CHILDREN WITH GENDER DYSPHORIA AND THE JURISDICTION OF THE FAMILY COURT

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I INTRODUCTION

Gender dysphoria is described as '[m]ental distress caused by unhappiness with one's own sex and the desire to be identified as the opposite sex'.[1] Gender dysphoria is distinguished from being intersex, the subject of a recent Australian Senate Committee report, which is referable to physical characteristics.[2] It is also distinguished from gender non-conformism, gender diversity or transsexualism[3] as, in addition to identifying and living as one's non-natal gender, it involves 'clinically significant distress'.[4] Unfortunately, children with gender dysphoria (and indeed many gender diverse young people) are almost by definition at a high risk of depression and anxiety, as well as social isolation, self-harm and

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1 Senate Community Affairs References Committee, Parliament of Australia, *Involuntary or Coerced Sterilisation of Intersex People in Australia* (2013) 55 [3.68] n 85. The term 'gender dysphoria' is preferred here over 'gender identity disorder' – the latter terminology has been abandoned in the most recent *Diagnostic and Statistical Manual of Mental Disorders*: *DSM-5*. See American Psychiatric Association, *Gender Dysphoria* (Fact Sheet, 2013) 1 <http://www.dsm5.org/Documents/Gender%20Dysphoria%20Fact%20Sheet.pdf>.

2 Senate Community Affairs References Committee, above n 1, 1–2 [1.6].

3 There is a wide and fluctuating range of terms used by the gender diverse and transgender communities: see, eg, the glossary in Elizabeth Smith et al, *From Blues to Rainbows: The Mental Health and Well-Being of Gender Diverse and Transgender Young People in Australia* (Australian Research Centre in Sex, Health and Society, La Trobe University and University of New England, 2014) 6–7. I use the term 'gender dysphoria' to describe the very particular situation of the children and young people in the Family Court cases and 'gender diverse' to capture a broader range of 'non-conforming' gender identities.

4 American Psychiatric Association, *Gender Dysphoria*, above n 1, 1.

suicide.[5] This is unsurprisingly often connected to the discrimination and abuse suffered by these groups.

It is now more readily accepted, and due to advances in medical technology, easier than ever before for persons with gender dysphoria to alter their own physical characteristics to more closely conform to their inner gender or identity, a process often referred to as 'transition'.[6] This may occur through hormone therapy or through surgical procedures.[7]

There is an expansive literature concerning the role which law plays in regulating sexual and gender identity, including in diverse gender communities. Scholarship around transgender communities and the law has examined areas such as discrimination and violence against gender diverse people,[8] and access to appropriate healthcare, including for young people.[9] For gender diverse youth, school, community and even family may be sites of oppression and victimisation:

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5 Smith et al, above n 3. They report that of the gender diverse young people in their study, '[e]ighty-one per cent (n = 104) … who had experienced abuse and/or discrimination due to their gender expression had thought about suicide and 37 [per cent] had made suicide attempts': at 67. See also American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (5th ed, 2013) 451–460; Jacqueline K Hewitt et al, 'Hormone Treatment of Gender Identity Disorder in a Cohort of Children and Adolescents' (2012) 196 *Medical Journal of Australia* 578, 578, 581; Michelle Henderson, Kids with Gender Issues Suffer Depression, *NineMSN* (online), 21 May 2012 <http://www.9news.com.au/technology/2012/10/10/10/ 47/kids-with-gender-issues-suffer-depression>, reporting that every child treated at Australia's first clinic for childhood gender dysphoria was suffering depression and anxiety; Rita Lee, 'Health Care Problems of Lesbian, Gay, Bisexual, and Transgender Patients' (2000) 172 *Western Journal of Medicine* 403, 403, reporting that 40 per cent of lesbian, gay, bisexual or transgender youth have either attempted or seriously contemplated suicide; Mary Huft, 'Statistically Speaking: The High Rate of Suicidality among Transgender Youth and Access Barriers to Medical Treatment in a Society of Gender Dichotomy' (2008) 28(1) *Children's Legal Rights Journal* 53, 53.

6 Smith et al, above n 3, 39; Erika Skougard, 'The Best Interests of Transgender Children' [2011] *Utah Law Review* 1161, 1169–72.

7 Hewitt et al, above n 5, 578; Bram Kuiper and Peggy Cohen-Kettenis, 'Sex Reassignment Surgery: A Study of 141 Dutch Transsexuals' (1988) 17 *Archives of Sexual Behavior* 439; F Leavitt et al, 'Presurgical Adjustment in Male Transsexuals With and Without Hormonal Treatment' (1980) 168 *Journal of Nervous and Mental Disease* 693.

8 Laura Grenfell and Anne Hewitt, 'Gender Regulation: Restrictive, Facilitative or Transformative Laws?' (2012) 34 *Sydney Law Review* 761; Alex Sharpe, 'Criminalising Sexual Intimacy: Transgender Defendants and the Legal Construction of Non-consent' [2014] *Criminal Law Review* 207; Abigail W Lloyd, 'Defining the Human: Are Transgender People Strangers to the Law?' (2005) 20 *Berkeley Journal of Gender, Law & Justice* 150; Andrew N Sharpe and Leslie J Moran, 'Violence, Identity and Policing: The Case of Violence against Transgender People' (2004) 4 *Criminal Justice* 395; Andrew Alston, 'Transgender Rights as Legal Rights' (1999) 7 *Canterbury Law Review* 329; Nan Seuffert, 'Reflections on Transgender Immigration' (2009) 18 *Griffith Law Review* 428.

9 Huft, above n 5; Amanda Kennedy, 'Because We Say So: The Unfortunate Denial of Rights to Transgender Minors Regarding Transitions' (2008) 19 *Hastings Women's Law Journal* 281; Sonja Shield, 'The Doctor Won't See You Now: Rights of Transgender Adolescents to Sex Reassignment Treatment' (2007) 31 *New York University Review of Law & Social Change* 361. See also Holly V Franson, 'The Rise of the Transgender Child: Overcoming Societal Stigma, Institutional Discrimination, and Individual Bias to Enact and Enforce Nondiscriminatory Dress Code Policies' (2013) 84 *University of Colorado Law Review* 497.

in Australia, the extension of formal legal protections to these groups is relatively recent.[10] The broader context of some work has been to challenge the law's promulgation of binary conceptions of gender and to promote ideas about rights to gender equality and self-determination.[11] It is against such a backdrop that this article seeks to explore one particular aspect of the legal regulation of gender diversity which concerns young people's access to hormone therapy in Australia.

While it is difficult to obtain estimates about the prevalence of gender dysphoria in the population,[12] greater attention has been paid in recent years to manifestations of gender dysphoria in children and adolescents, both in Australian popular media[13] and in scholarly journals.[14] The intensity of gender dysphoria experienced by young children is a predictor of its continuance,[15] and gender dysphoria that persists into adolescence is more likely to continue into adulthood.[16] As puberty is the time at which children begin to develop adult

10 *Sex Discrimination Act 1984* (Cth) ss 5A–5C, as inserted by *Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Act 2013* (Cth) sch 1 cl 17; see also Grenfell and Hewitt, above n 8, 778–82.

11 See, eg, P L Chau and Jonathan Herring, 'Defining, Assigning and Designing Sex' (2002) 16 *International Journal of Law, Policy and the Family* 327; Chinyere Ezie, 'Deconstructing the Body: Transgender and Intersex Identities and Sex Discrimination – The Need for Strict Scrutiny' (2011) 20 *Columbia Journal of Gender and Law* 141; Amy D Ronner, 'Let's Get the "Trans" and "Sex" Out of It and Free Us All' (2013) 16 *Journal of Gender, Race and Justice* 859. See also the sources cited in nn 8–9 of this article.

12 'For natal adult males, prevalence ranges from 0.005% to 0.014%, and for natal females, from 0.002% to 0.003%. Since not all adults seeking hormone treatment and surgical reassignment attend specialty clinics, these rates are likely modest underestimates': American Psychiatric Association, *DSM*-5, above n 5, 454.

13 *Four Corners: Being Me* (Directed by Janine Cohen and Catherine Scott, Australian Broadcasting Corporation, 2014) <http://www.abc.net.au/4corners/stories/2014/11/17/4127631.htm>; Simon Lauder, 'Teen Cross Gender Clinic Calls for More Services', *ABC News* (online), 21 May 2012 <http://www.abc.net.au/news/2012-05-21/teen-cross-gender-clinic-calls-for-more-services/4024426>; Paul Chai, 'Just a Girl, in the World', *The Sydney Morning Herald* (online), 9 September 2012 <http://www.smh.com.au/lifestyle/just-a-girl-in-the-world-20120908-25c80.html>; 'Gender Disorder Affects Girls Too', *The Australian* (Sydney) 5 June 2013; Jeannette Francis, 'How Young Is Too Young To Change Sex?', *SBS World News* (online), 1 May 2013 <http://www.sbs.com.au/news/article/2013/05/01/how-young-too-young-change-sex>; Myfanwy McDonald, 'Don't Demonise Doctors for Treating Gender Identity Disorder', *The Conversation* (online), 9 April 2013 <http://theconversation.com/dont-demonise-doctors-for-treating-gender-identity-disorder-9593>.

14 Hewitt et al, above n 5; Norman P Spack et al, 'Children and Adolescents with Gender Identity Disorder Referred to a Pediatric Medical Center' (2012) 129 *Pediatrics* 418; Peggy T Cohen-Kettenis, Thomas D Steensma and Annelou L de Vries, 'Treatment of Adolescents with Gender Dysphoria in the Netherlands' (2011) 20 *Child and Adolescent Psychiatry* 689; Annelou L C de Vries et al, 'Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study' (2011) 8 *Journal of Sexual Medicine* 2276; Thomas D Steensma et al, 'Factors Associated with Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study' (2013) 52 *Journal of the American Academy of Child & Adolescent Psychiatry* 582.

