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ANALYZING CONSENT LAWS FOR TRANS AND GENDER DIVERSE MINORS SEEKING GENDER-AFFIRMING HORMONE TREATMENT: A CRITIQUE OF AUSTRALIAN JURISPRUDENCE AND GILLICK COMPETENCY

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ABSTRACT

This article examines and critiques the Australian legal framework governing minors' ability to consent to gender-affirming hormone treatment, with a focus on the application of the Gillick v West Norfolk and Wisbech Area Health Authority decision. The Gillick principle, which allows minors to consent to medical treatment if they demonstrate sufficient maturity and understanding, is well-established in law. However, Australian jurisprudence applying Gillick to gender-affirming treatment for minors with gender dysphoria has diverged from the original reasoning and its contemporary interpretations. The article traces the development of Australian case law, highlighting how it has misinterpreted Gillick by adopting an overly paternalistic approach. This has led to requirements such as mandatory court oversight or parental consent, even for minors deemed Gillick competent, which undermines their autonomy. The analysis begins by outlining the foundational principles of Gillick and its subsequent interpretations, providing a basis for evaluating Australian cases. It then reviews key Australian legal developments concerning minors' consent to hormone treatment, critiquing the imposition of additional legal hurdles not supported by Gillick. The article argues that the current Australian approach creates inconsistencies, potentially affecting minors' rights beyond gender-affirming care. It concludes by advocating for judicial clarification to realign the application of Gillick with its original intent, ensuring minors' decision-making rights are upheld in gender dysphoria cases and other medical contexts. This is critical to address the broader implications of the current legal stance on minors' autonomy in healthcare decisions.

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1. INTRODUCTION

Over the past decade, the Family Court of Australia has adjudicated more than 100 applications concerning transgender and gender diverse (trans) minors seeking to initiate or continue hormone treatment for gender dysphoria. These cases have primarily addressed the legal authority to consent to such treatments, focusing on whether parents or minors themselves can provide lawful consent. The legal framework governing these decisions is rooted in the principle of *Gillick* competency, derived from the seminal House of Lords decision in *Gillick v West Norfolk and Wisbech Area Health Authority* (1986) AC 112. This principle recognizes that minors, typically presumed incompetent to consent to medical treatment, may do so if they possess sufficient maturity and understanding of the decision's nature and consequences. This article critically examines the Australian jurisprudence on minors' consent to gender-affirming hormone treatment, arguing that the application of *Gillick* competency in these cases has deviated from its original intent and contemporary interpretations, leading to a distinct and problematic legal approach.

The current Australian context for treating minors with gender dysphoria is guided by the *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents* (Telfer et al., 2021). These guidelines outline recommended care pathways, which are further elaborated in related scholarship (Jowett et al., 2022). The Family Court cases have grappled with two central questions: whether parents can lawfully consent to gender-affirming hormone treatment on behalf of their children, and whether minors can consent based on *Gillick* competency. While *Gillick* competency is a well-established legal standard, its application to gender-affirming treatment in Australia has introduced complexities that warrant scrutiny. This article contends that Australian courts have misinterpreted *Gillick*, resulting in a legal framework that imposes undue restrictions on minors' autonomy and diverges from the principle's foundational reasoning.

The *Gillick* decision established that minors could consent to medical treatment if they demonstrate sufficient understanding and intelligence to comprehend the proposed intervention fully. This principle has been widely accepted in common law jurisdictions, allowing minors deemed competent by medical practitioners to make healthcare decisions independently. However, its application to specific contexts, particularly those involving significant or irreversible decisions, has sparked considerable judicial and academic debate. Decisions about life-sustaining treatment, for instance, have highlighted the challenges of applying *Gillick* to high-stakes medical choices (Pattinson, 2018). Similarly, gender-affirming hormone treatment, which carries long-term physical and psychological implications, has raised complex legal questions. This article argues that Australian courts have strayed from *Gillick*'s original reasoning, adopting a paternalistic stance that undermines minors' decision-making rights in the context of gender dysphoria treatment.

To substantiate this argument, the article is structured as follows. Part Two provides a detailed overview of the *Gillick* decision, elucidating its core principles and subsequent interpretations in English law. This foundation is essential for understanding how *Gillick* should inform decisions about minors' consent. Part Three traces the evolution of Australian case law on gender-affirming hormone treatment, highlighting key decisions that have shaped the legal landscape. This section also briefly addresses the interplay between minors' consent and parental authority, as the two are closely intertwined in Australian jurisprudence. Part Four critically evaluates the application of *Gillick* competency in Australian cases, comparing it with English law developments, particularly the *Bell v Tavistock* case (Bell & Mrs A v The Tavistock and Portman NHS Foundation Trust, (2020) EWHC 3274 (Admin); (2021) EWCA Civ 1363). This comparison underscores the divergence in Australian law and its misalignment with *Gillick*'s principles.

The critique focuses on how Australian courts have imposed additional requirements, such as mandatory parental consent or court confirmation of *Gillick* competency, even when minors are assessed as competent by clinicians. This approach, exemplified in cases like *Re Imogen* (Re Imogen (No. 6) (2020) FamCA 761), suggests a unique legal standard for gender-affirming treatment that is not applied to other medical decisions. Such a standard raises concerns about consistency and fairness, as it restricts minors' autonomy in a manner not justified by *Gillick* or its subsequent interpretations. The article argues that this paternalistic approach is particularly problematic given the personal and identity-related nature of gender-affirming treatment, which demands respect for minors' decision-making capacity.

Previous scholarship has raised similar concerns about Australian law in this area (Jowett & Kelly, 2021; Ouliaris, 2022; Kelly et al., 2022). However, these analyses often focus on recent case law developments, particularly *Re Imogen*. This article builds on existing literature by offering a comprehensive examination of the Australian jurisprudence, from early cases like *Re Alex* (Re Alex: Hormonal Treatment for Gender Identity Dysphoria (2004) FamCA 297) to more recent decisions. By analyzing the full spectrum of key cases, the article demonstrates that the misapplication of *Gillick* began with the earliest decisions and has persisted, shaping a legal framework that is overly restrictive. The analysis highlights how Australian courts have adopted a cautious, court-centric approach, requiring judicial oversight even in cases where clinical assessments confirm a minor's competency. This deviates from *Gillick*'s emphasis on clinical judgment and minors' autonomy.

The article concludes by advocating for judicial reconsideration of how *Gillick* is applied to gender-affirming treatment decisions. Clarification is essential not only to align Australian law with *Gillick*'s original principles but also to address the broader implications of the current approach. The requirement for parental consent or court confirmation in cases of gender-affirming treatment sets a precedent that could affect minors' decision-making rights in other medical contexts. For instance, treatments involving significant personal or identity-related decisions, such as those related to reproductive health or mental health interventions, could be subject to similar restrictions if the current interpretation persists. This raises concerns about the erosion of minors' autonomy across various healthcare domains.

In summary, this article provides a critical analysis of the Australian legal framework governing minors' consent to gender-affirming hormone treatment, with a focus on the misapplication of *Gillick* competency. By tracing the development of case law and comparing it with English jurisprudence, the article underscores the need for reform to restore the principle's intended scope. The current approach not only limits the rights of trans and gender diverse minors but also risks broader implications for minors' healthcare decision-making. Judicial clarification is urgently needed to ensure that Australian law respects the autonomy of *Gillick* competent minors, particularly in decisions as personal as those concerning gender identity.

