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### Author

O'Dwyer, Skye

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# “Treatment” of Intersex Children as a Special Medical Procedure

Skye O’Dwyer\*

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*In Australia each year intersex children undergo invasive, identity-affecting, life-changing medical procedures. While some of these procedures are essential to save the child’s life, most are simply to ensure that the intersex child’s genitals are philologically either male or female. This article argues that this practice is wrong for the following reasons: these procedures should be recognised as Special Medical Procedures that require the oversight of the Family Court; psycho-social motivation, based on a binary conception of sex, is outdated and discriminatory; and the Family Court does not approve this sort of invasive surgery when asked to do so for transgender teens. Medical practitioners who perform these operations on intersex children expose themselves to criminal and civil liability. The best approach is to leave intersex children’s bodies alone and allow them to make decisions about their sexual morphology when they attain competence.*

## INTRODUCTION

Each year in Australia there are potentially hundreds of children that undergo highly invasive, identity-affecting and life-changing sex surgery. Most of these children are under the age of two. While some of these operations are essential to save the child’s life, many are for psycho-social reasons to ensure that the intersex child’s genitals are philologically either male or female and parental discomfort is alleviated. These operations are usually seen as an emergency and done with the permission of the child’s parents. This article argues that this practice is wrong. It is wrong because the level of intervention on the child’s body should properly be seen as a Special Medical Procedure (SMP) and as such requires the oversight of the Family Court. Further, the underlying psycho-social motivations, based on a binary conception of sex, are outdated and, indeed, discriminatory under Australian law. Finally, it is wrong because the Family Court does not approve the sort of extreme and invasive surgery that is being routinely performed on intersex children under the age of two to transgender children. This article suggests that medical practitioners who perform these operations on intersex children, in the absence of a life-threatening complication or without the approval of the Family Court under SMPs, expose themselves to criminal and civil liability. It concludes that the best approach to intersex children is to leave them alone and allow them to make decisions about their sexual morphology when they attain competence to give their own consent.

The following argument is in three parts. The first sets out the definitions of intersex and establishes the frequency and justifications of surgery on intersex children in Australia. It is shown that psycho-social concerns relating to sex and gender ambiguity strongly motivate medical practitioners and parents. It is also shown that intersex adults who have been operated on as children manifest considerable hardship, resentment and dissatisfaction with their bodies and identities. The second part argues that medical procedures on intersex children should be classified as SMPs as derived from *Secretary, Department of Health and Community Services v JWB and SMB (Marion’s Case)*.<sup>1</sup> This part utilises examples from the intersex cases that have been brought to the Family Court under this jurisdiction, with particular attention to the case of *Re A*,<sup>2</sup> in order to show that the Family Court has in fact already found sex-affecting procedures performed on intersex children to fall within SMPs. The

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\* PhD Candidate, Griffith Law School and Law Futures Centre, Griffith University. The author wishes to thank Dr Kieran Tranter and Dr Colleen Davis for their invaluable advice and assistance during all stages of the drafting of this article.

Correspondence to: [skye.odwyer@griffithuni.edu.au](mailto:skye.odwyer@griffithuni.edu.au).

<sup>1</sup> *Secretary, Department of Health and Community Services v JWB and SMB (Marion’s Case)* (1992) 175 CLR 218.

<sup>2</sup> *Re A* (1993) 16 Fam LR 715.

final part discusses the recognition of intersex as a status of sex under Australian law, and the legal acceptance that sex need not be identified as necessarily male or female. It argues that the concept of binary sex is socially and legally outdated, and therefore any psycho-social reasons given for continuing to perform medical and surgical interventions on intersex children are no longer relevant.

## INTERSEX CHILDREN, SURGERY AND CONSEQUENCES

In October 2013, the Australian Senate Community Affairs References Committee released its second report on its investigation into involuntary or coerced sterilisation. Entitled *Involuntary or Coerced Sterilisation of Intersex People in Australia*, the report included 15 recommendations for the protection of people diagnosed with intersex conditions at birth or later in life.<sup>3</sup> Although the report contained several recommendations that courts or similarly empowered legal bodies be much more involved in decisions to assign sex to intersex children, the status quo remains. There has been no action by federal or State Parliaments, no court involvement in decision-making, and no change in medical practice. Follow-up discussion in the Senate in March 2014 was attended only by the senatorial speakers, and the audience contained only two intersex activist organisation representatives who had been invited to attend due to their involvement in numerous submissions to the Inquiry.<sup>4</sup> Political interest in the matter seems to have dissipated, but parents and medical practitioners continue to make decisions about sex assignment: surgical, medical, and pharmaceutical intervention into a fundamental facet of the self-identity of children, and the adults they will grow to become, with no, or extremely little, oversight by courts.<sup>5</sup> In Australia, it appears, the law has not formally found this to be inappropriate.

“Intersex” as a term has no singular accepted definition – indeed there is not even a consensus on whether the term should be used at all.<sup>6</sup> The context of the term’s use can, but need not always, dictate the meaning. The most significant contexts for the use of the term “intersex” are social, legal, and medical.

OII Australia, a leading Australian intersex activism and advocacy organisation, provides a functional definition that encapsulates the social understanding of intersex:

Intersex is a term that relates to a range of congenital physical traits or variations that lie between ideals of male and female ... it is a spectrum or umbrella term, rather than a single category.<sup>7</sup>

Although the medical community has shifted to predominant use of the term “disorders of sex development” (DSD),<sup>8</sup> it is the non-clinical term “intersex” that is most popularly recognised and

<sup>3</sup> Senate Community Affairs References Committee, Parliament of Australia, *Involuntary or Coerced Sterilisation of Intersex People in Australia* (2013) xiii-xv.

<sup>4</sup> By the attendees’ report, “the public gallery was actually closed for the evening, which is why only two of us were there”: OII Australia – Intersex Australia, “Cross-Party Speeches on Intersex Health in the Australian Senate” (25 March 2014) <<http://oii.org.au/25037/cross-party-speeches-intersex-health-australian-senate>>.

<sup>5</sup> M O’Connor, “The Treatment of Intersex and the Problem of Delay: The Australian Senate Inquiry into Intersex Surgery and Conflicting Human Rights for Children” (2016) 23 JLM 531, 534-534, 538-539; J Hewitt et al (Australasian Paediatric Endocrine Group), Submission No 88, *Senate Inquiry Into the Involuntary or Coerced Sterilization of People with Disabilities in Australia: Regarding the Management of Children with Disorders of Sex Development* (2013) 8; The Royal Children’s Hospital Melbourne Disorder of Sex Development Multidisciplinary Team, Submission No 92, *Modified Terms of Reference for the Senate Inquiry. The Involuntary or Coerced Sterilisation of People with Disabilities in Australia: People with Intersex Conditions* (2013) 5; M Rillstone, *Clitoral Reduction: Is Surgery for Intersex Babies Justified?* (ABA – Healthcare Delivery Across Cultures, 2002) 5.

<sup>6</sup> M Carpenter, Submission No 23.1, *Senate Inquiry Into the Involuntary or Coerced Sterilization of People with Disabilities in Australia* (2013) 3.

<sup>7</sup> OII Australia – Intersex Australia, *Intersex for Allies* (2017) <<http://oii.org.au/wp-content/uploads/key/OII-Australia-Intersex-Ally.pdf>>.

