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# Legal and Medical Aspects of Diverse Gender Identity in Childhood

Felicity Bell and Anthony Bell\*

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*Diagnosis of gender identity dysphoria among children and young people appears to be increasing around the developed world. For a small proportion of children, the mismatch between their natal physical characteristics and desired gender causes significant distress. Though there are now accepted medical interventions that can assist in these cases, there is a lack of congruence between clinical practice and legal regimes governing the treatment of children and young people in this area. This article seeks to demonstrate the difficulties that may arise by providing a detailed explanation of medical interventions, juxtaposed with a discussion of the legalities of children's consent in some overseas common law jurisdictions.*

**Keywords:** *gender; gender dysphoria; consent; children and young people; treatment*

## I. INTRODUCTION

Increasing numbers of children and young people around the world are being diagnosed with “gender identity dysphoria” or choosing not to conform to traditional gender identities. Currently, referrals for treatment of young people for conditions related to gender nonconformism are growing more rapidly than for any other age group.<sup>1</sup>

The response to children and young people displaying gender nonconformism throws up a host of interconnected medical and legal issues involving the appropriateness of medical interventions, children's capacity to consent to medical treatment, the role of concerned adults including parents and guardians, and social and legal recognition of a person's chosen gender. The deeply personal nature of the issues that can arise – and which appear to be arising with ever-greater frequency among young people – demands a sophisticated understanding of the interaction of medical and legal constructs in this area.

It is important to note that “gender dysphoria” is distinct from being of diverse, non-binary or “nonconforming” gender identity, due to the levels of distress experienced by sufferers at the lack of congruity between their experienced gender and their body. While there is no uniform mode of “treatment” for gender dysphoria, as each individual's situation is different, there are various medical levels of what is referred to as “affirmation” of gender.<sup>2</sup> The most dramatic is surgery to redefine the genitalia, an irreversible and reproductively sterilizing surgery. Medical assessment before such surgery must ensure that it is essential for the individual's wellbeing. There are also less invasive options including hormone therapy. These less irreversible therapies, if successful, may also work to provide individuals with a satisfactory quality of life.

Medical advances in this area have not necessarily been matched by legal change in the common law world. Despite many progressive changes, it seems that there remains a significant mismatch between current medical best practice and legal regimes dealing with children and young people's gender expression. This article first discusses gender nonconformity and gender dysphoria in young people

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\* Dr Felicity Bell: Lecturer, School of Law, University of Wollongong, New South Wales. Dr Anthony Bell: Medical Advisor to the Coroner, Department of Justice, Tasmania. The views expressed here are those of the authors only.

Correspondence to: [fbell@uow.edu.au](mailto:fbell@uow.edu.au); [tony.bell@justice.gov.tas.au](mailto:tony.bell@justice.gov.tas.au).

<sup>1</sup> In the United Kingdom, eg it is suggested that referrals for young persons are growing at 50% per annum: Gender Identity Research and Education Society, *Monitoring Gender Nonconformity – A Quick Guide* < <https://uktrans.info/attachments/article/198/Monitoring.pdf> > (archived copy).

<sup>2</sup> This term is preferred over “reassignment”.



in Pt II. Part III describes various medical treatment options and what research suggests to date about outcomes. Part IV then considers the legal issues that can arise in relation to access to medical treatment for gender nonconforming children and young people, in various common law jurisdictions, while Pt V provides conclusions.

## Prevalence of Gender Nonconformism in Young People

A UK-based charity, the Gender Identity Research and Education Society (Gires) recently estimated the number of people identifying as gender nonconforming.<sup>3</sup> A survey of 1,000 people found that 1% were gender nonconforming to some degree: 0.2% overall were likely to seek medical treatment for their condition at some stage, while 0.03% had received such treatment already. This latter figure comprised those having already undergone transition (0.02%) and those having a gender recognition certificate<sup>4</sup> (0.005%) or who were likely to begin treatment during the year (0.004%). The numbers who have sought treatment seem likely to continue growing at 20% per annum (from a low total number base) or even faster.<sup>5</sup> Few younger people present for treatment despite the fact that most gender variant adults report experiencing the condition from a very early age, but as noted, referrals for this age group are increasing exponentially.

In a 2015 review, Fernández et al identified “a higher incidence of people seeking care at younger ages, the minimum age being 13 years”.<sup>6</sup> Likewise, Kaltiala-Heino et al observed that the number of attendees at two gender identity clinics for adolescents in Finland was higher than expected: “The number of referrals to the study unit already doubled the less conservative estimates based on adult figures”.<sup>7</sup> These authors noted that referrals to such services had increased across Europe.<sup>8</sup> Similar increases have been noted in Australia<sup>9</sup> and Canada.<sup>10</sup> There are now specialist gender identity clinics for adolescents in many countries.<sup>11</sup> A 2011 population-based survey in San Francisco in the United States found that 1.3% of children in grades six to eight (aged 11–13 years) self-identified as transgender.<sup>12</sup> The World Professional Association for Transgender Health (WPATH) reviewed 10 studies focused on individuals presenting to specialist transgender clinics. The prevalence ranged from 1:11,900 to 1:45,000 for male to female (MtF) individuals and 1:30,400 to 1:200,000 for female to male (FtM) individuals.<sup>13</sup> The authors considered these to be the minimal estimates, as the studies counted only people presenting for a specific type of treatment.

Accurate prevalence data – the actual rate of gender dysphoria in the general population – are lacking. Thus, there is no firm evidence that overall prevalence is changing. However, a common theme

<sup>3</sup> Gires, n 1.

<sup>4</sup> Certification that the person has “changed” gender from their natal gender.

<sup>5</sup> Gires, n 1.

<sup>6</sup> M Fernández et al, “New Perspectives in the Hormonal Treatment of Gender Dysphoria in Adolescence” (2015) 43 *Actas Espanolas De Psiquiatria* 24.

<sup>7</sup> In the period 2011–2013, R Kaltiala-Heino et al, “Two Years of Gender Identity Service for Minors: Overrepresentation of Natal Girls with Severe Problems in Adolescent Development” (2015) 9 *Child and Adolescent Psychiatry and Mental Health* 1.

<sup>8</sup> Kaltiala-Heino et al, n 7, 2; citing personal communications in 2013 and 2014 from child and adolescent gender identity teams in the United Kingdom, the Netherlands, Spain and Sweden.

<sup>9</sup> J K Hewitt et al, “Hormone Treatment of Gender Identity Disorder in a Cohort of Children and Adolescents” (2012) 196 *Medical Journal of Australia* 578.

<sup>10</sup> K J Zucker et al, “Is Gender Identity in Adolescence Coming Out of the Closet?” (2008) 34 *Journal of Sex & Marital Therapy* 287.

<sup>11</sup> Fernández et al, n 6, 25. Kaltiala-Heino et al, n 7 refer to four European gender identity clinics (together comprising the European network for the investigation of gender incongruence): Amsterdam (the Netherlands), Ghent (Belgium), Hamburg (Germany) and Oslo (Norway).

<sup>12</sup> J P Shields et al, “Estimating Population Size and Demographic Characteristics of Lesbian, Gay, Bisexual, and Transgender Youth in Middle School” (2013) 52 *Journal of Adolescent Health* 248. Grades 6–8 comprises children aged 11–14 years.

<sup>13</sup> World Professional Association for Transgender Health (WPATH) *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (7<sup>th</sup> version, 2012) 9.

discussed in the above studies is that there is an increasing incidence of case recognition: ie the number of cases diagnosed in the population, representing a proportion of the actual number of cases. Increased case recognition may increase the recognized numbers even if there is no increase or even if the true prevalence falls.<sup>14</sup> Regardless, it is clear that gender nonconformity in young people is increasingly recognised as requiring a sophisticated medical, social and policy response.

## II. GENDER CONCEPTS AND GENDER DEVELOPMENT

Gender, gender identity, gender role and gender expression are personal, psychological and cultural constructs referring to various aspects of maleness and femaleness. Gender identity is an individual's innate sense of being male, female or somewhere in between, while gender role is society's expectations of attitudes, behaviours and personality traits typically based on biologic gender. Masculinity and femininity are the main concepts conveying these cultural associations. Gender expression refers to the ways gender is presented to the outside world but does not necessarily correlate with gender identity of the individual. The concept that gender is binary – male or female – has become outdated and gender should be considered as a psychological continuum from female to male. As Otto has explained:

[E]veryone has a “gender identity” – including those who identify as cisgendered ... there is a dynamic relationship between the body and identity which gives rise to multiple possible alignments, which can change over time, or even from moment to moment.<sup>15</sup>

Such a continuum in essence means that gender nonconformity may be tolerable for an individual or may cause significant distress to the individual, the latter being referred to as gender dysphoria. The degree may fluctuate so the individual may be gender nonconforming or experience gender dysphoria at other times.