2. THE HOUSE OF LORDS DECISION IN *GILLICK* AND ITS SUBSEQUENT INTERPRETATION

The *Gillick v West Norfolk and Wisbech Area Health Authority* (1986) AC 112 decision is a cornerstone of medical law, particularly concerning minors' capacity to consent to medical treatment. Its principles have been extensively analyzed in legal scholarship due to their profound impact on the autonomy of minors in healthcare decision-making. This section provides a comprehensive exploration of the *Gillick* decision, detailing its original reasoning and how it has been interpreted in subsequent English case law. This analysis serves as a foundation for evaluating the application of *Gillick* competency in Australian cases involving gender-affirming hormone treatment, as discussed later in the article.

2.1. The House of Lords Decision in *Gillick*

The *Gillick* case addressed a challenge to guidance issued by the United Kingdom's Department of Health and Social Security, which permitted medical practitioners to provide contraceptive advice and treatment to minors under 16 without parental consent or knowledge. This guidance sparked a judicial review initiated by Victoria Gillick, who argued that such practices undermined parental rights. The case raised fundamental questions about the legal capacity of minors to make healthcare decisions and the extent to which parental authority governs such choices.

Under English law, the age of majority is 18, but the *Family Law Reform Act 1969* (UK) presumes that minors aged 16 or 17 are competent to consent to surgical, medical, and dental treatment, with such consent being legally effective to shield practitioners from liability for trespass to the person (s. 8). For minors under 16, no such statutory provision exists, prompting the House of Lords to consider whether common law principles could allow these minors to consent to medical treatment, specifically contraceptive advice and treatment.

The House of Lords addressed three primary issues in *Gillick*:

1. **Capacity of Minors Under 16**: Could a minor under 16 possess the legal capacity to consent to contraceptive advice and treatment?
2. **Parental Rights**: Did providing such advice and treatment without parental consent infringe upon parents’ rights over their children?
3. **Criminal Liability**: Could a doctor incur criminal liability by offering contraceptive advice or treatment to a minor under 16 without parental consent?

These questions extended beyond mere consent to encompass broader considerations, such as the confidentiality of medical consultations for minors. The *Gillick* principle emerged not only to affirm minors’ decision-making capacity but also to protect their ability to seek medical care confidentially, a point critical to the case’s policy rationale.

The concept of *Gillick* competency is often summarized through Lord Scarman’s formulation, which posits that a minor can consent to medical treatment when they achieve “sufficient understanding and intelligence to enable [them] to understand fully what is proposed” (Gillick v West Norfolk and Wisbech Area Health Authority, (1986) AC 112). However, this summary oversimplifies the nuanced reasoning in the majority judgments. The House of Lords’ majority, comprising Lords Fraser, Scarman, and Bridge, did not present a unified approach, leading to varied interpretations in subsequent case law (Pattinson, 2018).

Lord Fraser emphasized the welfare of the minor, suggesting that a child under 16 could consent if they were “capable of understanding what is proposed, and of expressing his or her own wishes” (Gillick v West Norfolk and Wisbech Area Health Authority, (1986) AC 112). His approach focused on the minor’s ability to comprehend the treatment and articulate their preferences, grounding the decision in the child’s best interests. Lord Fraser’s reasoning was context-specific, primarily addressing medical treatment decisions and prioritizing the minor’s welfare over absolute parental control.

In contrast, Lord Scarman adopted a broader perspective, framing the minor’s capacity in terms of rights. He argued that a minor with sufficient understanding and intelligence possesses a “right” to make their own decisions, extending beyond medical treatment to general decision-making (Pattinson, 2018). Scarman’s test imposed a higher threshold, requiring not only comprehension but also the ability to exercise “a wise choice” in the minor’s own interests (Gillick v West Norfolk and Wisbech Area Health Authority, (1986) AC 112). This requirement for a rational or wise decision has been criticized for setting a standard not applied to adults, who are presumed competent unless proven otherwise (Cave, 2014).

The differences between Lords Fraser and Scarman highlight a tension in *Gillick*. Fraser’s approach is more pragmatic, focusing on the minor’s ability to understand and express wishes, while Scarman’s is more principled, emphasizing autonomy and rights. Pattinson (2018) notes that these divergent perspectives have fueled alternative interpretations, complicating the application of *Gillick* in subsequent cases. The complexity of the decision lies in its attempt to balance minors' autonomy, parental rights, and the state's interest in protecting children.

A critical issue in *Gillick* is whether the test requires *actual* understanding of the treatment's implications or merely the *capacity* to understand. Cave (2014) argues that Lord Fraser's reasoning suggests the latter, emphasizing capability over actual comprehension. Fraser stated that a minor who is "capable of understanding what is proposed" can validly consent, implying that the potential to understand is sufficient (Gillick v West Norfolk and Wisbech Area Health Authority, 1986). This interpretation allows clinicians to assess competence before a decision is finalized, but it creates practical challenges, as courts may struggle to evaluate capacity without evidence of actual understanding (Cave, 2014). This distinction is particularly relevant for gender-affirming hormone treatment, where the complexity and long-term consequences of the decision demand careful assessment of a minor's understanding.

The *Gillick* decision also addressed parental rights, a central concern raised by Mrs. Gillick, who asserted an absolute right to be informed of and veto her daughters' medical decisions. The House of Lords rejected this claim, clarifying that parental rights exist to benefit the child, not to exert control (Gillick v West Norfolk and Wisbech Area Health Authority, 1986). Lord Scarman emphasized that parental rights are derived from duties and persist only as long as necessary to protect the child's person and property (184). Once a minor achieves *Gillick* competency, their right to make decisions supersedes parental authority for that specific decision, allowing them to act autonomously, potentially without parental involvement (186).

Lord Fraser, however, adopted a more cautious stance, suggesting that parental consent should "normally be asked" even when a minor is competent (174). He proposed the Fraser Guidelines, a set of criteria to guide clinicians in assessing whether a minor under 16 can consent to contraceptive advice or treatment without parental involvement:

1. The minor understands the advice provided.
2. The clinician cannot persuade the minor to inform their parents or allow the clinician to do so.
3. The minor is likely to engage in sexual activity with or without contraception.
4. The minor's physical or mental health is likely to suffer without contraceptive advice or treatment.
5. The minor's best interests require providing contraceptive advice or treatment without parental consent (Gillick v West Norfolk and Wisbech Area Health Authority, (1986).

These guidelines reflect Fraser's view that parental involvement is preferable unless exceptional circumstances justify proceeding with only the minor's consent. Pattinson (2018) notes that Fraser's approach implies that doctors should rely solely on a competent minor's consent only in rare cases, prioritizing parental judgment of the child's welfare.

