Pro Bono Centre
31 August 2021

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The Application of Gillick Competency to Abortion Cases

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About the Authors

This '*The Application of Gillick Competency to Abortion Cases*' report was researched and authored by UQ law students **Joey Lim, Radhika Peddibhotla** under the academic supervision of Director of UQ Pro Bono Centre **Mandy Shircore.** This '*The Application of Gillick Competency to Abortion Cases*' report was prepared for and on behalf of Children by Choice, an independent Brisbane-based non-profit organisation committed to providing unbiased information on all unplanned pregnancy options. Student researchers undertook this task on a *pro bono* basis, without any academic credit or reward, as part of their contribution to service as future members of the legal profession.

The UQ Pro Bono Centre and student researchers thank Children by Choice for allowing us to contribute to its vital work.

About this Document

This document is intended to provide research, information and law reform recommendations for Children by Choice to use in advocacy and policy work.

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1. Executive Summary

This paper explores the application of the Gillick competency test to minors who seek to undergo termination of pregnancy procedures. The Gillick competency test is a legal test to assess whether a young person has the required competence to provide informed consent to a medical procedure. The test is regularly performed by doctors who are trained to assess Gillick competency of minors.

The *Termination of Pregnancy Act* provides the circumstances in which a medical practitioner may perform a termination on a woman. A woman is defined under the Act as a female person of any age. It would appear therefore that the Termination of Pregnancy Act covers both minors and adult women.

Difficulties arise however, where there is doubt as to the Gillick competency of the minor to consent to the termination procedure and / or there is a disagreement between medical practitioners, the minor or parents about the appropriateness of the termination. While parents and legal guardians are able to consent to most general medical procedures on behalf of their child, there are some circumstances in which the Courts have held that in order to protect the child, court authorisation for the procedure is required This requirement stems from a seminal High Court of Australia case *Secretary of the Department of Health and Community Services v JWB and SMB*[1] *(**'Marion's Case'**).* As the principals arising from Marion's Case have been applied in two Queensland cases involving minors and termination procedures, it is important to understand the findings in Marion's case and how it has been interpreted and applied subsequently.

In *Marion's Case,* the High Court upheld the Gillick competency test described in *Gillick v West Norfolk Area Health Authority*[2] which states that a child is capable of consenting to medical treatment if they achieve a 'sufficient understanding and intelligence to enable them to understand fully what is proposed'. If a minor is not deemed to be Gillick competent, then the question of who can provide consent on their behalf to a medical procedure turns on two questions: whether the procedure is considered to be a 'special medical procedure'; if so, whether the special medical procedure is 'therapeutic' in nature.

A 'special medical procedure' was defined in Marion's case as one where there was: 1) a significant risk of the wrong decision being made; and 2) where the consequences of such a wrong decision are particularly grave.[3] In *Marion's Case,* the court held that sterilisation of an intellectually disabled young woman constituted a special medical procedure.

A special medical procedure will only fall under the scope of parental authority if it is also considered therapeutic. In *Marion's Case,* therapeutic treatment was defined as that which is "administered for the chief purpose of preventing, removing or ameliorating a cosmetic deformity, pathological condition or psychiatric disorder," provided the treatment is appropriate and proportionate to that purpose.[4] As the sterilisation for Marion was to prevent menstruation and possible pregnancy and not to treat an underlying medical condition (such as cancer) it was held to be non-therapeutic.[5] Accordingly the parents could not consent to this 'special medical treatment' on behalf of Marion and court authorisation for the sterilisation was required.

In two Queensland cases concerning abortion procedures for minors, the Supreme Court has held that an abortion constituted a special medical procedure.[6] In each case the judge did not address the therapeutic/ non-therapeutic distinction Instead, it was held in both cases that court authority was required merely because the terminations were deemed to carry a significant risk of the wrong decision being made and the consequences of such a wrong decision were considered to be particularly grave.

This is regrettable. The authors submit that had the principles from *Marion's Case* been carefully and appropriately applied, abortion would be considered a therapeutic procedure given that it has the capacity to

[1] (1992) 175 CLR 218, [18] *('Marion's Case').*
[2] [1986] 1 AC 112.
[3] *Marion's Case* (n 1) [49] (Mason CJ, Dawson, Toohey and Gaudron JJ).
[6] *State of Queensland v B* [2008] 2 Qd R 562, [17]; *Central Queensland Hospital and Health Service v Q* [2017] 1 Qd R 87, [20].
[6] *State of Queensland v B* [2008] 2 Qd R 562, [17]; *Central Queensland Hospital and Health Service v Q* [2017] 1 Qd R 87, [20].
[6] *State of Queensland v B* [2008] 2 Qd R 562, [17]; *Central Queensland Hospital and Health Service v Q* [2017] 1 Qd R 87, [20].

prevent, remove or ameliorate mental harm and / or conditions which are likely to accompany unwanted pregnancies in minors. Based on one interpretation of *Marion's case* if termination is determined to be a therapeutic treatment, court authorisation should not be required and parents and legal guardians can consent on behalf of a Gillick incompetent minor. This is always predicated on the basis that the child, parents and medical treatment team agree that this is the most appropriate course.

This argument gains further support when one considers how *Marion's Case* has been applied in many gender dysphoria cases across Australia. Gender dysphoria is a medical condition where a child suffers significant distress as they do not identify with their biological sex. Treatment for gender dysphoria involves 3 stages: stage 1 comprises providing medication to prevent puberty; stage 2 encompasses irreversible hormone treatment to facilitate development of physical characteristics in the sex in which the child identifies; stage 3 involves surgical intervention.

