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Case Note

Should court authorisation be required for surgery on intersex children? A critique of the Family Court decision in *Re Carla*

Fiona Kelly* and Malcolm K Smith†

Introduction

In its 2013 report on involuntary or coerced sterilisation of intersex people, the Australian Senate concluded that ‘in light of the complex and contentious nature of the medical treatment of intersex people’, oversight of medical-decision making is required for those who are too young to provide informed consent.¹ It was recommended that all proposed medical interventions for intersex children require authorisation from either a state civil or administrative tribunal or the Family Court of Australia.² It further recommended that ‘normalising treatment’ — that is, non-medically necessary surgeries that are designed to ‘enhance’ the visual presentation of a child’s genitalia — be deferred until the child can give ‘fully informed consent’.³ The Senate’s recommendations are consonant with a recent joint statement of four United Nations Committees, which recommended that ‘States must, as a matter of urgency, prohibit medically unnecessary surgery and procedures on intersex children.’⁴

A recent trial decision of the Family Court of Australia, *Re Carla*, took a very different position to both the Senate and the United Nations. In *Re Carla*,⁵ the parents of a 5-year-old intersex child brought an application to the Family Court requesting that the Court authorise them to consent to surgery to remove their child’s gonads, as well as ‘any further or necessary and consequential procedures to give effect to her treatment’ as recommended by her medical team. The parents also asked the Court to determine whether it

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1 Senate Community Affairs Reference Committee, Parliament of Australia, *Involuntary or coerced sterilisation of intersex people in Australia* (2013) Recommendation 5 xiii (‘*Senate Report*’).

2 Ibid Recommendation 6 xiii.

3 Ibid Recommendation 3.

4 UN Committee against Torture, the UN Committee on the Rights of the Child, the UN Committee on the Rights of People with Disabilities, and the UN Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, *End violence and harmful medical practices on intersex children and adults, UN and regional experts urge* (24 October 2016) <<http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20739&LangID=E>>.

5 (2016) 54 Fam LR 576.

was necessary for them to have applied for Court authorisation before the surgery could be performed. Forrest J accepted the uncontested medical evidence presented to the Court, as well as the views of the parents, both of which were unchallenged by the relevant government department, ultimately holding that the surgery was in Carla's best interests. It was Forrest J's view that there was 'no reason to delay the procedure especially given that there are physical and psychological risks associated with such a delay and particularly given that it will be less psychologically traumatic for Carla if it is performed before she is able to understand the nature of the procedure'.⁶ Forrest J also held that the Court's approval was *not* required to authorise doctors to perform the gonadectomy because the treatment was medically necessary and thus therapeutic.

In this case note, we argue that the decision in *Re Carla* sets a troubling precedent. Two key concerns are identified. First, the ruling appears to allow parents to authorise life-altering surgeries on babies and young children without the need for court approval in situations where the preponderance of medical opinion may actually support delay. The decision as to whether to pursue surgery is an agonising one for parents, and we do not doubt that they have their children's best interests at heart. However, surgical interventions are not always supported by current medical evidence and may, whether consciously or unconsciously, have more to do with alleviating parental and medical discomfort with the ambiguity surrounding the child's gender, than with furthering the child's best interests. Second, we argue that the reasoning and analysis concerning the therapeutic nature of the proposed surgery lacks rigour. In particular, we question the conclusion that the surgery should not have been deferred until Carla was old enough to confirm, or at least provide more evidence of, her gender identity.

Consonant with the recommendations of the Senate and Australia's anti-discrimination laws,⁷ this case note adopts the umbrella term 'intersex' to describe the 'range of congenital physical traits or variations that lie between ... male and female',⁸ rather than the medical term 'disorders of sexual development'. Intersex is the term most popularly recognised and preferred by the majority of intersex people and Australia's leading support and advocacy organisations.⁹ Intersex is also used strategically to highlight the slippage that occurs in cases such as *Re Carla*, where the language of 'disorder' enables judges and medical professionals to conflate surgical procedures that are medically necessary (and therefore argued as therapeutic), with those that are purely psychosocial.

6 Ibid 582 [30].

7 The *Sex Discrimination Act 1984* (Cth) was amended in 2013 to provide a legal definition of 'intersex status' in Section 4: 'Intersex status means the status of having physical, hormonal, or genetic features that are: (a) neither wholly female nor wholly male; or (b) a combination of male and female; or (c) neither female nor male.'

8 OII Australia — Intersex Australia, *Intersex for Allies* (21 November 2012) <<https://oii.org.au/allies/>>.

9 While the term intersex is not universally accepted, Australia's two leading advocacy and support groups, OII Australia and the Androgen Insensitivity Syndrome Support Group, use the term.

The facts

Carla was born with what the court refers to as a ‘sex development disorder’ known as 17 beta hydroxysteroid dehydrogenase 3 deficiency (17 β -HSD3). Carla is genetically male, but due to minimal in-utero exposure to androgens, her male organs were ‘under virilised’ at birth. She was born with gonads that were located intra-abdominally, and not contained within a scrotum. Carla has no female reproductive organs, but her genitals have the general appearance of a female child. On the basis of medical advice provided soon after her birth, Carla’s parents decided to raise her as a female ‘with the understanding that her gender identity would be assessed when it was developmentally appropriate to do so’.¹⁰ When she was 4 years old, Carla underwent a surgical procedure to ‘feminise [her] external appearance’.¹¹ The procedure was a ‘clitoral’¹² recession and labiaplasty.¹³ A clitoral recession involves the reduction of the visual prominence of the clitoris, usually conducted to make the genitalia look more ‘feminine’.¹⁴ The surgery was conducted without Family Court approval.