The interplay between Fraser's and Scarman's judgments creates ambiguity in *Gillick*. Scarman's emphasis on autonomy suggests that parental rights diminish significantly once a minor is competent, while Fraser's guidelines advocate for parental involvement as the default. This tension has shaped subsequent interpretations, with courts grappling with how to balance minors' autonomy and parental authority. Fraser's acknowledgment that parental control varies with a minor's understanding and intelligence reflects a practical recognition of developmental differences, but it complicates the application of a uniform standard (Gillick v West Norfolk and Wisbech Area Health Authority, (1986).

The *Gillick* decision's policy rationale extends beyond consent to include confidentiality. By allowing competent minors to consent independently, the House of Lords ensured that young people could access medical care without fear of parental disclosure, encouraging them to seek necessary treatment. This aspect of *Gillick* is critical when considering its application to gender-affirming hormone treatment, where confidentiality may be paramount for minors navigating sensitive identity issues.

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

The *Gillick* decision has profoundly influenced English law, establishing that competent minors can make medical treatment decisions in various contexts. However, subsequent case law has both clarified and limited the *Gillick* principle, particularly in cases involving complex or controversial decisions. This subsection examines how English courts have interpreted *Gillick*, focusing on its application to reproductive decisions, confidentiality, and refusals of life-saving treatment.

The *Gillick* principle's affirmation of minors' autonomy was tested in *R (Axon) v Secretary of State for Health* (2006), where the claimant, a parent, argued that she had a right to be informed of her *Gillick* competent children's medical decisions, particularly regarding contraception and abortion. The English High Court rejected this claim, affirming that competent minors are entitled to confidentiality (Jackson, 2019). The *Axon* decision leaned toward Lord Scarman's approach in *Gillick*, holding that parental authority over a specific decision ends when a minor achieves competency (R (Axon) v Secretary of State for Health, (2006). This ruling reinforced *Gillick*'s policy of protecting minors' access to confidential medical care, aligning with human rights standards under the European Convention on Human Rights (ECHR).

The *Axon* case highlights the importance of confidentiality in *Gillick*'s framework. By ensuring that competent minors can seek medical advice without parental knowledge, the decision supports the principle's original intent to encourage healthcare access. This is particularly relevant for gender-affirming treatment, where minors may fear parental disapproval or lack support, necessitating confidential consultations.

The application of *Gillick* in reproductive decision-making was further clarified in *An NHS Trust v A* [2014] EWHC 1445 (Fam), involving a 13-year-old seeking an abortion. Mostyn J held that if the minor was *Gillick* competent, the court's role would conclude, emphasizing that competency, not best interests, is the primary consideration

(An NHS Trust v A, [2014] EWHC 1445). However, the judge noted that the minor would require significant familial support regardless of her decision, highlighting a practical tension: while the law upholds the minor's autonomy, real-world consequences often necessitate family involvement (Moreton, 2015). Moreton critiques this as potentially masking a best interests decision in autonomy language, but it underscores that support does not equate to legal consent. This distinction is crucial for gender-affirming treatment cases, where parental support is common but should not be a legal prerequisite.

While *Gillick* empowers competent minors to consent to treatment, its application to refusals of treatment, particularly life-saving interventions, has been more restrictive. Cave (2014) argues that *Gillick*'s lack of clarity has enabled courts to limit its scope, partly because it was designed for contraceptive decisions, not universal application. Cases involving refusals of life-saving treatment illustrate this limitation.

In *Re E* (A Minor) (Wardship: Medical Treatment) (1993) 1 FLR 386, a 15-year-old with leukemia refused blood transfusions due to his Jehovah's Witness beliefs. Ward J found the minor competent for some decisions but lacking the capacity to fully understand the implications of refusing treatment, particularly the process of dying (p. 391). This high threshold of understanding has been criticized as unrealistic, with Jackson (2019) questioning whether adults possess such insight into death (Brazier & Cave, 2016, p. 468). The *Re E* decision suggests that courts may impose a stringent standard in life-or-death scenarios, potentially undermining *Gillick*'s emphasis on minors' autonomy.

A more significant limitation emerged in *Re W* (A Minor) (Medical Treatment: Court's Jurisdiction) (1993) Fam 64, involving a 16-year-old with anorexia nervosa who refused life-saving treatment. Lord Donaldson introduced the "flak jacket" analogy, stating that consent—whether from a competent minor, a parent, or the court—protects clinicians from liability. He clarified that under s. 8 of the *Family Law Reform Act 1969* (UK), 16- and 17-year-olds can consent to treatment, but their refusals can be overridden by parents or the court. For *Gillick* competent minors under 16, the same principle applies: their consent is valid, but refusals can be overridden).

Lord Donaldson emphasized the court's *parens patriae* jurisdiction, which allows it to authorize treatment despite a minor's refusal, prioritizing the minor's welfare (p. 81). He cited *Re B* (A Minor) (Wardship: Sterilisation) (1988) AC 199, noting that the court's paramount consideration is the minor's well-being). While acknowledging the importance of maximizing minors' decision-making, Lord Donaldson cautioned against risks with irreparable consequences (Re W, (1993). Crucially, he held that a minor's consent to treatment cannot be overridden by parents, but refusals can be, distinguishing between consent and refusal scenarios.

The *Re W* decision has faced significant criticism for limiting minors' autonomy (Cave, 2011; Gilmore & Herring, 2011a, 2011b, 2012). Critics argue that allowing parental or judicial override of a competent minor's refusal undermines *Gillick*'s recognition of autonomy. However, *Re W* clarifies that parental authority to override applies only to refusals of significant treatment contrary to the minor's best interests, not to consents to treatment.

The continued relevance of *Re W* was affirmed in *NHS Trust v X*, where a nearly 16-year-old with sickle cell syndrome refused blood transfusions due to religious beliefs. Sir James Munby held that the court's *parens patriae* jurisdiction allows it to override a competent minor's refusal, citing *Re R* (A Minor) (Wardship: Consent to Treatment) (1992) Fam 11 and *Re W* as binding precedent (NHS Trust v X, (2021). Munby acknowledged human rights concerns under the ECHR and the United Nations Convention on the Rights of the Child but found no obligation to treat competent minors as fully autonomous, particularly in life-saving contexts. He concluded that any change to this position requires parliamentary intervention, not judicial reinterpretation (Cave, 2021).

These cases illustrate that English law grants courts and parents significant authority to override a competent minor's refusal of life-saving treatment, prioritizing welfare over autonomy. Laurie and Mason (2016) note that parental interference is more likely in refusal cases, with courts deferring to clinical expertise in life-or-death scenarios. This approach contrasts with *Gillick*'s affirmation of minors' consent to treatment, highlighting a bifurcated application of the principle.

The *Gillick* decision's legacy is its recognition of minors' capacity to make healthcare decisions, but its application has been shaped by context. In reproductive and confidentiality cases, courts have upheld minors' autonomy, aligning with *Gillick*'s intent. In refusal cases, however, judicial and parental authority often prevails, reflecting a cautious approach to decisions with grave consequences. This dichotomy is critical when considering *Gillick*'s application to gender-affirming hormone treatment, where the balance between autonomy and oversight remains contentious.

Expanded Analysis and Contextualization

The *Gillick* decision's significance extends beyond its immediate context, influencing legal frameworks globally, including in Australia. Its emphasis on minors' autonomy challenged traditional notions of parental control, reflecting broader societal shifts toward recognizing children's rights. The United Nations Convention on the Rights of the Child, particularly Article 12, reinforces this by requiring that children capable of forming views be heard in matters affecting them, a principle echoed in *Gillick*'s reasoning (United Nations, 1989).