15 Steensma et al, 'Quantitative Follow-Up Study', above n 14, 583, 586–8.

16 Madeleine S C Wallien and Peggy T Cohen-Kettenis, 'Psychosexual Outcome of Gender-Dysphoric Children' (2008) 47 *Journal of the American Academy of Child & Adolescent Psychiatry* 1413, 1420–1.

physical characteristics, a treatment option for children with gender dysphoria is to suppress the onset of puberty through the use of hormones,[17] and subsequently to commence further hormone treatment so as to promote the development of non-natal physical attributes.[18]

Typically, when children or people with disabilities cannot agree to receiving medical treatment due to an inability to give informed consent, parents or guardians may authorise treatment instead, but not all treatment. In *Secretary, Department of Health and Community Services v JWB* ('*Marion's Case*'),[19] the High Court held that there are some categories of medical procedure to which parents or guardians *may not* consent. In that case, the majority found that the procedure in question, the sterilisation of an intellectually disabled girl, was outside the scope of parental authorisation.[20]

Applying *Marion's Case* to a different set of circumstances, the Family Court determined in *Re Alex* that hormone therapy for a child with gender dysphoria is similarly outside the bounds of parental consent.[21] Accordingly, hormone therapy could only commence with the approval of the Court, notwithstanding that a child, his or her family and his or her treating medical practitioners may all have been in agreement as to the course of treatment proposed.[22]

In 2013, the Full Court of the Family Court reconsidered this position in *Re Jamie*,[23] an appeal from a decision of Dessau J wherein her Honour authorised hormone treatment for a 10-year-old child, Jamie, with gender dysphoria.[24] Jamie's parents did not contest the effect of Justice Dessau's decision, but rather claimed that they already possessed the right to authorise treatment on Jamie's behalf, this being an aspect of parental responsibility. Accordingly, they challenged the Court's jurisdiction to authorise this kind of treatment.[25] The result was a modification, but not abandonment, of the need for court authorisation, wherein a guardian may authorise the first 'stage' of treatment but not the second.

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17 Specifically, gonadotrophin-releasing hormone analogue: see Royal College of Psychiatrists, 'Good Practice Guidelines for the Assessment and Treatment of Adults with Gender Dysphoria' (College Report No 181, 2013) 20. This is often referred to as 'stage one' treatment.

18 This is sometimes referred to as 'cross-sex hormone therapy' or 'stage two' treatment: Peggy T Cohen-Kettenis and Stephanie H M van Goozen, 'Sex Reassignment of Adolescent Transsexuals: A Follow-Up Study' (1997) 36 *Journal of the American Academy of Child & Adolescent Psychiatry* 263, 265; Marshall Dahl et al, 'Physical Aspects of Transgender Endocrine Therapy' (2006) 9(3–4) *International Journal of Transgenderism* 111, 112, 117, 121.

19 (1992) 175 CLR 218.

20 Ibid 249–54 (Mason CJ, Dawson, Toohey and Gaudron JJ).

21 *Re Alex* (2004) 180 FLR 89. Note that all decisions of the family law courts utilise pseudonyms for minors.

22 As discussed below, where a child's guardians or doctors do *not* agree is a situation in which the court's powers are more appropriately required: see Part V.

23 (2013) 278 FLR 155.

24 *Re Jamie (Special Medical Procedure)* [2011] FamCA 248.

25 *Re Jamie* (2013) 278 FLR 155, 157 [4] (Bryant CJ).

The extension of the ratio in *Marion's Case* to children with gender dysphoria has both practical and symbolic implications. The practical effect is to place a time-consuming, expensive and stressful hurdle in the path of young people who are seeking treatment, and their families.[26] It is ironic that, given the discursive focus on 'hearing' children and upholding children's rights in the family law jurisdiction,[27] the requirement to seek court authorisation adds an additional layer of anxiety and uncertainty for individual children already caught up in a very confusing time in their lives.

On a symbolic level, the concern surrounding cases of childhood gender dysphoria and the restrictions placed on access to treatment illustrate how ill-equipped the Family Court is to deal with childhood manifestations of sexuality and gender identity. It is hard to imagine that adolescents would be unable to pursue treatment if suffering another type of psychological condition carrying such devastating potential consequences,[28] raising the question of why this particular treatment is so highly regulated. This is especially so when the decision in *Marion's Case* does not compel the approach taken by the Family Court. By cementing its jurisdictional reach, the Court has positioned itself as part of the machinery of social regulation of non-normative gender identity.

This article contends that decisions about hormone therapy for children with gender dysphoria should be made, in the absence of disagreement between them, by children, their families and treating medical practitioners, without the need for application to a court. Two main arguments are raised in support. First, the extension of *Marion's Case* to children with gender dysphoria is based on a misreading of that decision and is thus legally unwarranted. Secondly, this expansion of jurisdiction produces harmful effects in the form both of material social and psychological consequences for individual young people, and in reinforcing ideas about the need to regulate 'abnormal' manifestations of gender identity.

Accordingly, Part II discusses the expansion of the Family Court's jurisdiction – to the exclusion of parental power and children's own capacity to consent – so as to encompass decisions relating to treatment for gender dysphoria. Part III examines in detail the High Court's reasoning in *Marion's*

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26 This was acknowledged by the Full Court in *Re Jamie* (2013) 278 FLR 155, 184 [138] (Bryant CJ), 192 [185] (Finn J). See also Hewitt et al, above n 5, 578; *Insight: Transgender* (Directed by Maggie Palmer, Special Broadcasting Service, 2013) <http://www.sbs.com.au/insight/episode/overview/573/Transgender#.U5ehzCgbgZY>.

27 See, eg, Justice Diana Bryant, 'The Role of the Family Court in Promoting Child-Centred Practice' (2006) 20 *Australian Journal of Family Law* 127; Susie O'Brien, 'Judge: Give Kids More Say' *Herald Sun* (Melbourne), 31 July 2014, 5.

28 Indeed, Beh and Diamond have observed of the United States that '[i]n 2003 some 3700 breast augmentation surgeries were performed on teenage girls … Males and females, thus, are denied surgery only if it is associated with a desire to change their sex, not if it is to enhance gender stereotypes': Hazel Beh and Milton Diamond, 'Ethical Concerns Related to Treating Gender Nonconformity in Childhood and Adolescence: Lessons from the Family Court of Australia' (2005) 15 *Health Matrix* 239, 270 n 152.

Case and how this has been applied by the Family Court. Part IV then turns to the impact of the decision in *Re Jamie* and considers when children may be able to consent to treatment themselves. Finally, Part V advocates the adoption of a broader interpretation of the right to personal inviolability in understanding and applying *Marion's Case* to children with gender dysphoria.

II THE LIMITS OF PARENTAL POWER

Marion's Case confirmed the existence of a category of certain medical procedures to which parents are unable to consent on behalf of their minor children.[29] The situation arose when the parents of an adolescent girl with physical and intellectual disabilities, Marion, sought that she be sterilised. The parents sought a hysterectomy for Marion on the basis that menstruation caused her pain, psychological distress and associated behavioural problems.[30] Marion's family and caregivers were also concerned about the negative impact that pregnancy and childbirth would likely have upon Marion.[31] Sterilisation would, of course, also have a contraceptive effect.

Under the common law, consent enables medical treatment which would otherwise be an assault on a person.[32] If a patient is unable to consent due to young age or disability, his or her guardian may authorise the treatment. The objective *seriousness* or riskiness of the situation is not relevant: parents may consent to both their child's heart operation and routine medical check-up. However, the High Court found that the sterilisation sought for Marion was for a 'non-therapeutic' purpose.[33] In so finding, the majority distinguished between sterilisation as an 'incidental result of surgery performed to cure a disease or correct some malfunction',[34] and the procedure sought for Marion.[35] Had sterilisation been the necessary consequence of medically approved treatment for cancer, this would be for a therapeutic purpose, and hence Marion's parents

29 The decision confirmed earlier Family Court determinations in *Re Jane* (1988) 94 FLR 1 and *Re Elizabeth* (1989) 96 FLR 248. Typically, the age of majority is 18 years. In usual circumstances, parents are able to consent to medical treatment on behalf of their children under 18, such consent being necessary to vitiate what would otherwise be an assault. If children are '*Gillick* competent', they may consent themselves.

30 *Marion's Case* (1992) 175 CLR 218, 229 (Mason CJ, Dawson, Toohey and Gaudron JJ).

31 Ibid.

32 Ibid 233–4 (Mason CJ, Dawson, Toohey and Gaudron JJ), 310 (McHugh J).

33 Ibid 250 (Mason CJ, Dawson, Toohey and Gaudron JJ).

34 Ibid 253 (Mason CJ, Dawson, Toohey and Gaudron JJ).

35 Ibid 306 (Deane J), 282 (Brennan J), 321 (McHugh J). Justice Deane held that sterilisation for contraceptive purposes would require court authorisation, Brennan J held that a 'non-therapeutic' procedure could not be consented to by the parents nor by the Court, while McHugh J held that the parents could consent to the procedure if it was for the protection of the child's physical or mental health.

could authorise the treatment.[36] A *non-therapeutic* medical procedure was different. The High Court held that parents are unable to consent to a procedure *not* in the child's best interests: it is this 'overriding criterion' which 'is itself a limit on parental power'.[37] There may, however, be cases where it is unclear as to whether the procedure is in the child's best interests or not.[38] In such instances, it will be up to a court to make the determination.

A court's ability to consent on behalf of the minor or incapacitated person who is the subject of the proposed procedure is founded in the general welfare jurisdiction of the superior state courts. Deriving from the power and responsibility of the state to provide care and protection to those unable to do so themselves, the parens patriae jurisdiction originally exercised by the Court of Chancery has both a lengthy history and considerable breadth.[39] The judges of the High Court, save for Brennan J, acknowledged it to be without limit.[40] The Court held that amendments to the *Family Law Act 1975* (Cth) ('*FLA*') in 1983 had conferred (as intended) a general 'welfare' jurisdiction on the Family Court akin to the parens patriae jurisdiction,[41] though absent the power to make a child a ward of court.[42] A child's welfare could accordingly be 'an independent subject' founding proceedings under the *FLA*.[43] Following further amendments to the *FLA* in 1995, this power is now contained in section 67ZC(1).[44] The four-member joint judgment of the High Court identified the non-therapeutic sterilisation of a

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36 Ibid 296 (Deane J).

