

PARENTING

Family Law and Health Care Decision Making for Children

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Introduction

A person's consent is generally required in Australia before medical treatment can be provided. People are not required to provide that consent, and there are various reasons why they may withhold their consent. The issue of consent is, however, complicated when the patient lacks the requisite capacity to provide consent and when people who are providing consent on behalf of that patient refuse to provide the consent. Both State and Federal law is relevant. This paper primarily focuses on Federal law but briefly refers to State law, in this case, Victoria for the sake of completeness.

Victorian law and treatment of children

Some of the states and Territories have specific legislation covering the giving of consent to medical treatment. Victoria has the *Medical Treatment Planning and Decisions Act 2016* (MTPD Act) defines decision-making capacity with respect to medical treatment. An adult (defined as the age of 18 or above) is presumed to have decision-making capacity unless there is evidence to the contrary (section 4(2)). Decision-making capacity is defined in section 4(1) of the Act as follows:

- (1) A person has **decision-making capacity** to make a decision to which this Act applies if the person is able to do the following -
 - (a) understand the information relevant to the decision and the effect of the decision;
 - (b) retain that information to the extent necessary to make the decision;
 - (c) use or weigh that information as part of the process of making the decision;
 - (d) communicate the decision and the person's views and needs as to the decision in some way, including by speech, gestures or other means.

Section 4(1)(a) is further explained in section 4(3) as follows:

- (3) For the purposes of subsection (1)(a), a person is taken to understand information relevant to a decision if the person understands an explanation of the information given to the person in a way that is appropriate to the person's circumstances, whether by using modified language, visual aids or any other means.

In determining whether or not a person has decision-making capacity, the following factors must be considered:

- (a) a person may have decision-making capacity to make some decisions and not others;
- (b) if a person does not have decision-making capacity for a particular decision, it may be temporary and not permanent;

- (c) *it should not be assumed that a person does not have decision-making capacity to make a decision -*
 - (i) *on the basis of the person's appearance; or*
 - (ii) *because the person makes a decision that is, in the opinion of others, unwise;*
- (d) *a person has decision-making capacity to make a decision if it is possible for the person to make a decision with practicable and appropriate support.*

The Act also sets out that a person who is assessing whether a person has decision-making capacity must take reasonable steps to conduct the assessment at a time and in an environment in which the person's decision-making capacity can be most accurately assessed.¹

With respect to decisions regarding medical treatment for a child, a “medical treatment decision maker” of a child is considered to be the child’s parent, guardian, or other person with parental responsibility for the child who is reasonable, available, and willing and able to make the medical treatment decision.² Pursuant to the Act, the appointed medical treatment decision maker of a person is the first person listed in the appointment who is reasonable available and willing and able to act at a particular time.³

Federal law

The Federal legislation which is relevant is the *Family Law Act 1975* (FLA). It is possible that the Federal law and the State law can conflict. The MTPD Act is new and we do not have clarity as to how it fits with the Federal law. The High Court has considered the position in relation to New South Wales law about medical treatment in *P v P*,⁴ which was a sterilisation case. It upheld the Family Court’s ability to decide whether a sterility procedure should be performed. The NSW Act was only invalid to the extent that it prohibited a medical or dental treatment which was authorised by the Family Court.

Parental responsibility

Decisions with respect to a child’s health and medical care can generally be made by a parent of the child, or any other person who has parental responsibility for that child. Pursuant to section 61C FLA, parents have parental responsibility of a child until they turn 18 years, unless that responsibility has been displaced by a court order. Parental responsibility is defined under the FLA as “all duties, powers, responsibilities and authority which, by law, parents have in relation to children.”⁵ Orders can be made in the Family Court of Australia

¹ Section 4(5) of the *Medical Treatment Planning and Decisions Act 2016*.

² Section 55(4) of the *Medical Treatment Planning and Decisions Act 2016*.

³ Section 28(2) of the *Medical Treatment Planning and Decisions Act 2016*.

⁴ [1994] HCA 20.

⁵ Section 61B of the Family Law Act.

or Federal Circuit Court of Australia which grant parental responsibility to another person who is not a parent, or to only one parent of the child.⁶ Parental responsibility gives the responsibility to make decisions about short-term and long-term issues. It is generally considered that where parties have joint or shared parental responsibility that long-term issues should be made jointly, but short-term issues can be made by one person. On a day-to-day basis if one parent is consenting to the treatment of the child, the consent of the other parent need not be sought and obtained even if the parents have joint parental responsibility. It is usual for one parent to take a child to a medical practitioner and consent to a variety of common childhood treatments, such as:

- Treatment for common illnesses such as flu and conjunctivitis;
- Vaccinations;
- Blood tests, x-rays and similar diagnostic tests; and
- Treatment of ongoing conditions such as asthma, epilepsy and diabetes.