In 2016, when Carla was 5 years old, her parents brought an application to the Family Court, requesting that the Court authorise them to consent to surgery to remove Carla’s gonads, as well as ‘any further or necessary and consequential procedures to give effect to her treatment’ as recommended by her medical team. The proposed surgery involved the bilateral removal of Carla’s gonads, which would render her infertile. It was further proposed that as Carla approached the age of 12, she should commence taking oestrogen in increasing doses to induce female pubertal development. She would then continue to take oestrogen for the rest of her life. It was also suggested that Carla might require additional surgery in the future to ‘enable her vaginal cavity to have adequate capacity for sexual intercourse’.¹⁵ Surgery of this kind was treated in the application as a ‘further or necessary and consequential procedure’ for which the parents’ sought approval in advance as part of the one application to the Court. The application was supported by affidavit evidence from Carla’s parents, as well as her treating paediatric specialists — an endocrinologist (Dr C), a surgeon (Dr B), and a psychiatrist (Dr S). The Director General of the ‘relevant government department’ (the report does not disclose the name of the department), who was given leave to appear as a friend of the Court, did not oppose the orders sought by the parents. Carla was

¹⁰ *Re Carla* (2016) 54 Fam LR 576, 580 [13].

¹¹ *Ibid* 578 [2].

¹² Forrest J places ‘clitoral’ in inverted commas because Carla does not actually have a clitoris.

¹³ A labiaplasty alters the appearance of the labia, the folds of skin surrounding the vulva. It is a purely cosmetic procedure with no medical benefit. Risks of the surgery include permanent scarring, infections, bleeding, irritation, and nerve damage leading to increased or decreased sensitivity.

¹⁴ Research on intersex adults who underwent clitoral recession as children has found that it contributes to significant impairment to sensitivity in the clitoris, as well as an increase in the inability to achieve orgasm. It has also been reported by intersex adults who have undergone clitoral recession as children that they frequently experience pain during sexual arousal. Catherine L Minto et al, ‘The effect of clitoral surgery on sexual outcome in individuals who have intersex conditions with ambiguous genitalia: a cross-sectional study’ (2003) 361 *Lancet* 1252, 1252.

¹⁵ *Re Carla* (2016) 54 Fam LR 576, 580 [18].

not provided with an independent children's lawyer.

The decision

At the hearing, Forrest J made the orders the parents sought. However, he reserved the delivery of his reasons in order to respond to the question of whether the proposed surgery was a procedure that 'requires the sanction of the Court'.¹⁶ The key issue was whether the surgery was a 'special medical procedure', and thus beyond the decision-making authority of Carla's parents. Counsel for the parents invited Forrest J to consider this question because in *Re Lesley*, a 2008 Family Court decision with almost identical facts, Barry J had held that the surgery fell 'squarely within the principles enunciated in *Marion's Case*'¹⁷ and thus required judicial approval.¹⁸

The decision in *Re Carla* raised two substantive issues. The first was whether the medical treatment proposed by Carla's parents, including the surgery to remove Carla's gonads, was in her best interests. The second was whether it was necessary for the parents to apply for Court authorisation before the surgery could be performed. While similar medical arguments were made in relation to both issues, they present two different legal questions and are therefore addressed separately.

(i) Was surgery in Carla's best interests?

Forrest J relied on the affidavit evidence of Carla's parents and her treating medical professionals to conclude that surgery was in Carla's best interests. In their affidavit, Carla's parents' stated that 'Carla acts as a girl' and does not identify as 'anything but female'.¹⁹ Dr C, Carla's endocrinologist, also formed the opinion that Carla identified as female. This conclusion was based on the parents' opinions and descriptions of Carla, as well as observations made at a medical appointment. The observations included that Carla had 'stereotypically female' interests, toys and favourite colours, evidenced by the pink curtains and Barbie bedspread in her room, and the presence of necklaces and lip gloss. She attended her medical appointment dressed in a floral skirt and shirt, with 'glittery sandals' and Minnie Mouse underwear. She wore her

¹⁶ Ibid 583 [35].

¹⁷ In *Department of Health and Community Services (NT) v JWB* (1992) 175 CLR 218 ('*Marion's Case*'), it was confirmed that the parental decision-making power is not unfettered and that there are certain types of medical procedures to which parents can never consent.

¹⁸ Barry J held, 'I accept a contrary view is arguable, but the better view is that this is a matter that falls squarely within the principles enunciated in *Marion's Case*': *Re Lesley* [2008] FamCA 1226 (12 December 2008) [38]. A similar position was reached in an earlier intersex case, *Welfare of a Child A*, where Mushin J stated:

There are clearly features of the proposed surgical procedures together with other factors involved in the complex determination to authorize those operations which result in the necessity, in order to ensure the protection of the interests of the child, that such decision to proceed with the proposed treatment should not come within the ordinary scope of parental power to consent to medical treatment. I conclude, therefore, that court authorisation is a necessary 'procedural safeguard' in the present case. *Re A* (1993) 16 Fam LR 715, 719 [20].

¹⁹ *Re Carla* (2016) 54 Fam LR 576, 580 [14].

'long blond hair' tied in braids. Her parents reported to Dr C that Carla had never requested that she be referred to using male pronouns and had never attempted to urinate standing up. It was thus concluded that Carla's gender identity was female and that surgery that supported her female identity was in her best interests.