<sup>8</sup> PA Lee et al, “Consensus Statement in Management of Intersex Disorders” (2006) 118 *Pediatrics* e488, e488, instigated the renaming, which has been followed throughout medical literature despite being the subject of continued debate. See, eg use of the term “DSD”: I Vidal et al, “Surgical Options in Disorders of Sex Development (DSD) with Ambiguous Genitalia” (2010) 24 *Best Practice & Research Clinical Endocrinology & Metabolism* 311; MA Parisi et al, “A Gender Assessment Team: Experience with 250 Patients Over a Period of 25 Years” (2007) 9(6) *Genetics in Medicine* 348; JD Wilson et al, “Advice on the

preferred by the majority of intersex advocates and intersex people. For that reason, the term intersex is used here despite it not appearing in any court judgments to date.<sup>9</sup>

Every year in Australia 300<sup>10</sup> children are likely to be born with one or more of the 30-50<sup>11</sup> medically defined varieties of intersex. Some indications that a child is intersex can be recognised by medical professionals from birth or even prenatally.<sup>12</sup> Others are not visibly detectable in infancy; some are never visibly detectable; and some are never detected at all.<sup>13</sup> Physical indicators found in two of the most common types of intersex – congenital adrenal hyperplasia and androgen insensitivity syndrome – can include a child being born with genitals that are visibly “neither wholly female nor wholly male”.<sup>14</sup> Such a visible expression of intersex is termed “ambiguous genitalia”<sup>15</sup> or “atypical sex characteristics”.<sup>16</sup> The need to “rectify” this ambiguity of genitals was historically perceived as a medical emergency, and procedures to “normalise” the bodies of these children were collectively termed “sex assignment”. To this day sex assignment remains an accepted medical “treatment” for intersex children with any degree of genital ambiguity.<sup>17</sup>

Other medical responses to intersex range from simply monitoring the condition, through hormonal and medical manipulation, to surgical intervention that does not amount to sex assignment,

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Management of Ambiguous Genitalia to a Young Endocrinologist from Experienced Clinicians” (2010) 30(5) *Seminars in Reproductive Medicine* 339; LH Gillam, JK Hewitt, GL Warne, “Ethical Principles for the Management of Infants with Disorders of Sex Development” (2010) 74 *Hormone Research in Paediatrics* 412; V Paterski et al, “Predictors of Posttraumatic Stress in Parents of Children Diagnosed with a Disorder of Sex Development” (2014) 43 *Archives of Sexual Behavior* 369; V Paterski, P Prentice, IA Hughes, “Impact of the Consensus Statement and the New DSD Classification System” (2010) 24(2) *Best Practice & Research Clinical Endocrinology & Metabolism* 187; JC Streuli et al, “Shaping Parents: Impact of Contrasting Professional Counseling on Parents’ Decision Making for Children with Disorders of Sex Development” (2013) 10 *Journal of Sexual Medicine* 1953; JM Crawford et al, “Results from a Pediatric Surgical Centre Justify Early Intervention in Disorders of Sex Development” (2009) 44(2) *Journal of Pediatric Surgery* 413. See also the discussion in: G Davis, “‘DSD is a Perfectly Fine Term’: Reasserting Medical Authority through a Shift in Intersex Terminology” (2011) 12 *Advances in Medical Sociology* 155; C Clune-Taylor, “From Intersex to DSD: The Disciplining of Sex Development” (2010) 5 *PhaenEx* 152.

<sup>9</sup> It is acknowledged that the term “intersex” is not universally accepted; however, for the purposes of this article it is utilised as the term recognised under legislation and governmental policy in Australia, and preferred by leading advocacy and support groups such as OII Australia and the Androgen Insensitivity Syndrome Support Group Australia Inc (AISSG Australia).

<sup>10</sup> Australian Bureau of Statistics, *Births, Australia, 2013* (2014); [Zwischengeschlecht.org](http://www.zwischengeschlecht.org), [Intersex.ch](http://www.intersex.ch) and [SI Selbsthilfe Intersexualität](http://www.silb.sthlf.se), *Intersex Genital Mutilations: Human Rights Violations of Children with Variations of Sex Anatomy, NGO Report to the 2nd, 3rd and 4th Periodic Report of Switzerland on the Convention on the Rights of the Child (CRC)* (2014) 10.

<sup>11</sup> Although it is universally accepted that intersex, or in medical discourse “disorders of sex development (DSD)”, are a diagnosable phenomenon, there is extensive disagreement in the medical community as to which diagnoses fall within the umbrella term. L Sax, “How Common Is Intersex? A Response to Anne Fausto-Sterling” (2002) 39 *Journal of Sex Research* 174, 175-177, provides some informative discussion on the requirements for medical classification as an intersex condition, and discusses a number of conditions that some clinicians do not place within that category, for example: late onset congenital adrenal hyperplasia can be exempted as a variety of intersex as it does not present at birth; Turner Syndrome, Klinefelter Syndrome and all other chromosomal variations from XX or XY can be exempted as varieties of intersex as they do not present with ambiguous genitalia or “confusion regarding sexual identity”; and vaginal agenesis can be exempted as a variety of intersex as it features no inconsistency of chromosomes or gonads, and is surgically corrected in a manner “conceptually no different from surgical correction for cleft palate”.

<sup>12</sup> Lee et al, n 8, e488-e500.

<sup>13</sup> Parisi et al, n 8, 348; The Royal Children’s Hospital Melbourne Disorder of Sex Development Multidisciplinary Team, n 5, 3; Sax, n 11, 176.

<sup>14</sup> *Sex Discrimination Act 1984* (Cth) s 4.

<sup>15</sup> SF Ahmed and M Rodie, “Investigation and Initial Management of Ambiguous Genitalia” (2010) 24(2) *Best Practice & Research Clinical Endocrinology & Metabolism* 197, 215; Lee et al, n 8, e494-e495; Victorian Department of Health and Human Services, *Decision-Making Principles for the Care of Infants, Children and Adolescents with Intersex Conditions* (2013) 1.

<sup>16</sup> JA Méndez, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (Human Rights Council, United Nations General Assembly, 2013) [77] <[http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53\\_English.pdf](http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf)>.

<sup>17</sup> Lee et al, n 8; PA Lee et al, “Advances in Diagnosis and Care of Persons with DSD Over the Last Decade” (2014) *Journal of Pediatric Endocrinology* 19; Victorian Department of Health and Human Services, n 15, 2.

as well as any combination of these options.<sup>18</sup> When surgery is used to “treat” intersex, it is most often performed shortly after birth or around puberty.<sup>19</sup> In some cases medicine intervenes both at birth to correct a perceived bodily flaw – most usually ambiguous or atypical genitalia – with follow up to support and/or expand the correction approaching and at puberty.<sup>20</sup> For some this follow up includes further surgery; in some cases intervention is of a less intrusive but equally physically interactive nature; in almost all detected cases there is some degree of hormonal medication prescribed, often for the remainder of the child’s lifetime.<sup>21</sup> Whether amounting to an entire sex assignment or otherwise affecting the sex or genitals of an intersex child, medical “treatment” of intersex constitutes a problematic intrusion on the bodies of children.

In their 2013 submissions to the Senate Committee investigation on the state of intersex medical “treatment” in Australia, both the Australian Paediatric Endocrine Group<sup>22</sup> and the Royal Children’s Hospital Melbourne (RCHM)<sup>23</sup> confirmed that procedures on intersex children are being undertaken in Australia.<sup>24</sup> The RCHM reported that it conducts “one to two gonadectomies a year on infants with undescended testicles”, and “10 to 15 genital reconstruction operations a year, often on girls under the age of two”.<sup>25</sup> However, the number of surgeries actually conducted on children with intersex conditions is likely to be much higher, and it is unlikely that they are only being conducted within Victoria.<sup>26</sup> Netzwerk DSD, the world’s largest response study on intersex outcomes, reported that by the age of 12, 87-91% of medically identified intersex children have been subject to at least one sex-affecting surgery.<sup>27</sup> Some children are subject to a dozen or more.<sup>28</sup> In a 2015 study conducted on intersex people in Australia, Jones et al reported that 60% of self-identified intersex respondents had been subject to invasive medical procedures, with 115 genital surgeries reported by the 272 respondents.<sup>29</sup>

In 2010, Vidal et al reported that feminising surgery as “treatment” for intersex most commonly occurs between two and six months of age,<sup>30</sup> and masculinising surgery between six and 24 months.<sup>31</sup> The Jones et al study confirmed the validity of this assertion to Australian practice, in that 45 of the

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<sup>18</sup> Vidal et al, n 8, 312.

<sup>19</sup> Ahmed and Rodie, n 15, 348.

<sup>20</sup> C Brain et al, “Holistic Management of DSD” (2010) 24 *Best Practice & Research Clinical Endocrinology & Metabolism* 335, 341; T Jones et al, *Intersex: Stories and Statistics from Australia* (Open Book Publishers, 1st ed, 2016) 102-104.

<sup>21</sup> GL Warne, S Grover and JD Zajac, “Hormonal Therapies for Individuals with Intersex Conditions: Protocol for Use” (2005) 4(1) *Treatments in Endocrinology* 19, 20.

<sup>22</sup> Hewitt et al, n 5, 3.

<sup>23</sup> The Royal Children’s Hospital Melbourne Disorder of Sex Development Multidisciplinary Team, n 5, 3.

<sup>24</sup> Senate Community Affairs References Committee, n 3.

<sup>25</sup> A Bock, “Call to End Intersex Genital Operations”, *The Age*, 30 June 2013.