More problems arise when decisions may have more long-term effect. Sole parental responsibility is not common, but may be ordered if the parents, or people who hold parental responsibility, cannot reach an agreement regarding long-term medical decisions. In some cases parental responsibility is shared but one person has the sole parental responsibility with respect to an issue which is particularly fraught for that family such as education, religion or health. A person with sole parental responsibility may be required to consult with the other person before making a final decision. An order for sole parental responsibility is rarely made by consent. The parties will probably have gone through 18 months to 2 years of litigation. There are many cases where there should probably be an order for sole parental responsibility because the parties cannot communicate or make decisions together, but people don't usually have the stamina or the money to finance that litigation, particularly where there is no guarantee of success.

If parents have shared parental responsibility, but cannot agree upon long-term medical treatment for their child, it may be necessary to seek that the court determine the issue. Further, there are certain major medical procedures which cannot be undertaken on a child without obtaining the consent of the court, irrespective of whether the parents consent to the procedure.

Section 67ZC FLA provides the court with power to make court orders in relation to the welfare of children. In deciding whether to make an order under that section, the court must

⁶ Section 64C of the Family Law Act.

have regard to the best interests of the child as the paramount consideration.⁷ Hence, when parents are in conflict with each other in relation to a child's medical treatment, the Court will determine that the action which is in the best interest of the child should proceed. Acting in a child's best interests is a maximizing concept and means to do whatever is best for the child overall. Given a number of factors feed into "best interests", it is obviously not always an option to fulfil all interests. For example, a child has an interest in living longer, but also an interest in being pain-free. It may not be possible to have both. In these circumstances, acting in a child's best interests requires one to decide between competing interests. It is also important to acknowledge that acting in a child's best interests does not necessarily mean prolonging the child's life.

Vaccinations

Although not generally considered to be a "special medical procedure",⁸ it is not surprising given the controversy in the community on the issue, and the "No Jab, No Pay" and "No Jab, No Play" government policies that disputes about whether a child should be given vaccinations are increasingly common in the courts. Also not surprising is that the Courts generally make orders to facilitate the giving of vaccinations. Both the Family Court and the Federal Circuit Court hear these cases which are primarily disputes between separated parents about the exercise of parental responsibility.

The case most commonly referred to is *Kingsford & Kingsford*.⁹ The father arranged for the child to be secretly given vaccinations knowing that the mother was very opposed to it and open about her belief that homeopathic remedies were in the child's best interests. The Family Court was critical of the father's subterfuge and said that it reflected poorly on his attitudes to the responsibilities of parenthood. However, even though the Court disapproved of the father's actions, it made orders for the child to be immunized in accordance with a schedule for catch-up vaccines. Importantly, the court had the benefit of expert evidence as to the benefits and risks.

In cases where the opposition of a parent to the giving of vaccinations is not a reasoned approach to decision-making in the best interests of a child (whether or not misguided), the court can be critical of a nonchalant attitude as it reflects poorly on their parental capacity.¹⁰

Medical treatment applications

⁷ Section 67ZC(2) of the *Family Law Act* 1975.

⁸ *Duke-Randall & Randall* [2014] FamCA126. In *Mains & Redden* [2011] FamCAFC 184 the Full Court of the family Court said that further evidence was required before it could decide whether immunisation was a "special medical procedure"

⁹ [2012] FamCA 889.

¹⁰ *Gaskill & Beveridge* [2018] FamCA 1114.

Australian courts have frequently been required to determine cases involving medical issues, particularly relating to children. Applications that are made under section 67ZC FLA relating to medical procedures for a child are heard by the Family Court of Australia. Prior to the establishment of the Family Court in 1975 the decisions were made by the Supreme Court exercising its *parens patriae* (parent of the country) jurisdiction. This is a very old jurisdiction which certain courts have to protect children, or others who are unable to protect themselves. It is an inherent power and does not arise from legislation. The extent to which the Family Court has *parens patriae* jurisdiction is unclear, and it usually relies on the FLA to exercise its powers over the welfare of the children. Parents do not need to be separated for the Family Court to make orders in relation to special medical procedures. The Supreme Courts are still occasionally asked to make orders utilising the *parens patriae* jurisdiction, but this is not common.

The Federal Circuit Court of Australia is a lower level court, and although it decides many parenting disputes, there is a protocol that special medical procedure disputes are determined by the Family Court. The types of issues which the courts have been required to determine has been wide-ranging and include the prescription of contraceptives,¹¹ termination of pregnancy,¹² disputes about blood transfusions,¹³ gender re-assignment,¹⁴ treatment of anorexia nervosa,¹⁵ and heart surgery.¹⁶

There are also a number of cases which are not in the category of “special medical procedure cases” such as disputes about vaccinations.

When is a child old enough to provide consent to medical treatment?

Parental responsibility is not unlimited, and in particular, the parents’ ability to consent to medical treatment on a child’s behalf reduces as the child matures. In Australia a person can have their own Medicare card once they are aged 15 years. They do not need the consent of their parents to obtain one. They can remain on their parents’ Medicare card (and can be on a maximum of two cards), so the parents may not even know that the child has applied for and obtained their own Medicare card.