The second piece of expert evidence provided in support of surgery related to the health risks associated with not removing Carla's gonads. It was the view of Drs B and C that surgery was in Carla's best interests because the positioning of Carla's gonads in the intra-abdominal cavity was such that if they were not removed, there was a risk of transformation into germ cell malignancy. In his affidavit, Dr C referred to the *Consensus Statement for Management of Disorders of Sexual Development* (2006), which puts the risk of malignancy in such circumstances as up to 28 per cent (an 'intermediate level').²⁰ Dr C's evidence was that due to the level of risk the *Consensus Statement* recommended removal. Dr B also indicated that there were limited alternatives to the proposed procedure. It was his evidence that because of the position of Carla's gonads, if they were left where they were it would be 'virtually impossible' to regularly monitor them for tumours.²¹ A possible alternative to surgical removal was to relocate the gonads outside the body so they could be more easily monitored. It was Dr B's view, however, that this option would likely have 'adverse psychological consequences'²² for Carla, though no specific evidence was cited in the judgment to support this claim. It was therefore Dr C's recommendation that surgery be performed to remove the risk of a tumour.

Dr C also provided evidence that not removing Carla's gonads might result in the production of testosterone as she approached puberty. This would result in a further virilisation of her body. Dr C conceded that 'in theory' male puberty could be suppressed hormonally, which would give Carla additional time to mature to the point where she could provide informed consent to surgery.²³ However, the doctor rejected this approach because it would involve ongoing medical oversight, require Carla to receive hormone injections every 3 months ('hormone blockers'), and prevent her from going through puberty at the same time as her peers.²⁴ Dr C concluded that the 'psychological risks to Carla of not undergoing the procedure outweigh the psychological risks to her of undergoing the surgery'.²⁵

In his decision, Forrest J identified the tumour risk as 'one of, if not the major reason for undertaking the proposed procedure'.²⁶ Based on the expert evidence provided to him it is not surprising Forrest J reached this conclusion. However, we are concerned that the evidence put to the Court is neither current nor accurate. Drs B and C both relied on the *Consensus Statement for*

20 Ibid 580–1 [19].

21 Ibid 581 [20].

22 Ibid 581 [20].

23 Ibid 581 [24].

24 Though it is notable that the proposed treatment protocol for Carla would also involve medical appointments and regular oestrogen injections from the age of 12 to induce female pubertal development.

25 *Re Carla* (2016) 54 Fam LR 576, 581 [26].

26 Ibid 580–1 [19].

Management of Disorders of Sexual Development (2006) to assess the risk of malignancy. It was their evidence that the *Consensus Statement* rated Carla's risk as an 'intermediate level' of risk and that surgery was thus recommended.²⁷ This recommendation, does not, however, conform to the *Consensus Statement*, which states that in the case of 17 β -HSD3, the gonads should be *monitored*, not removed,²⁸ and that the risk based on an individual assessment of the child may be significantly lower than the quoted rate. In fact, the *Consensus Statement* states that in a case such as Carla's the appropriate response is 'watchful waiting and possible biopsy'.²⁹

An additional concern is that the version of the *Consensus Statement* relied upon by the experts in *Re Carla* was out-of-date, particularly with regard to data on malignancy rates for children with 17 β -HSD3. More recent research, which was quoted in the 2013 *Senate Report* and would have been available to Carla's doctors, placed the risk of cancer for a child with 17 β -HSD3 at only 17 per cent.³⁰ These new estimates are considered more accurate as researchers have been able to draw on new diagnostic techniques as well as larger sample sizes. Most notably, diagnostic techniques now allow a *personalised* risk assessment to be carried out for each child, with a variety of factors to be taken into account, rather than assuming that every child with 17 β -HSD3 has a 17 per cent risk of cancer. An 'individualized management' of tumour risk is thus now recommended,³¹ particularly in cases such as 17 β -HSD where the 'quoting of risk estimates ... appears not necessarily to be based on strong evidence'.³² There was no evidence provided to the Court that an individualised assessment of Carla's risk of developing cancer was undertaken. Thus, while the risk of a tumour may justify surgery in some circumstances, in *Re Carla* the evidence provided to support a gonadectomy was based on a general (and inaccurate) risk of malignancy for *all children* with 17 β -HSD3, rather than the specific risk to Carla. Indeed, as the Senate noted: 'there are serious questions to be raised about ... why it is [children] facing "intermediate risk" should be subject to prophylactic gonadectomy in infancy ... In intermediate risk cases, the published literature has recommended gonadectomy only in some cases'.³³ The court was provided with no evidence that Carla's specific case was one that required surgery.

There is also growing evidence to suggest that doctors (and parents) may

27 Ibid.

28 P A Lee et al, 'Consensus Statement on Management of Intersex Disorders' (2006) 118 *Paediatrics* 488.

29 Ibid.

30 J Pleskacova et al, 'Tumor Risk in Disorders of Sex Development' (2010) 4(4-5) *Sexual Development* 7 (online version); Martine Cools et al, 'Disorders of sex development: update on the genetic background, terminology and risk for the development of germ cell tumors' (2009) 5 *World Journal of Pediatrics* 93.

31 M Cools, et al, 'Gonadal development and tumor formation at the crossroads of male and female sex determination' (2011) 5 *Sexual Development* 167, 178. The authors state that tumour risk in cases of immature and/or poorly differentiated gonadal tissue can be predicted, at least in part, from the presence of 'specific immunohistochemical markers'. This increase in knowledge therefore requires an 'individualized management with regard to tumor risk'.

