AUDIT FINDINGS

Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents, Version 1.4

The Royal Children's Hospital Melbourne, endorsed by the Australian Professional Association for Trans Health (AusPATH), November 2023

Three structural findings against Australian regulatory frameworks

1. Auditing Organisation

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2. Document Under Audit

Title	Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents
Version	Version 1.4
Publication Date	November 2023
Suggested Citation	Telfer, M.M., Tollit, M.A., Pace, C.C., & Pang, K.C. Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents Version 1.4. Melbourne: The Royal Children's Hospital; 2023
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Length	32 numbered pages, 70 references
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3. Audit Methodology

This audit (oracle testing against regulatory requirements) applies documentary analysis only. Each finding is verifiable from the document itself by reading the page reference cited. No contested empirical or clinical claims about gender-affirming care for minors are required for any finding to be sustained.

The Australian regulatory frameworks against which the document is tested include:

- National Health and Medical Research Council Standards for Clinical Practice Guidelines (Standards 5, 6, 9)
- Australian Commission on Safety and Quality in Health Care informed consent framework
- Rogers v Whitaker (1992) 175 CLR 479 – material risk disclosure standard
- AHPRA Good Medical Practice: A Code of Conduct for Doctors in Australia
- Australian Consumer Law s.18 (misleading or deceptive conduct in trade or commerce)
- Re Kelvin [2017] FamCAFC 258 and Re Imogen [2020] FamCA 761 – paediatric gender medicine consent framework

These frameworks apply to clinical practice in Australia regardless of whether the document under audit cites them. The audit asks whether the document under audit satisfies, engages with, or specifies processes adequate to satisfy the requirements of those frameworks. Where it does not, the finding rests on the document's own text and the framework's settled requirements, both checkable independently.

Three findings are presented. Each is independently sufficient. The findings do not depend on one another to land.

Finding 1 — The reference list omits the 2018–2023 international evidence available at time of publication

Statement

The Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents, Version 1.4 (November 2023) (hereafter ASTGTG v1.4) is the AusPATH-endorsed Australian clinical standard for paediatric gender-affirming care. Its reference list (pp.31–32) comprises seventy references, all dated 2017 or earlier. No reference is dated 2018, 2019, 2020, 2021, 2022, or 2023. The omission spans six full publication years during which the international evidence base for paediatric gender-affirming care was the subject of multiple government-commissioned systematic reviews, national health authority policy revisions, and superior court decisions, each directly addressing the two principal interventions specified in the document — puberty suppression and gender-affirming hormone treatment. The acknowledgments page identifies a substantial AusPATH GP Working Group as contributing to "the updated GP section in Version 1.4" (p.2), yet no new references appear in the document corresponding to that update.

Evidence

References 1–70 (pp.31–32). The latest dated references include Hembree et al. 2017 (ref 14, Endocrine Society guideline), Mahfouda et al. 2017 (ref 65, puberty suppression), Strauss et al. 2017 (ref 7, Trans Pathways), Marinkovic and Newfield 2017 (ref 69, chest reconstruction), and Milrod and Karasic 2017 (ref 70, vaginoplasty surgeons' attitudes). **No reference is dated 2018 or later.** The document's imprint at p.19 reads "230242 November 2023"; the suggested citation at p.2 reads:

> *"Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents Version 1.4. Melbourne: The Royal Children's Hospital; 2023."* (p.2)

International outputs available at time of publication (November 2023) that the document does not engage:

- The Cass Review interim report (Hilary Cass, February 2022), a UK-commissioned independent review of gender identity services for children and young people, covering directly the population the document addresses.
- NICE evidence reviews of puberty suppressants (E1) and gender-affirming hormones (E2) for children and adolescents with gender dysphoria (March 2021).
- The Karolinska Institute / Karolinska University Hospital position statement (April 2021) restricting puberty blockers and gender-affirming hormones in those under 18 outside approved research protocols.
- Swedish National Board of Health and Welfare revised guidance (February 2022).
- Finnish COHERE national guideline revision (June 2020).
- Bell v Tavistock [2020] EWHC 3274 (Admin) and the Court of Appeal decision in Quincy Bell v Tavistock and Portman NHS Foundation Trust [2021] EWCA Civ 1363, addressing capacity to consent in adolescents.
- Tavistock GIDS service review and closure announcement (NHS England, July 2022).
- Peer-reviewed literature 2018–2023 on persistence, desistance, regret, and detransition.

The omission spans across source categories. It is not limited to dissenting authors. It includes the position revisions of UK, Swedish, and Finnish national health authorities, NICE evidence reviews commissioned by the same authority that had previously supported the Dutch protocol, and UK superior court decisions. The 2023 v1.4 update added substantive content — the GP-led prescribing pathway at roles 11a and 11b (pp.21–22) — without introducing a single 2018–2023 reference into the document.

