

Gender CARE beyond the courts: an alternative framework for resolving disputes over gender health care for children and adolescents

Gender health care for transgender and gender diverse children and adolescents in Australia continues to be scrutinised in an increasingly polarised socio-political climate. Courts have labelled this area of health care “innovative”, “experimental” and “unique”,¹ with treatment options often raising moral, ethical, human rights and clinical dilemmas. These problems include respect for children’s evolving autonomy, the role of family in supporting health care outcomes, and the influence of cisnormative assumptions and socio-cultural expectations of gender.

The Australian family courts have gradually ceded their role in authorising medical treatment for children diagnosed with gender dysphoria. However, they are still involved in circumstances of “genuine dispute or controversy”.² Recent cases have concerned:

- disagreement between parents or between parents and clinicians over a child’s diagnosis, Gillick competence, or the proposed treatment;
- parental refusal to give consent to their child commencing treatment;
- the inability to obtain one parent’s consent; and
- parents seeking a declaration of their child’s Gillick competence following changes to a health service’s process for accessing gender-affirming hormone treatment.

The Australian legal framework regulating minors’ consent to medical treatment comprises “legislation sitting alongside the common law, including a patchwork of decisions” of the courts at trial and appellate levels.³ Some jurisdictions have passed legislation to recognise children’s capacity to consent to medical decision making below the age of majority (18 years). For instance, South Australian legislation provides that a person aged 16 years or over may make medical treatment decisions “as validly and effectively as an adult”.⁴ In jurisdictions without legislation prescribing whether a child can consent to medical treatment, the common law principle of Gillick competence applies. This principle provides that a minor is capable of consenting to medical treatment when they achieve “a sufficient understanding and intelligence to enable [them] to understand fully what is proposed”.⁵ Without a fixed age attached to the Gillick competence test, considerable discretion and burden are imposed on a child’s treating clinicians in making this assessment.⁶

The decision of the Family Court of Australia in *Re Imogen* [No 6]⁷ has reignited debate about whether the courts should be involved in resolving disputes where a child or adolescent is Gillick competent. Among the various concerns raised about the implications of this decision,⁸ prominent is its erosion of the Gillick

competence principle. The Family Court’s conclusion that Gillick competence is not determinative in cases of dispute stigmatises gender-affirming health care, undermines respect for the decision-making autonomy of Gillick competent minors, and may endanger their right to access other kinds of health care.⁹

The harms of court involvement

There is limited empirical evidence in Australia of the impacts of family court involvement in gender health care for children and adolescents.¹⁰ Kelly’s qualitative study involving 12 parents from across Australia who were either preparing for, actively engaged in, or had recently completed, the Family Court process found that it imposed an “unnecessary and harmful burden” on children and their families.¹¹ Judges have conceded the costs, stress and delays of court proceedings “when doctors and parents are in agreement”.¹² Ignoring these concerns, there has been a recent call to reinstate the family courts in gender care decision making, based on the perception that there is insufficient information available about alternatives to gender-affirming medical treatment.¹³ Yet even without court involvement, transgender and gender diverse children and young people experience challenges in accessing gender health care, including obtaining clinical support in an affordable and timely manner.¹⁴

Risks and uncertainties for clinicians

The English Court of Appeal recently highlighted the exposure of clinicians to legal action in individual cases involving gender-affirming health care interventions, stressing the need to take “great care” in prescribing treatment “in the light of evolving research and understanding of the implications and long-term consequences”.¹⁵ In Australia, the family courts have been reluctant to engage meaningfully with the clinical, moral, ethical and human rights dimensions of disputes over gender health care. We believe that greater clarity and transparency from courts about their role would be valuable for clinicians, to offer guidance about the nature and form of information that should be provided to obtain valid consent and to discharge the clinician’s duty to inform, and to enhance a Gillick competent adolescent’s capacity to use or weigh that information.

An alternative framework for resolving gender care disputes

We recommend that a nationally uniform dispute resolution framework be established for disputes

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over gender care for Gillick competent children and adolescents. The aims of this framework would be to:

- minimise family court involvement in gender health care;
- support Gillick competent children and adolescents to make informed health care decisions;
- protect clinicians against undue legal action;
- resolve disputes in a timelier, more cost-effective and less adversarial manner; and
- contribute to the ongoing body of evidence about gender care options and outcomes.

Our proposed alternative dispute resolution framework is a conceptual model, intended to stimulate debate about how disputes may be resolved outside the court process. A more detailed evaluation of how this model could be implemented in practice is beyond the scope of this article.