The law has developed positively for transgender youths through three significant gender dysphoria cases: *Re Alex*, *Re Jamie* and *Re Kelvin*. In *Re Alex*, the first gender dysphoria case heard by the Family Court, it was strictly held that given Alex was not Gillick competent, and both stages 1 and 2 of the gender dysphoria treatment were 'special medical procedures' which were 'non-therapeutic' because they were not considered to cure a disease or correct some malfunction, court authorisation was required for the relevant treatment. This decision meant that gender dysphoric children needed to apply to the court before undertaking treatment.

Nine years later, the Court in *Re Jamie* held that advances in medical understanding meant that gender dysphoria is a medically recognised diagnosed psychiatric condition, for which treatment is therapeutic. As stage one treatment is wholly reversible, the Court held court authorisation was not required. Nevertheless, the court interpreted that *Marion's case* still applied to stage 2 treatment because of the possible 'irreversible effects' of the hormone treatment and the possible 'grave consequences if a wrong decision was made'. Therefore court authorisation was still required for stage 2 treatment of Gillick incompetent child. The court went a step further and held it was for the court to determine Gillick competence.

Fortunately, 4 years later, *Re Kelvin* marked a positive turning point for gender dysphoric adolescents. While adopting different reasoning, the majority and minority of the Court held that stage 2 treatment, is no longer beyond the bounds of parental authority and therefore court authorisation for the treatment was no longer necessary. The different reasoning of the majority and minority is based on a fundamental difference in interpretation and application of *Marion's case.* These differences of interpretation leave the law and how it applies to abortion cases for minors unsettled.

It is the authors view that the Queensland abortion cases incorrectly applied *Marions Case* and should not have found that court authorisation was required for a termination procedure for a Gillick incompetent minor. Furthermore it is suggested that if decided today, after the series of gender dysphoria cases, a Court should find Court authorisation is no longer required. Nevertheless the

It is important however to note, that the above applies only where there is no dispute between the minor, parents and medical practitioners as to the appropriateness of a termination. In 2020, in *Re Imogen,* (another gender dysphoria case) the court took a step backwards by imposing the legal requirement of a court application where there is a dispute about consent or stage 2 gender dysphoria treatment between the parents of the child **regardless** of the child's Gillick competency. In other words, even where a child is considered Gillick competent by medical practitioners, if a dispute exists, a court authorisation is required before stage 2 treatment can take place. This unfortunately gravely undermines the concept and application of Gillick competence.

The law surrounding the application of Gillick competency to cases concerning special medical procedures, including abortions, for minors must be clarified. It is recommended that Parliament enacts legislation which defines Gillick-competency with the definition upheld in *Marion's Case.* It should be made clear that f the minor in question is deemed to be Gillick competent, then the *Termination of Pregnancy Act 2018* (Qld) *would* apply to minors seeking abortion the same way it applies to an adults.

If the minor is not Gillick competent, the proposed legislation should clarify that parents or legal guardians may consent to terminations on behalf of the child. In circumstances where there is dispute between the child, parents / guardians and / or medical practitioners then court authority should be required.

2. Introduction

This paper begins by providing a historical context which informs Court's decisions in both gender dysphoria and abortion cases. Then, the development of law in gender dysphoria cases over the last two decades is discussed, demonstrating the Courts' slow but eventual catch up with the medical profession on gender dysphoria treatment. Subsequently, we analyse two Queensland decisions involving abortion of young women, particularly critiquing the uncertainty surrounding those judgements, which ultimately leave young women seeking abortions in precarious positions. We conclude by proposing that treatments for these medical issues are best left to the domain of the adolescent or absent capacity, their parents/legal guardians and the medical professions rather than Courts. As evidenced by our analysis, Courts have consistently simply implemented medical professions' advice in determining such cases, rendering judicial oversight superfluous.

3. Historical Context

In the landmark decision of *Marion's Case,* the High Court of Australia adopted the view expressed by the House of Lords in *Gillick v West Norfolk Area Health Authority*,[7] that a child is capable of consenting to medical treatment if they achieve a 'sufficient understanding and intelligence to enable them to understand fully what is proposed'. This threshold is referred to as 'Gillick competence'. In *Marion's Case,* the High Court also considered the question of who is able to consent to medical treatments on behalf of a child who has not achieved Gillick competence.

Marion's Case involved a 14-year old child with a disability who lacked Gillick competence. Marion's parents sought a court order authorising a hysterectomy and ovariectomy (removal of ovaries) for their daughter, the practical effects of which would be sterilisation and the prevention of the hormonal fluxes of puberty. This case involved two major issues: first, whether a child, intellectually disabled or not, is capable of consenting to medical treatments; second, if a child is incapable of consenting, whether medical treatment falls outside the scope of parental authority.[8] The first question was answered in the affirmative under the condition that the child is Gillick competent.[9] Regarding the second question, the majority held that parents may give consent on behalf of Gillick incompetent children in a 'wide range of circumstances'.[10] Where treatment consists of a 'special medical procedure', the majority of the High Court suggested that the determinative factor was whether the procedure was 'therapeutic' or 'non-therapeutic'.[11]

A special medical procedure was defined as one where there was: 1) a significant risk of the wrong decision being made; and 2) where the consequences of such a wrong decision are particularly grave.[12] In *Marion's Case,* the High Court applied this test and ultimately held that sterilisation was a 'special medical procedure'. Indeed, they held that there was a significant risk of the wrong decision being made because of the complexity of the question of consent, where children and particularly disabled children are often wrongly assessed as to their capacity for providing informed consent.[13] Furthermore, the decision to sterilise often revolves around the opinions of medical professionals; this results in a lack of consideration for the non-