Children are considered mature enough to make their own decisions with respect to medical treatment if they are deemed to be “*Gillick* competent”. *Gillick* competence means that a

¹¹ *Gillick v West Norfolk and Wisbeck Area Health Authority and Another* [1986] AC 112.

¹² *K v Minister for Youth and Community Services and Another* [1982] 1 NSWLR 311.

¹³ See for example, *Elliott Birkett v Director General of Family and Community Services and Others* (Unpublished) Supreme Court of NSW (1993), File No. 3161/91; *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386.

¹⁴ *Re A (A Child)* (1993) FLC 92-402; *Re Jamie* [2013] FamCAFC 110; *Re Kelvin* [2017] FamCA 78.

¹⁵ *Re W (A Minor)* [1993] 1 FLR 1 (English Court of Appeal).

¹⁶ *Re Michael* (1994) FLC 92-471.

child has reached a level of understanding and intelligence required to make their own decisions in relation to their medical treatment.

In the English case of *Gillick*,¹⁷ the issue to be determined by the House of Lords was whether a medical practitioner could provide advice and prescribe contraceptives to a patient under the age of 16 years, without the prior knowledge or consent of her parents. The Department of Health and Social Security in England had issued guidance to the health sector which stated that medical practitioners could prescribe the oral contraceptive pill to a child under 16 years of age without the consent or knowledge of their parents if they were acting in good faith to protect the best interests of the child. A mother of 5 daughters sought a declaration of the Court that the guiding statement was unlawful as it was inconsistent with parental rights. Her claim was ultimately rejected by the House of Lords. The Court held that there were some circumstances in which a child could consent to their own medical treatment. Those circumstances involved when the child has “sufficient understanding and intelligence to enable him or her to fully understand what is proposed”.¹⁸ The parental “rights” to make decisions about a child’s medical treatment terminate at that time. Having *Gillick* competence also means that a child can prevent a parent from accessing their medical records.

The level of maturity required to provide consent will vary with the nature and complexity of the medical treatment.¹⁹ For example, the level of maturity required to provide consent for the treatment of minor cuts will be much less than that required to provide consent for the commencement of the oral contraceptive pill. The rate of development depends upon each individual child.²⁰

The “*Gillick* competence” test was adopted in Australia in the case of *Marion*.²¹ *Marion’s* case, related to sterilisation of an intellectually disabled child. Marion was 13 years at trial but by the time the case reached the High Court she was 14. She was severely disabled - with an intellectual disability, severe deafness, epilepsy, an ataxic gait and behavioural problems. She could not care for herself. The parents applied to the Family Court for:

- An order authorising the performance of a hysterectomy and an ovariectomy; or
- A declaration that it was lawful for them to consent to those procedures.

¹⁷ *Gillick v West Norfolk and Wisbeck Area Health Authority and Another* [1986] AC 112.

¹⁸ *Gillick v West Norfolk and Wisbeck Area Health Authority and Another* [1986] AC 112.

¹⁹ *NHS Trust v T (Adult: Refusal of Medical Treatment)* [2004] 3 FCR 297 at [53] refers to *Re MB (An Adult: Medical Treatment)* [1997] 2 FCR 541, 553-4.

²⁰ *Secretary of the Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218, 394.

²¹ *Secretary of the Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218.

The Family Court asked the Full Court of the Family Court to answer some legal questions so that the Family Court could then make orders taking into account the best interests of Marion. This is called a Case Stated. The Full Court said that the parents had the power to consent to the sterilisation. The Northern Territory Government (where the family lived), supported by the Attorney-General for the Commonwealth, appealed to the High Court.

In the High Court of Australia the two issues were broadened so that the High Court was required to determine whether the procedure could be authorised by Marion, the parents or a court such as the Family Court. The issues were:

1. The threshold question of consent, being whether a child is capable in law or in fact of consenting to medical treatment on their own behalf; and
2. If the child is incapable of consenting, whether the proposed treatment is outside the scope in which a parent can consent to on behalf of the child.

In relation to the threshold question, the Court adopted the test from *Gillick* and confirmed that if the child adequately understood the proposed medical treatment, she was capable of giving informed consent. The High Court went on to say that there is no fixed-age to determine whether a child is competent to give consent to a medical procedure. Instead, the Court stated that it was necessary to consider competence in each case based upon the individual characteristics of that child.

As to the question of whether the proposed treatment was outside the scope that a parent can consent to on behalf of the child, the High Court stated that there were clearly features of the proposed surgical procedures which meant court authorisation was necessary. The High Court made a distinction between therapeutic and non-therapeutic surgical procedures.

Consent after *Marion's case*

Marion's case was ground-breaking as the High Court recognised the rights of children with disabilities. The sterilisation could only occur if the procedure was in Marion's best interests and less invasive options had failed. In order to consent to medical treatment, a child must be in a position to do the following:

1. Understand the medical treatment of the proposed procedure, including the nature and consequences of the treatment;
2. Assess the medical treatment and all alternative options;
3. Freely wish to proceed with the treatment;

4. Not be influenced by the wishes of others, particularly when the child's parents cannot agree upon the treatment.²²

The medical practitioner must also meet the requirements of the *Medical Treatment Planning and Decisions Act 2016*.