37 Ibid 240 (Mason CJ, Dawson, Toohey and Gaudron JJ).

38 See, eg, the discussion of organ donation in Ian Kerridge, Michael Lowe and Cameron Stewart, *Ethics and Law for the Health Professions* (Federation Press, 3rd ed, 2009) 483–4; *Re GWW and CMW* (1997) 136 FLR 421.

39 *Marion's Case* (1992) 175 CLR 218, 258–9 (Mason CJ, Dawson, Toohey and Gaudron JJ). Robert van Krieken dates the parens patriae jurisdiction back to the 17th century, identifying its first 'judicial assertion' in *Falkland v Bertie* (1696) 2 Vern 333, 342; 23 ER 814, 818 (Somers LC): Robert van Krieken, 'The "Best Interests of the Child" and Parental Separation: On the "Civilizing of Parents"' (2005) 68 *Modern Law Review* 25, 27.

40 *Marion's Case* (1992) 175 CLR 218, 258 (Mason CJ, Dawson, Toohey and Gaudron JJ), 301–2 (Deane J). Justice Brennan considered this proposition both 'erroneous in law and disturbing in its social implications': at 282.

41 The Court noted that it was not strictly necessary to determine this issue as at the time the cross-vesting scheme later impugned by *Re Wakim; Ex parte McNally* (1999) 198 CLR 511 was still in force: *Jurisdiction of Courts (Cross-Vesting) Act 1987* (Cth); *Jurisdiction of Courts (Cross-Vesting) Act 1987* (NT); *Marion's Case* (1992) 175 CLR 218, 254–6 (Mason CJ, Dawson, Toohey and Gaudron JJ).

42 It has been held, however, that the absence of this power does not impact on the exercise of parens patriae: *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1992] Fam 64, 73F, 81C (Lord Donaldson MR).

43 *Marion's Case* (1992) 175 CLR 218, 257 (Mason CJ, Dawson, Toohey and Gaudron JJ), citing what were then *FLA* ss 63(1), 64(1).

44 Section 67ZC(1) was inserted by *Family Law Reform Act 1995* (Cth) s 31. It was later amended by *Family Law Amendment (Shared Parental Responsibility) Act 2006* (Cth) sch 1 cl 38.

person unable to consent to be a procedure requiring court authorisation.[45] Moreover, the majority concluded that the equivalent jurisdiction to make such a determination conferred by the *FLA* did not permit a court to 'enlarge' the powers of a guardian so as to be able to consent.[46] In a separate judgment, McHugh J considered that parents or guardians could consent to such a procedure only in the presence of 'compelling circumstances',[47] including where there was a likelihood of the child's health being seriously jeopardised or the child being in severe or regular 'pain, fear or discomfort'.[48] Similarly, Deane J held that parents could consent to sterilisation if it were, 'according to general community standards, obviously necessary for the welfare of the child'.[49] If sterilisation were not so obviously necessary, court authorisation would be required.[50]

Justice Brennan, in dissent, found that neither a child's guardian nor a court could consent to a non-therapeutic procedure. His Honour held that the 'welfare power' of a court was no wider than that of parents or guardians; a court could not authorise something contrary to the child's best interests either under the common law *or* pursuant to the *FLA*.[51] Rather, the jurisdiction is supervisory: a court can make declarations as to whether, for example, a guardian has the power to authorise a particular procedure.[52]

A The Jurisdiction of the Family Court

Over a decade after *Marion's Case,* the then Chief Justice of the Family Court considered the issue of consent in relation to a very different kind of medical treatment.[53] A 13-year-old child, Alex, born biologically female, sought hormone therapy to suppress development of female physical characteristics.[54] Alex had identified as male from a young age and had been diagnosed with gender identity dysphoria.[55] Having previously been taken into care, Alex's guardian was the Secretary of the Department of Health and Community Services, though he resided with his aunt. It was the Department which brought the application.

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45 *Marion's Case* (1992) 175 CLR 218, 249 (Mason CJ, Dawson, Toohey and Gaudron JJ). Subsequently, this doctrine has been applied to other medical procedures, including tissue donation and treatment of children who are born intersex: see, eg, Kerridge, Lowe and Stewart, above n 38, 591–3.

46 Ibid 257 (Mason CJ, Dawson, Toohey and Gaudron JJ).

47 Ibid 321.

48 Ibid.

49 Ibid 305.

50 Ibid 306.

51 Ibid 283–8.

52 Ibid 279.

53 *Re Alex* (2004) 180 FLR 89. The issue of authorising surgery in the case of a child with congenital adrenal hyperplasia had been considered by Mushin J in the earlier decision of *Re A* [1993] FLC 92-402.

54 *Re Alex* (2004) 180 FLR 89, 92 [1]–[2] (Nicholson CJ). Surgical procedures prior to Alex turning 18 were not contemplated: at 92 [3] (Nicholson CJ).

55 Ibid 92 [2] (Nicholson CJ).

Chief Justice Nicholson held that the determination about treatment required consideration first of whether Alex could consent to the treatment himself; and if not, whether Alex's guardian could consent on his behalf – ultimately finding that the guardian could not. On the question of whether Alex could himself consent, Nicholson CJ referred to the evidence of Alex's treating doctors, Professor P and Dr N, but considered both to be somewhat ambiguous on Alex's capacity. The Human Rights and Equal Opportunity Commission, intervening, submitted that if the Court should find that Alex '[had] achieved "a sufficient understanding and intelligence" to enable him "to understand fully what is proposed", then [the] Court has no further role in this matter'.[56] Chief Justice Nicholson doubted, however, that a 13-year-old would ever have the capacity to fully understand the implications of a change of sex.[57] The issue of children's consent to treatment is discussed further below at Part IV.

In *Re Alex*, two stages of treatment were discussed: the initial stage of hormone therapy was agreed to be 'reversible' treatment while the latter or second stage was 'irreversible' treatment. Importantly, Nicholson CJ determined to treat both stages as 'part of a single package', [58] noting:

> It was submitted that the evidence showed [Alex] was eager for the treatment to commence and that if treatment were to commence, he both perceived and wished it would progress through to the irreversible hormonal treatment contemplated by the application, unless of course Alex elects to cease the treatment or clinical contraindications arise. It was also put on the basis of the expert evidence that to authorise the first stage of treatment but leave the subsequent stages for future application and determination by this Court would be destructive and anxiety-provoking for him.[59]

Chief Justice Nicholson observed that given Alex conceptualised the treatment as a single plan, it would be unfair and possibly detrimental to allow the first stage to proceed only to herald the need for a further application to determine the 'second stage'.[60] Reasoning by analogy to *Marion's Case*, and such other case law as was applicable (although none of the cases dealt with precisely the same issue),[61] Nicholson CJ held that *Re Alex* did involve a 'special medical procedure'.[62] Thus, Alex's guardian could not authorise the procedure but Nicholson CJ gave court authorisation for treatment to commence.

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56 Ibid 119 [172] (Nicholson CJ).

57 Ibid 120 [173].

58 Ibid 122 [186].

59 Ibid. This has been reaffirmed by experts testifying in subsequent cases such as *Re O (Special Medical Procedure)* [2010] FamCA 1153, [54] (Dessau J) ('*Re O*').

60 Alex's case did however return to the court when he subsequently sought authorisation for a double mastectomy in *Re Alex* (2009) 248 FLR 312.

61 *Re Alex* (2004) 180 FLR 89, 120–2 [174]–[182], citing *Re A* (1993) 16 Fam LR 715; *Re Michael* (1994) 17 Fam LR 584; *Re Michael (No 2)* (1994) 18 Fam LR 27; *Re W* (1997) 136 FLR 421.

62 *Re Alex* (2004) 180 FLR 89, 116 [152], 123 [190].

This decision was highly controversial.[63] There was a particular focus by commentators on Alex's young age, his family history – which included a very close relationship with his father, his father's subsequent death and his rejection by his mother – and ultimately being taken into care.[64] Concern about *Re Alex* also stemmed from differing views of transsexualism, the very existence of 'gender dysphoria' and whether and how it ought be treated.[65]

Following the decision in *Re Alex*, a handful of cases involving transgender children were determined by the Family Court.[66] In each case, authorisation was given for treatment to proceed.

The parties in the case of *Re Bernadette*[67] mounted the first direct challenge to the jurisdiction of the Court, submitting that the power to make the decision about the child's hormone treatment was an aspect of parental responsibility.[68] Justice Collier made orders by consent at the conclusion of the hearing in November 2007 permitting Bernadette, then aged 15, to commence stage one treatment immediately and stage two treatment from January 2008.[69] However, his Honour did not deliver final orders and reasons until January 2010, the same month in which Bernadette turned 18.[70] Accordingly, although the parties lodged an appeal challenging his Honour's conclusions about jurisdiction, this was dismissed by the Full Court holding itself to lack jurisdiction following Bernadette's attainment of the age of majority.[71]

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63 Merle P Spriggs, 'Ethics and the Proposed Treatment for a 13-Year-Old with Atypical Gender Identity' (2004) 181 *Medical Journal of Australia* 319; Rachael Wallbank, '*Re Alex* "Through a Looking Glass"' (2004) 37 *Australian Children's Rights News* 28; ABC Radio National, '*Re Alex*; Torts Shopping', *The Law Report*, 20 April 2004, (Damien Carrick) <http://www.abc.net.au/radionational/programs/lawreport/re-alex-torts-shopping/3377178>.

64 See, eg, Jen Kelly, 'Court Backs Sex Swap For Girl, 13', *Herald Sun* (Melbourne), 14 April 2004, 3, reporting that the decision had 'ignited outrage from ethicists and sex-swap opponents, who feared Alex was delusional and needed psychiatric help'; Emma-Kate Symons, 'Sex Change Teenager "Needs Help Not Surgery"', *The Australian* (Sydney), 15 April 2004, 3, reporting comments of John Fleming, Director of the Southern Cross Bioethics Institute; Editorial, 'Child Gender Change Takes the Law Too Far', *The Australian* (Sydney), 15 April 2004, 12; Chris Goddard and Joe Tucci, 'When Too Much Intervention May Be the Problem', *The Age* (Melbourne), 4 May 2004, 11.