[7] [1986] 1 AC 112.
[8] *Marion's Case* (above n 1) [7], [18] (Mason CJ, Dawson, Toohey and Gaudron JJ).
[9] Ibid [19], [24] (Mason CJ, Dawson, Toohey and Gaudron JJ).
[10] Ibid [26] (Mason CJ, Dawson, Toohey and Gaudron JJ).
[11] Ibid [48] (Mason CJ, Dawson, Toohey and Gaudron JJ).
[12] Ibid [49] (Mason CJ, Dawson, Toohey and Gaudron JJ).
[13] Ibid [50] (Mason CJ, Dawson, Toohey and Gaudron JJ).

medical consequences of sterilisation (such as the social and psychological effects).[14] Lastly, a parent's decision to sterilise a child may inappropriately privilege the interests of persons other than the child, for example those of the parents or other care-givers.[15] Turning to the second question, the High Court held that the consequences of wrongly deciding to sterilise a child are particularly grave because they involve preventing the child from reproducing, and allowing a child to be acted upon against their best interests. The violation involved in sterilisation may have 'social and psychological implications concerning the person's sense of identity, social place and self-esteem'.[16]

If a medical procedure is 'special', the Court held that it will fall within the scope of parental authority **only if it** is 'therapeutic'.[17] In *Marion's Case,* therapeutic treatment was defined as that which is "administered for the chief purpose of preventing, removing or ameliorating a cosmetic deformity, pathological condition or psychiatric disorder," provided the treatment is appropriate and proportionate to that purpose.[18] Conversely, non-therapeutic treatment is that which falls outside of the aforementioned purposes, or which is inappropriate or disproportionate.[19] In *Marion's Case,* the majority held that non-therapeutic treatment falls outside of the scope of parental authority; indeed, courts, in the exercise of their 'parens patriae jurisdiction (which grants courts the inherent power and authority to protect those who are legally unable to act on their own behalf),[20] must authorise the procedure. To satisfy the court, the non-therapeutic special medical procedure must be in the 'best interests' of the child.[21] As the treatment sought by Marion's parents for their daughter was not for an accepted therapeutic purpose (for example, treating cancer), the sterilisation procedures were considered non-therapeutic; thus, judicial oversight was required. The principles in Marion's Case have been applied to subsequent cases concerning minors, primarily in relation to the gender dysphoria cases and also as noted to two Queensland decisions involving young women and abortions.

4. Application Of *Re Marion's* To Gender Dysphoria Cases

Marion's case, and the concept of a 'special medical procedure' generally, have been applied in many gender dysphoria cases across Australia. Each of these cases however, adopt somewhat varying applications in dealing with the relevant issue.

Gender dysphoria is the 'clinically significant distress or impairment' caused by a marked incongruence between one's sex assigned at birth and one's gender identity.[22] 'Transgender' is a term applying to individuals whose gender identity does not align with their biological gender. A person identifying as transgender is not necessarily gender dysphoric, but everyone with gender dysphoria is transgender. Symptoms of gender dysphoria become evident at different stages in a developing child, but are magnified during puberty. The distress resulting from gender dysphoria can cause depression, anxiety, self-harm and attempted suicide.[23]

Treatment for gender dysphoria involves 3 stages. Stage 1 treatment is also labelled 'puberty blocking treatment', with reversible effects when used for a limited period of time. It involves the injection of Gonadotropin releasing hormone analogue (GnRHa) to reduce the effects of adolescent's biological puberty.[24] Stage 2 treatment, or 'gender affirming hormone treatment' involves the use of testosterone to

14 Ibid.
15 Ibid.
16 Ibid [51] (Mason CJ, Dawson, Toohey and Gaudron JJ).
17 Ibid [10] (Brennan).
18 Ibid [11] (Brennan).
19 Ibid.
20 Ibid 68 (Mason CJ, Dawson, Toohey and Gaudron JJ); State of Queensland v. Nolan [2002] 1 Qd.R. 454 at 455–456 [7] (Chesterman J).
21 Marion's Case (above n 1) [34] (Brennan).
22 American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (5th edition, 2013).
23 *Re Kelvin* [2017] Fam CAFC 258 [19] ('*Re Kelvin*').
24 *Re Kelvin* [12].

masculinise or oestrogen to feminise the adolescent's body. This produces irreversible physiological effects.[25] Stage 3 treatment involves surgical interventions.[26] The risks of not providing stage 2 treatment for gender dysphoria include requiring the otherwise preventable surgical intervention in the gender dysphoric adolescent. The extended use of stage 1 treatment to delay stage 2 treatment may also lead to psychological and social complications for adolescents going through school in a pre-pubertal state that is incongruous with their peers.[27]

Recipients of gender dysphoria treatment commonly present positive progressions in their psychological wellbeing, including reduced anxiety levels and improvements in mood, which contribute to enhanced social outcomes in the recipient's life.[28]

The first gender dysphoria case that the Family Court heard was in 2004, the case of *Re Alex*.[29] This case concerned a 13 year old who was anatomically a female but possessed a long standing wish to undergo a transition to appear as a male.[30] Therefore, Alex has gender dysphoria. As a result, Alex's legal guardian, the Department of Human Services, sought court authorization for both stage 1 and stage 2 treatment for Alex while he began secondary school, which was in accordance with Alex's wish to start the proposed treatment as soon as possible. All the expert evidence presented to the court supported such medical intervention, as it was deemed to be in Alex's best interests, specifically in relation to his mental and emotional health.[31]

Upon considering expert evidence, Nichoson CJ concluded that although Alex was determined to have a 'general understanding' of the proposed treatment including its side effects and benefits, he did not possess the 'sufficient maturity to fully understand the grave nature and effects of the proposed treatment'.[32] Therefore, Alex was not 'Gillick competent'.