If the child is not in a position to do the above, and is considered not to be *Gillick* competent, they will not be able to make an informed decision relating to their medical treatment. Therefore, the authority falls back on the child's parents to consent to or refuse the proposed treatment on behalf of the child. If there is disagreement between parents and treating practitioners, it is prudent for the practitioner to obtain court approval before proceeding with the proposed treatment. On the other hand, if the child is considered *Gillick* competent, the proposed treatment may proceed even if the parents do not consent.

Are there any exceptions to obtaining consent?

Consent to medical treatment for a child is not required from a parent, the child, or a court in circumstances where emergency treatment is necessary.²³ This is recognised in Australia as the "emergency principle" or the "principle of necessity", whereby treatment can be provided if obtaining consent is not possible and there is an urgent need for treatment to prevent the child dying or suffering serious harm or disability.²⁴ These exceptions to obtaining consent are established under the common law and statute. At this point, it is also important to acknowledge the common law doctrine of *in loco parentis*. This doctrine will operate to enable those standing in the role of parent to make medical decisions on behalf of a child lacking capacity.

What if the parents withhold consent to treatment recommended by the medical practitioners?

In circumstances where a medical practitioner's views with respect to medical treatment of a child differs to that of the parents, a medical practitioner, hospital or Government authority may apply for a court order. In *Director Clinical Service, Child & Adolescent Health Services & Kiszko & Anor*,²⁵ the Family Court of Western Australia determined that the child should undergo chemotherapy treatment against the wishes of both parents. The Court heard evidence that the child would die without receiving treatment, but there was a good prospect of a long-term cure if the treatment proceeded. The hospital's position was that the 6-year

²² Family Court of Australia, "A Question of Right Treatment: The Family Court and Special Medical Procedures for Children" (1998) at 4-5, 8-9.

²³ See for example, *Marshall v Curry* [1933] 3 DLR 260.

²⁴ Skene L. *Law and Medical Practice, Rights, duties, Claims and Defences*. 3rd edition, Australia, LexisNexis, 2008.

²⁵ [2016] FCWA 19.

old child required chemotherapy and radiotherapy following surgery to remove a brain tumor. The parents did not agree with the proposed way forward and instead sought that the child be treated by way of alternative therapies with a focus on nutrition. The Court referred to the case of *Minister for Health v AS*,²⁶ where it was held that:

The question is not whether to respect the parent's wishes. The role of the court is to exercise an independent and objective judgment and balance the advantage or disadvantage of the medical step under consideration. While the parents' wishes may be relevant, they are not determinative.

The Court also stated that:

When faced with the stark reality that the child will die if lifesaving treatment is not performed, which has a good prospect of a long-term cure, it is beyond doubt that it is in child's best interests to receive that treatment...²⁷

It was ultimately considered to be in the child's best interests for the proposed chemotherapy to commence as soon as possible, and the Court made an order to that effect.

In *Re Michael*,²⁸ an application was made to the Family Court by the Public Advocate seeking an order for the performance of cardiac surgery on an 11 year old child as a result of the parents refusing to provide consent. The child had suffered from a serious cardiac condition since birth. Upon seeking medical advice from a cardiologist shortly after birth, it was recommended that a Senning procedure be carried out in order to relieve the child's symptoms, but not to cure his cardiac condition. The parents were concerned about the risks associated with the operation, including the possibility of death, or other complications which may arise following the surgery. The Court heard that a significant amount of pressure was applied to the parents to consent to the operation, but they continued to decline to do so.

Over many years, the child continued to consult medical professionals and pressure for consent to a Senning procedure increased. The doctors gave various estimates of the child's life expectancy. All of those expectations were surpassed. When the child was eight years old, the Department of Health and Human Services became involved through the intervention of a medical practitioner at the Royal Children's Hospital who was one of the many doctors seeking consent to the Senning procedure. After many meetings and the matter being referred to the Public Advocate, an application was made to the Family Court by the Public Advocate. Ultimately, the parents both signed undertakings in which, among other things, they said they would ensure the child received appropriate medical and/or

²⁶ [2004] WASC 286.

²⁷ *Minister for Health v AS* [2004] WASC 286.

²⁸ (1994) FLC 92-471.

surgical treatment in relation to any material and significant condition from which he suffered and which was reasonably attributable to his cardiac condition.

In *Re GWW and CMW*,²⁹ the Family Court was required to determine an application made by the parents of a 10 year old child who sought an order authorising the performance on the child of a bone marrow harvest or a peripheral blood collection. The parents also sought a declaration that the parents were able to authorise the performance of the harvest or collection in future. The child's aunt, who had leukemia, was the proposed donee. The Court noted that the fact that the procedure was not for the child's benefit, but rather for the benefit of a third party. This was an important factor to consider. When determining what was in the child's best interests, the Court took into account the child's wishes, the relationship he had with his aunt, and the risks involved with the procedures. Ultimately, the Court held that the psychological benefit to the child of permitting the procedure to proceed outweighed the risks and it was therefore in his best interests to permit him to be a donor.