A summary of gender development is important in the understanding of both nonconforming gender identity and the continuum concept. The timing of gender identity stability is important when considering any therapy but acutely so when considering irreversible hormonal or surgical therapies. Forcier et al present a summary of the early development of gender.<sup>16</sup> They report that:

Between 2 to 4 years children begin to understand gender differences, use gendered pronouns such as “him” and “her” correctly and can identify their own gender. By this age most children also play with toys and games that correlate with their anatomical sex.... By five to six years of age, their view of gender becomes constant. Young children assume gender stereotypes for themselves.<sup>17</sup>

The authors go on to describe a peer group that “generally continue to be same-sex; following rules and fitting in”.<sup>18</sup> Although this is the usual developmental path, many children experiment with different gender roles. Typically, adolescents' uncertainty about their sexual orientation, eg decreases with age, from 26% of 12-year olds to 5% of 17-year olds.<sup>19</sup> Within the continuum of gender expression, many individuals may find, with or without medical help, a gender role that is nondistressing (nondysphoric) associated with a satisfactory lifestyle. For reasons that are not understood, however, in some children “cross gender behaviour and expression is more consistent, persistent and insistent than it is in their peers”.<sup>20</sup> These

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<sup>14</sup> C Mitchell, “Rise in Gender Dysphoria Cases” (2015) 2 *Australian Medical Journal InSight* <<http://www.doctorportal.com.au/mjainsight/2015/2/rise-gender-dysphoria-cases/>>; N P Spack et al, “Children and Adolescents with Gender Identity Disorder Referred to a Paediatric Medical Center” (2012) 129 *Pediatrics* 418.

<sup>15</sup> D Otto, “Queering Gender [Identity] in International Law” (2015) 33 *Nordic Journal of Human Rights* 299, 300.

<sup>16</sup> M Forcier et al, *Overview of Gender Development and Clinical Presentation of Gender Nonconformity in Children and Adolescents* <<http://www.uptodate.com/contents/overview-of-gender-development-and-clinical-presentation-of-gender-nonconformity-in-children-and-adolescents>>.

<sup>17</sup> Forcier et al, n 16.

<sup>18</sup> Forcier et al, n 16.

<sup>19</sup> G Remafedi et al, “Demography of Sexual Orientation in Adolescents” (1992) 89 *Pediatrics* 714.

<sup>20</sup> M S C Wallien and P T Cohen-Kettenis, “Psychosexual Outcome of Gender-dysphoric Children” (2008) 47 *Journal of the American Academy of Child and Adolescent Psychiatry* 1413.

children or adolescents may well suffer intolerable gender dysphoria and require affirmation of their gender identity in some form.

The concept of a continuum of gender is anathema to legal constructs of gender.<sup>21</sup> Typically, legal regimes regulating birth and identity require a child's gender to be determined and fixed at birth and reflected in the issuance of a birth certificate. Trans\*, intersex and nonidentifying people may face many barriers in seeking legal recognition of their identity.<sup>22</sup>

In many countries, it is now possible to change one's legal status as male or female, through (for example) obtaining a "gender recognition certificate" or amending one's birth certificate. However, there is inconsistency in the prerequisites for doing so, namely, the degree of affirmation of gender identity – which may range from presenting or living as that gender to undergoing surgical procedures.<sup>23</sup> In many parts of the world, legal recognition will only follow if the most extreme forms of physical change have been pursued. The organisation Transgender Europe has collated information about Europe's different legal regimes and how they recognise gender.<sup>24</sup> While some jurisdictions, such as Malta Portugal and Argentina, have adopted statutes by which gender recognition is largely about the individual's subjective identity,<sup>25</sup> others, such as Belgium, France and the Czech Republic, accord recognition only if gender affirmation surgery has been performed.<sup>26</sup> The use of a "medical model" in determining a person's entitlement to legal recognition of their gender identity has been extensively criticised.<sup>27</sup>

Additionally, young people are not always able to make use of the provisions of gender recognition statutes. For example, Ireland, which has also seen growing awareness of gender nonconformity in children,<sup>28</sup> enacted a *Gender Recognition Act* in 2015 enabling people to apply for a legal change of gender. This legislation has, however, been criticised for omitting children and young people from its scope,<sup>29</sup> which is also the case for the United Kingdom's equivalent legislation.<sup>30</sup> Thus, a person must be 18 in order to have their legal gender changed, though 16- and 17-year olds can seek to do so through the courts. Children aged under 16 years cannot change their legal gender.<sup>31</sup>

Finally, it must be noted that regimes providing for a "change" in legal gender still deal primarily in the male/female binary. Tran and Glazer have identified that, at least in the United States, discrimination and other legal claims are easier to sustain when a person is seeking recognition of a such a "change", whether MtF or FtM.<sup>32</sup> In contrast, those whose gender identity is less dualistic face

<sup>21</sup> See, eg S V Tran and E Glazer, "Transgenderless" (2012) 35 *Harvard Journal of Law & Gender* 399.

<sup>22</sup> See, eg M Couch et al, "Chapter 9: Changing Documentation" in *Tranznation: A Report on the Health and Wellbeing of Transgender People in Australia and New Zealand* (Australian Research Centre in Sex, Health & Society, La Trobe University, 2007).

<sup>23</sup> L Grenfell and A Hewitt, "Gender Regulation: Restrictive, Facilitative or Transformative Laws?" (2012) 34 *Sydney Law Review* 761.

<sup>24</sup> See Transgender Europe, *Trans Rights Europe Map & Index 2014* (22 February 2015) <[http://tgeu.org/trans\\_rights\\_europe\\_map/](http://tgeu.org/trans_rights_europe_map/)>.

<sup>25</sup> See Transgender Europe, *Malta Adopts Ground-breaking Trans and Intersex Law* (1 April 2015) <<http://tgeu.org/malta-adopts-ground-breaking-trans-intersex-law/>>; ACT Law Reform Advisory Council, *Beyond the Binary: Legal Recognition of Sex and Gender Diversity in the ACT*, Report No 2 (2012) 19–20.

<sup>26</sup> P Dunne, *A Model for Ireland: Malta's Gender Identity, Gender Expression and Sex Characteristics Act* (4 April 2015) Human Rights in Ireland <<http://humanrights.ie/international-law/international-human-rights/guest-post-malta-and-gender-identity/>>.

<sup>27</sup> F H Romeo, "Beyond a Medical Model: Advocating for a New Conception of Gender Identity in the Law" (2005) 36 *Columbia Human Rights Law Review* 713; D Spade, "Resisting Medicine, Re/modeling Gender" (2003) 18 *Berkeley Women's Law Journal* 15; A E Silver, "An Offer You Can't Refuse: Coercing Consent to Surgery through the Medicalization of Gender Identity" (2014) 26 *Columbia Journal of Gender and Law* 488.

<sup>28</sup> P McGuire, "Ireland's Transgender Children", *Irish Times*, 11 April 2015 <<http://www.irish-times.com/life-and-style/people/ireland-s-transgender-children-1.2171777>>.

<sup>29</sup> M Minihan, "Reilly Disagrees with Tánaiste on Gender Recognition Bill", *The Irish Times*, 17 June 2015; B Dittrich, "Letter to the Government of Ireland on the Rights of Transgender Children", *Human Rights Watch*, 14 July 2015.

<sup>30</sup> *Gender Recognition Act 2004* (UK) s 1(1).

<sup>31</sup> *Gender Recognition Act 2004* (UK) ss 9 and 12.

<sup>32</sup> See Tran and Glazer, n 21.

increased difficulties.<sup>33</sup> Australia's highest court has recognised that a person may be legally identified as being of "non-specific" gender.<sup>34</sup> With a few exceptions, however, the recognition legislation of other jurisdictions has little to offer non-binary, genderqueer and nongendered people.

### III. MEDICAL TREATMENT OPTIONS AND OUTCOMES

Since the last third of the previous century, the treatment of gender dysphoria has involved hormonal delay of puberty, sex hormone therapy and surgery to affirm the gender of dysphoric patients. These three "stages" are described in detail below, followed by an analysis of the current research surrounding patient satisfaction with medical transition. Social concerns surrounding, in particular, irreversible physical effects including sterilization in young people mean that longer-term satisfaction is very important. However, while minimal irreversibility appears to be a sound therapy, this must not come at the detriment of the individual. Generally, satisfaction rates are high and have been quoted as 87% for MtF patients and 97% for FtM patients.<sup>35</sup> Dissatisfaction rates are reportedly correspondingly low: MtF 1–1.5%, FtM less than 1%.<sup>36</sup> Nevertheless, the irreversibility of surgery, and to some extent hormonal therapy, indicates that the clinician(s) involved must be cautious in every case. Thus, the development of standardized assessment and therapy regimes and multidisciplinary clinics has occurred in many parts of the world. As in all areas of medicine, treatment needs to be effective and safe.

#### Suppression of Puberty and Application to Gender Nonconforming Children

Much of the medical knowledge of how to suppress puberty comes from the medical treatment of what is called normal development precocious puberty (also known as central precocious puberty, gonadotropin-dependent precocious puberty or true precocious puberty). Normal development precocious puberty is the onset of pubertal development before the age of eight years in girls and nine years in boys.

The hypothalamic–pituitary–gonadal (HPG) axis is the controlling physiological system for pubertal development. The HPG axis is biologically active in utero and briefly during the first week of life. The axis then becomes more active again during infancy, with peak activity between one and three months of age. This state yields sex steroid levels comparable with those seen in early-to-mid puberty, but without peripheral effects because the target organs are insensitive. In boys, gonadotropin concentrations then decrease to prepubertal levels by six to nine months of age. In girls, luteinizing hormone (LH) levels decrease at the same time as in boys, but the follicle-stimulating hormone (FSH) concentrations can remain elevated into the second year of life.<sup>37</sup>

At the time of puberty, the HPG axis matures and the released sex hormones then *do* affect the peripheral organs (due to the development of organ hormone receptors) with the development of secondary sexual characteristics correlating to the child's biogenetic sex. The typical stages of development were described by Tanner and Marshall in 1969<sup>38</sup> and 1970<sup>39</sup> and are therefore known as Tanner stages 1 through 4. In most populations, attainment of pubertal milestones approximates a normal distribution, with a mean age of onset of puberty of about 10.5 years in girls and 11.5 years in boys and a standard deviation of approximately one year.