65 See, eg, Sheila Jeffreys, 'Judicial Child Abuse: The Family Court of Australia, Gender Identity Disorder, and the "Alex" Case' (2006) 29(1) *Women's Studies International Forum* 1; Nicholas Tonti-Filippini, John Paul II Institute for Marriage and Family, *Gender Reassignment* (2009) <http://www.jp2institute.org/Portals/39/Documents/NTF_Gender_Reassignment.pdf>.

66 *Re Brodie (Special Medical Procedures: Jurisdiction)* [2007] FamCA 776; *Re Brodie (Special Medical Procedures)* [2008] FamCA 334 ('*Re Brodie*'); *Re Sean* (2010) 258 FLR 192; *Re O* [2010] FamCA 1153. Note that pursuant to the administrative protocol between the Family Court and the Federal Circuit Court, in practice only the former hears these matters.

67 (2010) 244 FLR 242, affirmed by *Re Bernadette* (2011) 249 FLR 294.

68 *Re Bernadette* (2011) 249 FLR 294, 296 [3] (Bryant CJ and Strickland J).

69 *Re Bernadette* (2010) 244 FLR 242.

70 *Re Bernadette* (2011) 249 FLR 294, 296 [4]–[5] (Bryant CJ and Strickland J).

71 Ibid 300 [26] (Bryant CJ and Strickland J).

After this attempt, a second challenge to jurisdiction was then mounted in *Re Jamie.* Similarly to *Re Bernadette,* Jamie's parents, having received court authorisation for treatment to commence, challenged the need for the authorisation at all, arguing that the power to consent resided in them as Jamie's parents. This time, the Full Court did consider the necessity for application to a court to enable treatment for 'childhood gender identity disorder' to proceed.[72] The Full Court unanimously held that stage one (reversible) treatment could be consented to by the parents, but maintained that stage two (irreversible) treatment remained a procedure to which only a court *or* the child could consent.[73] Notwithstanding the finding that, in an appropriate case, a child could himself or herself consent to the 'stage two' treatment, the Full Court held that whether the child is able to consent must still be determined by a court as a 'threshold issue'.[74] Thus, for any stage two treatment to occur prior to the child turning 18, application must still, in all likelihood, be made to a court.

III A 'DISEASE' OR 'BODILY MALFUNCTION'

As noted, in *Marion's Case*, the High Court utilised the language of 'therapeutic' and 'non-therapeutic' sterilisation, distinguishing the former by describing it as 'appropriately carried out to treat some malfunction or disease'.[75] Such a distinction had been drawn previously by Nicholson CJ in deciding the case of *Re Jane*, also involving a child with an intellectual disability for whom a sterilisation procedure was sought.[76] The majority commented on their discomfort with the imprecision of these concepts, but concluded 'it is necessary to make the distinction, however unclear the dividing line may be'.[77] In his separate judgment in *Marion's Case*, Deane J opined that the imprecise distinction between 'therapeutic' and 'non-therapeutic' surgery 'may be all but meaningless' in the case of psychiatric illness.[78] Commentators have also noted the limitations and vagueness of the terminology: Kerridge, Lowe and Stewart observe that '[t]he distinction fails to tell us why some treatments need court

72 The terminology was used in *Re Jamie* (2013) 278 FLR 155, 156 [1] (Bryant CJ). This is notwithstanding the comments of Nicholson CJ in *Re Alex* (2004) 180 FLR 89, preferring the use of the term 'dysphoria' over 'disorder': at 92 [2].

73 *Re Jamie* (2013) 278 FLR 155, 178 [108], 184 [137] (Bryant CJ), 191 [179], 192 [184] (Finn J), 193 [194]–[195] (Strickland J).

74 Ibid 192 [184] (Finn J), 193 [196] (Strickland J).

75 *Marion's Case* (1992) 175 CLR 218, 250 (Mason CJ, Dawson, Toohey and Gaudron JJ).

76 (1988) 94 FLR 1.

77 *Marion's Case* (1992) 175 CLR 218, 250. Note Justice Deane's view that the common law draws no such distinction: at 297.

78 Ibid 296. This reflects the conception of the distinction in the United Kingdom, where it has never been adopted: *Re B (A Minor) (Wardship: Sterilisation)* [1988] AC 199, 204 (Lord Hailsham).

approval and others do not'.[79] Bogdanoski discusses the medicalisation of the desire for 'body modification', suggesting that it is only by rationalising cross-sex hormone therapy or surgery as the product of psychiatric abnormality that society can make sense of it:

> Rather than simply accepting the autonomous wishes of patients to … alter their gender, society is baffled by requests for body modification, and correspondingly needs to engage in discourses about whether such operations are therapeutic or non-therapeutic.[80]

In contrast, cosmetic surgeries aimed at 'normalising' or enhancing socially acceptable physical attributes (such as female breast enlargement) are considered culturally unremarkable.[81] Accordingly, critiques of a 'medical model' of transgender identity reject a pathologising approach and espouse a fluid concept of gender identity.[82] Yet, as Spade has noted, 'the reliance on medical evidence and the medical assessment of gender identity is so deeply entrenched, no legal strategist can avoid working within requirements of medical documentation at least sometimes'.[83] Spade goes on to discuss concerns about relying on this approach to achieve rights for gender diverse people. While important, these problems are outside the scope of this article, which focuses on the problem of legal rather than medical regulation and concerns children, rather than adults. Moreover, the Court's reliance on medical expertise in the case law indicates that it acts to replicate this regulation rather than as an independent safeguard, as noted below.

As a matter of law, it is within the scope of parental power to consent to *therapeutic* treatment for a child. Accordingly, the classification of gender dysphoria as a 'bodily malfunction' or as 'disease' assumes a central importance. In determining *Re Alex*, Nicholson CJ seemed caught by the 'therapeutic/non-therapeutic' distinction. His Honour determined that Alex's condition, which was deliberately referred to as dysphoria rather than a 'disorder',[84] was not a disease.[85] His Honour considered that to label the condition as such would likely be offensive to gender diverse persons such as Alex,[86] thus resisting the medical discourse or rationalisation described by Bogdanoski.[87] Yet, by refusing to

79 Kerridge, Lowe and Stewart, above n 38, 493.

80 Tony Bogdanoski, 'Every *Body* Is Different: Regulating the Use (and Non-use) of Cosmetic Surgery, Body Modification and Reproductive Genetic Testing' (2009) 18 *Griffith Law Review* 503, 508.

81 Ibid 509; Beh and Diamond, above n 28, 270 n 152. See generally Dean Spade, 'Resisting Medicine, Re/modeling Gender' (2003) 18 *Berkeley Women's Law Journal* 15, 15–16.

82 See, eg, Spade, above n 81; Alvin Lee, 'Trans Models in Prison: The Medicalization of Gender Identity and the Eighth Amendment Right to Sex Reassignment Therapy' (2008) 31 *Harvard Journal of Law & Gender* 447.

83 Spade, above n 81, 18. As Spade explains, in the United States, bringing claims based in disability discrimination to protect the rights of transgender people puts these issues in focus: at 32–7.

84 *Re Alex* (2004) 180 FLR 89, 92 [2].

85 Ibid 124 [195]–[197].

86 Ibid 124 [197].

87 Bogdanoski, above n 80, 505.

accede to the medicalisation or pathologising of Alex's beliefs about his identity, Nicholson CJ was also cementing the view of hormone therapy for gender dysphoria as non-therapeutic, with unfortunate practical consequences. As Kerridge, Lowe and Stewart observe, this has the corresponding (and also potentially 'insulting') implication that 'people with gender identity problems … have been necessarily classified as needing "non-therapeutic" treatment which sends a message that these illnesses are not real and devastating'.[88]

In contrast to *Re Alex*, the Full Court in *Re Jamie* clearly accepted and adopted a 'medical model' of gender diversity. The judgment uses the language of 'disorder' throughout, and the Court relied on the inclusion of 'childhood gender identity disorder' as a mental disorder in the *Diagnostic and Statistical Manual of Mental Disorders*: *DSM-4*.[89] Soon after, the American Psychiatric Association revised this label, explaining that the condition would now be referred to as 'gender dysphoria'.[90] The Association noted further that 'gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition'.[91]

Chief Justice Bryant commented that:

> it is readily understandable why people with transsexualism are concerned about the psychiatric diagnoses of gender dysphoria or gender identity disorder, as they see themselves as merely an example of diversity in human sexual formation, rather than having a psychiatric condition … However whilst understanding this discomfort, I do not need to determine whether that characterisation is correct or not for the purpose of these proceedings … *the weight of professional opinion is that it represents a particular category of pathology or mental illness*.[92]

As Bryant CJ noted, the majority in *Marion's Case* did not explicitly consider whether the ambit of the principles being espoused would extend to treatment of a 'pathological condition or psychological disorder'.[93] Only Brennan J appeared to consider this to be the case.[94] Nevertheless, Bryant CJ and Finn J concluded that there was no need to limit the statements of the majority in *Marion's Case* only to 'physical disease'.[95] Importantly, all three members of the Full Court in *Re Jamie* concluded that the 'therapeutic' nature of stage one treatment meant that it was within parental power to authorise treatment on behalf of the child.[96]

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88 Kerridge, Lowe and Stewart, above n 38, 493.
89 *Re Jamie* (2013) 278 FLR 155, 163 [26], 165 [44], 170–1 [69] (Bryant CJ).
90 American Psychiatric Association, *Gender Dysphoria,* above n 1, 1.
91 Ibid.
92 *Re Jamie* (2013) 278 FLR 155, 170–1 [68]–[69] (emphasis added).
93 Ibid 172 [74], citing *Marion's Case* (1992) 175 CLR 218, 269 (Brennan J).
94 *Marion's Case* (1992) 175 CLR 218, 269.
95 *Re Jamie* (2013) 278 FLR 155, 177 [97] (Bryant CJ), 190 [176] (Finn J).
96 Ibid 177 [98] (Bryant CJ), 191 [179] (Finn J), 193 [193]–[194] (Strickland J).