Blood transfusions

Another circumstance in which a medical practitioner's view may differ to that of a parent relates to the refusal of blood transfusions, usually due to religious beliefs. Those cases tend to be determined in the *parens patriae* jurisdiction of the Supreme Court rather than in the Family Court of Australia. A recent example was *Mercy Hospitals Victoria v D1 & Anor*.³⁰ The child was 17 years old, 38 weeks pregnant and a Jehovah's Witness. The risk of a caesarean section and of associated postpartum bleeding was high. The child and her mother objected to the child being given any blood products. The hospital brought proceedings for a declaration that it could administer blood products to save her life or prevent serious injury. Besides the new MTPD Act, s 24 of the *Human Tissue Act 1982 (Vic)* was also relevant. This section relieves a medical practitioner from criminal liability where they administer a blood transfusion without the consent of a child if the requirements of the section are met.

D1 had partially completed the Advanced Care Directive under the MTPD Act which would have enabled her to make a binding decision to refuse medical treatment if she had decision making capacity. The hospital referred D1 to a psychiatrist who refused to witness her signature on the form.

The Supreme Court found that the child lacked the necessary maturity and understanding to withhold her consent to a blood transfusion and said:

²⁹ (1997) FLC 92-748.

³⁰ [2018] VSC 519

In final submissions, the hospital said it was prepared to give an undertaking to the Court, as a condition of any declaration, to first use all strategies other than the transfusion of blood or blood products which in the opinion of two registered medical practitioners are reasonably available and clinically appropriate to attempt to avoid D1's death or serious injury. It is also willing to undertake only to give a blood transfusion on the concurring opinion of two registered medical practitioners. Those undertakings, if required, may alleviate, even if only to a small degree, the sense of violation D1 may feel: that is, through understanding that blood transfusion was withheld until all other reasonably available strategies were tried first and, in the final analysis, was only undertaken on the opinion of two doctors in order to save her life or avoid serious injury.

Taking into account these matters and the observations I have made, I am not satisfied D1 does have a sufficient understanding of the consequences of her choice. I am not convinced she has based her choice on a maturely formed and entrenched religious conviction. Put another way, I am not convinced that overriding her expressed choice would so rob her of her essential self as to outweigh the loss she would suffer through losing her life or sustaining a catastrophic injury. In summary, I do not consider that allowing her, in effect, to choose to die or only survive with serious injury is in her best interests taking into account a holistic view of her welfare (physical, spiritual and otherwise).

To the extent that her psychological and spiritual welfare may be addressed by her knowing that a blood transfusion was only administered as a last resort and upon very carefully considered medical opinion, I think it is appropriate that any declaration be made upon the undertakings that the hospital agrees to give.³¹

Can a 'Gillick competent' child refuse medical treatment?

The question of whether a child who is considered Gillick competent can refuse medical treatment has arguably not been dealt with consistently by legislation or legal precedent. There is an academic argument which suggests that once a child has been deemed to have Gillick competency, they should be treated as a competent adult who is in a position to make all medical decisions for which they have capacity, even if those procedures are high risk or complicated procedures. However, Australian case law is not reflective of this position. Currently, a court can override decisions made by a child which relate to medical treatment in circumstances where it is in the child's best interests to do so.

Special medical procedures

An application must be made to the Family Court to determine whether treatment can proceed in circumstances where the proposed treatment is considered a "special medical procedure". The *Family Law Rules 2004* define a medical procedure application as an application "seeking an order authorising a major medical procedure for a child that is not for the purpose of treating a bodily malfunction or disease".³² The only example given in the Rules is "a procedure for sterilising or removing the child's reproductive organs". Surgical

³¹ At [75]-[77]

³² Dictionary to the *Family Law Rules 2004*.

treatment which is not therapeutic in nature is considered to be a special medical procedure. They are usually operations that are irreversible and sensitive procedures, and a child's parents or guardian will not consent to a significant treatment or procedure regarded as necessary, the child's parents or guardian are in dispute about significant and recommended treatment, when the procedure is considered ethically contentious, or a child refuses treatment in a life-threatening situation.

In *Marion's case*, a distinction was made between therapeutic and non-therapeutic treatment. Therapeutic treatment was defined as treatment (including surgery) which "is administered for the chief purpose of prevention, removing or ameliorating a cosmetic deformity, a pathological condition or psychiatric disorder, provided the treatment is appropriate for and proportionate to the purpose for which it is administered". By contrast, non-therapeutic medical treatment was defined a treatment "which is inappropriate or disproportionate having regard to the cosmetic deformity, pathological condition or psychiatric disorder for which the treatment is administered and of treatment which is administered chiefly for other purposes".