<sup>33</sup> Tran and Glazer, n 21.

<sup>34</sup> *NSW Registrar of Births, Deaths and Marriages v Norrie* (2014) 250 CLR 490; [2014] HCA 11.

<sup>35</sup> Quoted in WPATH, n 13, 8.

<sup>36</sup> Quoted in WPATH, n 13, 8.

<sup>37</sup> J Harrington et al, *Definition, Etiology, and Evaluation of Precocious Puberty*, Uptodate Clinical Support Resource <<http://www.uptodate.com/contents/definition>>.

<sup>38</sup> W A Marshall and J M Tanner, "Variations in Pattern of Pubertal Changes in Girls" (1969) 44 *Archives of Disease in Childhood* 291.

<sup>39</sup> W A Marshall and J M Tanner, "Variations in the Pattern of Pubertal Changes in Boys" (1970) 45 *Archives of Disease in Childhood* 13.

Normal development precocious puberty is caused by early maturation of the HPG axis. It is characterized by sequential maturation of breasts and pubic hair in girls and maturation of the testes, penis and pubic hair in boys, with sexual characteristics corresponding to the child's biogenetic sex.<sup>40</sup> Delay of normal development precocious puberty is achieved by using gonadotrophin-releasing hormone (GnRH) agonist or an antagonist. GnRH agonists and antagonists exhibit different mechanisms of action. Agonists bind to GnRH receptors and produce an initial intense stimulation. This causes marked increases in LH, FSH and testosterone. Sustained pituitary overstimulation will eventually downregulate or desensitize GnRH receptors with a consequent decrease in hormone levels. In contrast, antagonists block receptors, immediately stopping LH secretion, and thus producing rapid testosterone suppression without the initial LH and testosterone surge. Once treatment is ceased, normal pubertal development recommences and occurs within one year.<sup>41</sup>

This treatment has been found to be safe and effective in delaying normal development precocious puberty. Treatment with GnRH agonists appears to have no significant long-term effects on the pituitary–gonadal axis. In long-term follow-up of girls who were treated with GnRH agonists, the rate of regular menstrual cycles and fertility was not different from the general population. For boys, small studies show normal gonadal function after completing treatment with GnRH agonists. Although earlier pubertal development is associated with obesity, long-term treatment with GnRH agonists does not appear to cause or exacerbate obesity in adolescence or adulthood. While bone mineral density may slightly decrease during GnRH agonist administration, these changes are not sustained, with preservation of peak bone mass accrual after discontinuation of therapy.<sup>42</sup>

The application of puberty-suppressing therapy to gender nonconforming children is used for reasons that differ from use in normal development precocious puberty. The goal of therapy is to allow adolescents more time to explore their gender nonconformity. Subsequent transition or affirmation of gender identity may be made easier by preventing the development of secondary sexual characteristics<sup>43</sup> and also by averting negative social and emotional consequences of gender dysphoria.<sup>44</sup>

The therapy is started when puberty reaches Tanner stage 2 (of 4).<sup>45</sup> Importantly, earlier therapy is *not* recommended as gender nonconforming prepubescent children have a significant rate of losing gender dysphoria with ageing.<sup>46</sup> Meanwhile, evidence suggests that patients with continued gender dysphoria at the onset of puberty do not change their minds.<sup>47</sup>

As in the treatment of precocious puberty the therapy has proven to be safe and reversible, having been used now for over 20 years.<sup>48</sup> Delay of puberty is recommended to continue until the age of 16 years when sex hormones are added to initiate pubertal development of the desired sex.<sup>49</sup> Further delay can lead to similar emotional concerns that have been associated with constitutional delay of puberty. Thus, some researchers advocate using the age of 16 years as a guideline while considering the earlier initiation of cross-gender hormones on a case-by-case basis. Earlier initiation would only come after

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<sup>40</sup> Harrington et al, n 37.

<sup>41</sup> Harrington et al, n 37.

<sup>42</sup> Harrington et al, n 37.

<sup>43</sup> WPATH, n 13, 19.

<sup>44</sup> WPATH, n 13, 20.

<sup>45</sup> Marshall and Tanner, nn 38 and 39; V Tangpricha et al, *Treatment of Transsexualism*, Uptodate Clinical Support Resource <<http://www.uptodate.com/contents/definition>>.

<sup>46</sup> Wallien and Cohen-Kettenis, n 20; W C Hembree et al, "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline" (2009) 94 *The Journal of Clinical Endocrinology & Metabolism* 3132.

<sup>47</sup> P T Cohen-Kettenis, H A Delemarre-van de Waal and L J G Gooren, "The Treatment of Adolescent Transsexuals: Changing Insights" (2008) 5 *The Journal of Sexual Medicine* 1892.

<sup>48</sup> Hembree et al, n 46, 3141; P T Cohen-Kettenis et al, "Puberty Suppression in a Gender-dysphoric Adolescent: A 22-year Follow-up" (2011) 40 *Archives of Sexual Behavior* 843.

<sup>49</sup> Hembree et al, n 46, 3142; see Pt III under the section "Use of Feminizing and Masculinising (Sex) Hormonal Therapy, Effects and Side Effects".

careful review of the potential risks and benefits with the young person and parents or guardians.<sup>50</sup> Continuation of pubertal suppression is recommended until gender affirmation surgery that includes gonadectomy (surgical removal of the gonads) is performed.<sup>51</sup> Surgical removal of the gonads removes the major natal sex hormone-producing glands and thus continuation of pubertal suppression becomes unnecessary.

Puberty can also be halted in adolescents who are in later stages of puberty. However, physical sex characteristics such as breast development in girls and lowering of the voice and outgrowth of the jaw and brow in boys cannot be completely reversed. Further, while hormones started during adolescence can decrease full development of the genitals, only surgery can change the appearance of the genitals to the desired gender.

### **Use of Feminising and Masculinising (Sex) Hormonal Therapy, Effects and Side Effects**

An important overarching point is that the use of hormonal therapy limits fertility. Therefore, all patients should be informed about the prospects for reproduction and the methods available for allowing reproduction. These methods include sperm preservation and oocyte (egg) or embryo freezing.<sup>52</sup>

Tangpricha et al list the goals of hormonal therapy as being to both suppress the hormones of the individual's biogenetic gender and induce secondary sex characteristics of the new, desired sex. After achieving these goals, the aim is to maintain the hormones in the normal physiological range for the desired sex. The therapy is continued even after surgical sex affirmation. Hormone doses in excess of the normal physiological requirements are unnecessary and harmful.<sup>53</sup> The following sections briefly describe the "ideal" treatment for both MtF and FtM patients who commence transition in adolescence with sex hormone therapy.<sup>54</sup>

#### ***Feminizing Hormone Therapy for Male to Female Transition in Adolescence***

The development of hormone therapy for male to female (MtF) transition (transgender female) has not occurred via controlled trials. Rather, the accepted regime follows that developed as treatment for hypogonadism, a condition where the normal development of sex hormone surge at puberty does not occur. The nature of the treatment means that MtF patients require antiandrogen (testosterone) therapy as well as feminizing hormones. Antiandrogens such as GnRH agonists (though these are typically expensive) or spironolactone (an inexpensive blood pressure-lowering agent with an excellent safety profile) are used.

Ideally, the patient's treatment starts early enough to bypass the development of male secondary sexual characteristics associated with puberty, allowing the individual to progress through puberty on a female trajectory. If a patient begins treatment after puberty is complete, or near-complete, administration of estradiol and androgen blockers will not affect voice pitch, laryngeal prominence, height, foot and hand size, or facial hair growth.

Oestrogen causes breast tissue growth whenever the hormone is administered and the effect is irreversible. The maximum growth occurs after two years of commencing administration. Thus, cosmetic surgery of the breast should be delayed until the breast tissue is in a stable situation. Other oestrogen effects include a change in body fat composition with increased subcutaneous fat and decreased lean body mass. There is a decrease in facial and body hair. These changes regress if oestrogen therapy is ceased. The skin has decreased sebaceous gland activity resulting in dry skin and nails.

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<sup>50</sup> J Olsen et al, "Management of the Transgender Adolescent" (2011) 165 *Archives of Pediatrics and Adolescent Medicine* 171.

<sup>51</sup> Hembree et al, n 46, 3142.

<sup>52</sup> WPATH, n 13, 50.

<sup>53</sup> Tangpricha et al, n 45.

<sup>54</sup> A more detailed discussion of the regimes is beyond the scope of this article.

Adverse effects include development of deep venous thrombophlebitis (though this appears related to the use of oral ethinyl estradiol, rather than other oestrogens). Oestrogens are associated with the development of prolactinoma (a prolactin-secreting tumour of the pituitary gland), hypertension, liver disease, decreased libido and increased risk of breast cancer. Androgen blockers can cause hyperkalemia and decreased blood pressure. Most transgender females receiving cross-gender hormones will experience a decrease in testicular mass, penis size and fertility, which is irreversible and slowly developing.