The issue for the court to decide then turned upon whether the proposed treatment was one that required the consent of the court, being a 'special medical procedure' as referred to as *Marion's Case*, or one to which Alex's legal guardian may consent.[33] Nichoson CJ recognised that 'special medical procedures' are not limited to sterilisation cases.[34] In addressing this issue, his honour viewed both stages 1 and 2 of the gender dysphoria treatment for Alex as a 'single treatment plan, acknowledging that stage 2 treatment involved irreversible consequences with significant risks of making the wrong decision, consequences of which are particularly grave.[35] Additionally, adopting the language of the majority decision in *Marion's case*, Nichoson CJ found that enabling the proposed treatment is not 'to cure a disease or correct some malfunction', which his honour understood to be referring to 'medical treatments seeking to address disease in or malfunctioning or organs'.[36] His Honour therefore classified the treatment as 'non-therapeutic' using the language of *Marion's case*, falling outside the boundaries of parental consent. In other words the treatment plan in question was considered a 'special medical procedure' and required court authorisation despite Alex's desire to undergo the treatment, the permission given by Alex's legal guardian and the support of medical practitioners.[37] Despite having taken this view, upon convincing evidence from medical experts suggesting that gender dysphoria treatment would have an empowering effect on Alex, Nichoson CJ held that granting authorisation for the treatment was in Alex's best interests.[38]

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[25] *Re Kelvin* [13]-[14].
[26] *Re Kelvin* [16].
[27] *Re Kelvin* [18].
[28] *Re Kelvin* [20].
[29] (2004) 31 Fam LR 503.
[30] *Re Alex* (2004) 31 Fam LR 503 [2] ('Re Alex').
[31] *Re Alex* [5].
[32] *Re Alex* [168].
[33] *Re Alex* [174].
[34] *Re Alex* [175].
[35] *Re Alex* [176], [188]; citing *Re GWW and CMW Fam LR* 616-7 (Hannon J).
[36] *Re Alex* [195].
[37] *Re Alex* [196].
[38] *Re Alex* [4].

While the decision in *Re Alex* marked a significant victory for Alex, it undesirably concreted the need for lengthy and expensive court procedures to obtain court authorisation for gender dysphoric individuals to overcome their dysphoria through the necessary treatments. Given the lack of guidance from other cases, *Re Alex* was followed in all subsequent cases to require court authorisation for all stages of gender dysphoria treatment.

Almost a decade later, in 2013, the case of *Re Jamie*[39] led to reconsideration by the Family Court of the gender dysphoria issue. Jamie was a 10 year old child diagnosed with 'childhood gender identity disorder' (i.e. gender dysphoria). Specifically, Jamie was born male but began identifying with the female gender at about two and a half years old and had been known exclusively as a female since mid 2009.[40] Medical experts supported Jamie's parents' application to the court for Jamie to undertake stage 1 and stage 2 treatments as a matter of urgency in order to suppress Jamie's male puberty.

At first instance, Dessau J determined that although it was in Jamie's best interests to authorise Stage 1 of the medical treatment for gender dysphoria, her honour did not provide authorisation for Jamie to undergo Stage 2 treatment, taking the view that Jamie was too young and unlikely to require stage 2 treatment until around 16 years of age, therefore it was too soon to decide this matter.

However, Jamie's parents appealed to the Full Court of the Family Court, arguing that, contrary to the trial judge's view and the decision in *Re Alex*, 'childhood gender identity disorder' is not a 'special medical procedure' which displaces parental responsibility and requires court authorisation.[41] They submitted that given there was unanimous agreement between the parents and all medical experts regarding the correct treatment to be administered to Jamie, court authorisation was not needed.[42] The applicants also argued that cases of childhood gender identity disorder can be distinguished from the facts in *Marion's case*, in that while sterilization is **non-therapeutic** in the sense that it is not carried out to treat some malfunction or diseases, gender dysphoria is a **medically recognised diagnosed psychiatric condition** with well-known treatment strategies. Accordingly, such psychiatric or psychological condition is akin to physical impairment, leading to the conclusion that treatments for gender dysphoria would be 'therapeutic', for which court authorisation is not required following *Marion's case*.[43]

In response, the court agreed that treatments for a psychiatric or psychological condition are 'therapeutic'.[44] Based on the discussion of Marion's Case earlier, this finding should have meant that Court authorisation for the therapeutic gender dysphoria treatments was not required.

Importantly however the judges took the view that *Marion's case* applied to both therapeutic and non-therapeutic treatments where such treatments involved **irreversible effects** and **grave consequences if a wrong decision was made**. Applying this interpretation to stage 1 treatment, the judges concluded that since it is a reversible process carrying a low risk of error from misdiagnosis, it falls within the ambit of parental responsibility.[45] However, despite also being therapeutic, they held that stage 2 treatment involves irreversible effects and significant risks to a child if a wrong decision was made, thereby requiring court authorisation where the child was not Gillick competent.[46] Particularly they noted that the therapeutic benefits of the treatment must be balanced against the risks involved and the consequences of the irreversible treatment.[47] While a Gillick competent child could consent to the treatments unilaterally, the judges held that the GIllick competency of a child is a question for the court.[48]

[39] *Re Jamie* [2013] FamCAFC 110 ('*Re Jamie*').
[40] *Re Jamie* [11].
[41] *Re Jamie* [12].
[42] *Re Jamie* [2013] [20].
[43] *Re Jamie* [2013] [26].
[44] *Re Jamie* [2013] [91], [97].
[45] *Re Jamie* [2013] [88].
[46] *Re Jamie* [2013] [182].
[47] Ibid.
[48] *Re Jamie* [2013] [186]-[187].