A 2023 update adding no 2018–2023 literature, after six years during which the field was the subject of multiple national reviews, suggests selection rather than oversight. This is an observation about what the reference set contains and what it omits, not a claim about the motivations of the document's authors.

Regulatory significance

The Australian National Health and Medical Research Council Standards for Guidelines (Standard 6, on evidence base; Standard 8, on currency and updating) require guideline documents to engage with the current evidence base and to be periodically updated. A document with no 2018–2023 references whose v1.4 update adds none does not demonstrate compliance with Standard 6 or 9.

AHPRA's **Good Medical Practice: A Code of Conduct for Doctors in Australia** (section 1.2.3 on practising in accordance with current and accepted evidence-based standards) requires practitioners to incorporate the best available evidence into their practice. A clinician following a peak-body-endorsed paediatric guideline that omits the major 2018–2023 evidence reviews of the same interventions is exposed to the argument that their practice is not informed by the best available evidence.

The Australian Consumer Law s.18 (misleading or deceptive conduct) is engaged where any clinic or organisation represents the document as reflecting current evidence-based practice, when the document's reference set caps at 2017 and excludes the post-2018 international reviews.

The strength of this finding is that anyone can verify it in minutes by reading the dates listed pp.31–32. The omission is documentary and uncontested.

Finding 2 — No consent process is specified in a document governing irreversible interventions in minors

Statement

ASTGTG v1.4 is the AusPATH-endorsed Australian clinical standard for paediatric gender-affirming care. Its only stated consent requirement is that "informed consent has been obtained" (p.23 criterion 4; p.24 criterion 3). The document does not specify what disclosures must precede consent, contains no consent form template or appendix, sets no minimum content for material-risk disclosure, prescribes no process for verifying the patient's understanding of the information provided, and does not engage the Australian Commission on Safety and Quality in Health Care (ACSQHC) informed consent framework. The population to which this absence applies is minors, for whom Australian law and clinical practice typically prescribe heightened consent duties.

Evidence

The criteria for commencement of puberty suppression (p.23) require:

> *"The treating team should agree that commencement of puberty suppression is in the best interest of the adolescent and assent from the adolescent and informed consent from their legal guardians has been obtained."* (p.23, criterion 4)

The criteria for commencement of gender-affirming hormone treatment (p.24) require:

> *"The treating team should agree that commencement of oestrogen or testosterone is in the best interest of the adolescent and informed consent from the adolescent has been obtained."* (p.24, criterion 3)

Neither criterion specifies what "informed consent" must encompass. The clinician role descriptions reference information provision without specifying its content:

> *"Provision of information and education to the adolescent and their parents/carers regarding options for medical transitioning including risks and benefits of puberty suppression and gender affirming hormones."* (p.19, paediatrician role 4; substantially identical wording at p.20 gynaecologist role 3 and p.21 GP role 5)

> *"Provision of education to enable adolescents and their families to make informed decisions regarding treatment options."* (p.20, nursing role 4)

No minimum disclosure content is specified anywhere in the document. There is no consent form, no template, no enumeration of required disclosures, no documentation standard, no verification of understanding process.

The document acknowledges multiple material uncertainties in its body text without requiring these be disclosed in the consent process:

> *"There is no empirical evidence to provide objective recommendations for the appropriate age for introduction of oestrogen or testosterone."* (p.16)

> *"The long term impact of puberty suppression on bone mineralisation is currently unknown."* (p.15)

> *"The degree to which testosterone may reduce one's reproductive potential when taken in adolescence and early adulthood is unknown."* (p.13)

> *"For trans females, there is evidence that oestrogen impairs sperm production, although whether these effects are permanent remain unknown."* (p.13)

Tables 1 and 2 on p.16 mark reversibility as "Unknown" for decreased sperm production, decreased testicular volume, clitoral enlargement, and vaginal atrophy. None of these acknowledgments is converted by the document into a required disclosure.

Material risk categories absent from the document altogether: detransition rates (zero mentions); persistence of mental health comorbidities post-treatment (not addressed; the document's framing is inverse, at pp.3 and 12); lifelong medical dependency (implied at p.26 but not framed as a material risk); cognitive and neurological effects of puberty suppression during the suppression window (not addressed); cardiovascular and venous thromboembolism risk in adolescent hormone treatment (not addressed); pelvic floor and urogenital effects of long-term testosterone (not addressed); evidence-quality framing for the cited studies (not characterised by certainty rating).