### ***Masculinising Hormone Therapy for FtM Transition in Adolescence***

In patients transitioning from FtM (transgender male), ideal treatment would again start early enough to bypass the development of female secondary sexual characteristics; however, some guidelines recommend starting GnRH analogues later, at Tanner stage 2 or 3.<sup>55</sup> Some natal females may have started menses, and most will have started breast tissue development by this time. The use of GnRH analogues may lead to the regression (disappearance) of the early stages of puberty (sequential maturation of breasts and pubic hair development), but large-scale studies are needed before definitive statements can be made about this aspect of treatment.

The administration of testosterone in transgender male patients will induce a drop in the voice and irreversible clitoral enlargement and reversible facial and body hair growth, cessation of menses, redistribution of fat and increase in lean muscle mass. Potential adverse effects include hyperlipidemia (an increase in the triglycerides or fat levels in the blood), which is associated with premature atherosclerosis (arterial disease); polycythaemia or increase in the red blood cell mass, which is associated with induced cerebral infarction (stroke); male pattern baldness (if a genetic predisposition exists); acne; and infertility.

### **Surgery as the Final Stage of Gender Affirmation**

Gender affirmation surgery refers to the removal of the gonads and genital cosmetic surgery. For some individuals, this is the final step to live in their preferred gender role. Gender diverse people may choose not to take this step, however. Formerly, in many countries, so-called sex reassignment surgery was required before a person's legal identity could be amended. As noted above, while many jurisdictions still retain such laws, others have amended their legislation so that a person's self-identification and living as their preferred gender is sufficient.

Cosmetic results of genital surgery have improved since the first operations were performed in Germany in the 1930s. An American, Christine Jørgensen, is perhaps the most famous recipient of gender affirmation surgery, having her surgery done in Denmark in late 1952.<sup>56</sup> With the current surgery, neurological sensation is now preserved, resulting in better patient satisfaction with sexual function. In all cases, genital surgery is complex and specialized, and accordingly best performed by an experienced team.

#### ***MtF Surgery***

The goal of MtF surgery is to create a "neo-vagina". Bilateral orchiectomy (removal of the testicles) is performed to remove endogenous testosterone production. This is followed by penectomy (removal of the penis) and surgery to create a clitoris and a vagina (using penile skin for vaginal lining and scrotal skin for the creating labia). Postoperatively, vaginal dilators are used on a regular basis to maintain the vaginal length until successful and consistent sexual intercourse has been established.

As breast development maximises after two years of hormonal (oestrogen) therapy, breast augmentation is delayed until final growth is attained. A decision for or against breast augmentation can then be made. Cosmetic facial surgery may also be performed to create more feminine features.

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<sup>55</sup> Hembree et al, n 46, 1341.

<sup>56</sup> See, eg J T McQuiston, "Christine Jorgensen, 62, Is Dead; Was First to Have a Sex Change", *The New York Times*, 4 May 1989 <<http://www.nytimes.com/1989/05/04/obituaries/christine-jorgensen-62-is-dead-was-first-to-have-a-sex-change.html>>.

## FtM Surgery

Major surgery involving oophorectomy, hysterectomy and vaginectomy is performed after several years of androgen therapy. One option is creation of a neo-penis or neo-phallus, but the surgery is complex and requires multiple stages. Free flaps removed from arms or legs are used to construct a neo-phallus.<sup>57</sup> Metoidioplasty,<sup>58</sup> the alternative, is a procedure where the clitoral hood is lifted and the suspensory ligament of the clitoris detached from the pubic bone, allowing the clitoris to extend further. When the female tissues have been primed with testosterone, the clitoral head may resemble an adolescent glans penis, although the proportionality or size may be smaller. The urethra is lengthened using an anterior vaginal wall flap to reach the tip of the phallic glans. A scrotum can be constructed from the labia majora, and testicular prostheses can be implanted. This surgical intervention allows the patient to urinate standing. A penile prosthesis confers the ability for sexual penetration. Breast size does not decrease significantly with androgen therapy, and breast glandular tissue remains. Thus, another common surgical procedure is mastectomy. These procedures are typically performed within two to three years of initiating testosterone therapy. The surgery is complex, and there may be significant complications.

## Prediction of Outcome and Eventual Outcome

Given the irreversibility of gender affirmation surgery, and to a lesser degree of cross-sex hormone administration, it would be desirable to have insight into factors that predict success or failure. Prospective controlled studies specifically designed to assess outcome and its prognostic factors are difficult with this relatively rare condition and are still lacking, though research is ongoing. In March 2016, the journal *Nature* reported on a United States National Institute of Health study, which will be both the largest ever study of transgender young people and only the second study to track the psychological effects of delaying puberty and its medical implications.<sup>59</sup>

Gender affirmation surgery does appear to improve gender dysphoria and psychological functioning in most individuals.<sup>60</sup> There are estimates that 1–2% will have regrets<sup>61</sup> although media representations, including internet forums, may suggest a different but unproven estimation. People who have experienced gender dysphoria late in adult life, without strong manifestations in childhood, and others who have difficulty in transitioning to the new sex because of their appearance or limited social skills are reportedly over-represented among those dissatisfied.<sup>62</sup>

Gender affirmation surgery that includes hormonal therapies results in significant improvements in quality of life and psychosocial outcomes. This was illustrated in a meta-analysis of 28 studies that enrolled 1,833 individuals with gender identity dysphoria (1,093 MtF and 801 FtM) who underwent gender affirmation surgery that included hormonal therapy.<sup>63</sup> The importance of a transitioning period to the desired gender relatively early in life and with significant psychosocial support appears essential. This pooled analysis showed that patients improved in relation to their gender dysphoria (80%), psychological symptoms (78%), quality of life (80%), and sexual function

<sup>57</sup> S J Monstrey et al, "Sex Reassignment Surgery in the Female-to-male Transsexual" (2011) 25 *Seminars in Plastic Surgery* 229.

<sup>58</sup> J J Hage, "Metoidioplasty: An Alternative Phalloplasty Technique in Transsexuals" (1996) 97 *Plastic and Reconstructive Surgery* 161.

<sup>59</sup> S Reardon, "Largest Ever Study of Transgender Teenagers Set to Kick Off" (2016) 531 *Nature* <<http://www.nature.com/news/largest-ever-study-of-transgender-teenagers-set-to-kick-off-1.19637>>.

<sup>60</sup> M H Murad et al, "Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-analysis of the Quality of Life and Psychosocial Outcomes" (2010) 72 *Clinical Endocrinology (Oxf)* 214; S Weyers et al, "Long-term Assessment of the Physical, Mental, and Sexual Health among Transsexual Women" (2009) 6 *The Journal of Sexual Medicine* 752.

<sup>61</sup> A A Lawrence, "Factors Associated with Satisfaction or Regret following Male-to-Female Sex Reassignment Surgery" (2003) 32 *Archives of Sexual Behavior* 299.

<sup>62</sup> Lawrence, n 61.

<sup>63</sup> Murad et al, n 60; Lawrence, n 61.

(72%). Little attention has been paid to the sexual function aspect, and research has been based on self-report. There appears to be a correlation between sexual function and the quality of the neo-vagina or neo-phallus.<sup>64</sup> While not all postoperative trans\* people are orgasmic, many report sexual satisfaction.<sup>65</sup>

A large prospective study from the Netherlands showed that fewer than 2% of patients undergoing gender affirmation surgery expressed regret.<sup>66</sup> Although unproven, these studies suggest that early transition starting at puberty provides adolescents with the best medical outcome.

#### IV. LEGAL ISSUES ARISING IN THE TREATMENT OF CHILDREN AND YOUNG PEOPLE OF NONCONFORMING GENDER IDENTITY

The legal situation for children and young people of nonconforming gender identity can be complex. As detailed above, there are various treatment options, with hormone therapy the most typical for children and adolescents, though adolescents may also seek surgery before the age of legal adulthood, which is typically 18 years. As explained, it is likely that the best physical and psychological outcomes for many gender dysphoric young people will be achieved by suppressing puberty. Thus, in many instances, treatment would ideally begin prior to reaching legal adulthood or even before the age of 16 years, an age at which young people are (in many jurisdictions) often presumed competent to consent to medical treatment. There is, accordingly, a mismatch between medical best practice and legal requirements around consent. Others have noted that the law on young people's consent to medical treatment is already "confusing and incoherent" for health workers.<sup>67</sup> The mismatch between clinical best practice and legal strictures may be bewildering and frustrating for families and doctors who wish their child or patient to receive the best possible care.<sup>68</sup> On the other hand, there is social concern about invasive treatment options which may have far-reaching consequences, being applied to young people who are not themselves considered capable of providing informed consent – especially as the condition may not persist.

It should be noted that often young people of diverse gender identity face a range of hurdles in their everyday life. In particular, bullying and harassment, absence of family acceptance and social stigma are important issues that have been the subject of campaigning.<sup>69</sup> Schools have been a particular focus, and in many jurisdictions, laws and policies are changing to foster more inclusive treatment of diverse gender identities.<sup>70</sup> This article's focus is, however, on young people's ability to access medical treatment, particularly in the absence of support or agreement from parents or guardians.

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<sup>64</sup> R Green, "Sexual Functioning in Post-operative Transsexuals; Male to Female and Female to Male" (1998) 10 *International Journal of Impotence Research* s22.

<sup>65</sup> C Klein and B B Gorzalka, "Sexual Functioning in Transsexuals Following Hormone Therapy and Genital Surgery: A Review" (2009) 6 *The Journal of Sexual Medicine* 2922.