If a medical practitioner commences treatment without obtaining court authorisation, they will be in breach of the FLA even if the parents have provided their consent. Hence, if a child is given invasive treatment without lawful consent, the medical professional may be open to the same actions available to adult patients who are given treatment without consent. Such actions include trespass, criminal prosecution, complaints made to the Medical Practice Board, and exposure to civil damages claims. Court orders are required in these circumstances because they are considered to extend outside the usual parental powers and the consequences of the medical procedures are usually irreversible or have the potential to significantly alter the child's life.

Sterilisation

Sterilisation is considered a special medical procedure which requires the approval of a court prior to the procedure, regardless of whether the parents' consent or the child is considered *Gillick* competent and consents.

For example, in *Re Marion*, the child's parents applied for a court order for a hysterectomy and ovariectomy.³³ The parents sought the procedure in order to prevent pregnancy and menstruation and to stabilise hormone fluxes. The High Court determined the legal principles which applied but the matter went back to the Family Court to decide what was in her best interests.

³³ *Re Alex: Hormonal Treatment for Gender Identity Dysphoria* (2004) FLC 93-175.

In *Re Sarah*,³⁴ the Court held that the proposed sterilisation of a 17 year old disabled girl was not in her best interests. In this case, the child suffered from severe intellectual and physical disabilities. She resided fulltime in a health care facility and was dependent on health care providers for her daily needs, including general hygiene, bathing, dressing, provision of food and toileting. She was unable to communicate, with the exception of smiling when she enjoyed something. Sarah's parents sought a declaration that removal of the uterus and cervix was in the child's best interests. The court considered *Re Marion* and

³⁴ *Between: L and GM Applicants and MM Respondent and the Director-General Department of Family Services and Aboriginal and Islander Affairs Respondent/Intervener* [1993] FamCA 124 (Re Sarah).

said:

*"Proportionality and purpose are the legal factors which determine the therapeutic nature of medical treatment. Proportionality is determined as a question of medical fact. Purpose is ascertained by reference to all the circumstances but especially to the physical or mental condition which the treatment is appropriate to affect."*³⁵

The Court heard that the procedure would provide benefits to the child such as minor improvement in hygiene, the risk of pregnancy would be avoided (although the court also considered other good safeguards against the possibility of pregnancy), possible relief of pain (although it was not known if Sarah suffered pain), removal of the concern that the treatment of uterine or cervical pathology may be impeded by her inability to communicate, and the parents' wishes would be met (noting that they only saw her four times per year). The detriments of the procedure which were put to the court included the risks associated with the operation and the long-term effects of removal of the uterus. There was no evidence that her quality of life would be improved by way of expansion of the activities in which she might be involved, or by decreasing the burden on carers, upon the cessation of her menstruation. The Court held that the proposed procedure would not with any certainty (subject to the removal of the risk of pregnancy) increase the child's capacity to enjoy life or meet a presently unmet need. A declaration was therefore made that sterilisation would not be in the child's best interests.

In *Re Carla*,³⁶ a five year old girl was born with a sexual development disorder. Both the child's parents and medical professionals agreed that it was in the best interests of the child to undergo the proposed procedure which involved the bilateral removal of the child's gonads. Orders were also sought so that such further or other necessary and consequential procedures to give effect to the treatment of the child for her condition able to be authorised by her parents. The procedure would result in the child becoming infertile.

Given the significance of the procedure, it was not known by the treating practitioners and parents whether the treatment fell outside the bounds of permissible parental authority. The parents were concerned that it did fall outside the bounds of parental authority after being informed of *Re Lesley*³⁷ in which the Court heard an application for the same procedure and concluded that the treatment fell "squarely within the principles enunciated in *Marion's case*" and "requires the sanction of a Court".³⁸ The parents, therefore, applied to the Family Court for a determination as to whether it was in the child's best interests to undergo the treatment.

³⁵ *Secretary of the Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218.

³⁶ (medical procedure) [2016] FamCA 7.

³⁷ (*Special Medical Procedure*) [2008] FamCA 1226.

³⁸ (*Special Medical Procedure*) [2008] FamCA 1226.

Ultimately, it was held that the medical treatment was considered to be therapeutic as it was necessary to appropriately and proportionately treat a genetic bodily malfunction that, untreated, posed real and not insubstantial risks to the child's physical and emotional health. Further, the Court determined that it was not a case where the decision to authorise the medical procedure fell outside the bounds of permissible parental authority as determined by the High Court in *Marion's Case*. As such, it did not require court sanction, but the Court nevertheless made an order that the procedure be carried out before the onset of pubertal changes so as to avoid significant risks to the child's physical and emotional health.

Gender dysphoria

There are three separate stages of gender dysphoria treatment.³⁹ Stage one relates to puberty blocking hormones being administered to the patient. This involves treatment of the medical condition known as childhood gender identity disorder and is not medical treatment which falls within the categories described in *Marion's case*. Following *Re Lucy*,⁴⁰ a court order for stage one treatment has generally not been required. In *Re Jamie*,⁴¹ the Family Court of Australia determined that a court order need not always be obtained in order to commence stage two treatment and found that a 15 year old was *Gillick* competent to consent to stage two treatment. However, a court order was required to determine that the child was *Gillick* competent, even if the parents and treating doctors believed the child was *Gillick* competent.