<sup>26</sup> In the 2014 NGO Report to the Convention on the Rights of the Child (n 10) the reporting of surgical treatment of children with “variations of sexual anatomy” (the report’s preferred term for intersex conditions, including but not limited to ambiguous genitalia) in Switzerland was considered to vary wildly in response to the audience for such reporting. When justifying the need for funding, for example, the number of surgeries conducted was reportedly higher; when answering human-rights or legal concerns, the number of surgeries was reportedly much lower, or claimed to be non-existent. Australia has adopted the same international consensus on medical treatment protocols as Switzerland, so it is likely that the prevalence of surgical intervention is in a similar order of magnitude.

<sup>27</sup> E Kleinemeier and M Jürgensen, “Erste Ergebnisse der Klinischen Evaluationsstudie im Netzwerk Störungen der Geschlechtentwicklung/Intersexualität in Deutschland, Österreich und Schweiz, Januar 2005 bis Dezember 2007” (2008) 16 <[http://www.netwerk-dsd.uk-sh.de/fileadmin/documents/netwerk/avalstudie/Bericht\\_Klinische\\_Evaluationsstudie.pdf](http://www.netwerk-dsd.uk-sh.de/fileadmin/documents/netwerk/avalstudie/Bericht_Klinische_Evaluationsstudie.pdf)>; *Zwischengeschlecht.org*, *Intersex.ch* and *SI Selbsthilfe Intersexualität*, n 10, 18, Table of Results.

<sup>28</sup> Kleinemeier and Jürgensen, n 27, 16; *Zwischengeschlecht.org*, *Intersex.ch* and *SI Selbsthilfe Intersexualität*, n 10, 18, Table of Results.

<sup>29</sup> Jones et al, n 20, 104.

<sup>30</sup> Vidal et al, n 8, 314.

<sup>31</sup> Vidal et al, n 8, 318.

reported 115 surgeries were conducted while the child was aged five years or below.<sup>32</sup> Lee et al assert: “The general consensus for the timing of surgical reconstruction in [intersex] patients ... remains in the first year of life based on family, patient and surgeon preference.”<sup>33</sup> The studies on which they base this conclusion, however, only reference feminising surgery for Congenital Adrenal Hyperplasia (CAH)<sup>34</sup> and certainly do not involve “patient ... preference” in cases in which the patient is too young to communicate, or perhaps even to have, a preference on the matter. It seems that the preference of medical professionals, which in turn can heavily influence what parents perceive to be their own preference,<sup>35</sup> is of paramount consideration in deciding whether surgery, or other medical intervention, will be conducted on intersex infants.<sup>36</sup>

Matters affecting the decision to “treat” intersex children also include risk of parental rejection,<sup>37</sup> embarrassment, social disadvantage and social stigma relating to ambiguity of genitalia.<sup>38</sup> “Treatment” protocols call for balance in consideration of psycho-social factors and “leaving options open for the child’s future autonomy and self-determination”<sup>39</sup> yet also assert that all intersex children should be assigned a gender, even if medical or surgical intervention to confirm that assignment is not pursued.<sup>40</sup> By insisting on a gender assignment, medical professionals send a clear message to parents that it is not appropriate for children to identify, or to remain identifiable, as intersex. Even in the absence of bodily interference to confirm that gender assignment, the requirement that all children be labelled as male or female implies a social, if not a medical, urgency, and prioritises social acceptance over self-identification.

Outcome studies have largely focused on the issue of self-identification, and suggest that medical intervention can create the very problems it claims to seek to avoid. The primary outcome measure addressed in medical literature is “satisfaction with assigned sex”, measured in terms of: psychological acceptance of the assigned sex; satisfaction with sexual function; and satisfaction with body image.<sup>41</sup> The few available studies that specifically investigate the outcomes of medical intervention on intersex children indicate that dissatisfaction with assigned sex is as high as 40% by adulthood.<sup>42</sup> There is a high frequency of significant dissatisfaction with the medical and/or surgical treatment provided (up to 56.1% dependant on type of intersex condition and sex of rearing) and, conversely, intersex persons who have not been subjected to medical procedures report significant satisfaction with having avoided intervention.<sup>43</sup> Dissatisfaction with the physical aesthetics (up to 47.1%) and sexual function (up to 40%) has also been recorded,<sup>44</sup> and it has been found that “[s]ensitivity is decreased in genital areas

<sup>32</sup> Jones et al, n 20, 105.

<sup>33</sup> Lee et al, n 17, 6.

<sup>34</sup> Lee et al, n 17, 7, referring to AB Wisniewski et al, “Psychosexual Outcome in Women Affected By Congenital Adrenal Hyperplasia Due To 21-hydroxylase Deficiency” (2004) 171 *Journal of Urology* 497; A Nordenskjöld et al, “Type of Mutation and Surgical Procedure Affect Long-Term Quality of Life for Women with Congenital Adrenal Hyperplasia” (2008) 93 *Journal of Clinical Endocrinology & Metabolism* 380; F Yankovic et al, “Current Practice in Feminizing Surgery for Congenital Adrenal Hyperplasia: A Specialist Survey” (2013) 9(6) *Journal of Pediatric Urology* 1103.

<sup>35</sup> HP Crissman et al, “Children with Disorders of Sex Development: A Qualitative Study of Early Parental Experience” (2011) 1 *International Journal of Pediatric Endocrinology* 6; Streuli et al, n 8, 1959.

<sup>36</sup> Lee et al, n 8, e490; Victorian Department of Health and Human Services, n 15, 3.

<sup>37</sup> Gillam, Hewitt and Warne, n 8, 415; adopted into Victorian Department of Health and Human Services, n 15, 5.

<sup>38</sup> Gillam, Hewitt and Warne, n 8, 415.

<sup>39</sup> Victorian Department of Health and Human Services, n 15, 18.

<sup>40</sup> Lee et al, n 8, e555; Victorian Department of Health and Human Services, n 15, 15.

<sup>41</sup> Parisi et al, n 8, 355; Hewitt et al, n 5, 4.

<sup>42</sup> Ahmed and Rodie, n 15, 215.

<sup>43</sup> Jones et al, n 20, 112. Although it is acknowledged that the sample size is small with only nine survey participants reporting no interventions, “all nine argued they had experienced positive impacts from not having had interventions”.

<sup>44</sup> B Kohler et al, “Satisfaction with Genital Surgery and Sexual Life of Adults with XY Disorders of Sex Development: Results from the German Clinical Evaluation Study” (2012) 97(2) *Journal of Clinical Endocrinology & Metabolism* 577, 581.

where feminizing genitoplasty has been done”.<sup>45</sup> It is clear that the potential for negative physical and psychological outcomes is significant, and the impact of medical intervention on intersex children can be both severe and enduring.

Intersex is a contentiously defined status, and the protocols of the medical community in defining it as a “disorder” continue to self-justify surgery on intersex children in Australia. Many procedures conducted on intersex children are driven by psycho-social concerns relating to sex and gender ambiguity, which appear to strongly motivate medical practitioners and parents. Emphasis should instead be placed on the perspectives of intersex adults who have been operated on as children, many of whom manifest considerable hardship, resentment and problems of identity. When these perspectives are accounted for within existing legal frameworks, it is apparent that doctors and parents should not be acting alone in authorising such procedures on intersex children. A mechanism for such consideration already exists under Australian law.

### INTERVENTION ON INTERSEX CHILDREN IS A SPECIAL MEDICAL PROCEDURE

Quite simply, medical procedures on intersex children should be classified as SMPs, as derived from *Marion’s Case*. Examination of the intersex cases that have been brought to the Family Court shows that the Court has in fact already found sex-affecting procedures performed on intersex children to fall within SMPs.

In *Marion’s Case*, McHugh J stated that “[a]t common law ... every surgical procedure is an assault unless it is authorised, justified or excused by law”.<sup>46</sup> Under criminal law, assault is an offence,<sup>47</sup> and under civil law the equivalent trespass to the person (battery) is a tortious act.<sup>48</sup> Both criminal law and tort allow consent as a defence to certain degrees of assault.<sup>49</sup> In the medical context, because of the potential for significant damage to be suffered by patients not only physically but also psychologically, emotionally, economically, and socially,<sup>50</sup> consent means more than merely agreeing to have one’s body interfered with. Medical treatment that is intrusive upon the person must only be conducted with informed consent.<sup>51</sup>

It is a legislated requirement as well as best practice that medical practitioners ensure that informed consent is given to all medical procedures, including but not limited to surgical procedures.<sup>52</sup> It is also a requirement that consent is given by the party whose scope of powers permits them to provide valid consent.<sup>53</sup>

A patient who is a legal adult and who otherwise has capacity to make decisions of a medical nature can give consent for themselves.<sup>54</sup> A patient who is under the age of 18,<sup>55</sup> or 16 in jurisdictions

<sup>45</sup> NS Crouch et al, “Sexual Function and Genital Sensitivity Following Feminizing Genitoplasty for Congenital Adrenal Hyperplasia” (2008) 179(2) *Journal of Urology* 634, 638.