The judgment in *Re Jamie* was at the time viewed as a step in the right direction, as it allowed better access to at least stage 1 treatments for transgender adolescents. However, the court's involvement remained mandatory for stage 2 treatments as well as determination that a child is Gillick competent. At this point in time, Australia was the only country in the world that still required court approval to access stage 2 treatment for gender dysphoria. It was not until 2017 that Australia caught up with the medical profession on gender dysphoria treatment through the landmark case of *Re Kelvin*.[49]

Re Kelvin was a significant turning point for adolescents with gender dysphoria. The case concerned 17-year-old Kelvin who had not undergone stage 1 treatment and hence experienced female puberty that resulted in considerable distress for him.[50] Both Kelvin and his parents supported him commencing stage 2 treatment. Kelvin's father sought a declaration by the court that Kelvin was competent to consent to stage 2 treatment.[51] Importantly, in the course of their judgment, all five judges unanimously held that court determination is no longer required to determine the Gillick competency of a child.[52] This is because stage 2 treatment 'can longer be considered a medical procedure for which consent lies outside the bounds of parental authority'.[53] Therefore, there is no longer a basis for the court to determine GIllick competence.[54]

In coming to the decision that court authorisation for stage 2 treatment is no longer required, the majority of the court (Thackeray, Strickland and Murphy JJ) reasoned that current medical knowledge justified a departure from the decision in *Re Jamie* as 'the risks involved and the consequences which arise out of the treatment being at least in some respects irreversible, can no longer be said to outweigh the therapeutic benefits of the treatment'.[55] However, the judges noted that the Court retains its jurisdiction and power to determine whether gender dysphoria treatment should be authorised where there is a genuine dispute between parents, child or medical practitioners as to whether the relevant treatment should be administered, or where the child was under the care of a State Government Department.[56]

Taking a different approach, Ainslie-Wallce and Ryan JJ (the minority) held that when the Full Court in *Re Jamie* determined stage 2 treatment to be therapeutic, *Marion's case* should not have been applied to come to a conclusion that the potentially grave consequences resulting from stage 2 warranted court approval.[57] Particularly, their honours reasoned that the application of *Marion's case* is limited to non-therapeutic medical procedures.[58] Therefore, it follows that, akin to the majority, the minority also agreed *Re Jamie* would be decided differently today.

Naturally, the decision *Re Kelvin* has been embraced by transgender and children's advocates, as it 'will improve human rights protection for young transgender people', and 'brings Australia in line with recommendations by the United Nations'.[59] It also eliminates a costly and time-consuming legal barrier for transgender adolescents seeking stages 1 and 2 of gender dysphoria treatment. Nevertheless, it remains the case that stage 3 treatment for gender dysphoria involving surgical interventions may still require court intervention, as this was not similarly exempted by the judges in *Re Kelvin*.

In September 2020, the case of *Re Imogen*[60] came before Watts J. Fittingly, this recent decision has been labelled as 'a step in the wrong direction'[61] as new legal requirements were imposed in the decision that will inevitably delay access to gender dysphoria treatment in circumstances where the child's parents are in conflict or where the child has an absent parent. Imogen was a 16-year-old gender dysphoric child who was

[49] [2017] Fam CAFC 258.
[50] *Re Kelvin* [39].
[51] *Re Kelvin* [42].
[52] *Re Kelvin* [182].
[53] *Re Kelvin* [164].
[54] *Re Kelvin* [182].
[55] *Re Kelvin* [162].
[56] R*e Kelvin* [167].
[57] R*e Kelvin* [188].
[58] R*e Kelvin* [189], [197].
[59] Australian Human Rights Commission, *Commission Welcomes Re Kelvin Decision,* 30 November 2017.
[60] (2020) 61 Fam LR 344 ('*Re Imogen'*).
[61] Stephanie Jowett and Fiona Kelly, 'Re Imogen: A step in the wrong direction' (2021) 34 A*ustralian Journal of Family Law* 31.

assigned male at birth and assessed as being Gillick-competent by her doctors.[62] However, in conflict with Imogen's father's view, her mother opposed Imogen receiving stage 2 treatment. The legal issue that came before Watts J was how treatment decisions should be made for gender dysphoric youths 'when there is a dispute about consent or treatment'.[63] His Honour ruled that a court application is always required where either or both parents do not consent to stage 2 treatment.[64] This remains the case even where the child is Gillick-competent, as was the case for Imogen.[65] Therefore, doctors cannot lawfully administer stage 2 gender dysphoria treatment without consent from both parents.[66]

Following the decision in *Re Imogen*, the concept of Gillick competency was eroded by allowing any type of dispute among parents to usurp the wishes of competent youths as to their gender identity.[67] This also opens the door for unsupportive, or otherwise absent, parents to inhibit their Gillick-competent child's access to an essential treatment, with the undesirable effects of increasing litigation in the Family Court and placing unnecessary cost burdens on the relevant parties. It is regrettable that this case has undermined the slow development of law in this area by taking a step back from *Re Kelvin*.

Application To Abortion

4.1 Queensland cases concerning abortion procedures for minors

The principles from Marion's Case have been applied to two Queensland cases concerning abortion procedures for minors. These cases are *State of Queensland v B*[68] and *Central Queensland Hospital and Health Service v Q*.[69] In both cases, it was held that abortion constitutes a 'special medical procedure' which requires court authorisation for minors who are not Gillick competent. Notably, in both cases, the respective presiding judges suggested that age itself may constitute a factor which means that a minor is not Gillick-competent.