As is apparent from the foregoing discussion, the Full Court in *Re Jamie* treated the issue of the 'stages' of treatment quite differently to Nicholson CJ in *Re Alex*. Following *Re Alex*, the practice in subsequent cases had been to consider stage one and stage two treatment as a single issue. Jamie, however, was only 10 at the time of the original hearing before Dessau J.[97] As it was suggested that stage two treatment would not be contemplated until Jamie was 16, Dessau J considered herself unable to be satisfied as to what would be in Jamie's best interests six years into the future.[98] Accordingly, a further application to the Court was foreshadowed to be necessary when Jamie was approaching this age.

Unfortunately, the separate consideration of stages one and two seems calculated to produce the exact result that Nicholson CJ considered it desirable to avoid in *Re Alex* – the creation of uncertainty and hence anxiety[99] – on the part of Jamie and her family. It is questionable whether delaying the decision could in fact even act as an additional safeguard. Court authorisation of stage two treatment would only result in that decision being placed back in the hands of the child, her family and the treating medical practitioners. Consistent with Chief Justice Nicholson's earlier observation,[100] there was no reason to suggest that Jamie would change her mind about proceeding with treatment, or more importantly that her family and doctors would not respect her wishes if she *did* change her mind. Moreover, if her treating medical practitioners at any time determined that it would not be in Jamie's best interests to proceed, treatment would clearly be refused and hence would *not* proceed. Any controversy between child, family and doctors about that would then fall to be resolved, if necessary by the Court. Absent these circumstances, there could be no relevant issue arising at a later stage which would cause the Court to reach a different determination about the child's best interests than it had at the earlier point in time. Indeed, the artificiality and irrelevance *to the child* of focusing on the two stages of treatment demonstrates a misunderstanding about the nature of gender dysphoria more generally.

This leads, then, to a more fundamental problem with the Full Court's reasoning in *Re Jamie* which arises in its consideration of stage two treatment.

A Therapeutic Treatment

The majority of the High Court in *Marion's Case* were clearly focused on 'non-therapeutic' procedures, notwithstanding their Honours' disquiet about the concept. The judges forming the majority twice distinguished the particular sterilisation under consideration for Marion from one carried out to remedy

97 Ibid 179 [113] (Bryant CJ).
98 *Re Jamie (Special Medical Procedure)* [2011] FamCA 248, [130].
99 *Re Alex* (2004) 180 FLR 89, 122 [186].
100 Ibid 125 [202].

disease or illness,[101] which would be a therapeutic procedure, stating: 'But first it is necessary to make clear that, in speaking of sterilization in this context, *we are not referring to sterilization which is a byproduct of surgery appropriately carried out to treat some malfunction or disease*'.[102]

The majority continued:

> As a starting point, sterilization requires invasive, irreversible and major surgery. But so do, for example, an appendectomy and some cosmetic surgery, both of which, in our opinion, come within the ordinary scope of a parent to consent to. However, other factors exist which have the combined effect of marking out the decision to authorize sterilization as a special case. Court authorization is required, first, because of the significant risk of making the wrong decision, either as to a child's present or future capacity to consent or about what are the best interests of a child who cannot consent, and secondly, because the consequences of a wrong decision are particularly grave.[103]

If, however, the procedure is a *therapeutic* one, the issues about the risk of making a wrong decision and the gravity of the consequences should not arise. Kerridge, Lowe and Stewart observe that in case of children with gender dysphoria, the Family Court appears to disregard the therapeutic nature of treatment which would otherwise bring it within the scope of parental consent.[104] This is what occurred in *Re Jamie*, where having determined the proposed treatment for Jamie to be therapeutic in nature, the Full Court nevertheless went on to consider issues relating to risk and gravity.

The majority in *Marion's Case* identified the grave consequences adverted to as being not only rendered unable to procreate but also the very fact of being so acted upon contrary to one's wishes. Indeed, the majority stopped short of recognising a basic human right to procreate, but rather founded their decision in the right to 'personal inviolability'.[105] In the majority judgment, the irreversible nature of sterilisation is not given greater weight, at least discursively, than the loss of control or subjugation of the child to an invasive procedure *not in the child's best interests*.[106]

In contrast, in the Family Court decisions the *irreversible* nature of the proposed treatment is accorded a key importance. Due to his finding that hormone therapy was *non*-therapeutic, Nicholson CJ in *Re Alex* focused on two

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101 *Marion's Case* (1992) 175 CLR 218, 250, 253 (Mason CJ, Dawson, Toohey and Gaudron JJ).

102 Ibid 250 (Mason CJ, Dawson, Toohey and Gaudron JJ) (emphasis added).

103 Ibid.

104 Kerridge, Lowe and Stewart, above n 38, 489–90; see also Malcolm K Smith, 'The Boundaries of Parental Decision-Making and the Requirement to Obtain Court Approval for "Special Medical Procedures": The Recent Decision of *Re Jamie* [2013] FAMCAFC 110' (2013) 33(3) *Queensland Lawyer* 182, 186–7.

105 *Marion's Case* (1992) 175 CLR 218, 253 (Mason CJ, Dawson, Toohey and Gaudron JJ). Here, the phrases 'personal inviolability' and 'bodily inviolability' seem to be used interchangeably. In *Re Jane* (1988) 94 FLR 1, Nicholson CJ noted the limitations of considering the issue in terms of a right to procreate: at 11; and concluded there is a common law right to bodily integrity: at 22–3.

106 *Marion's Case* (1992) 175 CLR 218, 252 (Mason CJ, Dawson, Toohey and Gaudron JJ).

aspects of the decision in *Marion's Case*: the 'invasive, permanent and irreversible' nature of the treatment; and that it was 'not for the purpose of curing a malfunction or disease'.[107] The decision of the Full Court in *Re Jamie* also hinged on the concept of irreversibility of treatment. In determining that stage one treatment was treatment within the normal scope of parental authorisation, Bryant CJ found that:

> if the treatment is in response to a disorder, even a psychological or psychiatric one, it is administered for therapeutic purposes. For that reason alone, in my view, the treatment at stage one … would not fall within the category of cases which the High Court was considering in *Marion's case*.[108]

If it is found that stage one treatment is administered for a therapeutic *purpose*, so too must stage two treatment be. The 'disorder' being responded to is the same one; the purpose does not change just because the treatment may change. Nevertheless, Bryant CJ found that '[t]he complete reversibility, with few, if any, side effects, of stage one is a significant issue. Stage two is acknowledged to be different'.[109]

Justice Finn was more explicit about the distinction between the stages:

> Stage two of the proposed treatment presents greater problems if only because it is … 'irreversible in nature' … This consideration must, in my view, remain important, even when it is accepted that the treatment can be categorised as therapeutic, and in this regard the concept of proportionality referred to by Brennan J must come into play.[110]

Justice Finn was here referring to dicta of Brennan J in *Marion's Case*, wherein his Honour said that '"[n]on-therapeutic" medical treatment is descriptive of treatment which is inappropriate or *disproportionate* having regard to the … psychiatric disorder for which the treatment is administered'.[111]

This interpretation, however, disregards the broader context of Justice Brennan's dissenting judgment, given that his Honour found that neither parents nor the courts have the power to authorise a *non-therapeutic* medical procedure on a person incapable of consent.[112] Justice Brennan held that what is or is not therapeutic is a question of fact involving consideration of both purpose and proportionality.[113] Thus, the question of proportionality goes to determining the initial, fundamental question of whether the treatment is therapeutic, which is 'determined as a question of medical fact'.[114] It is not to be balanced *against* undertaking a therapeutic treatment. Further, Brennan J noted that it could not 'be

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107 *Re Alex* (2004) 180 FLR 89, 116 [153].
108 *Re Jamie* (2013) 278 FLR 155, 177 [98].
109 Ibid 179 [111].
110 Ibid 191 [180].
111 *Marion's Case* (1992) 175 CLR 218, 269 (emphasis added).
112 Ibid 275–7.
113 Ibid 274.
114 Ibid.

right' to *prevent* a child from undertaking therapeutic treatment by compelling parents to first obtain leave of a court,[115] an issue discussed below at Part V.

The other judges in *Marion's Case* similarly held that parents can consent to treatment necessary to 'alleviate pain, fear or discomfort' (though not if there is a 'less drastic' means to avoid the procedure)[116] or if the treatment is 'so obviously necessary' for the child's welfare.[117] Logically, Justice Brennan's dicta might support an argument that stage one treatment is therapeutic because it is proportionate to the end to be achieved, but stage two treatment is *non*-therapeutic as its irreversible nature is disproportionate to that same end. This was not, however, the finding in *Re Jamie*. Furthermore, even this formulation is problematic as the emphasis which the Full Court placed on 'irreversibility' overlooks the irreversible effect of *not* undergoing treatment.

B Irreversible Effects

Without treatment, a child wishing to transition from male to female will, with the onset of puberty, begin to develop masculine characteristics, aspects of which are irreversible, such as the deepening of the voice. A child wishing to transition from female to male will develop feminine physical characteristics that also cannot be reversed, at least without surgical intervention.[118]

In the context of children with gender dysphoria, to distinguish between reversible and irreversible treatment is not a useful way to determine whether the treatment is itself therapeutic. In contradistinction to the situation in *Marion's Case*, for children with gender dysphoria, *not* receiving treatment is irreversible just as *receiving* treatment is irreversible. As Shield has argued, adolescents 'will forever see the mark of this delay on [their] body'.[119] Moreover, and importantly in light of the perceived connection between the 'sterilisation cases' and the 'gender dysphoria' cases, the second stage of hormone therapy does not necessarily result in irreversible sterilisation, although it is likely that with prolonged use of hormones fertility will diminish and eventually be lost altogether.[120] Yet by focusing on the concept of irreversibility, the Family Court

115 Ibid 278.
116 Ibid 309 (McHugh J).
117 Ibid 306 (Deane J).
118 It is further suggested that '[i]mperfect physical outcomes are a primary cause of post-operative mental health issues': Shield, above n 9, 379, citing Cohen-Kettenis and van Goozen, above n 18, 264; Yolanda L S Smith, Stephanie H M van Goozen and Peggy T Cohen-Kettenis, 'Adolescents with Gender Identity Disorder Who Were Accepted or Rejected for Sex Reassignment Surgery: A Prospective Follow-Up Study' (2001) 40 *Journal of the American Academy of Child & Adolescent Psychiatry* 472, 472–3.
119 Shield, above n 9, 362–3.
120 Johanna Olson and Michelle Forcier, Up To Date Clinical Decision Support Resource, *Overview of the Management of Gender Nonconformity in Children and Adolescents* (20 November 2014) <http://www.uptodate.com/contents/overview-of-the-management-of-gender-nonconformity-in-children-and-adolescents>.

sidesteps the logical consequence of the finding that hormone therapy for gender dysphoria is therapeutic, which is that a court need not make the determination.