Stage two requires the administration of hormones of the opposite sex, being either testosterone or oestrogen. In *Re Kelvin*,⁴² the Full Court of the Family Court overturned *Re Jamie* and held that a court order for this phase of treatment is no longer necessary if the child is *Gillick* competent.⁴³ *Re Kelvin* involved a child who was registered as a female at birth, but identified as transgender since he was nine years old. Kelvin received treatment from a psychologist, psychiatrist, and endocrinologist. All of Kelvin's medical practitioners were of the view that Kelvin met the diagnostic criteria for gender dysphoria and that he should undergo stage two treatment for gender dysphoria. In early 2017, an application was made to the Family Court of Australia by Kelvin's father who sought an order that Kelvin was competent to provide consent for stage two treatment. Kelvin, his parents, and his treating medical practitioners all agreed that it was in Kelvin's best interests to proceed with stage two treatment.

³⁹ *Re Kelvin* [2017] FamCA 78.

⁴⁰ [2013] FamCA 518.

⁴¹ [2013] FamCAFC 110.

⁴² [2017] FamCA 78.

⁴³ [2017] FamCA 78.

Following *Re Jamie*, the Family Court heard approximately 63 cases which sought an order for stage two treatment. Court orders were made by the court allowing treatment to proceed in 62 of those cases. In the one case where an order was not made, the case was dismissed because the child was aged 17 years and 11 months at the time of the hearing and insufficient evidence was produced with respect to *Gillick* competency. The average time between receiving advice from a medical practitioner that stage two treatment should proceed and when the case was determined by the Family Court was approximately eight months. During that time many of the children suffered from a decrease in their mental wellbeing with increased anxiety, depression, and self-harm. Given this, the Full Court in *Re Kelvin* considered whether it should confirm the earlier decision in *Re Jamie* that stage two treatment requires a court order.

In *Re Kelvin*, a majority of the Full Court of the Family Court found that the state of medical knowledge had evolved since the decision in *Re Jamie*, particularly in relation to the risks associated with not treating a child who has gender dysphoria. The process set out in *Re Jamie* was criticised by doctors and parents for unnecessarily increasing mental health risks for transgender young people. The majority agreed that a *Gillick* competent child can consent to stage two treatment without the need for a court order. A court order remains necessary for stage two treatment if the child lacks *Gillick* competence or there is disagreement between parents or treating doctors.

The last stage, being stage three, relates to irreversible surgery. Surgical intervention includes, for example, chest reconstructive surgery, hysterectomy, vaginoplasty.

In *Re Matthew*,⁴⁴ the Court considered whether it was necessary for the Family Court to determine *Gillick* competency where the treatment proposed was therapeutic. If stage three treatment is therapeutic, the medical practitioners considered the child to be *Gillick* competent, and there was no controversy about the application, then it is no longer necessary to seek an order from the court for stage three treatment.

What if the parents don't agree regarding a special medical procedure?

In *Re Ryan*,⁴⁵ the parties' 16 year old child had been diagnosed with gender dysphoria. The mother supported the child undergoing stage three treatment to transition to male and commenced court proceedings to facilitate the child's wishes. The father opposed the treatment and sought for the mother's application to be dismissed. In the alternative, the mother sought an order that she be allowed to authorise surgery or that the Court authorise the surgery pursuant to section 67ZC FLA. The father opposed the application on the basis

⁴⁴ [2018] FamCA 161.

⁴⁵ [2019] FamCA 112.

that the child would be 18 in approximately 12 months' time, and therefore could then make his own decisions. The father's relationship with the child became strained as Ryan began his transition from female to the gender that he identified with. The father did not live with the child on a day-to-day basis (and in fact there was no communication between the two at the time of the court hearing), and he maintained the view that Ryan was going through a "phase".

The Family Court had made previous orders, including a declaration that Ryan was competent to consent to stage one and two treatment. The evidence demonstrated that Ryan had benefited significantly as a result of having treatment for stage one and two. The court considered that Ryan's life would be in limbo for approximately 12 months if he was not permitted to proceed. This was likely to be detrimental to him given the physical inconsistency of his body's masculinity (as a result of having received stage two treatment) which was inconsistent with the presence of female breasts. The court gave weight to the fact that Ryan would experience significant distraction from his education, a decrease in his self-esteem, and a restriction on his ability to participate in the activities of young people his age. In those circumstances, the period of 12 months was considered by the court to be "no small matter". The court also noted that it was possible, as the father feared, that Ryan would regret his decision, but the evidence suggested that was highly unlikely given the success Ryan had with the first two stages of treatment. That issue was held to be "not determinative".