The tension between Lords Fraser and Scarman's approaches reflects differing philosophical perspectives on autonomy. Fraser's welfare-oriented framework prioritizes the minor's best interests, aligning with paternalistic tendencies in medical law. Scarman's rights-based approach, however, anticipates modern human rights frameworks, emphasizing individual agency. This philosophical divide complicates *Gillick*'s application, as courts must navigate between protecting minors and respecting their autonomy.

The *Gillick* principle's focus on confidentiality addresses a practical barrier to healthcare access. Minors may avoid seeking treatment if parental disclosure is required, particularly in sensitive areas like sexual health or gender identity. The *Axon* decision's reinforcement of confidentiality underscores this, ensuring that competent minors can access care without fear of reprisal. This is particularly relevant for trans and gender diverse minors, who may face familial rejection or stigma.

The limitations imposed in refusal cases like *Re W* and *NHS Trust v X* reflect a judicial reluctance to grant minors absolute autonomy in life-or-death scenarios. These cases highlight the court's role as a safeguard, prioritizing survival over self-determination. However, critics argue that this undermines *Gillick*'s core principle, creating an asymmetry where minors can consent to treatment but not refuse it (Gilmore & Herring, 2011a). This asymmetry raises questions about the coherence of *Gillick*'s application, particularly in complex cases like gender-affirming treatment.

The *Gillick* decision's adaptability to new medical contexts, such as gender-affirming care, depends on its core principle: that competence is assessed by clinicians based on the minor's understanding. The English Court of Appeal's decision in *Bell v Tavistock* (2021) EWCA Civ 1363 reaffirmed this, rejecting judicial overreach into clinical assessments. This contrasts with Australian jurisprudence, which, as later discussed, has imposed additional requirements like court confirmation of competency, diverging from *Gillick*'s intent.

In conclusion, the *Gillick* decision remains a landmark in medical law, affirming minors' capacity to consent to treatment when competent. Its subsequent interpretation in English law has clarified its scope, upholding autonomy in consent cases while imposing limits in refusal scenarios. Understanding these developments is essential for evaluating its misapplication in Australian gender-affirming treatment cases, where a paternalistic approach has strayed from *Gillick*'s principles.

3. LEGAL FRAMEWORKS GOVERNING GENDER-AFFIRMING HORMONE TREATMENT

This section explores the evolution of legal principles in Australia and England concerning minors' consent to gender-affirming hormone treatment, with a focus on how these jurisdictions have applied the *Gillick v West Norfolk and Wisbech Area Health Authority* (1986) AC 112 competency framework. In Australia, the legal landscape has developed incrementally through common law, particularly within the context of "special medical procedures," which delineate the boundaries of parental authority to consent. This analysis outlines key Australian judicial decisions, their reliance on precedent, and their divergence from *Gillick*'s original intent. It also examines recent English case law to provide a comparative perspective, setting the stage for a critical evaluation of Australian law in subsequent sections. By tracing these developments, this section highlights the complexities and inconsistencies in applying *Gillick* to gender-affirming care, underscoring the need for judicial clarification.

3.1. Australian Legal Developments on Minors and Hormone Treatment for Gender Dysphoria

In Australia, the legal framework for minors' consent to gender-affirming hormone treatment has emerged through a series of Family Court decisions, shaped by the High Court's ruling in *Secretary, Department of Health and Community Services (NT) v JWB* (1992), commonly known as *Marion's Case*. This case established criteria for "special medical procedures" that fall outside parental authority, requiring court approval due to their significant and irreversible nature. While *Marion's Case* addressed non-therapeutic sterilization, its principles have been extended to gender-affirming hormone treatment, creating a unique legal pathway for these decisions. This subsection examines how Australian courts have applied *Marion's Case* and *Gillick* to gender dysphoria treatment, highlighting key cases and their implications.

The Foundational Role of *Marion's Case*

Marion's Case involved a minor with profound disabilities whose parents sought to consent to a sterilization procedure. The High Court ruled that such decisions, being non-therapeutic and carrying significant consequences, required judicial oversight to safeguard the minor's interests (Secretary, Department of Health and Community Services (NT) v JWB, 1992). The Court identified "further factors" necessitating court involvement, including the procedure's invasiveness, irreversibility, potential for incorrect assumptions about the minor's capacity, and conflicts of interest among decision-makers. These factors were intended to protect minors from decisions that could profoundly affect their future autonomy.

The High Court affirmed *Gillick* as part of Australian common law, recognizing that a minor with sufficient understanding and intelligence can consent to medical treatment (Secretary, Department of Health and Community Services (NT) v JWB, 1992). However, this affirmation was *obiter dictum*, as the minor in *Marion's Case* was not *Gillick* competent, and the primary issue was parental consent. McHugh J clarified that once a minor achieves *Gillick* competency, parental authority to consent terminates, aligning with Lord Scarman's reasoning in *Gillick*. This position contrasts with English cases like *Re W* (A Minor) (Medical Treatment: Court's Jurisdiction) (1993) Fam 64, which allow parental override of a competent minor's refusal of life-saving treatment (Mathews & Smith, 2018).

Australian courts' jurisdiction over minors' medical decisions is primarily exercised by the Family Court under its statutory welfare jurisdiction, which focuses on the child's best interests but is narrower than the *parens patriae* jurisdiction of state and territory supreme courts (Stewart, 2017). This distinction is significant, as it influences the Family Court's approach to gender-affirming treatment cases, often emphasizing judicial oversight over clinical assessments.

Re Alex: Establishing Gender-Affirming Treatment as a Special Medical Procedure

The 2004 case *Re Alex: Hormonal Treatment for Gender Identity Dysphoria* (2004) FamCA 297 marked the first Australian judicial consideration of gender-affirming hormone treatment as a "special medical procedure." The case involved a 13-year-old minor seeking Stage 1 (puberty blockers) and Stage 2 (gender-affirming hormones) treatment. Chief Justice Nicholson applied *Marion's Case*, classifying both stages as non-therapeutic because they addressed a psychological condition rather than a physical illness (Re Alex, (2004). He argued that the treatments' irreversible and grave consequences, combined with the risk of misjudging the minor's capacity, necessitated court approval, removing the decision from parental authority.

On *Gillick* competency, Nicholson treated the minor's capacity as a threshold issue, requiring evidence of "sufficient understanding and intelligence to enable him or her to understand fully what is proposed". Expert evidence suggested Alex had a strong intellectual grasp of the treatment process, including its effects and side effects, and understood it better than peers of the same age. However, the treating psychiatrist opined that Alex should not bear sole responsibility for the decision, despite his understanding. Nicholson acknowledged that Alex might be *Gillick* competent or soon would be but declined to make a definitive finding, concluding that the court should decide based on best interests. This approach prioritized judicial oversight over the minor's autonomy, distinguishing gender-affirming treatment from contraceptive decisions in *Gillick* and suggesting that 13-year-olds might rarely be competent for such decisions.