The weight placed on irreversibility is all the more remarkable if one considers that if a child is diagnosed as having gender dysphoria, the diagnosis of itself determines the possible treatment. That is, the diagnosis stems from the fact that the desire of the child for his or her physical characteristics to correspond to his or her inner subjective feelings about his or her gender is so strong, physical change may be the best and indeed *only* method by which to preserve his or her mental health, and possibly life. As a medical professional quoted in *Re Lucy*[121] opined, '[u]ntreated Gender Dysphoria invariably progresses to immense disillusionment and then, to chronic depression which can often progress to Major Depression, with significant suicidal risk'.[122] The recent survey of Smith et al found not only extremely high reports of suicidal thoughts amongst young gender diverse people but also of suicide attempts.[123] In gender dysphoric children, the development of secondary sexual characteristics may increase unhappiness with the body and 'comorbid' symptoms (such as body dysmorphia and other obsessional disorders),[124] as well as 'depression, anxiety, self-harm, suicidality, substance use and high risk sexual behaviors'.[125] Thus, the seriousness of a 'change' of gender is seen as more grave than all of these well-documented risks.

The disaggregation of stages one and two, and the overwhelming concern with irreversibility, has a more subtle effect too, serving to reinforce norms about the essentially binary nature of social conceptions of gender.[126] The focus of the decision shows that any concept of gender fluidity is anathema – a person may be one gender or another, and the critical part of the decision is around when that may occur, hence the preoccupation with 'stage two'.

Stage one treatment can only provide a holding pattern, and like a holding pattern, for a finite amount of time. As Nicholson CJ correctly observed in relation to Alex,[127] children, their families and their treating medical practitioners do not enter into stage one treatment absent the intention to at least consider continuing to stage two treatment: the diagnosis in and of itself imports this. This is reflected in research suggesting that gender dysphoria existing since childhood and which is exacerbated rather than diminished with puberty, is unlikely to

121 (2013) 286 FLR 327.
122 Ibid 332 [18] (Murphy J).
123 Smith et al, above n 3, 67.
124 Hewitt et al, above n 5, 579.
125 Olson and Forcier, above n 120, citing Johanna Olson, Catherine Forbes and Marvin Belzer, 'Management of the Transgender Adolescent' (2011) 165 *Archives of Pediatrics and Adolescent Medicine* 171; Kenneth J Zucker, 'The DSM Diagnostic Criteria for Gender Identity Disorder in Children' (2010) 39 *Archives of Sexual Behavior* 477.
126 Senate Community Affairs References Committee, above n 1, 13 [1.51]; though note the recent decision of the High Court in *Registrar of Births, Deaths and Marriages (NSW) v Norrie* (2014) 250 CLR 490.
127 *Re Alex* (2004) 180 FLR 89, 122–3 [188]–[189].

subside.[128] A prospective follow-up study of 70 gender dysphoric young people found that all elected to proceed to cross-sex hormone therapy following hormonal suppression of puberty.[129] In the only Australian study, which predated *Re Jamie*, 17 out of 21 young people 'experienced persistence of profound [gender dysphoria] with increased distress following commencement of puberty and were therefore considered eligible for hormone treatment'.[130]

The artificiality of distinguishing between the two stages, as far as the child involved is concerned, is apparent. There is little utility in undertaking stage one treatment without this being followed by stage two treatment, other than to buy more time. While this may be necessary and appropriate in a treatment context, in a legal sense, drawing a distinction between stages one and two has the effect only of delaying the decision that a court will eventually be called upon to make. Yet, as discussed below, the Full Court in *Re Jamie* had reason to encourage this delay.

IV *GILLICK* COMPETENCE AND CONSENT

In the gender dysphoria cases, it has been accepted (and confirmed in *Re Jamie*) that children or young people may be able to consent to hormone treatment themselves while still minors, but the circumstances in which this will be possible are not defined with precision.[131] This imprecision arises from the approval in *Marion's Case* of a test of '*Gillick* competence' set out by Lord Scarman in that decision:[132] 'A minor is, according to this principle, 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"'.[133]

In *Re Alex,* Nicholson CJ was not satisfied on the evidence that Alex was able to fully comprehend the effect of the treatment envisaged. However, his Honour was not required to fully determine whether Alex could consent to treatment, as it was found both that Alex wanted the treatment and that it was in his best interests.[134]

As was argued by the appellants in *Re Jamie*, the situation of children with gender dysphoria is arguably starkly different to that of children (and indeed

128 Spack et al, above n 14; Annelou L C de Vries and Peggy T Cohen-Kettenis, 'Clinical Management of Gender Dysphoria in Children and Adolescents: The Dutch Approach' (2012) 59 *Journal of Homosexuality* 301; Thomas D Steensma et al, 'Desisting and Persisting Gender Dysphoria after Childhood: A Qualitative Follow-Up Study' (2011) 16 *Clinical Child Psychology and Psychiatry* 499.

129 De Vries et al, above n 14, 2276.

130 Hewitt et al, above n 5, 579.

131 *Re Alex* (2004) 180 FLR 89, 116 [155] (Nicholson CJ).

132 *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112.

133 *Marion's Case* (1992) 175 CLR 218, 237 (Mason CJ, Dawson, Toohey and Gaudron JJ), citing *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112, 189 (Lord Scarman).

134 *Re Alex* (2004) 180 FLR 89, 99 [49].

adults) with intellectual disabilities considered in the 'sterilisation' cases. The High Court in *Marion's Case* proceeded on an assumption that Marion would *never* attain the 'competence' to be able to consent to treatment herself.[135] Gender diverse children, by contrast, can be expected to draw nearer to attaining *Gillick* competence as they age.

Jamie herself was, as noted, only 10 at the time of the initial application. This is reportedly not uncommon: the years from 10 to 13 are likely to be a critical time for children displaying childhood gender non-conformism.[136] Jamie's treating doctors did not envisage 'stage two' treatment commencing until she reached the age of 16, which is the age proposed in Endocrine Society clinical guidelines.[137] This is also the age at which, in some Australian jurisdictions, children are presumed to be able to consent to medical treatment,[138] as Bryant CJ noted in her judgment.[139] Her Honour further explained, in a sensitive passage, that there is no reason why a competent child should not be able to make his or her own decision about commencing stage two treatment:

> 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.[140]

The positing of 16 as the typical age for stage two treatment to commence seems to have struck the Full Court as a useful escape route from the quagmire of judicial decision-making in such cases. If parents can consent to stage one treatment, and stage two treatment would typically proceed when the child is at an age where he or she is *likely* to be able to consent, then a court might not be required to make a determination about treatment at all. In *Re Lucy*, handed down just weeks before *Re Jamie,* Murphy J found that allowing Lucy to undergo reversible treatment would provide a 'hiatus' until the child is '*Gillick* competent' or becomes an 'adult'.[141]

Yet it becomes quickly apparent that any ostensible relinquishment of control over this area of decision-making is illusory, as the Full Court held that the

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135 The problems inhering in such an immutable view of disability are discussed elsewhere: see Linda Steele, 'Making Sense of the Family Court's Decisions on the Non-therapeutic Sterilisation of Girls with Intellectual Disability' (2008) 22 *Australian Journal of Family Law* 1.

136 Steensma et al, 'Quantitative Follow-Up Study', above n 14, 582–4. Hewitt et al report that patients presented to their specialist Melbourne clinic at a mean age of 10 years: Hewitt et al, above n 5, 580.

137 Wylie C Hembree et al, 'Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline' (2009) 94 *Journal of Clinical Endocrinology and Metabolism* 3132. The same is proposed in a Dutch protocol: Henriette A Delemarre-van de Waal and Peggy T Cohen-Kettenis, 'Clinical Management of Gender Identity Disorder in Adolescents: A Protocol on Psychological and Paediatric Endocrinology Aspects' (2006) 155 *European Journal of Endocrinology* 131.

138 See *Minors (Property and Contracts) Act 1970* (NSW) s 49; *Consent to Medical Treatment and Palliative Care Act 1985* (SA) s 6.

139 *Re Jamie* (2013) 278 FLR 155, 183 [130]–[131].

140 Ibid 183–4 [135] (Bryant CJ).

141 *Re Lucy* (2013) 286 FLR 327, 349 [93].

decision about whether or not a child *is* indeed *Gillick* competent is one that must be made by the Court itself.[142] Both Bryant CJ and Finn J described themselves as reluctant to reach this conclusion but bound by *Marion's Case* on the issue,[143] Finn J describing the latter as enshrining:

> the requirement … for court authorisation for irreversible medical treatment in circumstances where there is a significant risk of the wrong decision being made as to the child's capacity to consent to the treatment and where the consequences of such a wrong decision are particularly grave …[144]

In a short concurring judgment, Strickland J repeated this finding.[145]

Such an analysis of *Marion's Case* overlooks the fact that the High Court was concerned only with what was found to be a *non-therapeutic* procedure. In the Family Court's interpretation, the concept of 'irreversible' treatment seems to be substituted for 'non-therapeutic' treatment.