The document does not engage the ACSQHC informed consent framework. The ACSQHC fact sheet for clinicians specifies four conditions for valid consent (legal capacity, voluntary, specific to intervention, sufficient information including risks, benefits and alternative options) and a six-element capacity test, with material risks defined by reference to Rogers v Whitaker (1992) 175 CLR 479. ASTGTG v1.4 does not cite the ACSQHC, does not cite Rogers v Whitaker, and prescribes no process aligned with either.

Regulatory significance

Two structural exposures follow.

First, the Rogers v Whitaker standard applies regardless of whether the document cites it. A risk is material if a reasonable person in the patient's position would likely attach significance to it. A reasonable person — or, in the paediatric context, the parent or guardian acting on the child's behalf, alongside the child where Gillick-competent — considering puberty suppression or gender-affirming hormones for a minor would likely attach significance to
(a) the absence of empirical evidence for objective age cut-offs, which the document itself acknowledges at p.16;
(b) the unknown long-term effects on bone mineralisation, which the document itself acknowledges at p.15; (c) the unknown effects on fertility, which the document itself acknowledges at p.13; and
(d) the systematic reviews published 2020–2024 characterising the supporting evidence as low or very low certainty, which the document does not engage (cross-reference Finding 1).

A clinician following the ASTGTG framework whose consent conversation omits these matters is exposed to the argument that material risks were not disclosed under the Rogers v Whitaker standard.

Second, the population is minors, for whom the Australian legal framework is more developed than for adults. The Full Court of the Family Court in Re Kelvin [2017] FamCAFC 258 held that court authorisation was not required for stage 2 hormone treatment in cases without dispute, on the basis that the diagnostic, multidisciplinary, and consent processes specified in the prevailing Australian clinical guidelines provided sufficient safeguards. Where the operational standard specifies no consent process — no minimum disclosure, no verification of understanding, no documentation — the safeguard presumption underpinning the Re Kelvin framework is exposed. Re Imogen [2020] FamCA 761 clarifies that disputes about competence, diagnosis or treatment still require court authorisation, a process that itself presumes the underlying clinical assessment has been conducted under a specified standard — a standard this document does not provide.

The strength of this finding, like Finding 1, is that the absence is documentary and verifiable on inspection. There is no consent form in the document. There is no minimum content specification. There is no verification process. These absences are observable in minutes from the document itself, against a settled Australian legal standard for material-risk disclosure that the document does not engage.

Finding 3 — Internal inconsistency between the mandatory criteria and the Version 1.4 GP-section update

Statement

ASTGTG v1.4 specifies criteria for commencement of puberty suppression (p.23) and gender-affirming hormone treatment (p.24) which include diagnosis of Gender Dysphoria in Adolescence, made by a mental health clinician with specified expertise, as a precondition. The Version 1.4 update introduces a new section on the roles of the general practitioner (pp.21–22) which describes a GP-led prescribing pathway in which mental health professional referral is treated as discretionary ("if and as required"; "in some circumstances"). The two passages are not on their face reconciled. The document does not state whether MHP diagnosis is a mandatory precondition under the criteria, applied uniformly across all pathways, or a discretionary referral in the GP-led pathway.

Evidence

Criteria for commencement of puberty suppression (p.23) and gender-affirming hormone treatment (p.24) each specify, as criterion 1:

> *"A diagnosis of Gender Dysphoria in Adolescence, made by a mental health clinician with expertise in child and adolescent development, psychopathology and experience with children and adolescents with gender dysphoria."* (p.23, criterion 1; identical wording at p.24, criterion 1)

The Version 1.4 update to the GP section, at p.21 role 11a, specifies:

> *"GPs with sufficient expertise and skill in initiating and monitoring hormone therapy can consider initiating and optimising hormone therapy for suitable Gillick competent minors. This would typically be within a primary care led multidisciplinary team tailored to the patient's needs and availability of services, which may include non-GP specialists, such as paediatricians, adolescent physicians, paediatric or adult endocrinologists, sexual health physicians, fertility specialists, nurse practitioners, dietitians, speech therapists or social workers. Many young gender diverse people benefit from mental health support, and GPs should discuss this with patients and offer referrals to psychologists, psychiatrists, or other mental health professionals if and as required."* (p.21, role 11a)

At p.22 role 11b:

> *"In some circumstances, the GP/prescribing clinician might not be confident to assess the appropriateness of gender affirming medical treatments, or a patient's readiness to commence these treatments by themselves or may be uncertain about the patient's ability to consent to treatment. In these circumstances a referral should be made to a qualified mental health professional with experience in providing gender affirming care, so that the patient is supported to find the right pathway of treatment for their needs. The mental health professional can support a patient's exploration of their identity, assess their decision-making capacity, and help address any mental health concerns or complexities."* (p.22, role 11b)