<sup>46</sup> *Secretary, Department of Health and Community Services v JWB and SMB (Marion’s Case)* (1992) 175 CLR 218, 310.

<sup>47</sup> *Criminal Code 1899* (Qld) s 245; *Crimes Act 1900* (NSW) ss 33, 59, 61; *Crimes Act 1958* (Vic) s 31; *Criminal Code Act 1924* (Tas) s 184; *Police Offences Act 1935* (Tas) s 35; *Criminal Code* (NT) s 188; *Criminal Law Consolidation Act 1935* (SA) s 20; *Criminal Code Act Compilation Act 1913* (WA) s 223; *Crimes Act 1900* (ACT) s 26.

<sup>48</sup> *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, [73]; adopted by *Rixon v Star City Pty Ltd* (2001) 53 NSWLR 98.

<sup>49</sup> For example, as provided in: *Criminal Code 1899* (Qld) s 246; *Criminal Code Act 1924* (Tas) ss 51, 53, 182(4); *Criminal Code* (NT) s 188(3); *Criminal Code Act Compilation Act 1913* (WA) s 223; *R v Brown* [1993] 2 All ER 75; *Lergesner v Carroll* [1991] 1 Qd R 206; *R v Bonora* (1994) 35 NSWLR 74; *R v Wilson* [1996] 3 WLR 125. Consent as a defence to common assault is also implied in statute where specific exemptions for consent as a defence are noted.

<sup>50</sup> *Secretary, Department of Health and Community Services v JWB and SMB (Marion’s Case)* (1992) 175 CLR 218, 252.

<sup>51</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 489.

<sup>52</sup> Women’s Health Committee and The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Consent and Provision of Information to Patients in Australia Regarding Proposed Treatment* (2013) 2; Victorian Department of Health and Human Services, n 15, 14.

<sup>53</sup> *Secretary, Department of Health and Community Services v JWB and SMB (Marion’s Case)* (1992) 175 CLR 218, 249-250.

<sup>54</sup> *Secretary, Department of Health and Community Services v JWB and SMB (Marion’s Case)* (1992) 175 CLR 218, 316; *Gillick v West Norfolk & Wisbech Area Health Authority* [1986] AC 112, 118.

that have enacted legislation permitting decision-making from that age,<sup>56</sup> does not have the legal capacity to provide consent for procedures unless they can demonstrate “Gillick competence”. Gillick competence refers to the standard of maturity and understanding – of the decision or decisions to be made, as well as of any potential outcome or outcomes of those decisions – that is required for a child to make medical decisions on their own authority.<sup>57</sup> Gillick competence was adopted in *Marion’s Case*, and remains a relevant consideration to any case involving consent for medical procedures on a child.<sup>58</sup> If a child is Gillick competent, they can provide informed consent themselves. If the child has not attained Gillick competence, consent can instead be given by a legal guardian, usually the child’s parent or parents. Any person providing consent for a child in this way must act in the child’s best interests.<sup>59</sup>

However, there are some medical procedures for which legal guardians cannot provide consent – these are termed “Special Medical Procedures”. The term derives from the case of *Re Alex: Hormonal Treatment for Gender Identity Dysphoria*,<sup>60</sup> but the same procedures are described in *Marion’s Case* as a “special case”,<sup>61</sup> in *Re Jamie* as “medical procedures requiring court authorisation”,<sup>62</sup> and in the *Family Law Rules 2004* (Cth) as an “application for a medical procedure”.<sup>63</sup> By whatever name they are known, SMPs for children are seated within the jurisdiction of the Family Court of Australia, operating within its welfare jurisdiction under s 67ZC of the *Family Law Act 1975* (Cth).

In *Marion’s Case*, the High Court set out clear requirements for the categorisation of a medical act as an SMP. The majority held that there are some medical procedures to which parents are not able to give consent, as they fall outside the scope of parental power. The analysis of the specific procedure proposed, namely removal of Marion’s reproductive organs, firmly established that sterilisation of children other than for immediately life-saving purposes requires court consent. If a medical procedure conducted on an intersex child involves the complete removal of viable or potentially viable reproductive material, it is therefore an SMP by virtue of being a sterilisation procedure.

The decision regarding the scope of parental power in *Marion’s Case* has broader application,<sup>64</sup> and set down the circumstances under which consent to a medical procedure that does not constitute sterilisation will also fall outside the scope of parental power. To qualify as an SMP the proposed action must be invasive, irreversible and major; it must be non-therapeutic; it must carry a significant risk of a wrong decision being made, either as to the child’s competence or as to their best interests; and the likely consequences if a wrong decision is made must be grave.<sup>65</sup>

Subsequent decisions of the Family Court have elaborated on these criteria, and explored the evolving meanings of the qualifying terms, with particular emphasis on differentiating between

<sup>55</sup> *Age of Majority Act* (NT); *Age of Majority Act 1974* (ACT); *Age of Majority Act 1974* (Qld); *Age of Majority Act 1977* (Vic); *Age of Majority Act 1973* (Tas). *Consent to Medical Treatment and Palliative Care Act 1995* (SA).

<sup>56</sup> *Minors (Property and Contracts) Act 1970* (NSW) s 49(2); *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 6.

<sup>57</sup> *Gillick v West Norfolk & Wisbech Area Health Authority* [1986] AC 112, 139.

<sup>58</sup> As recent examples, see *Re Emery* [2016] FamCA 240; *Re Lincoln* [2016] FamCA 267; *Re Harley* [2016] FamCA 334.

<sup>59</sup> *Secretary, Department of Health and Community Services v JWB and SMB (Marion’s Case)* (1992) 175 CLR 218, 282.

<sup>60</sup> *Re Alex: Hormonal Treatment for Gender Identity Dysphoria* (2004) 180 FLR 89, [6], [8], [201].

<sup>61</sup> *Secretary, Department of Health and Community Services v JWB and SMB (Marion’s Case)* (1992) 175 CLR 218, 253-254.

<sup>62</sup> *Re Jamie (Special Medical Procedure)* [2011] FamCA 248, [153].

<sup>63</sup> *Family Law Rules 2004* (Cth) r 4.08.

<sup>64</sup> See, eg *Re GWW and CMW* (1997) 21 Fam LR 612, 618, in which donation of bone marrow by a nine-year-old child was found to be an SMP on the grounds that “the proposed procedure is invasive to the bodily integrity of a child of tender years and involves a surgical procedure although that procedure may be of less gravity than is involved in a sterilisation or an organ transplant”.

<sup>65</sup> *Secretary, Department of Health and Community Services v JWB and SMB (Marion’s Case)* (1992) 175 CLR 218, 250.



“therapeutic” or “non-therapeutic”.<sup>66</sup> Although the medical profession contends that this categorisation is a purely medical prerogative,<sup>67</sup> there is a strong argument that the nature of medical procedures on intersex children as therapeutic or otherwise within a legal context is instead a matter for legal determination, under advice from expert medical consultants where solicited. It is clear from case law on SMPs that the Family Court expends some effort considering the classification of individual medical procedures as therapeutic or non-therapeutic on a legal basis, and therefore does not find purely medical categorisation necessarily determinative.<sup>68</sup>

The legal definition provided by the majority in *Marion’s Case* is that a therapeutic procedure is one utilised “to treat some malfunction or disease”,<sup>69</sup> but in his dissenting judgment Brennan J added that the therapeutic category should include procedures “administered for the chief purpose of preventing, removing or ameliorating a cosmetic deformity, a pathological condition or a psychiatric disorder”.<sup>70</sup> Brennan J also suggested that a procedure must be “appropriate for and proportionate to the purpose for which it is administered”<sup>71</sup> in order to be considered therapeutic. More recently, in *Re Jamie*, Bryant CJ appears to have aligned the definition of therapeutic to that given by Brennan J as “treatment in response to a disorder, even a psychological or psychiatric one”.<sup>72</sup>

