2015, p. 447) concludes that '*Marion's Case* does not mandate a finding that such a risk is automatically present in cases involving children with gender dysphoria nor the asserted consequence that it is for a court alone to make the assessment of competence'.

When *Re Kelvin* was decided, it appeared to depart from earlier authority or *Re Jamie* and thus signal a change in the law. Interestingly, the majority in *Re Kelvin* addressed the influence of the "further factors" on the conclusions reached in *Re Jamie* as a basis for justifying court oversight for the specific issue of confirming the assessment of minors' competency. Submissions to the Full Court in *Re Kelvin* suggested that Bryant CJ had erred on this point, 'because nothing was said in *Marion's case* about who should determine *Gillick* competence, and certainly it was not suggested that the court should be tasked with that responsibility'.[128] The majority noted:

> What her Honour is saying is that because court authorisation is required where there is the significant risk of making the wrong decision and the consequences of a wrong decision are particularly grave, it was *also* appropriate that the Court determine *Gillick* competence. In other words, the nature of the treatment requires that to be the case (also see Finn J at [185]–[186]).
>
> Now, of course, if as appears to be the case, the nature of the treatment no longer justifies court authorisation, and the concerns do not apply, then there is also no longer a basis for the Court to determine *Gillick* competence.[129]

In this regard, it appears that the majority is saying that it is no longer *necessary* for the court to confirm the *Gillick* competency of minors, as the concerns about Stage 2 treatment no longer justify the court's involvement (except in cases of controversy). These conclusions were based on the change in understanding of gender dysphoria as a condition, as well as its treatment.[130] Of course, the majority acknowledged that court involvement may be required in cases of genuine dispute, and the meaning of controversy in this respect was noted to relate to decisions about the commencement of treatment. However, there is nothing in the Full Court's reasoning in *Re Kelvin* that suggested parental consent was needed in addition to the consent of a *Gillick* competent minor, nor that the court *must* confirm the minor's competency if the parent disagrees with the clinician's assessment. Indeed, the minority also arrive at this same conclusion. Ainslie-Wallace and Ryan JJ conveniently summarise the key aspects of *Marion's Case* and relevantly note that '[a]t common law, a parent is no longer capable of consenting on the child's behalf when the child achieves a sufficient understanding and intelligence to enable him or her to fully understand what is proposed'.[131] They also conclude that *Marion's Case* does *not* '[s]upport

[128] *Re Kelvin*, note 89, [180].
[129] Ibid, [181]–[182].
[130] Ibid, [183].
[131] Ibid, [199].

court intervention in relation to therapeutic procedures to which a legally competent person can consent'.[132]

Following the Full Court's decision in *Re Kelvin*, medical practitioners, quite reasonably, concluded that a minor who is regarded as *Gillick* competent can lawfully consent to gender affirming treatment, and that there is no need for parental consent in addition to this. Thus, the initial version of the *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents*, stated that '[a]lthough obtaining consent from parents/guardians for commencement of hormone treatment is ideal, parental consent is not required when the adolescent is considered to be competent to provide informed consent'.[133] This is a logical conclusion because as outlined earlier in this article, such a view accords with reasoning from the House of Lords decision in *Gillick*, which stated that whilst it is recommended that parental consent be obtained where possible, a competent minor may consent without parental involvement, and that such a consent when appropriately obtained provides the practitioner with a defence under the law of assault and trespass to the person. Furthermore, when considering this position from the perspective of the decision in *Axon*, not only would parental consent in addition to the competent minor's consent not be required, but the minor would be entitled to expect confidentiality in respect of their decision so that they could make the decision without parental involvement. However, as outlined above, in *Re Imogen* Watts J held that the approach proposed under the Australian standards was not an accurate reflection of the law and that parental consent was required *in addition to* the consent of the minor. Similarly, his Honour also concluded that in cases where a parent disagrees with the medical practitioner's assessment of the minor's competency, an application to the court is required. As noted by Jowett and Kelly (2021, p. 45):

> 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.