Nicholson's reasoning has been criticized for conflating competency with best interests, undermining *Gillick*'s emphasis on clinical assessment (Bell, 2015). By requiring court approval for both stages of treatment, *Re Alex* set a precedent that imposed significant legal barriers for trans minors, requiring costly and stressful court applications even when parents and clinicians agreed.

Re Jamie: Refining the Legal Framework

The 2013 Full Court decision in *Re Jamie* (2013) FamCAFC 110 revisited *Re Alex*'s approach, prompted by questions about whether Stage 1 treatment required court approval. The Full Court distinguished *Re Alex*, noting that it addressed consent by a government department under a care order, not parental consent. Chief Justice Bryant held that Stage 1 treatment, being reversible and therapeutic for a psychological condition, fell within parental authority, eliminating the need for court approval. However, Stage 2 treatment, due to its irreversible consequences, remained a "special medical procedure" requiring judicial oversight.

The Full Court's application of *Marion's Case* was contentious. By classifying Stage 1 as therapeutic, the Court diverged from *Re Alex*'s non-therapeutic categorization, arguing that *Marion's Case*'s "further factors" (e.g., conflict of interest) did not apply to Stage 1 (Re Jamie, (2013). Critics argue that if Stage 1 was therapeutic, Stage 2 should be similarly classified, as both address gender dysphoria (Smith, 2013; Bell, 2015). This inconsistency highlights a selective application of *Marion's Case*, prioritizing judicial caution over logical coherence.

Regarding *Gillick* competency, the Full Court introduced a novel requirement: when clinicians assess a minor as *Gillick* competent for Stage 2 treatment, the court must confirm this competency. Bryant CJ justified this by citing *Marion's Case*'s concerns about the risk of misjudging capacity and the gravity of erroneous decisions. This approach was influenced by the United Nations Convention on the Rights of the Child (UNCRC), particularly Article 12, which emphasizes children's right to express views based on their maturity (United Nations, 1989). However, Bryant acknowledged that requiring court confirmation for gender-affirming treatment, but not other medical decisions, could conflict with the UNCRC and *Gillick*'s autonomy principles (Re Jamie, 2013). Despite this, the Full Court prioritized judicial oversight, arguing that the treatment's significance warranted it.

Re Jamie's requirement for court confirmation of *Gillick* competency marked a significant departure from *Gillick*, which entrusts clinicians with assessing capacity. This paternalistic approach increased the burden on families, requiring court applications even when all parties agreed, contrary to *Gillick*'s emphasis on minor autonomy (Jowett & Kelly, 2021).

***Re Kelvin*: Attempting to Clarify the Law**

The 2017 Full Court decision in *Re Kelvin* (2017) FamCAFC 258 sought to address *Re Jamie*'s complexities, prompted by questions about parental consent and court involvement for Stage 2 treatment. The Full Court held that both Stage 1 and Stage 2 treatments were therapeutic, aligning with national and international guidelines, and could be consented to by parents for non-competent minors or by *Gillick* competent minors without court approval. Court involvement was only required in cases of "controversy," defined as genuine disagreements among decision-makers or clinicians about whether treatment should proceed.

The majority in *Re Kelvin* departed from *Re Jamie* without declaring it "plainly wrong," citing changes in medical understanding of gender dysphoria and its treatment. This factual shift justified relaxing *Re Jamie*'s requirements, recognizing that Stage 2 treatment no longer necessitated routine judicial oversight. The minority, however, argued that *Re Jamie* was plainly wrong in its application of *Marion's Case*, advocating for a clearer break from precedent.

Re Kelvin appeared to streamline the legal process, reducing the need for court applications when clinicians, parents, and minors agreed. However, it left ambiguity around "controversy," particularly whether parental disagreement with a clinician's competency assessment required judicial intervention. The majority's reasoning focused on treatment disputes, not competency disputes, suggesting that *Gillick* competency assessments could remain with clinicians (Re Kelvin, (2017).

Re Imogen: Reintroducing Complexity

The 2020 case *Re Imogen (No. 6)* (2020), decided by Watts J, reintroduced uncertainty by interpreting *Re Kelvin* narrowly. Watts held that *Re Jamie*'s requirement for court confirmation of *Gillick* competency remained binding in certain circumstances, as *Re Kelvin* did not explicitly overturn it. He ruled that court applications were mandatory when a parent or clinician disputes the minor's competency, the diagnosis of gender dysphoria, or the proposed treatment. If the dispute concerns competency, the court must issue a declaration on *Gillick* competency, independent of best interests considerations. For disputes over diagnosis or treatment, the court resolves these based on best interests.

Watts further stated that medical practitioners must obtain parental consent for all stages of treatment, even for *Gillick* competent minors, and cannot proceed without court authorization if a parent objects. This requirement lacks clear grounding in *Re Jamie* or *Re Kelvin*, as neither explicitly mandated parental consent alongside a competent minor's consent (Jowett & Kelly, 2021). Watts' interpretation imposes a unique legal standard for gender-affirming treatment, diverging from *Gillick*'s principle that a competent minor's consent is sufficient to negate liability for trespass (Cave, 2014).

Re Imogen's approach has significant implications. By requiring parental consent, it undermines the autonomy of *Gillick* competent minors, particularly those lacking parental support. It also conflicts with the *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents*, which state that parental consent is ideal but not required for competent minors (Telfer et al., 2021). Watts' insistence on court involvement in competency disputes further erodes *Gillick*'s clinician-driven framework, imposing unnecessary legal hurdles (Kelly et al., 2022).

3.2. English Jurisprudence: The *Bell* Case

In England, the application of *Gillick* to gender-affirming hormone treatment was clarified in *Bell & Mrs A v The Tavistock and Portman NHS Foundation Trust* (2020). This judicial review challenged the consent processes of the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Trust, which allowed minors to consent to Stage 1 treatment (puberty blockers). The High Court's initial ruling in 2020 raised concerns about minors' capacity to consent, while the Court of Appeal's 2021 decision reaffirmed *Gillick*'s principles, providing a contrast to Australian law.

High Court Decision in *Bell*

The claimants in *Bell* argued that minors under 16 were unlikely to be *Gillick* competent to consent to puberty blockers due to the treatment's significant implications (Bell & Mrs A v The Tavistock and Portman NHS Foundation Trust, (2020). The High Court agreed, holding that the complexity of Stage 1 treatment, its pathway to Stage 2 (cross-sex hormones), and its uncertain long-term effects made it difficult for minors to fully understand the decision. The Court outlined eight factors a minor must understand to be competent, including the treatment's physical and psychological effects, its progression to cross-sex hormones, potential fertility loss, and unknown risks. This high threshold effectively ruled out *Gillick* competency for most minors under 16, requiring court approval in many cases.

The High Court's reasoning mirrored Australian cases like *Re Alex* and *Re Jamie* by emphasizing judicial oversight over clinical assessments. It treated Stage 1 and Stage 2 as a single treatment pathway, requiring minors to comprehend both at the outset, a standard critics argued was overly stringent and inconsistent with *Gillick*'s focus on capacity (Smith, 2023).