The use of the terminology of “disorder” by Brennan J and subsequently Bryant CJ has given the medical profession a perception of ownership over the determination of “therapeutic”. Within medical literature “intersex” has been perceived as a pejorative term,<sup>73</sup> and since 2006 the majority of medical literature instead uses the term “disorders of sex development”. The originating definition of the newly coined term provided that “‘*disorders of sex development*’ (DSD) [is] defined by congenital conditions in which development of chromosomal, gonadal, or anatomic sex is atypical”.<sup>74</sup> The label “disorders of sex development” is the subject of scholarly debate and research,<sup>75</sup> as well as an attempted softening to “differences of sex development”, designed to maintain the same initials DSD.<sup>76</sup> More recently, commentators on the subject – largely outside the medical profession – have adopted the terminology “variations of sex anatomy”,<sup>77</sup> used to mean either “intersex” broadly or to refer to “ambiguous genitalia” more specifically.<sup>78</sup> Presently, there does not appear to be any ill-feeling

<sup>66</sup> The terms “therapeutic” and “non-therapeutic” have a mixed history within the Family Court, with several judges preferring not to use this terminology. Even in *Secretary, Department of Health and Community Services v JWB and SMB (Marion’s Case)* (1992) 175 CLR 218, 250, the majority judges stated: “We hesitate to use the expressions ‘therapeutic’ and ‘non-therapeutic’, because of their uncertainty. But it is necessary to make the distinction, however unclear the dividing line may be.” Whether used universally or otherwise, “therapeutic” remains a useful term in considering the principles it intends to project.

<sup>67</sup> Victorian Department of Health and Human Services, n 15.

<sup>68</sup> *Re A* (1993) 16 Fam LR 715, 720; *Re Alex* (2004) 180 FLR 89, [27]; *Re Bernadette (Special Medical Procedure)* (2010) 244 FLR 242, [113]-[114]; *Re Sean and Russell (Special Medical Procedures)* (2010) 258 FLR 192, [99]; *Re Jamie* (2013) 278 FLR 155, [66]-[79], [180]-[182]; *Re Lucy (Gender Dysphoria)* (2013) 286 FLR 327, [99]; *Re Sam and Terry (Gender Dysphoria)* (2013) 49 Fam LR 417, [97]-[99].

<sup>69</sup> *Secretary, Department of Health and Community Services v JWB and SMB (Marion’s Case)* (1992) 175 CLR 218, 243.

<sup>70</sup> *Secretary, Department of Health and Community Services v JWB and SMB (Marion’s Case)* (1992) 175 CLR 218, 269.

<sup>71</sup> *Secretary, Department of Health and Community Services v JWB and SMB (Marion’s Case)* (1992) 175 CLR 218, 269.

<sup>72</sup> *Re Jamie* (2013) 278 FLR 155, [98].

<sup>73</sup> Lee et al, n 8, e488; Hewitt et al, n 5, 1.

<sup>74</sup> Lee et al, n 8, instigated the renaming, which has been followed throughout medical literature despite being the subject of continued debate. See n 8 and references therein.

<sup>75</sup> Davis, n 8; Paterski et al (2010), n 8; Clune-Taylor, n 8.

<sup>76</sup> C Wiesemann et al, “Ethical Principles and Recommendations for the Medical Management of Differences of Sex Development (DSD)/Intersex in Children and Adolescents” (2010) 169(6) *European Journal of Pediatrics* 671, 671.

<sup>77</sup> [Zwischengeschlecht.org](http://Zwischengeschlecht.org), [Intersex.ch](http://Intersex.ch) and [SI Selbsthilfe Intersexualitat](http://SI.Selbsthilfe.Intersexualitat.org), n 10, 7.

<sup>78</sup> Intersex Society of North America, *What is Intersex?* <[http://www.isna.org/faq/what\\_is\\_intersex](http://www.isna.org/faq/what_is_intersex)>.

towards this terminology from intersex advocates,<sup>79</sup> but the medical profession has not shown any signs of adopting terminology that is less clinicalised than their preferred “disorders of sex development”.<sup>80</sup> The medical profession’s insistence on utilising its own terminology for conditions that have broad social, legal, and personal impacts, in addition to any medical aspects, is symptomatic of its wider approach to intersex as a whole.

Notwithstanding the ongoing debate, 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 SMPs.<sup>81</sup> 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”<sup>82</sup> suggests that medical nomenclature should not be taken at face value where there is evidence to the alternative nature of any given condition. In addition, the Court must consider whether a procedure is non-therapeutic by virtue of being “performed as a matter of routine for religious or social purposes”.<sup>83</sup> Naming intersex a “disorder” is not enough to escape the scope of SMPs; it is also essential that it is conducted for physical or psychiatric health, and not for social inclusion or parental comfort.

Some intersex conditions, including CAH, can involve life-threatening symptoms such as salt-wasting,<sup>84</sup> which requires immediate medical attention in order for the child to survive.<sup>85</sup> Other conditions, such as epispadias,<sup>86</sup> cloacal exstrophy,<sup>87</sup> and cryptorchidism,<sup>88</sup> may feature physical symptoms that require immediate surgical attention in order for the child to survive, or to function adequately in childhood. Clearly, medical intervention for these conditions – provided it is limited to addressing purely the medical emergency and not some perceived cosmetic function – is not only urgent but patently therapeutic.

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<sup>79</sup> For example, high-profile intersex advocacy organisations, Intersex Society of North America (no longer operating) and Organisation Intersex International, have used the terms in their own literature, and although they have been openly critical of DSD terminology neither has in any way criticised these alternative terms.

<sup>80</sup> Lee et al, n 17.

<sup>81</sup> Hewitt et al, n 5.

<sup>82</sup> *Re A* (1993) 16 Fam LR 715, 720; *Re Alex* (2004) 180 FLR 89, [27]; *Re Bernadette* (2010) 244 FLR 242, [113]-[114]; *Re Sean and Russell* (2010) 258 FLR 192, [99]; *Re Jamie* (2013) 278 FLR 155, [66]-[79], [180]-[182]; *Re Lucy* (2013) 286 FLR 327, [99]; *Re Sam and Terry* (2013) 49 Fam LR 417, [97]-[99]; *Re Martin* [2015] FamCA 1189, [34], [36].

<sup>83</sup> *Re Jane* (1988) 85 ALR 409, 440; cited with approval in *Secretary, Department of Health and Community Services v JWB and SMB (Marion’s Case)* (1992) 175 CLR 218, 242-243.

<sup>84</sup> Salt-wasting is an excessive loss of essential bodily salts through over-activity in the kidneys. If left untreated it leads to increasingly severe dehydration. See A Dauber, M Kellogg and JA Majzoub, “Monitoring of Therapy in Congenital Adrenal Hyperplasia” (2010) 56(8) *Clinical Chemistry* 1245, 1245.

<sup>85</sup> Wilson, n 8, 339; Parisi et al, n 8, 348.

<sup>86</sup> Epispadias, and the less severe but related condition hypospadias, are two of the conditions not universally agreed upon as falling within the “intersex” umbrella. For disagreeing viewpoints, see, eg Vidal et al, n 8; G Ocal “Current Concepts in Disorders of Sexual Development” (2011) 3 *Journal of Clinical Research in Pediatric Endocrinology* 105. The Royal Children’s Hospital Melbourne Disorder of Sex Development Multidisciplinary Team (n 5) advised the 2013 Senate Inquiry that hypospadias and similar “significant penis anomalies” do fall within “international criteria for intersex or DSD”, so it is clear that Australian protocols consider these conditions to fall within intersex categorisation. Neither condition necessarily features any related endocrine disorder, although it can occur concurrently with recognised intersex endocrine disorders, and is frequently found concurrently with microphallus/micropenis. Epispadias refers to a urinary opening situated on the top side of the penis, rather than at the tip; hypospadias refers to a urinary opening instead situated on the underside of the penis.

<sup>87</sup> Parisi et al, n 8, 350; The Royal Children’s Hospital Melbourne Disorder of Sex Development Multidisciplinary Team, n 5, 3. Cloacal exstrophy refers to lower digestive, and/or urinary processing, organs located outside the abdominal cavity. It is occasionally accompanied by a sealed anus and/or splitting of the external genitalia.

<sup>88</sup> Parisi et al, n 8, 348; The Royal Children’s Hospital Melbourne Disorder of Sex Development Multidisciplinary Team, n 5, 4. Cryptorchidism refers to the absence of one or both testes from the scrotum. Testes may be undescended, partly descended, “wandering” in other locations of the body such as the thigh or perineum, undeveloped, abnormal or entirely non-existent.