32 *Senate Report*, above n 1, [4.33].

33 Ibid [4.29], [4.30].

conflate the risk of cancer with other non-medical concerns, such as the success of decisions made about sex of rearing. This issue was raised in the *Senate Report* in its chapter devoted to cancer risk in intersex people. After hearing substantial evidence on the issue, including from the experts who authored the more recent literature noted above, the Senate concluded that clinical decisions based on probabilities of cancer risk may ‘be encapsulating treatment decisions based on other factors’.³⁴ As the report explained:

Other matters such as ‘sex of rearing’ or ‘likelihood of gender dysphoria’ are interpolated into the discussion of cancer risk. This confusion between treatment options to manage cancer risk and treatment options to manage intersex could undermine confidence in the neutrality of those advocating for surgical interventions. [It is therefore important] that cancer-related treatment considerations are kept visibly separate from other factors (such as ... normalising treatments).³⁵

The absence of an independent children’s lawyer in *Re Carla* meant that no one had the specific task of protecting Carla’s interests in a situation where those interests may have been in conflict with those of her parents and doctors. Notably, there was no one to provide evidence about the appropriateness of treatment who was not heavily invested in the success of Carla’s ‘genital enhancement’ and gender assignment.³⁶ This is a case where it might have been appropriate to request evidence from an independent (non-treating) medical expert who could evaluate the medical plan for Carla. Without the evidence of an independent children’s lawyer or a neutral expert, Forrest J was not encouraged to reflect on the risk of Carla’s interests differing from those of her parents and doctors.

The final argument made by the parents and medical experts in support of surgery was that delaying surgery might result in the production of testosterone as Carla approached puberty. This would produce a further virilisation of her body, which would conflict with Carla’s female identity. Dr C conceded that ‘in theory’ male puberty could be suppressed hormonally, which would give Carla additional time to mature to the point where she could provide informed consent to surgery.³⁷ However, Dr C rejected this approach because it would involve ongoing medical oversight and hormone treatment.³⁸ It was Dr C’s view that the ‘psychological risks to Carla of not undergoing the procedure outweigh the psychological risks to her of undergoing the surgery.’³⁹ The risks Dr C identified as flowing from not having the surgery were depression and anxiety caused by the onset of male puberty.

We are concerned that the evidence provided by Dr C in relation to puberty blockers does not acknowledge that delaying puberty using blockers, the effects of which are fully reversible, is the internationally accepted medical

³⁴ Ibid [4.39].

³⁵ Ibid [4.28], [4.33].

³⁶ Organisation Intersex International Australia, *The Family Court case Re: Carla (Medical Procedure)* [2016] FamCA 7 (8 December 2016) <<https://oii.org.au/31036/re-carla-family-court/>>.

³⁷ *Re Carla* (2016) 54 Fam LR 576, 581 [24].

³⁸ Ibid 582 [28]. Though it is notable that the treatment proposed for Carla would also involved medical appointments and regular oestrogen injections from the age of 12 to induce female pubertal development.

³⁹ Ibid 581 [26].

protocol applied to pre-pubertal transgender children. Hormone blockers prevent transgender children from entering puberty, giving them time to mature sufficiently to make an informed decision about their gender identity without risking the psychological harm and dysphoria that often accompanies pubertal development. Thus, while it may not be ideal to experience delayed puberty, the potential benefit of suppressing puberty until an intersex adolescent can assert their competence to make medical decisions is an option that should not be dismissed lightly. Even where a child is yet to reach the *legal* standard expected for a determination of competency, it might be argued that a delay in surgical intervention (accompanied by hormone blockers to delay the onset of biological puberty), affords time for the child's gender identity to become more pronounced. It also provides greater opportunity for the *child* to provide evidence of their gender identity, rather than the Court relying solely on the observations of parents and medical professionals. In Carla's case, the onset of puberty is still years away, making it even harder to justify immediate surgery.

The only argument against surgery that was canvassed in *Re Carla* was that the removal of Carla's gonads prior to puberty would render her infertile. The medical evidence was that there was nothing that could be done prior to surgery that could preserve any fertility Carla might have. Extraction of sperm at the time of trial was not an option as Carla's testes had not matured sufficiently to produce viable sperm, and Carla could not produce female gametes as she has no female reproductive organs. It was thus conceded by the medical experts that the removal of Carla's testes would ensure her infertility. Somewhat surprisingly given the seriousness of the outcome, Forrest J dismisses the fertility implications of the surgery on two grounds. First, he relies on the evidence of Dr C that where a child's gonads are located intra-abdominally, the child may grow up to be infertile or sub-fertile anyway. Forrest J states that 'there is no certainty of future fertility if the surgery does not take place'.⁴⁰ While this is true, infertility is *guaranteed* if the surgery proceeds. Furthermore, the experts provided no evidence to support the assertion that Carla *herself* would be infertile or sub-fertile.⁴¹ Deferring surgery is the only way in which that question can be answered. Even if Carla was sub-fertile, developments over the past decade in *in vitro fertilisation* ('IVF') techniques mean that many sub-fertile men are able to become biological fathers by way of a technique that injects viable sperm directly into an egg. In fact, Dr C acknowledges that technologies might develop that would enable Carla to have a child of her own, including the possibility of sourcing mature sperm from cryopreserved pre-pubertal testicular tissue. However, the option of deferring surgery so that fertility could be determined is dismissed by Forrest J on the basis that 'the prospects of [new] technology are unknown at this stage'.⁴² Carla's parents, with the support of Dr C, also decided not to cryogenically store Carla's testicular tissue, making it impossible for her to benefit from any new technology that might emerge.