Below, we outline key features of a five-stage decision-making process underpinned by guiding principles, which supports Gillick competent minors to access gender-affirming treatment. We note that many disputes are likely to be resolved in the early stages, such that a strict linear approach incorporating each stage will not be necessary or appropriate for every dispute:

- The first stage is shared decision making, based on a relational account of patient autonomy.¹⁶ This stage acknowledges the importance of family in medical treatment decisions, even if the patient is Gillick competent. Children's decision making is influenced in many ways by the support and structure provided by their parents and caregivers. In cases of dispute between a child and their parent or caregiver, the process of obtaining informed consent for treatment should carefully consider the views of each, as well as the views of the treating team.
- The second stage is consultation with bioethicists, preferably through a specialist clinical ethics support service, with expertise in child and adolescent health care.¹⁷ We anticipate this to be an advisory (as opposed to a directive) service, providing support to clinicians through the language of ethics without undermining clinical autonomy.
- The third stage is mediation, to assist the parties to reach a greater shared understanding, even if this step fails to resolve the dispute entirely. Where disagreement among clinicians about a patient's care is a contributing factor, it has been suggested that psychiatrists could play a more active liaison role, including through mediation of diverse perspectives to facilitate best-practice care.¹⁸ This would not constitute a gatekeeping role in terms of accessing treatment.
- If mediation is unsuccessful, the fourth stage is resolution by an independent, multidisciplinary specialist panel. Panel membership may include one or more individuals with lived experience, as well as multidisciplinary specialists including a paediatrician, endocrinologist, psychiatrist, psychologist or counsellor, and lawyer. The focus

of the panel would be to explore viable options for accessing treatment, as opposed to re-evaluating diagnosis or treatment. We do not envisage the panel operating as a decision-making body established by legislation. Rather, the panel would make recommendations about viable treatment options, explaining the benefits and risks of each based on current evidence and the individual values of key stakeholders. A specialist panel that is independent of the treating hospital or clinic is more likely to foster trust and confidence among all stakeholders through independent medical assessment.¹⁹ Drawing on therapeutic jurisprudence research, the aim of a solution-focused panel would be to promote the wellbeing of all relevant parties,²⁰ by addressing disagreements in a "respectful, considered, ethically informed, and compassionate" manner.²¹

Ideally, this independent, multidisciplinary specialist panel would operate under a national framework, with safeguards to ensure consistency, independence and accountability through compliance with national guidelines that incorporate the CARE principles below. We acknowledge that there are limitations to a national framework, including less transparency than a court or tribunal, creating potential for bias if reporting and auditing are not conducted properly. There would also be less precedent to guide and protect clinicians from future litigation, although the aim of the process overall is to minimise the need for court involvement. However, the benefits of national guidelines in this context include that they are easier to implement than legislation, given the constitutional limitations in Australia, and they would reduce regulatory duplication. There is also greater scope for flexibility in design and less likelihood that treatment will become politicised. Further, a national framework would promote a consistent ethical approach based on current evidence. It would also improve national data collection to create a stronger evidence base for gender-affirming treatment.

- The family courts would be "the last resort and reserved for the most serious of cases where the dispute is patently intractable".²² In these exceptional cases, greater transparency and clarity in judicial reasoning about the basis for court intervention would assist clinicians to address concerns about their obligations and the consent process.

The CARE approach

We suggest four overarching CARE principles to guide the development of the proposed framework:

- C – Communication: that is open, accessible and provides clarity about the decisions to be made and the roles of the patient, parents and clinicians in the decision-making process.²³ Children and adolescents and their parents are likely to be emotionally invested in decisions about gender care. This is a prime example of an "emotionally hot context",²⁴ which may further polarise the parties to a dispute. However, the usual clinical response "is not to remove the decision-making to a court of

law, but to find ways to ease the emotional tension or distress and help patients make more reflective decisions".²⁵

- A – Autonomy: recognises that children and adolescents should experience increasing agency and responsibility for decision making about their health as they develop and mature.²⁶ This principle respects each child's right to participate meaningfully in the decision-making process, consistent with their evolving capacities and with appropriate guidance and direction. In line with recent international clinical guidelines,²⁷ this principle promotes a holistic biopsychosocial model of care, which supports a child or adolescent to fully explore their gender identity within their specific socio-cultural context, while addressing any co-existing mental health concerns.
- R – Relationships: acknowledges the fundamental role that families play in the psychological health and wellbeing of children and adolescents in the gender care context. This principle promotes supportive relationships between the patient, their family and the treating team. As a Gillick competent child or adolescent relies on their parents or caregivers for ongoing care and access to treatment, support must be offered to the child or adolescent themselves, and to the family.²⁸
- E – Expertise: in the form of interdisciplinary input into the decision-making process. *The Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents* (Australian Standards) provide an extensive treatment protocol that outlines defined roles for individual specialists within a coordinated, multidisciplinary team.²⁹ This principle could be supported by further training for health professionals in the field of trans and gender diverse health.³⁰ A formal regimen for ongoing patient monitoring and review, as well as for reporting and recording longitudinal patient findings, could also be embedded into the framework, to enhance the empirical evidence base.

Conclusion

We have proposed an alternative framework for resolving disputes over gender care for Gillick competent children and adolescents, underpinned by the principles of Communication, Autonomy, Relationships and Expertise (CARE). We consider that this framework would better promote the rights, wellbeing and autonomy of Gillick competent children and adolescents than court involvement in the medical treatment process. It is unlikely that such a framework would be legislated in Australia, given the absence of legislative intervention in this area of health care to date. Rather, the framework might feature in clinical treatment guidelines. The current review of the Australian Standards may be an opportune time to incorporate a staged dispute resolution process.

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