As quoted above, the majority in *Marion's Case* described non-therapeutic sterilisation of a child with an intellectual disability as carrying a 'significant risk of making the wrong decision, either as to a child's present or future capacity to consent or about what are the best interests of a child who cannot consent'.[146] These two issues are not clearly distinguished from one another in the ensuing discussion, but earlier in their judgment the majority had dealt at some length with the reasons why the decision about capacity to consent will be more difficult to make in the case of a child with an intellectual disability.[147] Having described the *Gillick* test, the majority noted that 'the fact that a child suffers an intellectual disability makes consideration of the capacity to consent *a different matter*'.[148] The majority explained that this was due to the widely differing capabilities of children with disabilities, who cannot be treated as homogenous.[149] Importantly, their Honours concluded 'there is no reason to assume that all disabled children are *incapable* of giving consent to treatment'.[150]

Of even greater import, perhaps, the majority identified the risk of making the wrong decision in such cases and expressed caution about assuming medical professionals would always make 'correct' decisions.[151] This derived from the judges' awareness of 'misconceptions on the part of others in society'[152] about persons *with* intellectual disabilities and the fact that such misconceptions are

142 *Re Jamie* (2013) 278 FLR 155, 184 [136]–[138] (Bryant CJ)
143 Ibid 184 [137] (Bryant CJ), 192 [184]–[186] (Finn J).
144 Ibid 192 [186].
145 Ibid 193 [196].
146 *Marion's Case* (1992) 175 CLR 218, 250 (Mason CJ, Dawson, Toohey and Gaudron JJ).
147 Ibid 238 (Mason CJ, Dawson, Toohey and Gaudron JJ).
148 Ibid (emphasis added).
149 Ibid.
150 Ibid (emphasis added).
151 Ibid.
152 Ibid.

likely to be heightened when it comes to issues involving sexuality or sexual identity.[153]

The majority therefore clearly distinguish the assessment of competency in the case of children with intellectual disabilities from the assessment of those without. It is the presence of intellectual disability as well as the context of the decision to be made that creates the 'significant risk of making the wrong decision' as to competency.[154] *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.

From its earliest consideration of these types of cases, the Family Court has been relatively reluctant to find children able to consent to treatment for gender dysphoria. The nature of the way that the decisions had always been considered prior to *Re Jamie* meant that it was unnecessary to make definitive findings about children's consent, as the Court would always have material available to determine that treatment was nevertheless in children's best interests. Thus, the procedure seems to have been to consider whether the child is 'capable of making an informed decision' concerning treatment,[155] but in the knowledge that the Court was not authorising something which the child did not want or which was not also appropriate.

A Conflicting and Coincident Interests

One concern of the majority in *Marion's Case* was that the interest of parents and families in the child undergoing sterilisation might be different from, or in conflict with, the interests of the child herself.[156] Appropriately, the High Court was exceedingly concerned about the improper treatment of children with disabilities.[157] Mandating application to a court is for the purpose of ensuring protection against an abuse of rights – primarily, the right to 'bodily inviolability'.[158] Justice Brennan, who considered that *no one* could have the power to permit non-therapeutic sterilisation, referred to 'the law's protection of the human dignity of the intellectually disabled child'.[159]

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153 Ibid 239 (Mason CJ, Dawson, Toohey and Gaudron JJ).

154 Ibid 250 (Mason CJ, Dawson, Toohey and Gaudron JJ).

155 *Re Rosie* [2011] FamCA 63, [100] (Dessau J); *Re O* [2010] FamCA 1153. Though note cases post-*Re Jamie* where the Court has made a declaration as to the child's competence: *Re Spencer* [2014] FamCA 310; *Re Colin* [2014] FamCA 449.

156 There was evidence, for example, that sterilisation would make the job of Marion's family in caring for her less onerous: *Marion's Case* (1992) 175 CLR 218, 251–2 (Mason CJ, Dawson, Toohey and Gaudron JJ).

157 Ibid 253 (Mason CJ, Dawson, Toohey and Gaudron JJ).

158 Ibid 233, 248–9 (Mason CJ, Dawson, Toohey and Gaudron JJ).

159 Ibid 273.

Again, however, the situation of gender dysphoric children is not analogous, particularly when the 'irreversibility' of both proceeding or *not* proceeding with treatment is considered. This is illustrated by the distressing situation of the child in the early case of *Re A*, decided by Mushin J.[160] A natal female, A, had been born with congenital adrenal hyperplasia, causing him to develop masculine characteristics. Due to receiving inadequate hormone treatment as a child, these characteristics became more pronounced and thus, as a 14-year-old, A was forced to apply to the Family Court seeking further surgical procedures to enable him to present as a male.[161] Justice Mushin was critical of A's parents for not appropriately adhering to the treatment plan for A and the 'appalling situation' that A subsequently found himself in.[162]

For gender dysphoric children, the decision about treatment options cannot be delayed beyond a certain point without this affecting the outcome, nor is there a 'less invasive' option for consideration. Indeed, as one of Jamie's treating doctors explained, to withhold hormone treatment 'would be experienced as quite "invasive" in itself [due to] the unwanted masculinisation of her body'.[163]

The eugenicist overtones imported by the sterilisation of girls with disabilities which so concerned the High Court[164] are not present. Arguably, parents and doctors are rather responding *appropriately* to children's expression of their gender and severe distress and unhappiness with their body.[165] The appellants in *Re Jamie* submitted that the only benefit to them of Jamie undergoing treatment was to have a child who was well and not unhappy.[166] In the case of *Re O*, the evidence was that:

> The past two years for O have been dogged by periods of significant depression and suicidal thoughts associated with his gender identity. O has reported to his treating psychiatrist, Professor P, disgust about his body. … O has told him that 'at times he feels his life is not worth living because of the feeling of being trapped in the wrong body'.[167]

It is common in the case law for children to have reported suicidal thoughts and sometimes suicide attempts.[168] It seems likely also that the court process

160 *Re A* [1993] FLC 92-402.

161 The procedures sought were 'bilateral mastectomies, a hysterectomy and oophorectomy, unfolding of the clitoris to increase its length and to relieve pain caused by erections, a closure of the labia to create the appearance of a scrotum and the insertion of prosthetic testes': *Re A* [1993] FLC 92-402, 80 113.

162 Ibid 80 114.

163 *Re Jamie* [2011] FamCA 248, [86] (Dessau J).

164 *Marion's Case* (1992) 175 CLR 218, 275 (Brennan J), 295, 300–3 (Deane J), 321 (McHugh J).

165 See Shield, above n 9, 372. Shield makes a persuasive argument for the medical necessity of hormone therapy for adolescents with gender dysphoria. See also Laura R Givens, 'Why the Courts Should Consider Gender Identity Disorder a Per Se Serious Medical Need for Eighth Amendment Purposes' (2013) 16 *Journal of Gender, Race and Justice* 579.

166 *Re Jamie* (2013) 278 FLR 155, 163 [27] (Bryant CJ).

167 *Re O* [2010] FamCA 1153, [60]–[62] (Dessau J).

168 *Re Rosie* [2011] FamCA 63; *Re O* [2010] FamCA 1153; *Re Sam* [2013] FamCA 563; *Re Spencer* [2014] FamCA 310. See also Hewitt et al, above n 5, 578; Smith et al, above n 3, 12, 17–18.

would contribute to children's distress and anxiety due to a perception that a court may not permit or allow the treatment sought,[169] as well as the attendant stress placed on their family. It is inhumane that children must experience the level of suffering described in the case law before being permitted to access treatment, and would seem to be inconsistent with the child's 'best interests'.[170]

This is distinct from a situation involving conflicting views about the diagnosis and treatment of gender dysphoria for a child, where it may be appropriate that a court's powers are invoked. The Family Court's mandate is, inter alia, to resolve disputes relating to the parenting of children. Thus, similarly to case law involving other types of medical procedure, if for example parents have differing views about the type of treatment that is appropriate, it may be necessary for application to be made to a court for determination of the issues.[171] This is, however, quite different to requiring children and parents to apply to the Court under section 67ZC(1) of the *FLA* for permission to undergo treatment which everyone is agreed upon. If there is a debate about whether a particular treatment is indeed therapeutic or not, for example due to parental disagreement about treatment, this gives rise to a situation more appropriate for a court to consider if only because of the failure to agree on a major long-term issue in the child's life. Otherwise, it is unacceptable that children must endure years of suffering before being permitted access to hormone therapy, or more pertinently post-*Re Jamie*, whether they will be allowed to continue treatment which has commenced in the form of 'stage one'.

To date, there is a general absence of countervailing viewpoints in the cases involving children with gender dysphoria. In *Re Alex*, Alex's mother was reported to be unsupportive of Alex's gender identification, but she no longer had parental responsibility, could not be located and did not participate in the proceedings despite being named as respondent.[172] Aside from this, the reported cases have tended to involve children, parents, medical practitioners, family report writers, independent children's lawyers and concerned intervenors such as the Human Rights Commission,[173] who concur in supporting treatment.

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169 See *Re A* [1993] FLC 92-402, 80 114, 80 116–7; *Re O* [2010] FamCA 1153, [60]–[62] (Dessau J).

170 *FLA* s 67ZC(2).

171 This has occurred in the United States. See, eg, Shannon Shafron Perez, 'Is It a Boy or a Girl? Not the Baby, the Parent: Transgender Parties in Custody Battles and the Benefit of Promoting a Truer Understanding of Gender' (2010) 9 *Whittier Journal of Child and Family Advocacy* 367, 392–3; David Alan Perkiss, 'Boy or Girl: Who Gets To Decide? Gender-Nonconforming Children in Child Custody Cases' (2014) 25 *Hastings Women's Law Journal* 57, 70–4; Skougard, above n 6, 1161–2. These authors all discuss *Smith v Smith* (Ohio Ct Common Pleas, Case No. 01 DR 86, 4 September 2004), affirmed by *Smith v Smith* (Ohio Ct App, Case No. 05 JE 42, 23 March 2007).

172 The evidence was that Alex's mother had rejected him which led to his being taken into care: *Re Alex* (2004) 180 FLR 89, 101 [62], [65] (Nicholson CJ).

173 The Human Rights Commission intervened in *Re Alex* (2004) 180 FLR 89 and *Re Jamie* (2013) 278 FLR 155; an unnamed public authority was also permitted to intervene in Jamie's case: *Re Jamie* (2012) 257 FLR 41.