Court of Appeal's Reversal

The Court of Appeal overturned the High Court's decision, reaffirming *Gillick*'s core principle that clinicians, not judges, assess a minor's competency (Bell & Mrs A v The Tavistock and Portman NHS Foundation Trust, (2021). The Court criticized the High Court for generalizing about minors' capacity, noting that *Gillick* provides guidance, not rigid legal requirements. It rejected the eight-factor test as misaligned with Lords Fraser and Scarman's approaches, which emphasize a flexible, case-by-case assessment.

The Court of Appeal emphasized that *Gillick*'s *ratio decidendi* entrusts doctors with determining competency, drawing parallels between contraception in 1985 and puberty blockers today. It acknowledged the complexity of gender-affirming treatment but stressed that clinicians must ensure informed consent, considering evolving research and long-term consequences. This approach contrasts sharply with Australian law, particularly *Re Imogen*, which mandates judicial confirmation of competency in disputed cases.

The *Bell* decision is persuasive in Australia, given *Gillick*'s adoption in *Marion's Case*. McHugh J's rejection of English refusal cases like *Re W* was based on their inconsistency with *Gillick* (Secretary, Department of Health and Community Services. Since *Bell* aligns with *Gillick*'s original reasoning, it should influence Australian courts, particularly in restoring clinician-driven competency assessments (Smith, 2023).

Expanded Analysis and Contextualization

The Australian legal framework for gender-affirming hormone treatment reflects a cautious, court-centric approach that diverges from *Gillick*'s emphasis on minor autonomy. This divergence stems from the application of *Marion's Case*'s "special medical procedure" framework, which was designed for non-therapeutic interventions like sterilization, not psychological treatments like gender dysphoria care. The extension of *Marion's Case* to gender-affirming treatment has created a unique legal category, subjecting trans minors to stricter oversight than other medical decisions (Stewart, 2017).

Re Alex's classification of hormone treatment as non-therapeutic set a precedent that prioritized judicial control, reflecting societal and medical uncertainties about gender dysphoria in 2004. However, as medical understanding evolved, *Re Jamie* and

Re Kelvin recognized the therapeutic nature of these treatments, aligning with guidelines like those from the World Professional Association for Transgender Health. Despite this, *Re Imogen*'s insistence on parental consent and court confirmation reintroduced paternalism, undermining *Gillick*'s principles and exposing minors to potential harm from delayed treatment (Kelly et al., 2022).

The English *Bell* decision offers a corrective lens, emphasizing that *Gillick* competency is a clinical, not judicial, determination. Its rejection of a rigid competency threshold contrasts with Australian cases' tendency to impose additional legal requirements. This contrast highlights a broader issue: Australian courts' reliance on *Marion's Case* has conflated parental consent issues with minor competency, creating a framework that restricts autonomy without clear justification (Bell, 2015).

The requirement for court involvement in competency disputes, as in *Re Imogen*, raises human rights concerns, particularly in jurisdictions with privacy protections like Victoria and Queensland (Jowett et al., 2022). Mandating parental consent may violate a competent minor's right to confidentiality, a core *Gillick* policy rationale, and could deter minors from seeking care (Jackson, 2019). The UNCRC's emphasis on children's participation in decision-making further supports prioritizing minors' autonomy over parental control (United Nations, 1989).

The Australian approach also has practical implications. Court applications are costly and time-consuming, potentially exacerbating gender dysphoria's psychological impact (Telfer et al., 2021). For minors without parental support, like those in care, these barriers are even more significant, as seen in *Re Alex*. The *Australian Standards of Care*'s position that parental consent is not required for competent minors reflects *Gillick*'s intent, but *Re Imogen*'s judicial override undermines this, creating uncertainty for clinicians (Jowett & Kelly, 2021).

Future Australian cases should consider *Bell*'s reaffirmation of *Gillick* to realign the law with its original principles. Legislative reform, as suggested by Jowett et al. (2022), could clarify consent processes, reducing reliance on judicial discretion. Until then, the current framework risks perpetuating inequities for trans and gender diverse minors, with broader implications for minors' healthcare autonomy.

4. EVALUATING THE APPLICATION OF THE *GILLICK* TEST IN AUSTRALIAN LAW FOR MINORS SEEKING GENDER-AFFIRMING TREATMENT

This section critically assesses how Australian courts have interpreted and applied the *Gillick* competency test, derived from *Gillick v West Norfolk and Wisbech Area Health Authority* (1986), in cases involving minors seeking gender-affirming hormone treatment. The analysis argues that Australian jurisprudence has deviated from *Gillick*'s original principles, imposing additional legal requirements that undermine the autonomy of competent minors. By comparing Australian case law with English developments, particularly *Bell & Mrs A v The Tavistock and Portman NHS Foundation Trust* (2020), this section identifies key inconsistencies and proposes a realignment with *Gillick*'s intent. The discussion is structured around three core issues: the requirement for court confirmation of *Gillick* competency, the obligation to obtain parental consent even for competent minors, and the inconsistent treatment of gender-affirming care compared to other medical decisions.

4.1. Requiring Court Confirmation of *Gillick* Competency

The *Gillick* decision established that a minor with sufficient understanding and intelligence can consent to medical treatment, with clinicians responsible for assessing this capacity (Gillick v West Norfolk and Wisbech Area Health Authority, (1986). In Australia, however, cases like *Re Jamie* (2013) FamCAFC 110 and *Re Imogen (No. 6)* (2020) have introduced a requirement for judicial confirmation of *Gillick* competency, a departure from the original framework. This subsection examines how this requirement has complicated the consent process and eroded minors' autonomy.

The Emergence of Judicial Oversight

In *Re Jamie*, the Full Court of the Family Court mandated that when clinicians assess a minor as *Gillick* competent for Stage 2 (irreversible) gender-affirming hormone treatment, the court must verify this competency (Re Jamie, (2013). Chief Justice Bryant justified this by citing *Secretary, Department of Health and Community Services (NT) v JWB* (1992) 175 CLR 218 (*Marion's Case*), which requires court approval for "special medical procedures" due to risks like misjudging capacity. This approach assumes that gender-affirming treatment's gravity necessitates judicial scrutiny, even when medical professionals confirm competence (Bell, 2015).

Re Imogen reinforced this requirement, with Justice Watts ruling that court applications are mandatory when a parent or clinician disputes a minor's competency (Re Imogen, (2020). Watts interpreted *Re Kelvin* (2017) FamCAFC 258 narrowly, arguing that it did not overturn *Re Jamie*'s competency confirmation mandate. He emphasized that courts must independently whether a minor meets *Gillick* criteria, separate from best interests considerations, in cases of disagreement (para. [40]). This judicial oversight is unique to gender-affirming treatment, as other medical decisions for competent minors typically rely on clinical assessments (Jowett & Kelly, 2021).

Deviation from *Gillick*

This requirement contravenes *Gillick*'s core principle, which entrusts clinicians with assessing competency based on a minor's ability to understand the treatment's nature and consequences (Cave, 2014). Lord Fraser's reasoning in *Gillick* emphasized the minor's capacity to comprehend and express wishes, without mandating judicial review (Gillick v West Norfolk and Wisbech Area Health Authority, (1986). Lord Scarman's broader rights-based approach further supports minors' autonomy, suggesting that competent minors have a right to decide independently. By requiring court confirmation, Australian courts have shifted this responsibility from medical professionals to judges, undermining *Gillick*'s clinician-driven framework.