<sup>66</sup> Y S L Smith et al, "Sex Reassignment: Outcomes and Predictors of Treatment for Adolescent and Adult Transsexuals" (2005) 35 *Psychological Medicine* 89.

<sup>67</sup> E Cave and Z Stavrinides, *Medical Practitioners, Adolescents and Informed Consent Project Final Report* (University of Leeds, 2013) 16; citing C S Ashteka et al, "How Much Do Junior Staff Know about Common Legal Situations in Paediatrics?" (2007) 35 *Child: Care, Health and Development* 631.

<sup>68</sup> See Hewitt et al, n 9.

<sup>69</sup> See, eg E 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); M 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 *Children's Legal Rights Journal* 53.

<sup>70</sup> School bathroom use has been a significant issue, eg in the United States, see H J Tobin and J Levi, "Securing Equal Access to Sex-segregated Facilities for Transgender Students" (2013) 28 *Wisconsin Journal of Law, Gender and Society* 301.

## Young People's Access to Medical Treatment

In common law jurisdictions, access to any kind of medical treatment is an issue primarily revolving around informed consent. Without this, medical treatment may constitute trespass to the person, assault or battery.<sup>71</sup> Consent is both legally and ethically essential as a precursor to any kind of invasive medical treatment. A person must understand the implications, pros and cons of receiving or not receiving treatment in order to be deemed capable of making the decision to agree. Thus, if children are found to be “competent” to consent to treatment, they may do so themselves. If not, parents or guardians can typically authorise treatment for the child.

Bridgeman has noted that this focus on free agreement and individual autonomy is the hallmark of liberal individualism.<sup>72</sup> Young children, she suggests, “[confound] this understanding of the self” due to their dependency on others to care for them.<sup>73</sup> Historically, children were thought to lack the ability to make various decisions for themselves, including about medical treatment. Fernández et al explain that the early versions of the WPATH Standards of Care<sup>74</sup> presumed that only adults could seek treatment, due to the requirement for informed consent.<sup>75</sup> Yet, views about young people's capacity to provide such consent have changed over time, so while a young person may still be deemed to lack capacity to make a certain decision, there is no blanket assumption that this is the case. The most recent version of the WPATH Standards thus explains that treatment can occur where:

The adolescent has given informed consent and, especially when the adolescent has not reached the age for giving such consent, the parents or other guardians have consented to treatment and are involved in supporting the adolescent during treatment.<sup>76</sup>

Often, young people *are* able to give informed consent. In situations where this is not the case, a parent or guardian is usually able to agree to the treatment on the young person's behalf. Thus, if recommended by medical professionals and supportive of the child accessing or commencing treatment, in many jurisdictions, this will be sufficient. Australia differs from other common law countries in this regard by requiring (at the time of writing) court approval to be obtained before a minor may commence feminizing or masculinising hormone therapy.<sup>77</sup> Of course, aside from the legal regime, practical problems still arise in accessing treatment for gender dysphoria, including a lack of specialised clinics and medical professionals, and healthcare costs.<sup>78</sup>

If a young person's parents or guardians are *not* supportive of his or her gender identity or treatment or if only one is supportive, the legal situation becomes more complex. Young people may be reluctant to disclose feelings about gender and sexuality to their family: Hoshall has noted that “[m]any children and teens who identify as LGBTQ are not open with their parents about their orientation or identity”.<sup>79</sup> Shield cites one study of young people using a gender identity clinic, which “found that over half reported

<sup>71</sup> See P Trowse, “Refusal of Medical Treatment - A Child's Prerogative?” (2010) 10 *QUT Law & Justice Journal* 191, 193.

<sup>72</sup> J Bridgeman, *Parental Responsibility, Young Children and Healthcare Law* (Cambridge University Press, 2007) 10–11.

<sup>73</sup> Bridgeman, n 72, 11.

<sup>74</sup> WPATH: the versions from 1979, 1980, 1981 and 1990.

<sup>75</sup> Fernández et al, n 6, 25.

<sup>76</sup> Fernández et al, n 6, 27, Table 1.

<sup>77</sup> *Re Jamie* (2013) 278 FLR 155; [2013] FamCAFC 110; see also Hewitt et al, n 9; F Bell, “Children with Gender Dysphoria and the Jurisdiction of the Family Court” (2015) 38 *UNSW Law Journal* 426. This requirement is to be reconsidered by the Full Court of the Family Court in the latter part of 2017.

<sup>78</sup> See, eg S E Gage, “The Transgender Eligibility Gap: How the ACA Fails to Cover Medically Necessary Treatment for Transgender Individuals and How HHS Can Fix It” (2015) 49 *New England Law Review* 499; N Hose, “Transgender Children Left with Few Options in Northern Territory”, *ABC News* (online) 24 July 2016; McGuire, n 28; Minihan, n 29; Dittrich, n 29.

<sup>79</sup> L Hoshall, “What Can We Do for You Today: Minors' Medical Consent Legislation and Sexual Minority Youth” (2012) 32 *Children's Legal Rights Journal* 37, 37.

relationship difficulties with their parent or guardian”.<sup>80</sup> Thus, a young person may only wish to access treatment privately, without his or her family’s knowledge.

The options for the young person are then varied. An adolescent may be unable to access any treatment until he or she reaches the age of majority when parental consent is typically no longer required.<sup>81</sup> Alternatively, there are various options for young people to access treatment in the absence of parental consent, including seeking consent elsewhere or demonstrating sufficient maturity to be permitted to do so. As a last resort, young people may also turn to unregulated methods of obtaining hormones.

The following sections consider some issues which may arise involving: children’s ability to consent to different treatment options whether children are able to access medical advice and treatment without the consent of a parent or legal guardian and when two parents or guardians are in conflict over the best treatment for a child or young person.

### **The Capacity of Children and Young People to Consent**

Generally, a young person’s capacity to consent to receiving medical treatment is acknowledged to vary with individual circumstances. Hence, those below the age of legal majority can often still consent to medical treatment. Cave reports that while some jurisdictions, such as Bulgaria, “insist” on legal adulthood as a precursor to consent, others prescribe younger ages: she quotes 15 in Denmark and Slovenia; 16 in Spain.<sup>82</sup>

In England and Wales,<sup>83</sup> the seminal House of Lords decision *Gillick v Wisbech Area Health Authority*<sup>84</sup> determined that whether a child or young person is competent to consent to medical treatment depends upon the comprehension and maturity of the individual child. *Gillick* enshrined the position that it is possible for children to consent to their own health care if they are of “sufficient maturity and intelligence to understand the nature and implications of the proposed treatment”.<sup>85</sup> Although this would apply to any child under 18, the legal age of majority, the *Family Law Reform Act 1969* extends this by presuming that a person of 16 years and above is able to consent to “surgical, medical or dental treatment”.<sup>86</sup> Similar statutes, setting a presumptive age of consent to medical treatment, exist in many jurisdictions, for example, Ireland,<sup>87</sup> Scotland,<sup>88</sup> New Zealand,<sup>89</sup> some states of Australia<sup>90</sup> and Denmark.<sup>91</sup> Australia has also adopted the test from *Gillick*,<sup>92</sup> as has Canada<sup>93</sup> which recognises a similar doctrine of the “mature minor”.<sup>94</sup> This doctrine says that young people who are not yet legal adults may

<sup>80</sup> S Shield, “The Doctor Won’t See You Now: Rights of Transgender Adolescents to Sex Reassignment Treatment” (2007) 7 *Dukeminier Awards Best Sexual Orientation & Gender Law Review* 99, 110; citing D Di Ceglie et al, “Children and Adolescents Referred to a Specialist Gender Identity Development Service: Clinical Features and Demographic Characteristics” (2002) 6 *International Journal of Transgenderism* Table 8.

<sup>81</sup> Adults may also be unable to consent to receiving treatment if, eg they lack the cognitive capacity to do so.

<sup>82</sup> E Cave, “Adolescent Consent and Confidentiality in the UK” (2009) 16 *European Journal of Health Law* 309, 310–311; citing L Stultiens et al, “Minors and Informed Consent: A Comparative Approach” (2007) 14 *European Journal of Health Law* 21, 39.

<sup>83</sup> England and Wales, Scotland and Northern Ireland.

<sup>84</sup> *Gillick v Wisbech Area Health Authority* [1986] 1 AC 112.

<sup>85</sup> P Parkinson, “The Gillick Case - Just What Has It Decided?” [1986] *Family Law* 11, 11–14.

<sup>86</sup> *Family Law Reform Act 1969*, s 8(1).

<sup>87</sup> *Non-Fatal Offences Against the Person Act 1997* (Ireland) s 23(2).

<sup>88</sup> *Age of Legal Capacity (Scotland) Act 1991*, s 2(4).

<sup>89</sup> *Care of Children Act 2004* (NZ) s 36.

<sup>90</sup> *Consent to Medical Treatment and Palliative Care Act 1995* (SA) and *Minors (Property and Contracts) Act 1970* (NSW).

<sup>91</sup> “Section 17(1) of the *Health Act 2005* (Denmark) includes a presumption of capacity from 15 years of age”: Cave, n 82, 325.

<sup>92</sup> *Marion’s Case* (1992) 175 CLR 218; [1992] HCA 15.