Summary of *State of Queensland v B* [2008] 2 Qd R 562

B was a 12 year old girl who was almost 18 weeks pregnant at the time that the case was heard, in the Queensland Supreme Court.[70] She was the patient of a public hospital conducted by the State of Queensland, the applicant, who applied to the Court in its *parens patriae* jurisdiction for authorisation of the termination of B's pregnancy.[71] The Court's *parens patriae* jurisdiction could only be exercised with respect to B, and not her unborn child.[72]

Justice Wilson, presiding over this case, applied the test of Gillick competence as upheld in *Marion's Case*.[73] B had expressed that she wished to have her pregnancy terminated; however, her Honour held that B was not capable of giving informed consent to an abortion - i.e., she was not Gillick-competent.[74] In arriving at this conclusion, Her Honour considered that B was of below average intelligence and maturity due to overwhelming evidence. B's intellectual capacity had been likened to that of a 9 year old by her father, and a 6 year old by her obstetrician.[75] Furthermore, one of B's psychiatrists who had examined B's mental status had described her intellect as in the 'very low range, possibly even lower'.[76] Wilson J went even further by asserting, in obiter dicta, that it was 'unlikely that [even] a 12 year old child of average intelligence and

[62] *Re Imogen* [1].
[63] *Re Imogen* [2].
[64] *Re Imogen* [35].
[65] *Re Imogen* [35].
[66] *Re Imogen* [63].
[67] Stephanie Jowett and Fiona Kelly, 'Re Imogen: A step in the wrong direction' (2021) 34 A*ustralian Journal of Family Law* 31, 45.
[68] [2008] 2 Qd R 562 *('Queensland v B').*
[69] [2017] 1 Qd R 87 *('CQHHS v Q').*
[70] *Queensland v B* (n 61) [2].
[71] Ibid.
[72] Ibid.
[73] Ibid [17].
[74] Ibid [15].
[75] Ibid [16].
[76] Ibid.

maturity could fully understand the significance of a termination of pregnancy, including the immediate and long term risks to herself as the mother of the baby'.[77]

After concluding that B was not Gillick-competent, Wilson J analogised B's case to *Marion's Case,* holding that B's parents should not be able to consent to the abortion because there were 'risks of [the parents] making the wrong decision and grave consequences of their doing so'.[78] Clearly, Wilson applied the test for identifying a 'special medical procedure'; however, it is worth noting that Her Honour did not specifically signpost the term 'special medical procedure'. Nevertheless, Her Honour's reasoning for holding that court authorisation was necessary in this case drew directly from much of the reasoning in *Marion's Case* which led to the conclusion that sterilisation is a 'special medical procedure'. Specifically, in terms of the 'risks of making the wrong decision', Her Honour considered that the Court, exercising its *parens patriae* jurisdiction, would have to act in the best interests of the child while B's parents may factor other and conflicting interests into the decision.[79] Furthermore, as with sterilisation, the medical profession may 'play a central role in the decision to terminate the pregnancy' and 'the procedure itself'.[80] As such, as was held in *Marion's Case,* the Court would serve to ensure that relevant and important non-medical perspectives (such as social or psychological perspectives) were also considered in the decision-making process.[81] Wilson J appeared to hold that the 'grave consequence' of making the wrong decision to terminate a pregnancy is that the mother may ultimately give birth to a live baby.[82]

Summary of *Central Queensland Hospital and Health Service v Q*[83] [2017] 1 Qd R 87

This case was heard approximately 8 years after *State of Queensland v B.* Q was a 12 year old who, at the time of the proceedings, was approximately 9 weeks pregnant.[84] Q was a patient at a public hospital conducted by the applicant, Central Queensland Hospital and Health Service.[85] The applicant applied to the Queensland Supreme Court in its *parens patriae* jurisdiction seeking authorisation of the termination of Q's pregnancy.[86]

McMeekin J, the presiding judge, followed *Marion's Case* and applied the Gillick competency test. His Honour found that Q was a mature child who was not 'intellectually handicapped as was the 12 year old in *State of Queensland v B* and who may even have possessed a higher level of maturity than her chronological age'. Although Q appeared to possess a 'very good understanding' of the risks of an abortion procedure[87], His Honour accepted a psychiatrist's report that Q's understanding was only that which is typical of a 12 year old. The psychiatrist, who had only seen Q once, reported that she had a very limited idea of the process of pregnancy and no idea of the realistic emotional and physical demands part of child-rearing and caretaking. In light of this, McMeekin J upheld Wilson J's view that a 12 year old typically lacks the maturity to understand the decision to terminate a pregnancy.[88]

In addition to concluding that Q was not Gillick-competent by virtue of her age as a 12 year old, McMeekin J upheld (without analysis or justification) Wilson J's view that termination of pregnancy is a procedure where parental consent is arguably insufficient.[89] As such, it was held that court authorisation for Q's abortion was necessary.

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[77] Ibid.
[78] Ibid [17].
[79] Ibid.
[80] Ibid.
[81] Note that Wilson J did not herself assert this, the author is merely inferring that this was Wilson J's reasoning behind considering it important that the medical profession would play a role in the decision-making process.
[82] *Queensland v B* (n 61) [17].
[83] *CQHHS v Q.*
[84] Ibid [1], [6].
[85] Ibid [1].
[86] Ibid [2].
[87] Ibid [30].
[88] Ibid [32].
[89] Ibid [20].