However, medical intervention purely for the purposes of “normalising” a child’s physiological representation of sex is more accurately ascribed to “social purposes”.<sup>89</sup> The RCHM provided the Senate Inquiry<sup>90</sup> with three grounds for continued early surgical intervention on intersex children’s bodies even when their lives were not at risk: “satisfactory/good anatomical and cosmetic outcomes” when surgery is conducted in early childhood; “potential negative impacts ... of psychosexual wellbeing” when surgery is delayed until the child is able to provide their own input to the decision; and “the clinical experience that surgery undertaken in teenagers is actually more difficult”.<sup>91</sup> These grounds appear to support the concept that psycho-social outcomes are valued above concerns for physical integrity, sexual identity, and risk of negative outcomes for the intersex infant. Medical procedures conducted with these motivations should be found to be non-therapeutic.

If it is accepted that non-urgent medical procedures on intersex children are non-therapeutic, the remaining determinative factors of SMP must then also be considered. Medical procedures conducted on intersex children are also 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.<sup>92</sup> 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.<sup>93</sup>

Furthermore, while there is no risk of wrong decisions being made about the competence of intersex children under the age preferred by surgeons for surgical intervention (two years old),<sup>94</sup> there is proven risk of inappropriate, or incorrect, sex selection, which can only be deemed to be contrary to the best interests of the child.<sup>95</sup> The consequences of a wrong decision can include the outcomes of those same risks, namely persistent and intrusive dissatisfaction with sex,<sup>96</sup> but also unhappiness with physical appearance and functionality.<sup>97</sup> In some cases, it can also result in sterilisation, which is not only grave in itself but the impact can stretch beyond dissatisfaction into grave psychological damage.<sup>98</sup> Some intersex persons report clinically diagnosable trauma as a result of medical interventions, and grief at the loss of bodily integrity.<sup>99</sup> As Creighton observes: “Adult patients are unhappy and feel mutilated and damaged by surgery performed on them as young children, however worthy the clinician’s motives.”<sup>100</sup>

“Treatment” of intersex is predominantly non-therapeutic: it is invasive, irreversible and major; it carries significant risk of wrong decisions being made about the short and long-term interests of the child involved; and the consequences of those wrong decisions can be particularly grave. Application of the requirements for SMPs appears to clearly demonstrate that medical “treatment” of intersex children should require court authorisation, but the reasons why Australian law has failed to intervene to protect the bodies of children from surgical and hormonal intervention designed to allocate them a

<sup>89</sup> *Re Jane* (1988) 85 ALR 409, 440.

<sup>90</sup> Senate Community Affairs References Committee, n 3.

<sup>91</sup> The Royal Children’s Hospital Melbourne Disorder of Sex Development Multidisciplinary Team, n 5, 6.

<sup>92</sup> Victorian Department of Health and Human Services, n 15, 22.

<sup>93</sup> *Re Leo* (2015) 52 Fam LR 533, [9].

<sup>94</sup> Ahmed and Rodie, n 15, 348.

<sup>95</sup> Victorian Department of Health and Human Services, n 15, 23.

<sup>96</sup> Parisi et al, n 8, 355; Hewitt et al, n 5, 4.

<sup>97</sup> Ahmed and Rodie, n 15, 215.

<sup>98</sup> Victorian Department of Health and Human Services, n 15, 23.

<sup>99</sup> Jones et al, n 20, 123.

<sup>100</sup> S Creighton, “Surgery for Intersex” (2001) 94(5) *Journal of the Royal Society of Medicine* 218, 220.

physical sex are far less clear. Although the Family Court has reported judgments on six cases<sup>101</sup> involving a total of seven intersex children, only one case involved a child whose age fell within the medically preferred timeframe for surgical sex assignment.<sup>102</sup> Five of the six cases were requests for the removal of internal testicular tissues only, without accompanying “genital normalisation” or otherwise sex-affecting surgery.<sup>103</sup> In these five cases, the Court found that the risk of cancer inherent in internal testes rendered, or contributed to rendering, the procedures in the child’s best interests,<sup>104</sup> although the cancer risk did not in itself render the proposed “treatments” therapeutic. As a result, in two cases the proposed “treatments” were deemed SMPs;<sup>105</sup> in one case the “treatment” proposed was found to be therapeutic on other grounds, as well as not to be invasive or major;<sup>106</sup> and in the fourth case it was found that there was no risk of parental conflict with the best interests of the child, and the risk of cancerous malignancy was so severe that parental consent was deemed to be sufficient.<sup>107</sup> In all six cases any required future follow-up medical procedures were also pre-authorized.<sup>108</sup>

In the most recent case, *Forrest J* was invited to make a finding on the submission that court authorisation was not required for sterilisation-type procedures on intersex children.<sup>109</sup> The Court was asked to authorise procedures to remove all gonadal tissue from Carla, a five-year-old intersex child who had already undergone surgical procedures to feminise genitals that were medically considered ambiguous at birth.<sup>110</sup> Those “feminising” procedures had already been conducted without submission to the Court, and no discussion was raised as to the validity of parental authority for those procedures. Contrary to the earlier finding in *Re Lesley*,<sup>111</sup> *Forrest J* held that the procedures that the Court had been asked to authorise, those removing gonadal material, similarly required no submission to or authorisation from the Family Court.<sup>112</sup> *Forrest J* made no comment on the earlier “feminising” surgeries, seemingly accepting that such procedures were unquestionably within the authority of parents to authorise. The sole concern of the Court was whether removal of Carla’s gonadal tissue “fell ‘squarely within the principles enunciated in *Marion’s case*’”.<sup>113</sup> *Forrest J* concluded that the proposed surgical procedure, and any follow-up medical or surgical procedures, were best classified as therapeutic.<sup>114</sup> *Re Carla* signals a regression in the Court’s understanding of the needs of intersex children, and the adults they will grow into.

Decades earlier, in the judgment on the single case that authorised genital-affecting surgery, *Re A*, the Family Court accepted that the surgery requested did require court authorisation, was not merely therapeutic, and was in the child’s best interests.<sup>115</sup> However, that case concerned a child who was

<sup>101</sup> *Re A* (1993) 16 Fam LR 715; *Re Lesley (Special Medical Procedure)* [2008] FamCA 1226; *Re Sally (Special Medical Procedure)* [2010] FamCA 237; *Re Sean and Russell* (2010) 258 FLR 192; *Re Sarah* [2014] FamCA 208; *Re Carla (Medical Procedure)* (2016) 54 Fam LR 576.

<sup>102</sup> *Re Sean and Russell* (2010) 258 FLR 192, [1].

<sup>103</sup> *Re Lesley* [2008] FamCA 1226, [6]; *Re Sally* [2010] FamCA 237, [5]; *Re Sean and Russell* (2010) 258 FLR 192, [97]; *Re Sarah* [2014] FamCA 208, [4].

<sup>104</sup> *Re Lesley* [2008] FamCA 1226, [46]; *Re Sally* [2010] FamCA 237, [72]; *Re Sean and Russell* (2010) 258 FLR 192, [152], [179]; *Re Sarah* [2014] FamCA 208, [42].

<sup>105</sup> *Re Lesley* [2008] FamCA 1226, [38]; *Re Sally* [2010] FamCA 237, [26].

<sup>106</sup> *Re Sarah* [2014] FamCA 208, [25].

<sup>107</sup> *Re Sean and Russell* (2010) 258 FLR 192, [100]-[101].

<sup>108</sup> *Re A* (1993) 16 Fam LR 715, 722; *Re Lesley* [2008] FamCA 1226; *Re Sally* [2010] FamCA 237; *Re Sean and Russell* (2010) 258 FLR 192.

<sup>109</sup> *Re Carla* (2016) 54 Fam LR 576, [8].

<sup>110</sup> *Re Carla* (2016) 54 Fam LR 576, [2].

<sup>111</sup> *Re Lesley* [2008] FamCA 1226.

<sup>112</sup> *Re Carla* (2016) 54 Fam LR 576, [7]-[9].

<sup>113</sup> *Re Carla* (2016) 54 Fam LR 576, [36], citing *Re Lesley* [2008] FamCA 1226, [38] (emphasis in original).

<sup>114</sup> *Re Carla* (2016) 54 Fam LR 576, [7]-[9].