The significance of this is not that parents and guardians are uniformly supportive of childhood manifestations of gender non-conformism. In fact, the opposite is likely to be true.[174] If parents or guardians lack understanding of gender dysphoria or the particular treatment recommended, a child is unlikely to be sufficiently supported to access treatment, let alone the court process.[175] Rather, it illustrates the practical limits of the protective function that a court is intended to fulfil in such cases. Though Family Court proceedings are sometimes described as semi-inquisitorial, judges are confined to making determinations on evidence appropriately brought before the Court.[176] In *Re A*, Mushin J commented on the attendant difficulty faced by the Court when there was nobody to put a 'contrary view'.[177] Where all the evidence tends in a single direction only, it is hard to see what independent safeguard a court can provide. Though it is typical for the Family Court to appoint an independent children's lawyer to represent the child's interests in such cases, these lawyers have always been supportive of the child accessing treatment.[178]

It is also to be remembered that in each reported case, it is the child or young person in question who has been the main instigator of the process, at times contrary to the wishes, at least initially, of his or her parents. Indeed, displaying 'strong cross-gender identity from an early age'[179] forms part of the diagnostic criteria for gender dysphoria. Again, by definition, these young people have spent many years thinking about who they are and what they want in terms of their gender identification.

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174 Smith et al report that 25 per cent of gender diverse young people in their survey reported being abused at home because of their gender orientation: Smith et al, above n 3, 60.

175 De Vries, Cohen-Kettenis and Delemarre-van de Waal report 'clinical consensus' that a precondition to commencing hormone therapy for adolescents is that the young person lives in a supportive environment: Annelou L C de Vries, Peggy T Cohen-Kettenis and Henriette Delemarre-van de Waal, 'Clinical Management of Gender Dysphoria in Adolescents' (2006) 9(3–4) *International Journal of Transgenderism* 83, 85–6.

176 See *Maluka v Maluka* [2012] FamCA 373.

177 [1993] FLC 92-402, 80 116.

178 Though also of the court's jurisdiction: note the independent children's lawyer in *Re Jamie* supported stage one treatment commencing but submitted that the matter should return to court for the determination about stage two treatment, in contrast to Jamie's parents and doctors: *Re Jamie* [2011] FamCA 248, [9]–[10] (Dessau J). Appointing an independent children's lawyer can be contrasted with the approach of Wilson J in determining an application brought in the parens patriae jurisdiction of the Queensland Supreme Court concerning the termination of a child's pregnancy wherein her Honour determined it was appropriate that she appoint 'a contradictor': *Queensland v B* [2008] QSC 231, [25].

179 De Vries, Cohen-Kettenis and Delemarre-van de Waal, above n 175, 85.

V CONCLUSION: THE RIGHT TO PERSONAL INVIOLABILITY

The significance of continued judicial control over decision-making in this area cannot be underestimated. In terms of practical consequences, there is considerable expense, time and distress associated with applying to the Family Court.[180] This is not alleviated by reference to the small numbers of children making application to the Court or the fact that the Court has *never* refused to permit treatment in a gender dysphoria case.[181] Generally, it is suggested that the relative numbers of adolescents receiving treatment for gender dysphoria is low, and often patients present later on, when suppression of puberty will be less effective.[182] In Australia, Hewitt et al reported (pre-*Re Jamie*) that some families did not pursue hormone treatment due to the cost and stress of making a court application.[183] Thus many young people, as a medical practitioner opined in *Re Brodie*, 'just suffer out there'.[184]

Although the Chief Justice in *Re Jamie* foreshadowed that applications concerning a child's capacity to consent 'would only need to address the question of *Gillick* competence and once established the court would have no further role',[185] two problems can be immediately identified. First, although her Honour was suggesting that *less* evidence would be required, this does not diminish the need for an applicant to instruct solicitors, obtain advice, make application to the Court and produce evidence in proper form. Expense, stress and time are unlikely to be considerably diminished.

Secondly, there remains uncertainty surrounding the decision that a court will actually make. In the cases to date, as discussed above, the Family Court will not necessarily find a child competent to make such a life-altering decision. Children, parents and lawyers would thus be unwise to proceed to a hearing of the application without being able to lay their hands on the further evidence needed to demonstrate that treatment is in the child's best interests in the event that the claims about competency are not accepted. To prepare the case on a more limited basis could lead to a situation where, if a court finds a child is not competent to make the decision, a second application would need to be made.

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180 This has been the consistent argument of lawyer Rachael Wallbank, who acted for Bernadette: Wallbank, above n 63, 28; see also sources cited in n 26. The cost and delay associated with making a court application was also noted by the High Court in *Marion's Case* (1992) 175 CLR 218, 253 (Mason CJ, Dawson, Toohey and Gaudron JJ).

181 At least insofar as the reported case law suggests.

182 Daniel E Shumer and Norman P Spack, 'Current Management of Gender Identity Disorder in Childhood and Adolescence: Guidelines, Barriers and Areas of Controversy (2013) 20 *Current Opinion in Endocrinology, Diabetes & Obesity* 69, 71.

183 Hewitt et al, above n 5, 580.

184 *Re Brodie* [2008] FamCA 334, [231] (Carter J).

185 *Re Jamie* (2013) 278 FLR 155, 163 [139] (Bryant CJ).

The majority in *Marion's Case* discussed the importance of the right to bodily or personal inviolability by reference to the serious implications of 'violation' of the right. It was recognised that such impacts extend beyond the physical to 'serious questions of a person's "social and biological identity"',[186] and attendant social and psychological effects. Their Honours observed that sterilisation 'is not merely a *medical* issue'.[187] The Court was, after all, considering an 'invasive' *medicalised* procedure (an hysterectomy) undertaken for ostensibly 'non-medical' (and, the judges concluded, non-therapeutic) reasons, including concerns about the potential effects of menstruation, pregnancy and childbirth on Marion.

In applying the principles of *Marion's Case* to the situation of gender dysphoric children, the right to personal inviolability needs to be reconsidered in light of a very different set of circumstances. Yet the serious questions about 'identity, social place and self-esteem'[188] remain entirely relevant. As two commentators have noted, such procedures:

> are not simply for the purpose of curing an illness or improving health, but are inextricably associated with the patient's self-identity. The consequences of not allowing treatment where that is sought or alternatively, of carrying out treatment where that is not wanted, can be terrible, having consequences lasting throughout a person's lifetime and affecting not only health, fertility and the ability to have a fulfilling sex life, but also psychological well-being and identity.[189]

In the case of gender dysphoric children, having treatment or not having treatment both result in some irreversible physical effects. To deny young people the opportunity to access treatment is to deny the opportunity to develop the physical characteristics of the person they already see themselves as being; or indeed, *know themselves to be*.

A broader conceptualisation of the right to personal inviolability would encompass the idea of a right to control one's own body, whether this is to restrict or prevent an invasive procedure *or* to access treatment that will result in alterations to one's physical characteristics.[190] The majority in *Marion's Case* referred to 'a right to do with one's person what one chooses'.[191] This is commensurate also with the right to access medical treatment regardless of whether the treatment transgresses social norms about gender identity.

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186 *Marion's Case* (1992) 175 CLR 218, 252 (Mason CJ, Dawson, Toohey and Gaudron JJ).

187 Ibid 251 (Mason CJ, Dawson, Toohey and Gaudron JJ) (emphasis in original).

188 Ibid 252 (Mason CJ, Dawson, Toohey and Gaudron JJ).

189 Kate Parlett and Kylie-Maree Weston-Scheuber, 'Consent to Treatment for Transgender and Intersex Children' (2004) 9 *Deakin Law Review* 375, 396.

190 Other commentators have called for this in the context of transgender rights: see, eg, Alston, above n 8; Milton Diamond and Hazel Glenn Beh, 'The Right to Be Wrong: Sex and Gender Decisions' in Sharon E Sytsma (ed), *Ethics and Intersex* (Springer, 2006) 103.

191 *Marion's Case* (1992) 175 CLR 218, 254 (Mason CJ, Dawson, Toohey and Gaudron JJ).

This is not to suggest that hormone therapy is appropriate for all children exhibiting gender non-conforming behaviour.[192] The point is that decisions about the appropriate therapy for individual children are ones that should be made collectively by children, parents and treating medical professionals, *absent disagreement* amongst them. The diagnosis of gender dysphoria already imports a clinical level of distress and attendant risk. As Murphy J noted in *Re Sam*: 'Each of the experts identifies that the proposed treatment not only accords with the clinical practice guidelines, but is, at present, the *only treatment available* for individuals suffering from Gender Dysphoria'.[193]

As Millbank observed following the decision in *Re Alex*, hormone therapy carries some risks and some unknowns, but 'to ignore a child in this deep distress, in suicidal distress, is also experimenting in the cruellest way on children'.[194] Hewitt et al also note that the long-term outcomes of hormone therapy are unknown, but continue:

> These do not seem equitable or just reasons for restricting a young person's access to medical care. Furthermore, a young person observing the distress that court application causes for the parents may feel uncomfortable expressing any doubts they have regarding hormone treatment.[195]

That is, once court approval is obtained, a young person may actually feel *less* able to cease the treatment given the expenditure and stress he or she has caused to his or her parents or guardian to be able to proceed in the first place.

The decision in *Re Jamie* is a step in the right direction, but growing medical consensus, the absence of alternate viewpoints and evidence in the reported cases, and the established serious risks of harm to children who are not able to access treatment, all mitigate against the Court continuing to play *any* role in determining whether treatment can proceed. If hormone therapy in this context is accepted as being therapeutic, it cannot be *right*, as Brennan J observed, to insist that children obtain the Court's permission to undergo that treatment.[196] The Court's expansion of its jurisdiction to encompass treatment for gender dysphoria is not fulfilling its stated function of protecting children. Rather, it is causing further distress and harm.

As noted, Kerridge, Lowe and Stewart suggest that the distinction between therapeutic and non-therapeutic procedures is unhelpful.[197] Instead, they recommend that specific types of medical intervention be listed or included in regulations specifying whether judicial permission is required before they

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192 Steensma et al, 'Quantitative Follow-Up Study', above n 14, 582.
193 [2013] FamCA 563, [94] (emphasis added).
194 ABC Radio National, above n 63.
195 Hewitt et al, above n 5, 580.
196 *Marion's Case* (1992) 175 CLR 218, 278.
197 Kerridge, Lowe and Stewart, above n 38, 493.

be undertaken or performed on children or incapacitated persons.[198] This may, indeed, be the preferable course.

Regardless of whether the therapeutic/non-therapeutic distinction remains as a matter of law, commencing treatment for gender dysphoria in children is a decision that children, their parents or guardians and a multidisciplinary team of medical professionals should make, not the courts.

198 Ibid 493–5.