40 Ibid 582 [29].

41 The potential for fertility in individuals with 17 β -HSD3 is unknown: *Senate Report*, above n 1, [1.47].

42 *Re Carla* (2016) 54 Fam LR 576, 581–2 [27].

The second justification Forrest J provided for dismissing concerns about sterilisation was that preserving Carla's fertility may not be beneficial to her. In fact, Forrest J treated the possibility of Carla becoming a biological parent as potentially damaging. He stated that such a scenario 'raises ... significant social and emotional complexities', because Carla identified as female (at least according to her mother) and 'any fertility she could potentially attain is based on male gametes'.⁴³ In concluding that preserving Carla's fertility could be harmful to her, Forrest J relied on the evidence provided by Carla's parents and doctors that because she identified as female she would not want to use male gametes to reproduce. However, it is our view that this evidence was unconvincing for the following reasons.

When medical professionals identify an intersex infant, common practice is to insist on a gender assignment of male or female,⁴⁴ though Australia now permits a third category, 'intersex'.⁴⁵ In Carla's case, her parents were advised to raise her as a girl and they embraced this identity. It is this *parental* decision that formed the basis of the affidavit evidence that Carla identified as female. It was her *parents* who purchased her Barbie bedspread, her 'glittery' sandals, and her Minnie Mouse underwear, that are cited to support the assertion that she identifies as female. It was her *parents* who provided evidence to medical professionals and the Court to describe Carla's 'consistent' female gender identity. Yet, at no point in their evidence did the medical experts acknowledge that Carla had been socialised female or that she did not know she was intersex and might therefore have suppressed aspects of her gender identity that did not conform to her parents' messaging. Without a children's lawyer to represent her, there was also no opportunity for an independent third party who was not invested in the outcome of earlier surgery and the initial gender assignment to explore whether Carla's gender identity was likely to remain fixed. The research suggests that Carla may grow up to identify as female, but the opposite outcome is also possible. Studies that measure the impact of medical intervention on intersex children have shown that dissatisfaction with assigned sex⁴⁶ is as high as 40 per cent by adulthood, depending on the type of intersex variation present.⁴⁷ In fact, research indicates that the majority of children born with 17 β -HSD3 develop a male gender identity in adolescence or adulthood.⁴⁸ However, without evidence of this research put to him, Forrest J accepted the conclusion of the parents and doctors that Carla 'identifies as female' and would continue to do so into adulthood.

The second assumption Forrest J relied on to assert that surgery that would render Carla infertile was in her best interests, was that Carla was

43 Ibid 582 [28].

44 Lee et al, above n 28, 490–1.

45 *Sex Discrimination Act 1984* (Cth) s 4.

46 'Satisfaction with assigned sex' is measured in outcome studies in terms of psychological acceptance of the assigned sex, satisfaction with sexual function, and satisfaction with body image: Melissa A Parisi et al, 'A Gender Assignment Team: Experiences with 250 Patients over a Period of 25 Years' 9 *Genetics in Medicine* 348, 355.

47 S F Ahmed and M Rodie, 'Investigation and initial management of ambiguous genitalia' (2010) 24 *Best Practice & Research Clinica Endocrinology & Metabolism* 197, 215.

48 Ibid. See also Genetics Home Reference, *17-beta hydroxysteroid dehydrogenase 3 deficiency* <<https://ghr.nlm.nih.gov/condition/17-beta-hydroxysteroid-dehydrogenase-3-deficiency>>.

heterosexual, and would thus be able to rely on the sperm of her male partner to procreate. The medical experts did not provide Forrest J with any evidence on this issue. Rather, it was an assumption everyone made. Medical decisions about intersex children are often criticised for being inherently heterosexist. As medical anthropologist Katrina Karkazis explains:

Typically, heterosexuality is seen as the natural sexuality and the successful sexual outcome for treated children; penile-vaginal intercourse as the exclusive or most important sexual act; and genital appearance as taking priority over sexual pleasure and sensation.⁴⁹

Thus, doctors assume heterosexuality as a norm, and ‘build’ bodies designed for penetrative heterosexual sex.⁵⁰ It may be, however, that Carla will have a female partner in adulthood and having access to Carla’s sperm will enable them to conceive a biological child together. Yet, neither the judge nor doctors consider this possibility. Forrest J also assumes that even if Carla grows up to be heterosexual, she would prefer to have a child using donated gametes rather than use her own sperm. It is difficult to support this assumption given the lengths to which some couples engaged in IVF go to have a biological child. It seems presumptuous to assume that Carla would not have this same desire. If Carla and a male partner decided to pursue parenthood, they would need an egg donor and a surrogate to carry their baby. It is possible that, like gay male couples, each member of the couple could provide sperm and thus each become a biological parent. Given the various permutations that may unfold in the future, it is difficult to conclude that it is in Carla’s best interests to take the opportunity of biological parenthood away from her.