4.2 Commentary on *State of Queensland v B* and *Central Queensland Hospital and Health Service v Q*

1. Can a 12 year old satisfy the Gillick competency test?

Both Wilson J and McMeekin J held that 12 year olds, by virtue of their age, typically cannot satisfy the Gillick competency test in relation to terminations.[90] Wilson J reasoned that 12 year olds could not fully understand the significance of a termination of pregnancy including the immediate and long term impacts; McMeekin J appeared to accept that a 12 year old may (as Q did) have a 'very good understanding' of the risks of the procedure but they will still typically lack the maturity to understand long term impacts.

Neither of Their Honours proceeded to explain a hypothetical 'threshold' age for understanding an abortion, much less substantiate their reasoning behind arriving at this age. Their Honours did not provide explanation for the finding that a 12 year old is unlikely to understand the impacts (short or long term) of an abortion; indeed, it could be argued that their assertion is unconvincing.

While neither judge commented upon the age at which a young person could be deemed Gillick competent and thus able to consent to a termination in their own right, it is clear that the older and more mature the minor the more likely they are to be found Gillick competent. Based on the current law each case will be fact specific and it is suggested that the treating doctor would be in the best position to assess Gillick competency.

2. Therapeutic vs Non-Therapeutic Special Medical Procedures

Both Wilson J and McMeekin J neglected to consider whether abortion, as a special medical procedure, constituted therapeutic or non-therapeutic treatment in the respective cases of B and Q. In doing so, their Honours failed to acknowledge that *Marion's Case* did not exclude all special medical treatments from falling within the scope of a parent's authority to consent on behalf of their Gillick-incompetent children. Indeed, as per the majority of the High Court in *Marion's Case,* special medical treatments such as abortion may fall within the scope of a parent's authority if the treatment is therapeutic. This conclusion was also confirmed by the minority judges in *Re Kelvin.* The majority judges came to the same conclusion, if the therapeutic benefits of the treatment outweigh the risks of the treatment. Given that prior to the introduction of the *Termination of Pregnancy Act 2018*, doctors routinely had to assess the therapeutic benefits of terminations in order to legally perform the procedure, it is expected that this would be a relatively straightforward task for experienced doctors.

In *Central Queensland Hospital and Health Service v Q*[91]*,* McMeekin J acknowledged that Q was at risk of suffering serious psychological and physical harm if the pregnancy was not terminated. At the time of the case, Q had a very recent history of self harm and suicidal attempts. This was confirmed by Q,[92] her parents[93] and her psychiatrist.[94] Furthermore, both of Q's parents and her psychiatrist advised that a failure to terminate Q's pregnancy would result in a significant, increased risk of patterns of self harm and suicidal thoughts. In corroboration with this advice, Q's obstetrician concluded that the risks of continuing the pregnancy, some of which were life threatening, far outweighed the risks involved in the abortion. The overwhelming nature of this evidence was recognised by McMeekin J who stated that the 'evidence was all one way' in favour of termination. Clearly, the chief purpose of the termination of pregnancy procedure was to ameliorate or prevent the significant psychiatric and physical risks of continuing the pregnancy. There is no issue suggesting that a termination of pregnancy procedure is not appropriate or proportionate to the purpose of terminating a pregnancy. As such, it appears plainly uncontroversial that Q's abortion constituted 'therapeutic treatment' as defined in *Marion's Case*. Therefore, even if Q was held not to be Gillick

[90] Wilson J only discussed this in obiter dicta.
[91] *CQHHS v Q.*
[92] Ibid [10].
[93] Ibid [12].
[94] Ibid [15].

competent (which, as discussed in section b(1) of this paper, does not seem open on the facts) then the court should have held that Q's parents had the authority to consent to the abortion on her behalf.

B's case is largely analogous to Q's case. Wilson J accepted the opinions of the two psychiatrists and the obstetrician who had examined B and found that the 'continuation of her pregnancy would pose serious danger to her mental health and well-being, beyond the normal dangers of pregnancy and childbirth'. The specialists opined that the abortion was the only way to avert the aforementioned dangers and the procedure would not be disproportionate. Again, applying the definition of 'therapeutic treatment' from *Marion's Case*, it is clear that B's abortion also constituted 'therapeutic treatment'. As B was not Gillick-competent due to her low maturity and intelligence, the court should have held that her parents had the authority to consent to the abortion on her behalf.

5. Where are we now?

This area of law is complex. The High Court's rationale in *Marion's Case* has arguably been incorrectly applied in the Queensland cases concerning abortion for minors. Specifically, the Gillick competency test has potentially been misapplied to hold that 12 year olds can never consent to abortions in their own right. The therapeutic/ non-therapeutic distinction for special medical procedures has not been duly considered, meaning that according to these cases parents cannot consent to terminations on behalf of their Gillick incompetent child. No guidance has been given as to the age at which a minor may be considered sufficiently mature to be Gillick competent and consent to a termination of pregnancy in their own right.

The most recent gender dysphoria case further complicates the legal position. Should the position in *Re Immogen* remain unchallenged, the position would appear to be that where there is any dispute between the minor, parents or medical practitioners regarding the special medical procedure, court authorisation is required. This applies even where the child is assessed by medical practitioners to be Gillick competent. It also seems to apply where a parent is absent. Taken at its extreme, this means that medical practitioners need to confirm with both parents that they agree to the special medical procedure, even when the minor is Gillick competent.

The diagram (annexure A) aims to explain the current legal position. It should be noted that this is based on our analysis of the current legal position which is unsettled. The Queensland cases are prior to the most recent gender dysphoria cases which provide a more contemporary analysis of *Marion's Case* based on a greater understanding of the medical treatments for gender dysphoria. It is suggested that should the issue of a Gillick incompetent minor seeking termination be further considered by the Courts, the gender dysphoria case of Re Kelvin would be highly persuasive resulting in a different outcome to the two Queensland termination cases.

