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UNDERSTANDING THE LAW GOVERNING MEDICAL TREATMENT OF GENDER DYSPHORIA IN YOUNG PEOPLE

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THE laws governing treatment consent in gender dysphoria have rapidly evolved in the past two decades, with the uncertainty, and at times confusion, regarding the law resulting in volatility in clinical practice, according to the author of an Ethics and Law article published today by the *Medical Journal of Australia*.

Dr Calina Ouliaris, a lawyer and psychiatry registrar with the Northern Sydney Local Health District, wrote that it was essential that clinicians knew the law in order to shape its evolution.

"The legal frameworks governing consent for the treatment of gender dysphoria in children and adolescents have rapidly evolved alongside medical advances," she wrote.

There are three stages to medical treatment for gender dysphoria, beginning in early puberty:

1. puberty suppression with puberty blockers;
2. gender-affirming treatment with gender-affirming hormones; and,
3. surgical gender-affirming treatment with surgical interventions.

"Currently, all three stages of treatment for gender dysphoria in children and adolescents require consent from all parties with parental responsibility," wrote Dr Ouliaris.

"This applies even when a young person is Gillick competent and consents to their own treatment. If there is any dispute between treating medical practitioners or parents regarding a young person's Gillick competence and/or diagnosis or treatment, a court application is required.

"Once an application is made, the court will make a finding about the young person's Gillick competence in all cases. Where the dispute is only regarding an adolescent's Gillick competence, the Court will make an order or declaration under general powers conferred by s 34(1) of the *Family Law Act 1975* (Cth) (the Act).

"If the adolescent is declared a mature minor and there is no other dispute, they may determine their own treatment without court authorisation.

"However, if the young person does not have capacity or there is dispute about diagnosis or treatment, the court will proceed to consider whether treatment should be authorised, having regard to the young person's best interests under its welfare jurisdiction."

Dr Ouliaris goes on to explain the evolution of the current situation via the cases *Re Kelvin* (2017) and *Re Imogen* (2020).

"On a practical level, *Re Kelvin* shifted the responsibility for authorising stage 2 treatment from the Court onto clinicians, some of whom experienced greater pressure from children and families to provide treatment," she wrote.

"Following *Re Imogen*, the right to decide treatment is more widely dispersed among clinicians, the court, the young person, and their families.

"Conversely, there are concerns that the requirement for positive parental consent from both parents places a significant administrative burden on medical practitioners to seek consent from parents and support patients through litigation processes that may also result in treatment delays for many patients.

"While Courts have yet to make a declaration that departs from the wishes of a Gillick competent child seeking treatment for gender dysphoria, requiring mature minors to obtain positive parental consent undermines the very principle of Gillick competence. This has been criticised as a paternalistic intrusion into a young person's right to self-determination."

Dr Ouliaris wrote that the rapid evolution of the laws governing consent had led to "uncertainty, and at times confusion", and "volatility in clinical practice".

"It is essential that all clinicians know the law, not only to abide by it but also to effectively advocate for patients within current frameworks and, in doing so, shape its evolution for optimal clinical outcomes," she concluded.

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