The English Court of Appeal's decision in *Bell* (2021) EWCA Civ 1363 provides a contrasting perspective. Overturning the High Court's restrictive ruling, the Court of Appeal reaffirmed that *Gillick* competency is a clinical determination, rejecting judicial overreach into consent processes. It criticized the High Court's eight-factor test for competency as inconsistent with *Gillick*'s flexible, case-by-case approach, emphasizing that clinicians are best placed to assess understanding. This aligns with *Gillick*'s original intent and highlights Australia's divergence, where judicial confirmation adds an unnecessary layer of scrutiny (Smith, 2023).

Practical and Ethical Implications

Requiring court confirmation imposes significant burdens on trans and gender diverse minors. Family Court applications are costly, time-consuming, and emotionally taxing, potentially exacerbating gender dysphoria's psychological impact (Telfer et al., 2021). For minors in unsupportive families or state care, these barriers are particularly acute, as seen in *Re Alex: Hormonal Treatment for Gender Identity Dysphoria* [2004] FamCA 297, where a government department sought approval (Jowett et al., 2022). The *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents* advocate for streamlined consent processes, noting that delays can harm mental health (Telfer et al., 2021).

Ethically, judicial oversight undermines the trust between minors and clinicians, a cornerstone of *Gillick*'s policy rationale. By allowing minors to seek confidential care, *Gillick* encourages access to treatment without fear of external interference (Jackson, 2019). Court involvement risks breaching confidentiality, particularly in jurisdictions like Victoria with strong privacy protections, potentially deterring minors from pursuing care (Jowett & Kelly, 2021). This conflicts with Article 12 of the United Nations Convention on the Rights of the Child (UNCRC), which emphasizes children's right to express views based on their maturity (United Nations, 1989).

Misapplication of *Marion's Case*

The reliance on *Marion's Case* to justify judicial confirmation is problematic. *Marion's Case* addressed non-therapeutic sterilization, a procedure with distinct ethical and legal considerations, and its "further factors" (e.g., irreversibility, conflict of interest) were not intended to apply universally (Secretary, Department of Health and Community Services (NT) v JWB, 1992). Gender-affirming treatment, recognized as therapeutic in *Re Kelvin*, does not inherently involve the same risks, particularly when clinicians and parents agree (Bell, 2015). The selective application of *Marion's Case* to gender-affirming care creates an inconsistent standard, treating trans minors differently from others seeking medical treatment.

4.2. Requiring Parental Consent for *Gillick* Competent Minors

A second significant deviation is the requirement for parental consent, even when a minor is *Gillick* competent, as mandated in *Re Imogen* (Re Imogen, (2020). This subsection analyzes how this requirement conflicts with *Gillick*'s principles and its implications for minors' autonomy.

Contradiction with *Gillick*'s Principles

Gillick established that a competent minor's consent is legally sufficient, negating the need for parental approval (Gillick v West Norfolk and Wisbech Area Health

Authority, (1986). Lord Scarman explicitly stated that parental rights yield to the minor's decision-making capacity, ensuring autonomy for specific decisions. In *Re Imogen*, however, Watts J held that clinicians must obtain parental consent for all stages of gender-affirming treatment, and cannot proceed without court authorization if a parent objects. This requirement lacks precedent in *Re Jamie* or *Re Kelvin*, which focused on parental consent for non-competent minors, not competent ones (Jowett & Kelly, 2021).

This approach contradicts *Gillick*'s legal effect, where a competent minor's consent protects clinicians from liability for trespass to the person (Cave, 2014). By mandating parental consent, *Re Imogen* imposes a higher standard for gender-affirming treatment than for other medical decisions, such as contraception or abortion, where competent minors can consent independently (Jackson, 2019). The English case *R (Axon) v Secretary of State for Health* (2006) EWHC 37 (Admin) reinforces this, affirming that competent minors are entitled to confidentiality and autonomy.

Impact on Minors' Autonomy

Requiring parental consent undermines the autonomy of *Gillick* competent minors, particularly those with unsupportive parents. Trans and gender diverse minors often face familial rejection, and mandating parental approval may prevent access to treatment, exacerbating mental health issues (Kelly et al., 2022). The *Australian Standards of Care* explicitly state that parental consent is not required for competent minors, aligning with *Gillick*'s intent (Telfer et al., 2021). *Re Imogen*'s requirement thus creates a legal barrier not supported by clinical guidelines or *Gillick*'s principles.

This paternalistic approach also risks violating minors' privacy rights. *Gillick*'s policy rationale emphasizes confidentiality to encourage healthcare access, particularly for sensitive issues (Pattinson, 2018). By requiring parental involvement, *Re Imogen* may deter minors from seeking care, fearing disclosure or opposition, especially in jurisdictions with privacy protections (Jowett et al., 2022). This conflicts with the UNCRC's emphasis on children's decision-making rights and could infringe on human rights frameworks in Australia (United Nations, 1989).

Comparison with English Law

The English *Bell* decision contrasts sharply with *Re Imogen*. The Court of Appeal emphasized that *Gillick* competency allows minors to consent independently, without requiring parental approval unless clinically necessary (Bell & Mrs A v The Tavistock and Portman NHS Foundation Trust, (2021). This aligns with *Gillick*'s original reasoning and highlights Australia's unique restriction. The *Bell* ruling's focus on clinical assessment over judicial or parental override offers a model for restoring minors' autonomy in Australia (Smith, 2023).

Practical Consequences

The parental consent requirement has significant practical implications. For minors in state care or with estranged parents, obtaining consent may be impossible, necessitating court applications that delay treatment (Jowett & Kelly, 2021). Even in supportive families, the requirement adds unnecessary complexity, as clinicians must navigate legal risks if parents disagree, despite a minor's competence (Kelly et al., 2022). This contrasts with *Re Kelvin*'s attempt to streamline consent processes, highlighting *Re Imogen*'s regressive impact.

4.3. Inconsistency with Other Medical Decisions

The third issue is the inconsistent application of *Gillick* competency to gender-affirming treatment compared to other medical decisions. Australian courts have treated gender-affirming care as exceptional, imposing stricter requirements than for treatments like contraception or mental health interventions (Ouliaris, 2022).

Unique Legal Standard

In cases like *Re Jamie* and *Re Imogen*, courts have justified additional requirements by citing the "special" nature of gender-affirming treatment, drawing on *Marion's Case*'s framework (Re Jamie, (2013). However, *Marion's Case* addressed non-therapeutic procedures, whereas *Re Kelvin* recognized gender-affirming treatment as therapeutic (Re Kelvin, (2017). This shift should align gender-affirming care with other therapeutic treatments, yet courts continue to impose unique standards, such as court confirmation and parental consent (Bell, 2015).

For example, competent minors can consent to contraception or abortion without parental involvement or judicial oversight, as these decisions fall within *Gillick*'s clinician-driven framework (Jackson, 2019). Similarly, mental health treatments, despite their complexity, do not require court confirmation of competency (Ouliaris, 2022). The selective application of stricter requirements to gender-affirming care lacks justification, as the treatment's psychological benefits and risks are comparable to other significant decisions (Telfer et al., 2021).