6. Legislative Reform

Based on this research paper it is suggested that Parliament should amend the *Termination of Pregnancy Act* to make it clear:

- That a termination is not a 'special medical procedure' as defined in Marion's Case
- That a Gillick competent minor can consent to a termination in their own right.
- That a qualified medical doctor can assess Gillick competency for this purpose.

Where the minor is not Gillick competent, the amendment should make it clear that:

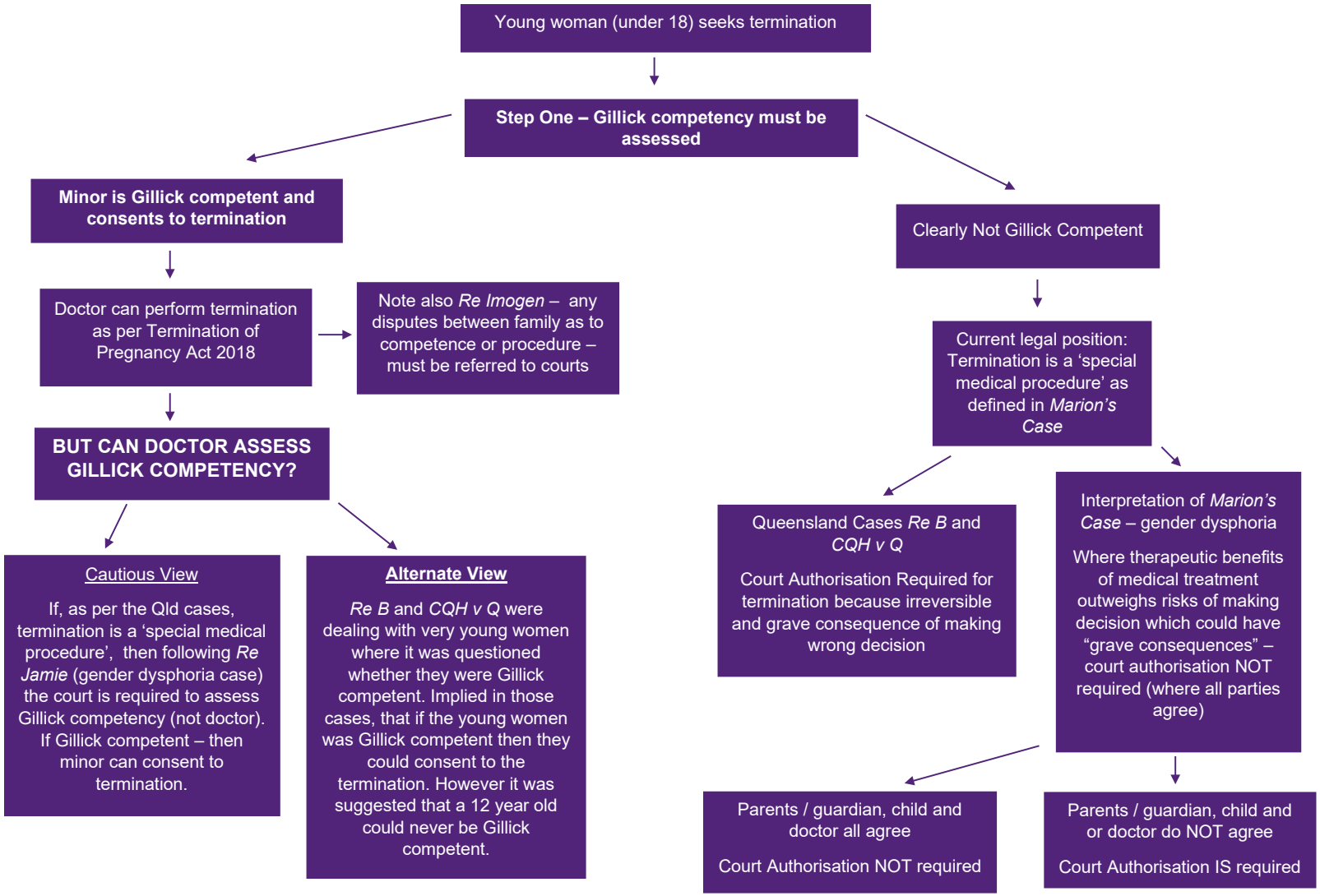
- where the child, parents/ legal guardian and medical professionals agree that the termination is appropriate, the parent / legal guardian can consent to the termination on the child's behalf. (some consideration needs to be given as to how to deal with situations where one parent is absent)

- If there is any disagreement between the parties then court authorisation for the procedure should be sought. (it would be difficult to avoid this as the Court has jurisdiction for the welfare of minors).

7. Conclusion

The law surrounding the access that minors have to important medical procedures, particularly abortions, is unclear. Our analysis suggests that the two Queensland courts dealing with termination of pregnancy for a minor (12 years of age) have incorrectly applied the principles endorsed by the High Court in *Marion's Case* . It is suggested that upon proper interpretation of *Marion's Case,* arguably there currently exists an avenue for parents to consent to abortions on behalf of minors who do not satisfy the Gillick-competency test. This avenue is found in the therapeutic/ non-therapeutic distinction of special medical procedures. As it stands, the failure to consider this distinction in the Queensland cases has led to prolonged court cases for minors who are already experiencing the mental and physical difficulties of pregnancy (which are exacerbated due to their youth and in some cases, intellectual or physical disabilities). The authors stress the importance of immediate attention to this issue. The recommendations which have been provided will seek to clarify the law and ultimately, create a more accessible, fair and considerate legal system.

8. Appendix – Gillick Competency Flow Diagram



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