In the absence of anyone opposing the application, or an independent children’s lawyer, none of the arguments we have raised were presented to the Court in *Re Carla*. Based on the evidence provided to him, Forrest J approved the gonadectomy, finding it to be in Carla’s best interests. Forrest J also approved ‘such further or other necessary and consequential procedures to give effect to the treatment of Carla’. Beyond oestrogen treatment these ‘consequential procedures’ are not defined and for this reason, we are of the view that it was not actually possible to determine that a range of undefined procedures planned for some time in the future, are in Carla’s best interests.⁵¹ The judgment gives Carla’s parents a broad power to consent to any further

49 Katrina Karkazis, *Fixing Sex: Intersex, Medical Authority, and Lived Experience* (Duke University Press, 2008) [139].

50 As biologist Professor Anne Fausto-Stirling puts it ‘penetration in the absence of pleasure takes precedence over pleasure in the absence of penetration’: Anne Fausto-Sterling, ‘How to Build a Man’ in Maurice Berger, Brian Wallis and Simon Watson (eds), *Constructing Masculinity* (Routledge, 1995) 127.

51 By way of contrast, in decisions concerning the approval of treatment for gender dysphoria in transgender children, the Family Court has stated that at the time that hormone blockers are requested (typically 3–5 years before gender affirming hormones might be administered), it is not possible or appropriate to determine whether gender affirming hormone treatment will be in the child’s best interests. The Court has treated the two stages of treatment as separate (*Re Jamie* (2013) 50 Fam LR 369). By contrast, in *Re Carla* (2016) 54 Fam LR 576 Forrest J makes a decision when Carla is 5 years old that applies to any and all future treatment, including irreversible surgeries. The disconnect between these two positions in cases where treatment is so similar is concerning.

related medical treatment, including additional surgeries. This is concerning given Carla's age and vulnerability.

Was court authorisation necessary?

Parents are ordinarily presumed to have the legal authority to consent to their children's health care, by virtue of their parental responsibility. Section 61C of the *Family Law Act 1975* (Cth) stipulates that each parent of a child is vested with parental responsibility which includes 'all the duties, powers, responsibilities and authority which, by law, parents have in relation to children'.⁵² Nevertheless, in the High Court decision of *Department of Health and Community Services (NT) v JWB*,⁵³ it was confirmed that the parental decision-making power is not unfettered, and more importantly, that there are certain types of medical procedures to which parents can never consent. These cases are referred to as 'special medical procedures'.

The second substantive issue for determination in *Re Carla* centred on whether Carla's parents could consent to the treatment, or whether it was necessary to apply for, and receive, Court authorisation before the surgery could be performed. Thus, the key question was whether the surgery was a 'special medical procedure' and therefore beyond the decision-making authority of Carla's parents. An application was made to the Family Court for determination of this issue, as it was established in *Re Lesley*, a 2008 case with almost identical facts, that the proposed surgical intervention is a special medical procedure.⁵⁴ Despite the ruling in *Re Lesley*, Forrest J concluded that Court approval was unnecessary in *Re Carla*. His Honour justified this conclusion with reference to the reasoning in *Marion's Case*.

In *Marion's Case*, the High Court of Australia determined that the parents of a 14-year-old girl, given the pseudonym 'Marion', could not consent to the performance of a 'non-therapeutic' sterilisation procedure. Marion had a serious disability, was severely deaf and also had epilepsy. It was determined that the proposed sterilisation procedure was primarily intended to prevent menstruation and pregnancy and control Marion's hormonal stability, as well as improve her behavioural problems. In this landmark decision, the majority made reference to a number of principles to explain why the provision of consent in the circumstances of the case fell outside the boundaries of parental consent. It was stated that:

As a starting point, sterilisation requires invasive, irreversible and major surgery. But so do, for example, an appendectomy and some cosmetic surgery, both of which, in our opinion, come within the scope of a parent to consent to. However, other factors exist which have the combined effect of marking out the decision to authorise sterilisation as a special case. Court authorisation is required, first because of the significant risk of making the wrong decision, either as to a child's present or future

⁵² *Family Law Act 1975* (Cth) c 61B.

⁵³ (1992) 175 CLR 218.

⁵⁴ *Re Lesley* [2008] FamCA 1226 (12 December 2008). Barry J held, 'I accept a contrary view is arguable, but the better view is that this is a matter that falls squarely within the principles enunciated in *Marion's Case*': at [38].

capacity to consent or about what are the best interests of a child who cannot consent, and secondly, because the consequences of a wrong decision are particularly grave.⁵⁵

A number of key principles can therefore be distilled from the reasoning in *Marion's Case* to explain why certain 'non-therapeutic' medical procedures or interventions may require court approval. Thus, court approval may be required where the treatment is 'non-therapeutic', and:

- there is a significant risk of making the wrong decision without the involvement of the court;
- the procedure in question has particularly grave consequences;
- the procedure is irreversible and invasive; and,
- there is potential for conflict in terms of the interests of the parties involved (for example, the parents, clinicians, and the patient).