<sup>93</sup> J M Gilmour, “Children, Adolescents, and Health Care” in J Downie, T Caulfield and C Flood (eds), *Canadian Health Law and Policy* (Butterworths, 2<sup>nd</sup> ed, 2002) 212.

<sup>94</sup> See, eg M Bailey, “Limits on Autonomy” (2010) *The International Survey of Family Law* 95, 103.

nevertheless consent to medical treatment if they are able to understand the nature of the treatment, alternatives to it, and consequences.<sup>95</sup>

In the United States, people under the age of 18 years typically cannot consent to medical treatment, and therefore the consent of a guardian is required though this varies greatly by State.<sup>96</sup> Coleman and Rosoff have explained that there is no uniform rule regarding exceptions to the requirement for parental or guardian consent though many States do have such exceptions.<sup>97</sup> For example, a young person can be “emancipated”, married or enlisted in the armed forces at the age of 16 years and thereafter make his or her own decisions about medical treatment.<sup>98</sup> However, Coleman and Rosoff reported in 2013 that 33 States and the District of Columbia had no other exceptions; in other words, no exceptions related to the young person’s capacity or maturity.<sup>99</sup> Of the remaining 17 States, they explain that:

14 ... permit mature minors to consent to general medical treatment either in all or a range of restricted circumstances, and 3 states allow minors regardless of their age or maturity to consent to treatment in either all or limited circumstances.<sup>100</sup>

Coleman and Rosoff emphasise however that there is no consistent doctrine regarding “mature minors” in the United States.

### ***The Right to Refuse Medical Treatment***

In a number of common law jurisdictions, a young person’s right to *refuse* medical treatment has been (and arguably continues to be) perceived as a more pressing and divisive issue than the right to access it.<sup>101</sup> Many of the key cases involving parental or guardian refusal of consent are those where the young person has also refused treatment. This has occurred where young people or their families hold religious beliefs which prohibit certain treatment, such as blood transfusion; where families prefer alternative therapies; or where the child and family determine that the pain and suffering that would be caused to the child by the proposed treatment outweigh its potential benefits.<sup>102</sup>

Though courts have been willing to find children are able to consent to medical treatment, they have often balked at finding that children may refuse treatment, particularly if refusal will have serious or life-threatening consequences.<sup>103</sup> A minor’s refusal of treatment is considered differently in law, as was explained in the English case of *Re R (A Minor) (Wardship: Medical Treatment)*,<sup>104</sup> a decision of the House of Lords:

[W]here a young person objects [to receiving treatment], even where that young person is *Gillick* competent or where that person is entitled to consent under section 8 of the *Family Law Reform Act 1969*, they do not

<sup>95</sup> Bailey, n 94; citing B Sneiderman et al, *Canadian Medical Law* (Thompson, 3<sup>rd</sup> ed, 2003) 459–500.

<sup>96</sup> Hoshall, n 79, 37; Shield, n 80.

<sup>97</sup> D L Coleman and P M Rosoff, “The Legal Authority of Mature Minors to Consent to General Medical Treatment” (2013) 131 *Pediatrics* 786, 789.

<sup>98</sup> L Hudock, “Deference to Duplicity: Wisconsin’s Selective Recognition of the Mature Minor Doctrine” (2014) 98 *Marquette Law Review* 973, 999; Coleman and Rosoff, n 97, 792. Minors may also be able to access treatment when this is in the interests of public health, eg for sexually transmitted infection.

<sup>99</sup> Coleman and Rosoff, n 97, 791.

<sup>100</sup> Coleman and Rosoff, n 97, 789.

<sup>101</sup> See, eg C Bridge, “Religious Beliefs and Teenage Refusal of Medical Treatment” (1999) 62 *Modern Law Review* 585; *Re E (A Minor) (Wardship: Medical Treatment)* [1992] 2 FCR 219 (CA); *Re L (Medical Treatment: Gillick Competency)* [1992] 2 FCR 524 (CA); Cave, n 82.

<sup>102</sup> See, eg, D Weber, “Court Orders Chemotherapy for Cancer-stricken Boy Oshin Kiszko after Parents Refuse”, *ABC*, Australia (online) 8 April 2016; E Grice, “Hannah Jones: I have Been in Hospital Too Much”, *The Telegraph* (UK) 12 November 2008.

<sup>103</sup> See, eg, *L v P (Paternity Test: Child’s Objection)* [2011] EWHC 3399 (Fam) [24]–[25] (Hedley J) noting that the *Children Act 1989* (UK) ss 38(6), 43(8) and 44(7) make clear the rights of children in some situations to refuse medical assessments.

<sup>104</sup> *Re R (A Minor) (Wardship: Medical Treatment)* [1992] 1 FLR 190.

thereby acquire a right to refuse consent; a refusal of consent, unless statute otherwise indicates, always raises the issue of welfare.<sup>105</sup>

The child's refusal may be overridden by the court's obligation to act in the child's best interests.<sup>106</sup> This is in contrast to a competent adult's right to decline treatment regardless of the severity of consequence.<sup>107</sup> Cave suggests that the position is arguably different in Scotland, where the enabling statute would allow 16- and 17-year olds to refuse consent as well as give it.<sup>108</sup>

In Canada, the issue of whether a "mature minor" could refuse life-saving treatment arose in *AC v Manitoba (Director of Child and Family Services)*,<sup>109</sup> a case involving a 14-year old. The first instance judge found that although AC was competent, her decision to refuse a blood transfusion was subsumed to the court's statutory power to act in the best interests of a child under the age of 16 years.<sup>110</sup> Ultimately, the Supreme Court of Canada found that this statute was constitutional.<sup>111</sup> Similar cases have arisen in the United States involving adolescents' rejection of blood transfusions, where the court has not permitted refusal.<sup>112</sup>

## Disputes Over Young People's Access to Medical Treatment

Young people's rights to access medical treatment in the face of opposition, or lack of support, from parents or guardians or even without their parents or guardian's knowledge, have arisen in cases involving adolescents' access to contraception and abortion. As noted, in many jurisdictions, a person under the age of 16 years cannot access treatment without parental consent but there are various exceptions. In an emergency situation, treatment may be administered regardless. Court orders may also be sought to enable treatment without parental or guardian consent.<sup>113</sup>

If a young person's parents or guardians do not support a course of treatment, and the child is not able to consent, the courts can be called upon to decide whether the family's opposition should be overridden. Cases have dealt with instances where the child's life is at risk, including through needing a blood transfusion,<sup>114</sup> having cancer<sup>115</sup> and being HIV positive.<sup>116</sup> In these cases, children have tended to be either too young to express an opinion, being babies or infants;<sup>117</sup> or be in agreement with their parents' rejection of treatment.

The failure or refusal of parents or a guardian to consent to appropriate medical treatment for a child may also constitute neglect – grounds for taking the child into the care of the State or monitoring how the child is being cared for within the family.<sup>118</sup> This is the case, eg in England and Wales,<sup>119</sup> Ireland,<sup>120</sup>

<sup>105</sup> *Re R (A Minor) (Wardship: Medical Treatment)* [1992] 1 FLR 190 (Lord Donaldson).

<sup>106</sup> For example *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64; [1993] 1 FLR 1.

<sup>107</sup> For example *Re T (Adult: Refusal of Treatment)* [1992] 3 WLR 782 (CA).

<sup>108</sup> Cave, n 82.

<sup>109</sup> *AC v Manitoba (Director of Child and Family Services)* 2009 SCC 30, [2009] 2 SCR 181.

<sup>110</sup> *AC v Manitoba (Director of Child and Family Services)* 2009 SCC 30, [2009] 2 SCR 181, [12] (Abella J).

<sup>111</sup> See also A Campbell et al, "Child Citizenship and Agency as Shaped by Legal Obligations" (2011) 23 *Child and Family Law Quarterly* 489, 506–07.

<sup>112</sup> See *Re Long Island Jewish Medical Center*, 557 NYS2d 239 (1990); *Dane County v Sheila W* 2013 WI 63, T 42; 348 Wis 2d 674; 835 NW2d 148; Hudock, n 98.

<sup>113</sup> *Children Act 1989* (UK) s 10; *Children (Scotland) Act 1995*, s 57.

<sup>114</sup> *Re R (A Minor) (Blood Transfusion)* [1993] 2 FLR 757 (UK).

<sup>115</sup> *An NHS Trust v SR* [2012] EWHC 3842 (Fam); [2013] 1 FLR 1297.

<sup>116</sup> *Re JM (A Child)* [2015] EWHC 2832 (Fam).

<sup>117</sup> See, eg *North Western Health Board v HW and CW* [2001] 3 IR 622.

<sup>118</sup> See, eg *Re JA (A Minor) (Medical Treatment: Child Diagnosed with HIV)* [2014] EWHC 1135 (Fam).

<sup>119</sup> *Children Act 1989* (UK) s 31(2).

<sup>120</sup> *Child Care Act 1991* (Ireland) s 18.

Canada,<sup>121</sup> Australia<sup>122</sup> and the United States.<sup>123</sup> This type of state intervention has occurred in some of the “refusal” cases described above. For example, in *AC v Manitoba (Director of Child and Family Services)*, child welfare authorities “apprehended” AC and applied for a court order requiring the blood transfusion to be administered.<sup>124</sup>

The medical treatment of gender nonconforming children and young people differs in key respects from the existing debate around parental refusal of treatment for their child, however. First, although strongly worded arguments are made to suggest that the denial of treatment for gender identity issues can be life-threatening (attested to by the tragically high rate of suicide by gender nonconforming young people),<sup>125</sup> this is harder to ascertain in individual cases than, eg the prognosis for cancer or immediate need for a blood transfusion. Given the length of time that treatment potentially spans, emergency exceptions are also highly unlikely to apply.