A charitable reading would hold that the GP-section update does not displace the criteria. The GP coordinates a pathway that includes MHP diagnosis as a separate step satisfying p.23 or p.24 criterion 1, and the discretionary text about MHP referral refers only to additional support beyond that diagnostic step. The document does not foreground this reading. The GP-section text does not state “MHP diagnosis is required under the criteria; the discretionary referrals described below are additional to that mandatory step.” It states that GPs “should discuss this with patients and offer referrals to psychologists, psychiatrists, or other mental health professionals if and as required” without distinguishing diagnostic referral from supportive referral. The multidisciplinary team list at role 11a — which describes who the GP-led pathway “may include” — does not name mental health professionals as a required member.

A separate point of inconsistency arises in the specification of the mental health professional. The criteria at p.23 and p.24 require “a mental health clinician with expertise in child and adolescent development, psychopathology and experience with children and adolescents with gender dysphoria.” The GP-section update at p.22 specifies “*a qualified mental health professional with experience in providing gender affirming care*.” These are not the same specification. The first describes expertise in development and psychopathology; the second describes orientation to gender-affirming care. A clinician who satisfies one may not satisfy the other. The document does not state which specification governs.

Regulatory significance

Internal inconsistency between mandatory criteria and operational guidance is a guideline-quality problem under NHMRC Standards for Clinical Practice Guidelines, which require recommendations to be clear, consistent, and applicable. Clinicians attempting to follow ASTGTG v1.4 receive different operational instructions depending on which passage of the document they consult. A clinic that operates a GP-led prescribing pathway on the strength of the v1.4 update, without obtaining MHP diagnosis under the specification at criterion 1, may believe itself to be in compliance with the document while not satisfying the document’s own stated criteria.

Two further regulatory exposures follow.

First, the Family Court reasoning in Re Kelvin [2017] FamCAFC 258 presumed proper diagnostic processes — a presumption explicitly grounded in the prevailing Australian clinical guidelines at the time. Where the operational document permits, or appears to permit, a GP-led pathway without explicit MHP diagnosis, the presumption is exposed. A dispute under Re Imogen [2020] FamCA 761 — about diagnosis, competence, or treatment — would require court authorisation; if the GP-led pathway has not obtained MHP diagnosis under the criteria’s specification, the question of whether diagnosis was properly conducted is open before the court.

Second, the GP section’s narrowed MHP specification (“qualified mental health professional with experience in providing gender affirming care,” p.22) raises an additional concern about referral integrity. Referral to a clinician selected on the basis of orientation to gender-affirming care, rather than on the basis of expertise in child and adolescent development and psychopathology, may not satisfy the criteria’s specification at p.23 and p.24. A clinician with experience in providing gender-affirming care has, by description, an orientation toward providing it. The criteria’s specification — expertise in development and psychopathology — describes an orientation toward assessing it. The two are different professional postures. Where the criteria require the second and the operational pathway directs to the first, the criteria’s requirement is not satisfied.

The strength of this finding is that it rests on two passages of the same document placed side by side. A reader can verify it by reading pp.21–22 and then reading p.23 and p.24 in sequence. The inconsistency is documentary, internal, and uncontested.

How the three findings relate

Each finding is independently sufficient. Finding 1 is a binary documentary check on the reference list. Finding 2 is the absence of consent process specification in a paediatric document. Finding 3 is internal inconsistency between two passages of the same document. None requires the reader to take a view on contested clinical or empirical questions about gender-affirming care. Each is verifiable from the document itself in minutes.

Compounded, they describe a peak-body-endorsed Australian paediatric clinical standard that
(a) does not engage the international evidence base from the past six years, including the major systematic reviews and national health authority revisions;
(b) specifies no consent process at the level of disclosure, alternatives, or verification, in a document governing irreversible interventions in minors; and
(c) is internally inconsistent on whether mental health professional diagnosis is mandatory or discretionary. These are three different points of failure on the same general Australian framework — NHMRC Standards for Guidelines, ACSQHC informed consent, Rogers v Whitaker, AHPRA Code of Conduct, Re Kelvin / Re Imogen — that the document does not engage but which apply regardless.

If one finding were to lead a submission, Finding 2 is the strongest in regulatory terms because it converts directly into Rogers v Whitaker exposure for any clinician operating under the document's instruction and into a Re Kelvin presumption issue for the paediatric legal framework as a whole. Finding 1 is the easiest to verify (read the reference list at pp.31–32; the omission is binary). Finding 3 is the most surgical because it identifies an internal contradiction the document does not resolve, and it shows the v1.4 update moving the children's standard in the direction of the adult AusPATH standard rather than away from it.