<sup>115</sup> *Re A* (1993) 16 Fam LR 715, 721.

undergoing surgery that amounted not to a sex assignment, but to a sex reassignment. The child in question was born intersex and assigned female at birth in a process that included genital surgery, with no oversight from the Court. During A’s childhood, she did not receive adequate doses of the hormonal medication prescribed to maintain her appearance and pubertal progression as female, and her body virilised as puberty commenced.<sup>116</sup> A grew at a rate more expected of a boy, her body shape became more masculine, and her external genitals began to look more like male genitalia.<sup>117</sup> A reported that she “felt like a boy”.<sup>118</sup> An application was made to the Court to medically reassign A from the female genital appearance she had been given to the male appearance her body had adopted and was continuing to develop. As a result, despite featuring as an intersex child, the medical and surgical procedures requested and the effect on A’s self and legal identities are more strongly analogous to the existent transgender cases than to the other intersex cases. It demonstrates that the sex/gender identity and medical categorisation of the child applicant appears to hold stronger influence over the Court than does the actual procedure that is the subject of the application. It also shows that the principles applying to SMP transgender cases are applicable to intersex children, potentially to the point of rendering them indistinguishable. The legal similarities between sex reassignment in transgender children and so-called sex assignment of intersex children are so compelling that even the Family Court has struggled to enunciate the difference.<sup>119</sup>

Medical procedures on intersex children should be classified as SMPs as defined in *Marion’s Case*. Intersex cases that have been brought to the Family Court have already found sex-affecting procedures performed on intersex children to fall within SMPs. The Family Court’s determination that sterilisation-type procedures on intersex children necessarily serve a therapeutic function and therefore do not require court authorisation is patently inconsistent with other applications of the SMP requirements by the Court.

## INTERSEX IN AUSTRALIAN LAW AND “SEX REASSIGNMENT”

Medical intervention on intersex children that are not *Gillick* competent should properly be an SMP. As a result, the current practice in Australia is wrong. The psycho-social reasons given for performing these procedures reflect an outdated and discriminatory approach to the understanding of sex and gender in Australia. The law has demonstrated that it recognises and adopts these understandings in existing case law concerning SMPs in the Family Court involving transgender children and teens. In those cases, the Court is very concerned that the types of procedures featuring in the “treatment” of intersex children seem to involve the same considerations that have necessarily required court authorisation. Medical practitioners who perform these operations on intersex children, in the absence of a life-threatening complication or without the approval of the Family Court under SMPs, expose themselves to criminal and civil liability. The best approach to intersex children is to leave them alone and allow them to make decisions about their sexual morphology and identity when they attain competence to give their own consent.

On 1 August 2013, amendments to the *Sex Discrimination Act 1984* (Cth) provided a current accepted legal definition of intersex. This definition is also found within the *Legislation Act 2001* (ACT),<sup>120</sup> and refers to intersex as a “status” rather than as a “sex”:

Intersex status means the status of having of 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.<sup>121</sup>

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<sup>116</sup> *Re A* (1993) 16 Fam LR 715, 717-718.

<sup>117</sup> *Re A* (1993) 16 Fam LR 715, 717.

<sup>118</sup> *Re A* (1993) 16 Fam LR 715, 717.

<sup>119</sup> *Re A* (1993) 16 Fam LR 715.

<sup>120</sup> *Legislation Act 2001* (ACT) s 169B.

<sup>121</sup> *Sex Discrimination Act 1984* (Cth) s 4.

With this legal recognition of intersex as something defined outside the medical realm as something other than purely a medical disorder, the psycho-social justifications for sex-affecting surgery on children are immediately diminished. Arguments that children *must* be physically categorised as either male or female with a degree of urgency are no longer valid, and the medical call for “normalisation” is similarly outdated. It is no longer arguable that intersex is a status recognised only by medicine, or that it is a condition or disorder that must immediately be brought to an acceptable, ordered, healthy state. Once intersex is accepted as an example of diversity of sexual physiology rather than as a medical disorder,<sup>122</sup> medical responses cannot be seen to fulfil an adequate definition of “treatment”. The question of the therapeutic nature of “treatment” for intersex can therefore be resolved unequivocally: non-emergency procedures that are not essential to life-sustaining function are non-therapeutic.

Furthermore, with the added weight of governmental guidelines,<sup>123</sup> State and Territory legislation,<sup>124</sup> and case law<sup>125</sup> also acknowledging that neither sex nor gender need be simply male or female, the legal processes involved in sex-reassignment procedures for transgender persons, and sex-assignment procedures for intersex persons become identical. Intersex infants are not children with no sex or sex identity: in the eyes of the law they are children with sex other than purely male or female. The process of surgically allocating these children to a male or female sex morphology, then, is also a sex reassignment in legal terms. Sex reassignment of children has been considered at length, over a period of decades, by the Family Court.

To the extent that the law is concerned with medical detail, the medical processes involved in gender reassignments of transgender teens and pre-teens are very similar to some of the “treatment” recommended for intersex infants. Sex reassignment is a multi-staged process when referring to sex reassignment from male to female, or female to male, which the majority of the relevant Family Court cases concern. It is described as being conducted in three key stages. If the child has not yet completed full puberty, the first stage involves the prescription of hormonal medication to prevent puberty in the sex of birth between the ages of approximately 12 and 16 years.<sup>126</sup> The second stage, consisting of hormonal medication prescribed after the age of 16,<sup>127</sup> induces puberty in the so-called “destination” sex. The third stage is surgery, which can include modification to the genitals, secondary sex characteristics, and/or general body shape. Stages 2 and 3 are not reversible for the purposes of establishing whether they constitute SMPs.<sup>128</sup>

All reported Family Court cases concerning sex reassignment from male to female or female to male authorised the transgender children to commence hormonal medication. Non-*Gillick*-competent children who were able to express their wishes have never received court authorisation for complete Stage 3 sex-reassignment surgery. Meanwhile, exactly the same sort of surgical intervention is being carried out on intersex children who cannot communicate their wishes, with no oversight of the Court at all.<sup>129</sup>

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<sup>122</sup> *Re Kevin (Validity of Marriage of Transsexual)* (2001) 165 FLR 404; *Re Bernadette* (2010) 244 FLR 242.

<sup>123</sup> Australian Government, *Australian Government Guidelines on the Recognition of Sex and Gender* (2013) 2-3.

<sup>124</sup> For example, *Births, Deaths and Marriages Registration Act 1995* (NSW) s 32A(b); *Births, Deaths and Marriages Registration Act 2003* (Qld) Sch 2, definition of “sexual reassignment surgery”; *Births, Deaths and Marriages Registration Act 1997* (ACT) s 24; *Births, Deaths and Marriages Registration Act* (NT) s 28A.

<sup>125</sup> *NSW Registrar of Births, Deaths and Marriages v Norrie* (2014) 250 CLR 490, [1].

<sup>126</sup> PT Cohen-Kettenis, HA Delemarre-van de Waal and LJJ Gooran, “The Treatment of Adolescent Transsexuals: Changing Insights” (2008) 5 *Journal of Sexual Medicine* 1982, 1894.

<sup>127</sup> Cohen-Kettenis, Delemarre-van de Waal and Gooran, n 126, 1894.

<sup>128</sup> *Re Jamie* (2013) 278 FLR 155, [140]. In *Re Leo* (2015) 52 Fam LR 533, Rees J noted the possibility that Stage 2 may be better classified as “partially reversible”, but was not required to draw any conclusions on that point as the case was determined by a finding of *Gillick* competence.

<sup>129</sup> Victorian Department of Health and Human Services, n 15, 3.

In part this has been considered allowable by the labelling of surgery on the bodies of intersex children as “normalisation”, and the labelling of intersex as a “disorder”. This labelling is increasingly untenable when Australian law recognises intersex as a legally accepted sex. It has also been considered allowable by the categorisation of medical procedures on the bodies of intersex infants being labelled sex assignment, rather than reassignment; however, as Australian law recognises that sex is not confined to male and female, medical efforts to ensure intersex infants fit the physical representation of one of those two sexes cannot accurately be referred to as sex assignment.

The procedures conducted on intersex infants are fundamentally similar to those conducted on transgender children, but with one significant difference: in “treatment” for intersex, surgery is often performed first, with hormonal and other medical intervention following<sup>130</sup> to ensure that the infant’s body continues to function in the sex it has purportedly been assigned. The stages the Family Court perceives to be highly invasive and irreversible and therefore to require court approval for transgender children are the very same stages that the medical profession are conducting on intersex children, preferably under the age of two,<sup>131</sup> with no legal oversight whatsoever.