The above analysis demonstrates a range of significant issues in terms of how *Gillick* has been applied in Australian cases relevant to decisions about gender affirming treatment. This has culminated in a position, outlined by Watts J in *Re Imogen*, that is concerning for several key reasons, as I outline below. Although others have critiqued the decision in *Re Imogen*, my analysis adds to the existing literature on this topic as it moves beyond an analysis of individual judicial decisions, and considers the Australian jurisprudence more broadly on this topic for the purpose of situating it within a contemporary judicial understanding of *Gillick*.

First, the current legal position in Australia exposes some minors who may not have the support of all family members, to the unnecessary delay, expense, and stress[134] of having to seek the approval of the court in circumstances where they have been assessed as *Gillick* competent by their treating practitioners. If the minor is deemed *Gillick* competent by their treating clinicians, an application to the court should not be necessary. If hormone treatment is a real prospect for the minor, the proposed treatment would not normally be suggested unless the treating team have determined that it is clinically appropriate and in the minor's best interests, as is required under the national standards of care (Telfer et al.

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132 Ibid, [200].

133 *Re Imogen*, note 96, [27].

134 On this point, see the important work of Fiona Kelly: (Kelly 2016).

2021, pp. 23–24). The law is clear, in that the *Gillick* competent minor has a lawful right to consent in such circumstances without the need for parental consent. Thus, the requirement to involve the court in such circumstances is unnecessary and potentially exposes some young trans and gender diverse persons, to harm.

Second, the current legal position in Australia diminishes the significance of the *Gillick* principle in terms of how it applies to decisions about consenting *to* treatment. Indeed, Bryant CJ in *Re Jamie* noted that there was no need to read down the rule in *Gillick* because the decision was about hormone treatment for gender dysphoria rather than contraceptive advice and treatment.[135] This should, in theory, give full recognition to the principle of *Gillick* competency, thereby allowing the minor to consent *to* treatment (especially treatment that is regarded as in their best interests), bringing an end to the parental power in this respect. As outlined above, Family Court judges have frequently recognised that the issue of the minor's *Gillick* competency is a threshold issue to be determined in such cases, and if the minor's competency is confirmed, the parental power for that purpose is at an end and the court has no further involvement. Yet, this is not reflected in the current position that requires parental consent *in addition to* the consent of a *Gillick* competent minor. Watts J's reasoning in this regard is inconsistent with the well-established approach that the *Gillick* competent minor can lawfully consent to treatment in their best interests, and that the parental power is at an end. Indeed, as noted by Lord Scarman in *Gillick*, parental rights are extinguished in respect of the minor where they are no longer required to protect the child from harm, and although Lord Fraser adopted a different approach in this regard, it might be argued that subsequent English jurisprudence such as *Axon* has favoured Lord Scarman's approach on this point. Given that the proposed treatment under the Australian standards is only considered when appropriate and in the minor's best interests, there is no basis to require parental consent. Such a situation does not fall within any of the post-*Gillick* cases that contemplate that a minor's decision to consent to treatment can be limited, as the decisions in the gender affirming treatment cases are not decisions about refusing treatment that is contrary to the minor's best interests. Consequently, the Australian Family Court has taken the *Gillick* principle off course and has interpreted *Gillick* in a way that intrudes upon the minor's right to consent to medical treatment. Such an interpretation is not supported by the jurisprudence relevant to *Gillick*.