Second, family support is generally a very important aspect of clinical decision-making concerning treatment for gender identity issues. As noted, while accepting that young people may consent to treatment, the WPATH Standards also emphasise the importance of family support, stating that “[m]ental health professionals should help families to have an accepting and nurturing response to the concerns of their gender dysphoric child or adolescent. Families play an important role in the psychological health and well-being of youth”.<sup>126</sup> Thus, proceeding with treatment when a young person lacks emotional and social supports may lead to complications and difficulties.

Third, children will not be babies or infants. No form of hormone therapy is appropriate until the onset of puberty, which as noted is typically around 10 or 11 years. Thus, although the court’s “welfare” impetus will remain the same, the views of the child or young person in question must inevitably be considered.

A further issue will arise if parents or guardians cannot agree with one another as to whether a young person should be permitted to undergo treatment. In the jurisdictions discussed above, this would generally be treated by the courts as a family law issue concerning an aspect of parental responsibility. Typically, the concept of “custody” or “residence” of a child includes the responsibility for making medical decisions for the child. Thus, disputes over medical care may be treated as an aspect of parental responsibility to be dealt with through family law processes. In England and Wales, and Scotland, eg this could occur by seeking a specific issues order in relation to treatment.<sup>127</sup>

In instances where those with parental responsibility do not agree with one another, it may be that the court must make a determination about whether a child may or may not access either hormonal suppression of puberty, feminizing or masculinising hormonal therapy, or even surgical procedures. If parties retain competing experts on the topic, this will make the court’s decision all the more difficult.

The following sections consider the issues of young people accessing medical treatment without the knowledge of, or consent of, their families or guardians and where family law disputes have involved disagreement over appropriate treatment for a young person.

<sup>121</sup> Bailey, n 94, 104, citing *Child and Family Services Act 1984* (Canada) CCSM c C80, ss 17(2)(iii) and 21(1).

<sup>122</sup> See, eg *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 23(1)(b); *Children, Youth and Families Act 2005* (Vic) s 162(1)(f).

<sup>123</sup> Shield, n 80.

<sup>124</sup> Bailey, n 94, 106.

<sup>125</sup> Shield, n 80; Emily Ikuta, “Overcoming the Parental Veto: How Transgender Adolescents Can Access Puberty-suppressing Hormone Treatment in the Absence of Parental Consent under the Mature Minor Doctrine” (2016) 25 *Southern California Interdisciplinary Law Journal* 179; Huft, n 69.

<sup>126</sup> WPATH, n 13, 15; citing S A Brill and R Pepper, *The Transgender Child: A Handbook for Families and Professionals* (Cleis Press, 2008); A I Lev, *Transgender Emergence: Therapeutic Guidelines for Working with Gender-variant People and their Families* (Haworth Clinical Practice Press, 2004).

<sup>127</sup> *Children (Scotland) Act 1995*, s 11(2)(e).

## England and Wales

The *Gillick* case itself involved a minor's confidential access to contraception.<sup>128</sup> Mrs Gillick sought assurances from the local health authority that her daughters would not be provided with confidential medical advice and contraception while they were under 16. The health authority refused to provide such assurances. Mrs Gillick's claim was rejected by the House of Lords, holding that a girl under the age of 16 years could be able to consent to the medical examination and treatment. Twenty years later, in *R (Axon) v Secretary of State for Health*,<sup>129</sup> another mother, Ms Axon, also unsuccessfully challenged her children's rights to confidential medical consultation.<sup>130</sup> It was held in *Axon* that a medical practitioner's duty of confidentiality to a young person who is *Gillick*-competent is unqualified. Moreover, the court held that Art 8 of the *European Convention on Human Rights*, which protects the right to privacy and family life, does not confer a right upon parents to be notified about their child's seeking medical treatment once the child is able to make his or her own decisions. Silber J explained:

As a matter of principle it is difficult to see why a parent should still retain an Article 8 right to parental authority relating to a medical decision where the young person concerned understands the advice provided by the medical professionals and its implications.<sup>131</sup>

Cave explains that the "extinguishment" of parental rights upon the young person attaining the competence to make the medical decision constitutes the controversial part of Silber J's judgment.<sup>132</sup>

What *Gillick* and *Axon* do not explain, however, is what will occur if the medical professional considers that the child is *not* competent to consent to the treatment but nevertheless, in the view of the medical practitioner, *requires* treatment; and how this interacts with the child's rights (if any) to confidentiality. Cave points out that the assessment of whether a child can consent to disclosure (and hence a desire for confidentiality should be respected) differs from the assessment of the child's ability to consent to treatment.<sup>133</sup> Thus, a young person may not be able to consent to receiving treatment but nevertheless insist that the fact of the medical consultation itself not be disclosed to a parent or guardian. On the other hand, the more necessary the treatment, the more justifiable may be the medical professional's breach of confidentiality by informing a parent or guardian.<sup>134</sup>

If a child or young person's parents or guardians do not support the child receiving medical treatment, the hospital or medical professional may seek an order permitting the treatment to go ahead regardless. In England and Wales, such an order may be sought under the court's inherent jurisdiction to make orders for the welfare of children and others unable to care for themselves, the *parens patriae* jurisdiction. Alternatively, as recently explained by the High Court,<sup>135</sup> a "specific issues" order pursuant to s 8 of the *Children Act 1989* (UK) may be sought, as the decision involves an aspect of parental responsibility for a child.<sup>136</sup>

<sup>128</sup> *Gillick v Wisbech Area Health Authority* [1986] 1 AC 112.

<sup>129</sup> *R (Axon) v Secretary of State for Health* [2006] EWHC 37 (Admin).

<sup>130</sup> See generally R Taylor, "Case Commentary: Reversing the Retreat from *Gillick*? *R (Axon) v Secretary of State for Health*" (2007) 19 *Child and Family Law Quarterly* 81.

<sup>131</sup> *R (Axon) v Secretary of State for Health* [2006] EWHC 37 (Admin) [130], quoted in *PD v SD* [2015] EWHC 4103 (Fam) [28].

<sup>132</sup> Cave, n 82, 313; citing A Hall, "Children's Rights, Parents' Wishes and the State: The Medical Treatment of Children" (2006) 36 *Family Law* 317; J Fortin "Children's Rights - Substance or Spin?" (2006) 36 *Family Law* 757.

<sup>133</sup> Cave, n 82, 323.

<sup>134</sup> J Loughrey, "Can you Keep a Secret?" (2008) 20 *Child and Family Law Quarterly* 312; Cave and Strinides, n 67, 18.

<sup>135</sup> *Re JM (A Child)* [2015] EWHC 2832 (Fam) (Mostyn J). The judgment also explores the pros and cons of each approach and when each is most appropriate.

<sup>136</sup> The court may make a specific issues order to deal with a particular issue that is an aspect of parental responsibility for the child: *Re JM (A Child)* [2015] EWHC 2832 (Fam) [20]-[27].

In the specific context of gender identity, this type of disagreement over medical treatment arose in an English case, *PD v SD*.<sup>137</sup> PD, aged 16 years and a natal female, identified as male. PD's adoptive parents, however, found PD's gender identity difficult to accept.<sup>138</sup> As a result, PD "at 16 years of age ... decided to disengage completely from family life with them"<sup>139</sup> and was placed with foster carers. The judgment concerned PD's application to prevent his parents from receiving any information about his treatment, life or welfare. This application was acceded to Keehan J relied on *Axon*, finding that PD's competence to consent to medical treatment effectively squeezed out the parents' authority regarding medical decisions.

PD was presumed to be competent to consent to medical treatment, being 16 years old. A much more difficult issue might arise if a younger child, eg a 12-year old, wished to access hormone therapy for the purpose of delaying puberty. As Fortin has noted, the *Gillick* test puts considerable power in the hands of medical professionals, who "must decide not only whether treatment is medically indicated, but also whether [the] patient is competent to consent to the procedure".<sup>140</sup> However, she goes on to note that in all likelihood, for any treatment lying somewhere between "trivial" and "life-saving", medical professionals will tread cautiously in the absence of parental knowledge or consent.<sup>141</sup>

It is possible that parental failure to consent to a child undergoing hormone therapy for gender dysphoria could be "life-threatening". Certainly there are many reports suggesting increased risk of self-harm and suicide for children of diverse gender identity.<sup>142</sup> For such a dispute to reach the courts, however, the clinic or treatment facility would need to commence court proceedings against a child's parents. In reality, a more likely outcome is perhaps what occurred in *PD v SD*, where PD's disagreement with his parents was so fundamental that it led to his departing their care.<sup>143</sup> This occurred after PD was admitted to hospital following an overdose and subsequently spent time in a residential treatment facility.

### Canada

The Supreme Court of British Columbia recently dealt with an interlocutory issue in a case where appropriate treatment for an 11-year-old child diagnosed with gender identity dysphoria was the subject of dispute between the child's separated parents.<sup>144</sup> In *K(N) v H(A)*, the child (referred to as JK) was born female but expressed a strong desire to be male. Following medical consultation with various specialists, including a psychologist and an endocrinologist, JK had commenced suppression of puberty with hormone therapy and had been administered two injections (to be administered on an ongoing, monthly basis) of Lupron.<sup>145</sup> JK had also commenced social transition at school.