Importantly, then, *Marion's Case* determined that court authorisation is required for surgery that results in the sterilisation of a child and the factors outlined above are at issue. Forrest J relied heavily on the majority's distinction between sterilisation for non-therapeutic reasons and therapeutic sterilisation 'which is a by-product of surgery appropriately carried out to treat some malfunction or disease'.⁵⁶ To further support this distinction between therapeutic and non-therapeutic treatment, Forrest J made reference to Brennan J's judgment in *Marion's Case*:

It is necessary to define what is meant by therapeutic medical treatment. I would define treatment (including surgery) as therapeutic when it is administered for the chief purpose of preventing, removing or ameliorating a cosmetic deformity, a pathological condition or a psychiatric disorder provided the treatment is *appropriate for and proportionate* to the purpose for which it is administered. 'Non-therapeutic' medical treatment is descriptive of 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 (emphasis added).⁵⁷

Forrest J also considered whether the proposed treatment could be seen as advancing Carla's welfare, as a basis to determine the treatment's therapeutic nature. To support this approach, he made further reference to *Marion's Case* by considering the judgment of Deane J, who emphasised that only treatment that advances the welfare of the child can be considered therapeutic. Thus, Deane J stated that parental authority exists to authorise sterilisation surgery 'for the purpose, and only for the purpose, of advancing the welfare of the child'.⁵⁸ Furthermore, Deane J stated that '[i]n relation to a serious matter such as a major medical procedure, parental authority can be validly [exercised] only after due inquiry about, and adequate consideration of, what truly represents the welfare of the child'.⁵⁹

55 *Marion's Case* (1992) 175 CLR 218, 250.

56 *Re Carla* (2016) 54 Fam LR 576, 584 [44]–[45].

57 *Department of Health and Community Services (NT) v JWB* (1992) 175 CLR 218, 269 (Brennan J).

58 *Ibid* 295 Deane J.

59 *Ibid*.

Finally, Forrest J addressed the issue of capacity in terms of its impact on determining whether the procedure should be delayed, quoting from McHugh J's judgment in *Marion's Case* that:

If there is any real possibility that, at some future time, the child will acquire the capacity and maturity to choose whether he or she should be sterilized, the carrying out of that procedure cannot be in the best interests of the child unless, of course, protection of the child's health urgently requires that the procedure be carried out during incompetency.⁶⁰

Based on his analysis of the decision in *Marion's Case*, Forrest J ultimately concluded that the medical treatment proposed for Carla was therapeutic and therefore fell within the bounds of parental authority. Although Forrest J made reference to the above reasoning from the judgments in *Marion's Case* to justify his conclusion about the therapeutic nature of the treatment, there was a failure to fully evaluate this reasoning in the context of the specific facts in *Re Carla*, as well as a failure to critically analyse the evidence of the health professionals involved. This is demonstrated by reference to the following arguments.

First, when referring to the notion of whether or not the proposed treatment was therapeutic, Forrest J relied heavily on the view that intersex children are suffering from a 'disorder' of sexual development, which can be 'treated' by way of medical intervention. Above, it was noted that the medicalisation of such interventions — when labelled as 'treatment' for a 'disorder' — is problematic; it represents a slippage where the language of 'disorder' facilitates the categorisation of 'treatment' as therapeutic based on medical necessity, rather than an acknowledgment that the interventions are often psychosocial. As O'Dwyer notes:

the persistent use of the 'disorder' terminology has allowed medicine to assert that any and all purported 'treatment' for intersex is necessarily therapeutic, and therefore does not fall within judicial consideration of [special medical procedures]. The simple fact that the Court continues to examine the characterisation of procedures as therapeutic and non-therapeutic despite medical classification of other so-called 'disorders' suggests that medical nomenclature should not be taken at face value where there is evidence to the alternative nature of any given condition.⁶¹

Second, when relying upon the notions of appropriateness and proportionality with reference to Brennan J's reasoning in *Marion's Case*, Forrest J assumed that the proposed treatment was in fact both appropriate and proportionate, without adequately considering the other options available. In particular, the alternative course of action — relocating the gonads outside of the body so that the cancer risk could be monitored — was rejected on the basis that it would likely have 'adverse psychological consequences'.⁶² However, the exact likelihood and extent of the psychological consequences for Carla was not examined. We mention this not to suggest that the risk of psychological

⁶⁰ Ibid 320 (McHugh J). McHugh J also states: 'Since sterilisation has grave consequences for a person's adult life, it cannot be in the best interests of a child to pre-empt a choice about that procedure which the child would otherwise have as an adult person.'

⁶¹ Skye O'Dwyer, "'Treatment' of Intersex Children as a Special Medical Procedure" (2017) 24 *Journal of Law and Medicine* 870, 878 (citations omitted).

⁶² *Re Carla* (2016) 54 Fam LR 576, 581 [20].

harm to Carla was insignificant, but because there was a need to consider the appropriateness and proportionality of all options available, and to appropriately balance these against all risks. Given that relocating Carla's gonads to outside her body was, at least, an option, means that a less drastic method of minimising Carla's risk of cancer (in conjunction with regular monitoring) without rendering Carla infertile was available. This casts new light on the question of whether the proposed treatment was both 'appropriate' and 'proportionate'. This is particularly so when the risk factors in question were not considered in the context of an individual assessment of Carla's circumstances but based on the general risk of malignancy for all children with 17 β -HSD3. In fact, it could be argued that the proposed surgery was a *disproportionate* response, as recent research and the *Consensus Statement* indicate that there were less restrictive options available. This reinforces our earlier argument above, with regard to the need for more current and accurate research to have been provided to the Court by way of evidence. These concerns might also have been addressed if Carla had been represented by an independent children's lawyer. As an interesting point of comparison, in the context of the law governing decision-making for, and on behalf of, incompetent adults, decision-makers are often required to exercise their powers in a way that is least restrictive of the adult's rights.⁶³ In this case, the Court instead adopted a contrary position, choosing the most restrictive treatment option when determining Carla's welfare, without a full consideration of other, less restrictive, options. Exercising decision-making authority on behalf of Carla in a way that is least restrictive of her rights would be more consistent with the approach taken when assessing treatment for incompetent adults.