Broader Implications

This inconsistency has broader implications for minors' healthcare autonomy. By singling out gender-affirming treatment, Australian courts set a precedent that could extend to other identity-related or complex decisions, such as reproductive health or experimental treatments (Jowett et al., 2022). This risks eroding *Gillick*'s universal applicability, creating a patchwork of consent standards that undermine legal clarity and fairness (Cave, 2014).

The English approach in *Bell* avoids this inconsistency, applying *Gillick* uniformly across medical contexts. The Court of Appeal's rejection of a rigid competency test for puberty blockers ensures that gender-affirming care is treated similarly to other treatments, with clinicians assessing capacity (Bell & Mrs A v The Tavistock and Portman NHS Foundation Trust, (2021). Australia's exceptional treatment of gender-affirming care thus appears an outlier, warranting reform (Smith, 2023).

Societal and Cultural Factors

The unique standard may reflect societal unease with transgender identities, particularly among minors. Australian courts' caution in early cases like *Re Alex* coincided with limited medical and social understanding of gender dysphoria (Bell, 2015). While *Re Kelvin* acknowledged evolving knowledge, *Re Imogen*'s paternalism suggests lingering judicial skepticism, potentially influenced by cultural debates about transgender rights (Jowett & Kelly, 2021). This contrasts with *Gillick*'s progressive recognition of minors' autonomy, highlighting the need for courts to align with contemporary medical and human rights standards.

4.4. Recommendations for Reform

To address these issues, Australian courts must realign their application of *Gillick* with its original principles. Three recommendations emerge:

1. **Eliminate Court Confirmation**: Courts should defer to clinicians' assessments of *Gillick* competency, as in *Bell*, removing the requirement for judicial confirmation. This respects *Gillick*'s clinician-driven framework and reduces barriers to treatment (Smith, 2023).
2. **Remove Parental Consent Requirement**: Following *Gillick* and *Bell*, competent minors should consent independently, without mandatory parental approval. This upholds autonomy and aligns with the *Australian Standards of Care* (Telfer et al., 2021).
3. **Apply *Gillick* Consistently**: Gender-affirming treatment should be treated like other medical decisions, eliminating exceptional requirements. This ensures fairness and prevents broader erosion of minors' autonomy (Ouliaris, 2022).

Legislative reform, as proposed by Jowett et al. (2022), could clarify consent processes, reducing reliance on judicial discretion. Until then, courts should look to *Bell* and *Gillick* to restore minors' decision-making rights, particularly for trans and gender diverse youth.

Expanded Analysis and Contextualization

The Australian approach to *Gillick* competency in gender-affirming treatment reflects a broader tension in medical law: balancing autonomy with protection. *Gillick*'s recognition of minors' capacity challenged paternalistic norms, aligning with human rights frameworks like the UNCRC (United Nations, 1989). However, Australian courts' deviations suggest a protective instinct, possibly rooted in the irreversible nature of Stage 2 treatment and societal debates about transgender identities (Jowett & Kelly, 2021).

The requirement for court confirmation and parental consent contrasts with *Gillick*'s policy rationale, which prioritizes confidentiality and access to care. This is particularly critical for trans minors, who may face stigma or rejection, necessitating confidential consultations (Jackson, 2019). The *Australian Standards of Care*'s emphasis on timely treatment underscores the harm of legal delays, which can worsen gender dysphoria's psychological toll (Telfer et al., 2021).

The inconsistency with other medical decisions raises equity concerns. By treating gender-affirming care as exceptional, Australian courts risk perpetuating disparities for trans youth, who already face significant barriers (Kelly et al., 2022). The English *Bell* decision offers a model for uniformity, ensuring that *Gillick* applies equally across contexts (Smith, 2023). Australian courts should adopt this approach to uphold fairness and human rights.

Future cases could leverage *Bell*'s persuasive authority, given *Gillick*'s adoption in *Marion's Case* (Secretary, Department of Health and Community Services (NT) v JWB, 1992). Judicial or legislative reform is essential to restore *Gillick*'s intent, ensuring that trans minors can access treatment without undue obstacles. This would align Australian law with international standards and protect minors' autonomy across healthcare domains.

5. CONCLUSIONS

This article has critically examined the application of the *Gillick* competency principle in Australian case law concerning minors seeking gender-affirming hormone treatment, highlighting a significant divergence from the foundational principles established. The analysis reveals that Australian courts have misinterpreted *Gillick*, imposing additional legal requirements that undermine the autonomy of trans and gender diverse minors. Specifically, the mandates for court confirmation of *Gillick* competency and parental consent, even for competent minors, as seen in cases, represent a paternalistic approach that deviates from *Gillick*'s emphasis on clinician-driven assessments and minors' decision-making rights (Jowett & Kelly, 2021). This misalignment not only restricts access to essential medical care but also risks broader implications for minors' autonomy in other healthcare contexts.

The *Gillick* decision established that minors with sufficient understanding and intelligence can consent to medical treatment, entrusting clinicians with assessing this capacity. In contrast, Australian jurisprudence has shifted this responsibility to the judiciary, requiring court verification of competency in cases like *Re Imogen*. This requirement, rooted in a misapplication of *Secretary, Department of Health and Community Services*, imposes unnecessary barriers, particularly for minors facing familial opposition or financial constraints. Similarly, the insistence on parental consent, even for *Gillick* competent minors, contradicts *Gillick*'s principle that a competent minor's consent is legally sufficient, undermining their autonomy and privacy.

The English Court of Appeal's decision in *Bell & Mrs A v The Tavistock and Portman NHS Foundation Trust* offers a corrective perspective, reaffirming *Gillick*'s clinician-driven framework and rejecting judicial overreach into consent processes. By contrast, Australian cases have treated gender-affirming treatment as exceptional, applying stricter standards than for other medical decisions like contraception or mental health interventions. This inconsistency raises concerns about fairness and equity, potentially setting a precedent that could limit minors' rights in other contexts, such as reproductive health or experimental treatments.

To address these issues, Australian courts must realign their approach with *Gillick*'s original intent. This involves eliminating the requirement for court confirmation of competency, allowing clinicians to assess capacity as in *Bell*, and removing the mandate for parental consent for competent minors, consistent with the *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents*. Such reforms would reduce legal and financial burdens, ensuring timely access to treatment and respecting minors' autonomy.

Legislative intervention, as advocated by Jowett et al, could provide clarity, codifying consent processes to align with *Gillick* and international human rights standards, of the United Nations Convention on the Rights of the Child. Until then, judicial reconsideration is essential to prevent further erosion of minors' rights. The current framework's paternalism risks perpetuating harm, particularly for trans youth who rely on timely care to alleviate gender dysphoria's psychological toll.

In conclusion, the misapplication of *Gillick* in Australian gender-affirming treatment cases reflects a broader tension between protecting minors and respecting their autonomy. By imposing unique legal hurdles, Australian courts have restricted trans minors' access to care and set a concerning precedent for healthcare decision-making. Realigning with *Gillick*'s principles, informed by *Bell* and clinical guidelines, is critical to uphold the rights of trans and gender diverse youth and ensure consistency in minors' autonomy across medical contexts.

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