Third, the current approach in Australia not only fails to accord with the foundational reasoning in *Gillick* (that is, that a competent minor can lawfully consent *to* treatment), but it also destroys a fundamental and underlying basis of the *Gillick* decision itself. As established, one of the key policy reasons in *Gillick* for allowing the minor to consent is to preserve the minor's confidence. This position—which recognises the right of the competent minor to make decisions about their medical treatment in a sphere of confidence—has been confirmed in subsequent English decisions.[136] In practical terms, Watts J's approach in *Re Imogen* removes this protection from the *Gillick* competent minor and *mandates* that parents must also consent. Although the relevant standards of care in Australia recognise the involvement of family members in terms of supporting the minor's journey and transition (Telfer et al. 2021, pp. 9–11, 17–21), parental support may not always be available. Indeed, in cases like *Re Alex* where the minor is under the care of a local authority, such a requirement may add a significant hurdle and possible distress to the minor, and others involved. In addition, the issue of parental support and involvement is not synonymous to the giving of a legally valid consent. The involvement of family members in terms of supporting the individual, is legally distinct from the concept of consenting to treatment. Although the two may often overlap, this will not always be the case. Consequently, the requirement to obtain the consent of the *Gillick* competent minor's parents *requires* that the parents are provided with private and confidential information. Under the current law, *Gillick* competent minors have no choice but to agree to such a disclosure, despite them being

[135] *Re Jamie*, note 72, [135].

[136] *Axon*, note 18. For a discussion of the issue of confidentiality, see (Cave 2009).

assessed as competent by their treating practitioners. Such a position erodes the concepts of privacy and confidentiality, and thus contradicts the policy reasoning that underpinned *Gillick*. This is an unsatisfactory position for the law to adopt and does not reflect the position in relation to other types of medical treatment, in circumstances where Bryant CJ had explicitly acknowledged that there was no need to read down the significance of the *Gillick* principle. Moreover, in jurisdictions that have human rights legislation, such as the Australian Capital Territory,[137] Queensland,[138] and Victoria,[139] which directly protects the human right to privacy and/or a private and family life,[140] the *requirement* to involve the parents may, in some cases where care is provided in the public sector, result in a potential violation of a *Gillick* competent minor's human rights.

Fourth, the approach suggested by Watts J is inconsistent with basic principles around the law of consent, that require consent as a basis for negating liability for trespass to the person and/or assault. If consent is provided by someone with lawful authority to give such consent, this is normally sufficient for the purpose of negating such liability. As outlined above, although the reasoning from the refusal cases is not directly binding in the context of decisions about consenting *to* treatment, the reasoning in these cases concerning basic consent principles supports the view that parental consent is not required in addition to the consent of the competent minor. In the refusal cases, English courts have confirmed that in situations where the minor is refusing life-saving treatment contrary to their own best interests, a parent can lawfully consent to the treatment and this will protect the health professional from liability in assault and/or trespass to the person.[141] Thus, to re-emphasise Lord Donaldson's comments in *Re W*, he stated that consent:

> protects the doctor from claims by the litigious whether he acquires it from his patient, who may be a minor over the age of 16 or a "*Gillick* competent" child under that age, or from another person having parental responsibilities which include a right to consent to treatment of the minor. Anyone who gives him a flak jacket (ie consent) may take it back, *but the doctor only needs one and so long as he continues to have one he has the legal right to proceed*.[142]

This basic principle should similarly apply in the context of *Gillick* competent minors who wish to consent to gender affirming treatment. Thus, based on such reasoning, if the health professional has obtained a consent from a person who can lawfully provide such consent, such as a *Gillick* competent minor, then this should protect the health professional from a claim in assault and/or trespass to the person. Although, of course, the courts have recognised that there may be other professional consequences for failing to follow professional standards, it must be remembered that the main purpose of a lawful and valid consent is to negate criminal and civil liability for assault and trespass, and the post-*Gillick* caselaw has emphasised this.

Fifth, the position outlined by Watts J in terms of the need for the court to confirm the assessment of the minor's competency, is based on reasoning from *Re Jamie* that is arguably no longer applicable following the Full Court's decision in *Re Kelvin*. As outlined above, Bryant CJ relies on reasoning from *Marion's Case* to justify court oversight of clinical assessments of the minor's competency. As explained, this incorrectly merges the High Court's reasoning in *Marion's Case* concerning the risks inherent in parental decision-making for "special" cases, with the principles applicable to decisions made by *Gillick* competent minors. Given that the Full Court in *Re Kelvin* appears to accept that there is no longer the same degree of concern about gender affirming treatment since *Re Jamie* was decided,