By way of labelling sex reassignment for transgender children and teens as an SMP, the Court is pursuing the objective of protecting children from their own and their parents’ decisions,<sup>132</sup> and ensuring the child’s best interests are upheld. The Court’s role and responsibility is to protect intersex children in the same way: if a less invasive stage of the same procedure is regulated for teens and pre-teens, then there is even stronger reason for a more invasive stage to be regulated by courts for babies and young children. Failure to regulate for the protection of intersex children, while regulating the same procedure for the protection of children and teens who in the eyes of the law are also infants, represents a significant legal inconsistency.

If both have the same legal outcome, and both fulfil the legal requirements for SMPs, there is no obvious reason for the law to treat intersex children any differently from the way the law treats transgender children and teens. There appears to be an inherent conflict within Australian law: it offers strong protection to one group of children from harms against their bodies and their sex and gender identities, but does not protect another. If a less invasive stage of the same procedure is regulated for teens and pre-teens, then there is even stronger reason for a more invasive stage to be regulated for babies.

As medical interventions on intersex children are properly categorised as SMPs, consent cannot be provided for such “treatment” by legal guardians. Medical practitioners who conduct surgical and other medical procedures on intersex children without approval from the Court open themselves to criminal and civil liability.<sup>133</sup> Consent is a defence to criminal assault, but if consent has not been given validly the defence is not effective.<sup>134</sup> The seriousness of assault increases with the damage inflicted on the body, so surgeons conducting sex assignment on intersex children could face severe criminal charges up to and including grievous bodily harm.<sup>135</sup> Every medical professional who persists with psycho-socially motivated sex-assignment procedures on intersex children without court approval remains at risk of criminal liability.

So too consent is a defence to trespass to the person under tort, but if the consent has not been validly given the defence is not effective.<sup>136</sup> Adults who have undergone sex assignment as children report that the procedures significantly impact their lives, in some cases leading them to require further

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<sup>130</sup> Brain et al, n 20, 340.

<sup>131</sup> Ahmed and Rodie, n 15, 13.

<sup>132</sup> *Secretary, Department of Health and Community Services v JWB and SMB (Marion’s Case)* (1992) 175 CLR 218, 249-250.

<sup>133</sup> *Secretary, Department of Health and Community Services v JWB and SMB (Marion’s Case)* (1992) 175 CLR 218.

<sup>134</sup> *Reeves v The Queen* (2013) 227 A Crim R 444.

<sup>135</sup> *Reeves v The Queen* (2013) 227 A Crim R 444.

<sup>136</sup> *Dean v Phung* [2012] Aust Torts Reports 82-111; *Finch v Southern Health* [2004] VCC 44.

physical interventions as extreme as sex-reassignment surgery as adults.<sup>137</sup> The psychological impact of childhood sex-affecting medical “treatment” can also be severe, affecting self-identity as well as psychological wellbeing.<sup>138</sup> The quantum of damages increases with the damage inflicted, so doctors and surgeons conducting sex assignment on intersex children could face significant awards made against them. Every medical professional who persists with psycho-socially motivated sex-assignment procedures on intersex children without court approval remains at risk of civil liability.

Between January 2015 and April 2016 inclusive, 24 judgments concerning transgender teens were released by the Family Court of Australia.<sup>139</sup> In 20 of these cases, the issue of genital surgery was avoided entirely due to findings that the transgender applicants, aged between 15 and 17, were *Gillick* competent.<sup>140</sup> The decisions rendered each applicant thereby entitled to authorise their own medical procedures, including surgery as well as hormonal treatment.<sup>141</sup> These cases appear to indicate a trend towards a court preference for self-determination by transgender children; and even in those cases in which the applicant was not found *Gillick* competent, the Court placed significant weight on the child’s own wishes in finding that the procedures requested were in the best interests of the child.

These recent judgments each constitute an acknowledgment by the Family Court that people should, wherever possible, be permitted to make decisions that affect their own sex and/or gender identity and expression. Until intersex children are able to make legally competent decisions about their own bodies, the role of the Family Court remains “to ensure that the best interests of children are met” and that means delaying non-reversible surgical interventions.<sup>142</sup> Sex reassignments of intersex infants should only be considered in cases that are urgent; otherwise, decisions as to sex reassignment should “reasonably await the acquisition of *Gillick* competence”.<sup>143</sup> Authorisation of non-therapeutic invasion into children’s bodies, and manipulation of children’s sex, should never be permitted “if there is any real possibility that, at some future time, the child will acquire the capacity and maturity to choose”.<sup>144</sup>

## CONCLUSION

The current practice of medical intervention on the bodies of intersex children in Australia is wrong. It is wrong because the level of intervention on the child’s body should properly be seen as an SMP and as such requires the oversight of the Family Court. It is further wrong because the underlying psycho-social motivations, based on a binary conception of sex, are outdated and, indeed, are discriminatory under Australian law. Finally, it is wrong because where the Family Court is being asked to approve SMPs that involve transgender children the Court does not approve the sort of extreme and invasive surgery that is being routinely performed on intersex children under the age of

<sup>137</sup> Ahmed and Rodie, n 15, 215.

<sup>138</sup> Parisi et al, n 8, 355; Hewitt et al, n 5, 4.

<sup>139</sup> *Re Leo* (2015) 52 Fam LR 533; *Re Xanthe* [2015] FamCA 116; *Re Jordan* [2015] FamCA 175; *Re Janson* [2015] FamCA 499; *Re Drew* [2015] FamCA 784; *Re Ashley* [2015] FamCA 373; *Re Christopher* [2015] FamCA 454; *Re Jamie* [2015] FamCA 455; *Re Dale* [2015] FamCA 473; *Re Sasha* [2015] FamCA 785; *Re Julian* [2015] FamCA 562; *Re Flynn* [2015] FamCA 629; *Re Kate* [2015] FamCA 705; *Re Karsen* [2015] FamCA 733; *Re Marley* [2015] FamCA 878; *Re Cameron* [2015] FamCA 1113; *Re Jacinta* [2015] FamCA 1196; *Re Martin* [2015] FamCA 1189; *Re Logan* [2016] FamCA 87; *Re George* [2016] FamCA 136; *Re Marco* [2016] FamCA 187; *Re Emery* [2016] FamCA 240; *Re Lincoln* [2016] FamCA 267; *Re Harley* [2016] FamCA 334.

<sup>140</sup> *Re Leo* (2015) 52 Fam LR 533, [51]; *Re Xanthe* [2015] FamCA 116, [31]; *Re Janson* [2015] FamCA 499, [25]; *Re Drew* [2015] FamCA 784, [32]; *Re Ashley* [2015] FamCA 373, [60]; *Re Christopher* [2015] FamCA 454, [58]; *Re Jamie* [2015] FamCA 455, [86]; *Re Dale* [2015] FamCA 473, [76]; *Re Sasha* [2015] FamCA 785, [54]; *Re Julian* [2015] FamCA 562, [66]; *Re Flynn* [2015] FamCA 629, [71]; *Re Kate* [2015] FamCA 705, [60]-[61]; *Re Jacinta* [2015] FamCA 1196, [17]; *Re Martin* [2015] FamCA 1189, [49]; *Re Logan* [2016] FamCA 87, [74]; *Re George* [2016] FamCA 136, [23]; *Re Marco* [2016] FamCA 187, [64]; *Re Emery* [2016] FamCA 240, [60]; *Re Lincoln* [2016] FamCA 267, [36]; *Re Harley* [2016] FamCA 334, [65].

<sup>141</sup> *Re Colin (Gender Dysphoria)* [2014] FamCA 449, [54]; *Re Spencer* [2014] FamCA 310, [46]; *Re Leo* (2015) 52 Fam LR 533, [51], referring to Order 2.

<sup>142</sup> Family Court Act 1975 (Cth) s 60B.

<sup>143</sup> *Re Sean and Russell* (2010) 258 FLR 192, [86].

<sup>144</sup> *Secretary, Department of Health and Community Services v JWB and SMB (Marion’s Case)* (1992) 175 CLR 218, 320.



two. Medical practitioners who perform these operations on intersex children, in the absence of a life-threatening complication or without the approval of the Family Court under SMPs, expose themselves to criminal and civil liability. The best and most legally appropriate approach to intersex children is to leave them alone and allow them to make decisions about their sexual morphology when they attain competence to give their own consent.