JK's father sought to restrain administration of hormones to JK and for counselling related to JK's gender identity to cease. The father also sought to terminate JK's legal representation by a particular lawyer. In response, JK's mother sought sole parental responsibility for JK, and JK sought to be joined to the proceedings as a party. JK's lawyer submitted that the father's case was "in effect a claim against JK, since [the father] is seeking to halt JK's treatment".<sup>146</sup>

<sup>137</sup> *PD v SD* [2015] EWHC 4103 (Fam).

<sup>138</sup> *PD v SD* [2015] EWHC 4103 (Fam) [30].

<sup>139</sup> *PD v SD* [2015] EWHC 4103 (Fam) [30].

<sup>140</sup> J Fortin, *Children's Rights and the Developing Law* (Cambridge University Press, 3<sup>rd</sup> ed, 2009) 149.

<sup>141</sup> Fortin, n 140.

<sup>142</sup> See Couch et al, n 22, 27.

<sup>143</sup> The suicide of Leelah Alcorn illustrates another possible outcome of a lack of family support: see Ikuta, n 125, 179–182.

<sup>144</sup> *K(N) v H(A)* (2016) Carswell BC 1141; 2016 BCSC 744.

<sup>145</sup> *K(N) v H(A)* (2016) Carswell BC 1141; 2016 BCSC 744, [14]–[16]. "Lupron" is Leuporelin, a synthetic gonadotropin-releasing hormone which acts to shut down the body's usual hormone production – in other words, to suppress pubertal development.

<sup>146</sup> *K(N) v H(A)* (2016) Carswell BC 1141; 2016 BCSC 744, [32].

Skolrood J acceded to the application to join JK but found that JK should be represented by a litigation guardian. His Honour said:

I agree ... that this case is really about JK and his role in determining his own future. In my view, these issues cannot be properly considered without JK's direct participation, nor would it be fair to JK for the court to attempt to do so.<sup>147</sup>

As the decision concerned only whether JK should be joined, the father's substantive concerns – about the dangers of the drug being currently administered to JK and that JK had not been properly diagnosed – did not fall to be addressed.

JK's case illustrates the potential complexities of decision-making in this area for children at the very early stages of treatment for gender dysphoria. In several regards, it is quite different to an earlier decision from Ontario, *Halton Children's Aid Society v GK*.<sup>148</sup> That case concerned a much younger child, being only four years old. The child's mother was found to be disregarding expert opinion that at this age, her son was too young to be "socially transitioned" to be a girl, and it was not yet clear that any desire to be a girl would persist.<sup>149</sup> The judge found however that the children could continue to be cared for by both parents under the supervision of the Children's Aid Society.<sup>150</sup>

In terms of minors accessing treatment without the consent of either parent, there are reported cases from several provinces of Canada indicating that a minor's request for an abortion will be granted where it is found to be in the child's best interests despite parental opposition. In a case from Ontario, this was achieved by taking the 14-year-old child into state care on a temporary basis.<sup>151</sup> The court concluded that the relevant statute required "the best interests of the child be given paramountcy over the valid, religious concerns of her parents".<sup>152</sup> In a decision from Alberta, the parents challenged the finding that a 16-year old had given informed consent to an abortion and sought an injunction to restrain the procedure.<sup>153</sup> By reference to *Gillick*, the court found that the young person did have capacity to consent.<sup>154</sup> The differences between treatment for gender dysphoria and an abortion, however, are significant. An abortion is a "one-off" procedure rather than an ongoing course of therapy. Moreover, as the discussion of JK's case above illustrates, children may be seeking treatment – at least suppression of puberty – prior to the commencement of puberty.

### **The United States**

In the United States, young people's ability to access medical treatment in the face of parental opposition is governed by State law. Such laws have developed particularly in response to minors seeking abortion. This issue has given rise to what are referred to as "judicial bypass" procedures. While States may legislate to require parental consent for a minor's abortion when the minor is below a certain age, a judicial bypass option must also be provided.<sup>155</sup> This means that the statute must give the young person the opportunity to seek the court's permission to have an abortion instead.<sup>156</sup> This came about through constitutional challenges to State legislation purporting to compel minors to seek parental consent prior to obtaining an abortion.<sup>157</sup> However, in the context of treatment related to gender identity, Shield posits

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<sup>147</sup> *K(N) v H(A)* (2016) Carswell BC 1141; 2016 BCSC 744, [40].

<sup>148</sup> *Halton Children's Aid Society v GK* (2015) ONCJ 307.

<sup>149</sup> *Halton Children's Aid Society v GK* (2015) ONCJ 307, [101]–[103].

<sup>150</sup> See also "Let Child Discover His Own Gender, Ontario Judge Tells Parents in Custody Order", *CBC News*, Canada, 12 June 2015.

<sup>151</sup> *Children's Aid Society of Peel (Region) v S(P)* 1991 CarswellOnt 295; [1991] WDFL 892.

<sup>152</sup> *Child and Family Services Act 1984* (Canada); *Children's Aid Society of Peel (Region) v S(P)* 1991 CarswellOnt 295, [3].

<sup>153</sup> *C (JS) v Wren* (1986) CarswellAlta 278; [1987] 2 WWR 669 (Alberta Court of Appeal).

<sup>154</sup> *C (JS) v Wren* (1986) CarswellAlta 278; [1987] 2 WWR 669 (Alberta Court of Appeal) [13]–[16].

<sup>155</sup> *Bellotti II*; *Lambert v Wicklund* 520 US 292 (1997).

<sup>156</sup> *Hodgson v Minnesota*, 497 US 417 (1990).

<sup>157</sup> See Shield, n 80.

that “judges are no more likely to be knowledgeable about the needs of transgender adolescents than are parents or the State”.<sup>158</sup> Shield argues therefore that “judicial bypass” should be seen as a less preferable option and that additional exceptions to seeking the consent of parents or guardians should instead be sought. Specifically in relation to LGBTQ youth, Hoshall has also commented on the potential for persons “in loco parentis” to consent to medical treatment for a child, but noted that this could be difficult unless a court has already confirmed the person’s status.<sup>159</sup>

A child’s gender identity has been a subject of contention between his or her parents in at least two United States cases. A decision of the Ohio Court of Appeals indicates some of the difficulties that may arise for the court, the parties and particularly children, in cases where the child’s gender identity becomes a site of contestation in custody proceedings.<sup>160</sup> In the 2007 case of *Smith v Smith*, the mother claimed that her natal son identified as female, a claim disputed by the child’s father. The appellate court upheld the trial judge’s findings that the child did not in fact have gender dysphoria. The mother’s failure to accept this lead ultimately to her losing custody of both her children. At the trial, four experts were called, two who found that the child did have gender dysphoria and two who did not. However, the court noted that none of the experts recommended any hormonal intervention, given that the child was aged only nine years at the time. The mother’s apparent determination to enable such treatment to proceed regardless clearly counted against her.

There is a brief reference to gender dysphoria in a much earlier decision from Texas. A 1998 decision of the Texas Court of Appeals involving a 10-year-old natal boy diagnosed with “gender identity disorder” reports that the “recommended treatment was for [the child] to spend more time with his father, and to lessen his dependence on his mother”.<sup>161</sup> Another expert quoted in the case concluded that the child’s mother “was unable to admit that [the child] had a problem, and that [he] needed to separate his identity from his mother’s”.<sup>162</sup> These findings contributed to the order that the two children should live with their father.

## V. CONCLUSION

The increasing numbers of young people seeking treatment for issues related to gender identity indicate that increased knowledge in this area is important for both medical and legal professionals. There is now a body of medical evidence that provides clear indications of the safety and appropriateness of various pubertal suppression therapy, sex hormonal or surgical interventions. The suppression of puberty, in particular, is safe with minimal side effects, as explored above. Suppression allows for the commencement of sex hormone therapy to be delayed, providing greater certainty that the patient will not “change their mind”.

As the court in *Smith v Smith* noted, there are “severe limitations in using the judicial system to resolve complex and possibly controversial childrearing and childhood mental health issues”.<sup>163</sup> Nevertheless, it seems inevitable that disputes between children and their parents or guardians, and between parents and guardians themselves, over questions of gender identity will continue to arise. Meanwhile, at least in the common law legal systems discussed in this article, existing case law – dealing with such issues as abortion, contraception or refusal of life-saving medical treatments – does not necessarily provide useful guidance on how courts ought to approach treatment for gender dysphoria. The difficulties arising through conflicting expert opinion on the subject of children’s gender identity are also apparent. While presently rare, the increasing numbers of children and young people whose gender identity does not conform to traditional roles will continue to test the limits of common law systems.

<sup>158</sup> Shield, n 80, 398.

<sup>159</sup> Hoshall, n 79, 37–38.

<sup>160</sup> *Smith v Smith* (Court of Appeals of Ohio, Seventh District, Jefferson County, WL 901599, 2007).

<sup>161</sup> *Shrader v Spain* (Court of Appeals of Texas, Dallas, WL 40632, 4 February 1998).

<sup>162</sup> *Shrader v Spain* (Court of Appeals of Texas, Dallas, WL 40632, 4 February 1998).

<sup>163</sup> *Smith v Smith* (Court of Appeals of Ohio, Seventh District, Jefferson County, WL 901599, 2007) [81].