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137 *Human Rights Act 2004* (ACT).
138 *Human Right Act 2019* (Qld).
139 *Charter of Human Rights and Responsibilities Act 2006* (Vic).
140 See *Human Rights Act 2004* (ACT) s 12; *Human Rights Act 2019* (Qld) s 25; and, *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 13.
141 *Re W*, note 30, p. 640.
142 Ibid, p. 645 (emphasis added).

and general oversight of Stage 2 treatment is no longer required, this raises the question of why court involvement is still required in respect of minors who would ordinarily have a lawful basis to provide consent without seeking the court's sanction. Such an approach is also contradicted by the more recent decision of the English Court of Appeal in *Bell*, which clearly notes that the assessment of the minor's competency is for clinicians to make. Thus, it was stated that '[t]he *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'. Like Bryant CJ in *Re Jamie*, and the Full Court in *Re Kelvin*, the English Court of Appeal concluded that:

> 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 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.[143]

5. Conclusions

Gillick is a landmark decision that provides minors with the right to make treatment decisions when they achieve the capacity to fully understand the consequences of the decision and are sufficiently mature for such a purpose. Although *Gillick* focused on decisions about contraceptive advice and treatment, it has subsequently been applied to other types of decision, providing a basis for competent minors to lawfully consent to treatment. Subsequent caselaw has confirmed that *Gillick* competent minors can make healthcare decisions in confidence, without parental involvement. Although limits have been placed on the principle, such limitations apply only to decisions about refusal of life-saving treatment in circumstances where the refusal is contrary to the minor's best interests.

In this article, I have demonstrated that the Australian cases relevant to minors and gender affirming treatment decisions have erred in the application of *Gillick*, both in its original form and its subsequent interpretation. The caselaw in this arena has adopted a particularly paternalistic approach to the issue of *Gillick* competency, initially requiring that the court confirm all clinical assessments of minors' competency in relation to decisions about gender affirming hormone treatment. Although the legal position on this point was changed by the Full Court in *Re Kelvin* in 2017, recent cases suggest that parental consent is required *in addition to* the consent of a minor assessed as *Gillick* competent, and that in cases where a parent disagrees with the clinical assessment of the minor's competency, the court must confirm this matter. As I have outlined, there are a number of reasons that support my conclusions that the current approach under Australian law is inconsistent with *Gillick*. This raises the question as to whether Watts J in *Re Imogen* is suggesting that there is a special rule that applies in such cases, which regards a consent provided by a *Gillick* competent minor as ineffective in respect of a decision to commence gender affirming treatment in some circumstances, unless confirmed by a court. Questions arise as to why the consent of a *Gillick* competent minor is not effective in terms of negating liability on the part of the health professional in cases where the minor's competency is disputed by a parent, despite the fact that the law recognises that the assessment of a minor's competency is for clinicians to make rather than courts, and such a finding gives the minor the right to lawfully consent.

The current position under Australian law removes autonomous decision-making from *Gillick* competent minors in relation to decisions that are so inherently personal. Concerningly, it also potentially deprives such individuals of the right to confidentiality and respect for privacy, and in some cases, causes further distress by having to obtain the court's approval despite being assessed as competent by treating practitioners for the purpose of giving consent. If it is the position that a special rule exists in relation to this type of treatment, then it must be clearly articulated and supported by established legal

143 *Bell* Court of Appeal, note 104, [76], see also [80]–[81].

principle, as such a rule is not supported by the reasoning in *Gillick*, nor its subsequent interpretation. Even if there is legislative reform to address how decisions about gender affirming treatment should be regulated as argued by other authors in this special issue (Jowett et al. 2022), it is vitally important that the issues I have outlined are clarified judicially. This is because, there may indeed be other types of "special" treatment decisions in the future, where judges rely on the current erroneous interpretation of the *Gillick* principle. Reliance on this jurisprudence may then have the effect of depriving *Gillick* competent minors of the ability to make treatment decisions about other matters that similarly relate to issues of personal identity.

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