To add further weight to the argument that the Court's response was not proportionate, the reasoning concerning the non-urgent nature of the treatment must also be considered. Forrest J recognised that the protection of Carla's health did not 'urgently' require the procedure at 'this very point in her minority'.⁶⁴ However, he found that it needed to be conducted 'before the onset of pubertal changes in order to ameliorate real and not insubstantial risks to Carla's physical and emotional health'.⁶⁵ Thus, the surgery would occur before Carla reached a point of *Gillick v West Norfolk and Wisbech Area Health Authority*⁶⁶ competency. What is neglected in the reasoning, however, is recognition that delaying the surgery would allow further time for Carla's gender identity to be confirmed and expressed, not only by Carla's parents, but importantly by Carla.

Forrest J also failed to acknowledge the assertion in *Marion's Case* that, where possible, decisions made on behalf of those who are not competent should be delayed in cases where that person may *gain* capacity at some later stage. Forrest J assumed that should he refuse to authorise the treatment, the *only* alternative was for Carla to consent to the surgery once she reached the

63 See, eg, the 'Health Care Principle' outlined in *Guardianship and Administration Act 2000* (Qld) sch 1, which states that '[t]he health care principle means power for a health matter ... should be exercised by [a decision-maker] ... in the way least restrictive of the adult's rights.'

64 *Re Carla* (2016) 54 Fam LR 576, 586 [51].

65 *Ibid.*

66 *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 ('*Gillick*').

legal threshold of *Gillick* competency. This assumption overlooked the fact that there were numerous alternative options worthy of consideration. These might include regular monitoring, so that should a risk of malignancy increase (based on an individual assessment), intervention may become ‘therapeutic’ and thus necessary, and therefore within the bounds of parental power. Another option would be to delay treatment until Carla was in a better position to confirm her gender identity. At the time of the application Carla was 5 years old and the evidence relied upon by the Court was relayed to Forrest J via Carla’s parents and treating medical professionals. Carla’s gender identity was likely to develop further prior to the onset of biological puberty. If surgical intervention was regarded as appropriate prior to Carla reaching the legal threshold of *Gillick* competency, a further application to the Court might be commenced to authorise the intervention. At this stage, the Court would be able to consider further evidence confirming Carla’s gender identity not only from her parents and treating health professionals, but also *from Carla*. Should Carla’s gender identity remain uncertain before the onset of puberty, it might also be an option to delay puberty with puberty blockers, so that the physical and psychological consequences of these changes can be averted until Carla’s gender identity was more certain. None of these alternative options were considered in any detail by Forrest J. It is difficult to see how a conclusion could be reached that the surgery was a proportionate response without such consideration.

Based on the above reasoning, it can be argued that the ‘treatment’ in question is non-therapeutic. As outlined in *Marion’s Case*, in circumstances where an intervention such as this is regarded as non-therapeutic, the question of whether it falls outside the realm of parental consent is subject to a consideration of a range of further factors. This includes a consideration of the seriousness, gravity and irreversibility of the treatment, as well as the risk of making a wrong decision. In these particular circumstances, it is not difficult to argue that these factors are potentially engaged. The removal of the gonads — which thereby causes infertility — is certainly a serious, grave decision, which carries irreversible consequences (both physically, as well as potential long-term psychological consequences). Similarly, other surgeries (including the surgical interventions noted as part of Carla’s ‘medical history’) also fall within this reasoning. As O’Dwyer notes:

Medical procedures conducted on intersex children are almost certainly invasive, irreversible and major as they involve significant changes surgically, medically and pharmaceutically made to the bodies of children in ways that can only be undone by further invasive procedures. Tissues are discarded in surgical sex assignment that are irretrievable; other medical procedures stretch and reshape tissues in ways that are not able to be undone without surgery; changes are made to the shape and function of the body via hormonal means that do not revert if the hormonal medication is stopped.⁶⁷

Conclusion

In our view, the decision in *Re Carla* sets a dangerous precedent concerning the Family Court’s involvement with authorising surgical interventions for

⁶⁷ O’Dwyer, above n 61, [879] (citations omitted).

intersex children. As outlined above, the medical evidence provided to the Court to justify surgery was incomplete and the reasoning and analysis concerning the therapeutic nature of the proposed surgery lacks rigour. In addition, a concerning aspect of Carla's earlier medical care (undertaken prior to the application to the Family Court that was made by Carla's parents in this case), was that the surgical interventions that occurred — which were described as purely cosmetic in nature — were made by the parents and health care team without Court approval. This runs contrary to the principles in *Marion's Case*.

Although Forrest J stated that the Family Court's authorisation was not required *in the circumstances of the case*,⁶⁸ suggesting that the decision was confined to this case only and did not set a precedent for other, similar cases, the significance of the case as a precedent for the future remains unclear. This is because, although being careful to confine his decision to the individual circumstances of the case, Forrest J noted that the parents were seeking to apply to the Court so that they could establish 'for the potential benefit of any parents, like them, who might find themselves in these very same factual circumstances in the future, that Court sanction is not actually required ...'⁶⁹ The basis of the parents' application to the Court was to test the significance of the Family Court's approach in *Re Lesley*, which Forrest J disagreed with. This, inevitably, suggests that the previous precedent set by the Family Court was decided incorrectly and should not be followed, thereby rendering surgical intervention in these circumstances something other than a 'special medical procedure'. This is an unsatisfactory outcome.

68 *Re Carla* (2016) 54 Fam LR 576, 579 [9].

69 *Ibid* 579 [8].