It was held that the evidence strongly suggested that Ryan had sufficient intelligence that enabled him to understand the treatment that was proposed. He had previously been assessed to be *Gillick* competent and nothing had changed which suggested he no longer held competency, rather, it suggested his understanding had deepened. Ryan had officially changed his name and a new birth certificate was being issued. The court considered that this represented a further stage in the transition to Ryan becoming male. Evidence was provided to the court (and accepted by the judge) by two single experts and a senior family consultant with respect to Ryan having the relevant ability to understand the consequences of his decision. Ultimately, the Court determined that Ryan was *Gillick* competent to consent to stage three treatment.

Is a court order required to withdraw life sustaining treatment of a child?

In *Re Baby D (No 2)*,⁴⁶ the parents sought to implement the medical advice received in relation to their baby, a twin born at 27 weeks' gestation. The medical advice was to remove a tube which had been inserted to relieve airway obstruction. During an earlier attempt to

⁴⁶ (2011) FamCA 176.

remove the intubation, Baby D suffered severe brain damage from a lack of oxygen. The tube was reinserted 35 minutes later to prevent any further complications.

Baby D remained intubated for approximately five months, at which point the medical practitioners believed the best course of action was to remove the tube. However, it was not known what would happen if the tube was removed again, and if Baby D had a similar reaction to the earlier attempt, whether Baby D should be immediately intubated again.

The matter was referred to the Ethics Committee at the hospital which was of the view that the tube should be removed, and if there was another reaction to that removal, Baby D should be placed into palliative care. Despite this view, the Ethics Committee recommended that the parents first seek approval of the Family Court. As a result, the parents applied to the Court for approval to consent to the removal of the tube and also to provide palliative care, if necessary. The Court made that order but noted that the decision to withdraw treatment was within the scope of parental power and did not require authorisation of the court. However, it was noted that “other similar medical procedures within a different factual context may require court authorisation”.⁴⁷

Who should apply and what evidence is needed prior to making an application?

In accordance with Rule 4.08 of the *Family Law Rules 2004*, various people can make an application to the court seeking orders that relate to medical treatment of a child. Those people include a parent of the child, a person who has a parenting order for a child, the child, an Independent Children’s Lawyer, and any other person concerned with the welfare and development of the child. The final category includes medical and other professionals responsible for medical treatment of the child.

Applicants must ensure that sufficient evidence has been collated prior to filing an application in the Family Court relating a child’s medical treatment. In particular, they must be in a position to give sufficient evidence which satisfies the Court that the proposed medical procedure is in the best interests of the child.⁴⁸ Practitioners should ensure that there is evidence from a medical, psychological, or other relevant expert witness which demonstrates the following:

1. The exact nature and purpose of the proposed medical procedure;
2. The particular condition of the child for which the procedure is required;

⁴⁷ (2011) FamCA 176.

⁴⁸ Rule 4.09 of the *Family Law Rules 2004*.

3. The likely long-term physical, social, and psychological effects on the child in circumstances of both the procedure being carried out and the procedure not being carried out;
4. The nature and degree of any risk to the child from the procedure;
5. If alternative and less invasive treatment is available, the reason the procedure is recommended instead of the alternative treatments;
6. That the procedure is necessary for the welfare of the child;
7. If the child is capable of making an informed decision about the procedure, whether the child agrees to the procedure;
8. If the child is incapable of making an informed decision about the procedure, that the child is currently incapable of making an informed decision and is unlikely to develop sufficiently to be able to make an informed decision within the time in which the procedure should be carried out, or within the foreseeable future; and
9. Whether the child's parents or carer agree to the procedure.

When reviewing the evidence, the Court will consider each fact individually whilst focusing on what is in the best interests of that particular child.⁴⁹ The evidence should be provided to the Court in the form of an affidavit. If the evidence is to be provided orally, it is necessary to seek permission of the Court.⁵⁰

Upon the filing of a medical procedure application, the Court must fix a date for a hearing before a judge of the Family Court. In accordance with Rule 4.11 of *the Family Law Rules*, the Court is required to fix a date to hear the application as soon as possible after the date of filing the application, and if possible, within 14 days of the application being filed. On the first court date, the Court must either make procedural orders for the conduct of the case and adjourn the matter to a fixed date of hearing, or hear and determine the application.

Conclusion

A considerable onus is placed upon medical practitioners when treating children in particular. It is necessary to obtain consent by either the child or his or her guardian, depending on the age and maturity of the child and the nature of the proposed procedure. This consent must obviously be obtained prior to commencing any treatment. In addition to complying with the *Medical Treatment and Decisions Act 2006*, in cases which involve a special medical

⁴⁹ Section 68F(2) of the *Family Law Act 1975*.

⁵⁰ Rule 4.09(3) of the *Family Law Rules 2004*.

procedure, the approval of the Family Court is necessary notwithstanding consent is provided by parents and/or the child. The definition of "special medical procedure" has changed with social and medical developments and knowledge. The cases show a balancing of the conflict between the ability of a child to give consent and the authority of parents and the courts to make the decision despite the views of the child.